DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 424, 485, and 489

[BPD–825–FC]

RIN 0938–AG95

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1996 Rates

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

ACTION: Final rule with comment period.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In addition, in the addendum to this final rule, we are describing changes in the amounts and factors necessary to determine prospective payment 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, 1995. We are also setting forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are setting forth several requirements concerning Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs), in accordance with provisions of the Social Security Act Amendments of 1994.

DATES: *Effective Date:* This final rule is effective on October 1, 1995, except that revised § 412.46 (concerning the physician attestation requirement for inpatient claims) is effective September 1, 1995.

Comments: Comments on revised § 485.645 (concerning the requirements for RPCH providers of long-term care services (''swing beds'')) will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 31, 1995. We will not consider comments concerning any other issue.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–825–FC, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, or Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–825–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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FOR FURTHER INFORMATION CONTACT:
Nancy Edwards, (410) 786–4531, Operating Prospective Payment, DRG, Wage Index Issues.
Tzvi Hefter, (410) 786–4529, Capital Prospective Payment, Excluded Hospitals, EACH, RPCH.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), 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 was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment for hospital inpatient operating costs is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. On September 1, 1994, we published a final rule with comment period (59 FR 45330) to implement changes to the prospective payment system for hospital operating costs beginning with Federal fiscal year (FY) 1995.

For cost reporting periods beginning before October 1, 1991, hospital inpatient operating costs were the only costs covered under the prospective payment system. Payment for capital-related costs had been made on a reasonable cost basis because, under sections 1886 (a)(4) and (d)(1)(A) of the Act, those costs had been specifically excluded from the definition of inpatient operating costs. However, section 4006(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) revised section 1886(g)(1) of the Act to require that, for hospitals paid under the prospective payment system for operating costs, capital-related costs would also be paid under a prospective payment system effective with cost reporting periods beginning on or after October 1, 1991. As required by section 1886(g) of the Act, we replaced the reasonable cost-based payment methodology with a prospective payment methodology for hospital inpatient capital-related costs. Under the new methodology, effective for cost reporting periods beginning on or after October 1, 1991, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs. (See subpart M of 42 CFR part 412, and the August 30, 1991, final rule (56 FR 43358) for a complete discussion of the prospective payment system for hospital inpatient capital-related costs.)

B. Major Contents of the Provisions of the June 2, 1995 Proposed Rule

On June 2, 1995, we published a proposed rule in the **Federal Register** (60 FR 29202) setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs, as well as changes affecting hospitals excluded from those payment systems. The following is a summary of the major changes that we proposed to make:

- We proposed changes for FY 1996 DRG classifications and relative weighting factors as required by section 1886(d)(4)(C) of the Act.
- We proposed to update the wage index for FY 1996. Specific issues included allocation of general service salaries and hours to excluded areas, and revisions to the wage index based on hospital redesignations.

• We also proposed revisions to the criteria for seeking MGCRB reclassification and discussed comments received on alternative labor market areas.

• We discussed several provisions of the regulations in 42 CFR parts 412, 424, and 485 and set forth certain proposed changes concerning the following:

—Payment for transfer cases.
—Rural referral centers.
—Determination of number of beds in determining the indirect medical education adjustment.
—Disproportionate share adjustment.
—Essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs).
—Rebasing the hospital market baskets.

• We discussed several provisions of the regulations in 42 CFR part 412 concerning the prospective payment system for capital related costs and set forth certain proposed changes concerning the following:

—New update framework.
—Specific adjustment for taxes to the capital prospective payment system Federal rate.

• We discussed changes to the regulations at 42 CFR parts 412 and 413 for hospitals and hospital units excluded from the prospective payment system. The proposed changes concerned the following:

—Requirements for certain long-term care hospitals excluded from the prospective payment systems.
—Payment window for preadmission services.
—Criteria for exclusion.
—Request for payment adjustment.

• In the addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1996 prospective payment rates for operating costs and capital-related costs. We also proposed new update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 1996 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 our technical appendix on the proposed FY 1996 capital acquisition model.

• In Appendix C to the proposed rule as corrected (60 FR 39304, August 2, 1995), we included our report to Congress on our initial estimate of an update factor for FY 1996 for both hospitals included in and hospitals excluded from the prospective payment systems as required by section 1886(e)(3)(B) of the Act.

• As required by sections 1886 (e)(4) and (e)(5) of the Act, in Appendix D, we provided our recommendation of the appropriate percentage change for FY 1996 for the following:

—Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community hospitals) for hospital inpatient services paid for under the prospective payment system for operating costs.
—Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

• In the proposed rule, we discussed in detail the March 1, 1995 recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(e)(2)(A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average standardized amounts. In addition, section 1886(e)(2)(B) of the Act directs ProPAC to make recommendations regarding changes in each of the Medicare payment policies under which payments to an institution are prospectively determined. In particular, the recommendations relating to the hospital inpatient prospective payment systems are to include recommendations concerning the number of DRGs used to classify patients, adjustments to the DRGs to reflect severity of illness, and changes in the methods under which hospitals are paid for capital-related costs. Under section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2) (A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We printed ProPAC's March 1, 1995 report, which included its recommendations, as Appendix E of the proposed rule. The recommendations, and the actions we proposed to take with regard to them (when an action is recommended), were discussed in detail in the appropriate sections of the preamble, the addendum, or the appendices to the proposed rule. Set forth below in sections II, III, IV, V, VI, and VII of this preamble, the addendum to this final rule, and the appendices are detailed discussion of the June 2 proposed rule, the public comments received in response to the proposed rule, and the responses to those comments, as well as the changes we are making.

C. Public Comments Received in Response to the June 2 Proposed Rule

A total of 2,006 items of correspondence containing comments on the proposed rule were received timely. Two issues, physician attestation of hospital patient claims and the DRG classification of the procedure for insertion of a coronary artery stent, were the subject of write-in campaigns. We received close to 1,000 letters on physician attestation and over 700 letters on coronary stent. Of the remaining letters, the main areas of concern addressed by the commenters were the following:

• The adjustment for taxes to the capital prospective payment system Federal rate.

• The new requirements for certain long-term hospitals excluded from the prospective payment system.

• The discussion on the definition of a transfer case.

II. Changes to DRG Classifications and Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 1995, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment

system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM). The Medicare fiscal intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

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

Currently, cases are assigned to one of 492 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, principal diagnosis determines MDC assignment. However, there are five DRGs to which cases are assigned on the basis of procedure codes rather than first assigning them to an MDC based on the principal diagnosis. These are the DRGs for liver, bone marrow, and lung transplant (DRGs 480, 481, and 495, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

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

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

We proposed to make several changes to the DRG classification system for FY 1996. These proposed changes, the comments we received concerning them, our responses to those comments, and the final DRG changes, are set forth below.

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

a. Automatic Implantable Cardioverter Defibrillator (AICD) Procedures (DRG 116). For several years, we have received correspondence regarding the appropriate DRG assignment of certain procedures involving automatic implantable cardioverter defibrillators (AICDs). When a patient whose principal diagnosis is classified to MDC 5 (Diseases and Disorders of the Circulatory System) receives a total AICD system implant or replacement (procedure code 37.94), the case is assigned to DRG 104 or 105 (Cardiac Valve Procedures With or Without Cardiac Catheterization). However, for discharges occurring before October 1, 1992, if a procedure was performed that involved the implantation or replacement of only part of the AICD system (that is, replacement or implant of either the leads or pulse generator only), the case was assigned to DRG 120 (Other Circulatory System OR Procedures). Effective with discharges occurring on or after October 1, 1992, these procedures were reclassified to DRG 116 (Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure). In the proposed rule, we presented our analysis of AICD cases based on FY 1994 MedPAR data. We concluded that these cases continue to be appropriately assigned to DRG 116. Therefore, we did not propose any further changes to the DRG assignment. We received two public comments on our analysis and conclusion.

Comment: One commenter commended the continued assignment to DRG 116 of cases in which replacement or implantation of only part of the AICD system is performed. However, the other commenter requested that we change the DRG assignment for these cases to DRG 115 (Permanent Cardiac Pacemaker Implantation with AMI, Heart Failure or Shock). The second commenter stated that the resource use of these patients is similar to those in DRG 115, even though the patients in DRG 115 have much longer lengths of stay.

Response: Since reassignment of these procedures to DRG 116, we have annually analyzed the cases based on the most recent data. Based on data in the latest update of the FY 1994 MedPAR file (June 1995), the average standardized charge for the 2,569 AICD cases assigned to DRG 116 is $27,806. The average standardized charge for all cases in DRG 116 is $19,637 and for DRG 115, is $29,086. The $8,169 difference between the average charge for AICD cases in DRG 116 and all cases in DRG 116 is within the normal range of charges for that DRG. (One standard deviation from the mean of the charges for DRG 116 is $10,512.) We note that, compared to last year's analysis using FY 1993 MedPAR data, the average charge for the AICD cases has decreased slightly as has the difference in charges between all cases in DRG 116 and the AICD cases.

The average length of stay for the AICD cases in DRG 116 is 3.98 days compared to 5.89 days for all cases in DRG 116. However, the length of stay for cases in DRG 115 is 11.8. In general, the patients classified to DRG 115 are seriously ill and the long length of stay supports this contention. We continue to believe that the AICD patients are clinically much more similar to the patients classified to DRG 116 than to those in DRG 115 and that it is the cost of the AICD device that is responsible for the high average charge for these cases and not the intensity of hospital services required to treat the patient.

In the September 1, 1994 final rule (59 FR 45346), we stated our belief that as new AICD devices were approved by the FDA and entered the market, increased competition would result in a decrease in the price of the devices and a corresponding drop in the average charge for a hospital stay for AICD procedures. Second and third generations of several manufacturers' devices are now on the market. In addition, we believe that the slight decrease in average charges seen in the FY 1994 data compared to the FY 1993 data is a direct result of hospitals' ability to obtain AICD devices from multiple sources. (The increase in

charges for AICD cases between the FY 1992 and FY 1993 data was approximately $6,000.) Based on this evidence, we will continue to assign the AICD implant cases to DRG 116 for FY 1996. However, we will reassess this assignment as a part of our FY 1997 DRG analysis in order to verify that the current pattern is maintained.

b. Sympathectomy Procedures. When performed in connection with a principal diagnosis assigned to MDC 5, procedure code 05.24 (presacral sympathectomy) is assigned to DRGs 478 and 479 (Other Vascular Procedures)[1]. However, the four other sympathectomy procedures related to MDC 5 diagnoses are classified to DRG 120 (Other Circulatory System OR Procedures). In order to improve clinical consistency, we proposed to assign procedure code 05.24 to DRG 120 rather than to DRGs 478 and 479.

We received one comment on this proposal, which supported our proposed change. Therefore, we are adopting this change as final.

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

In the September 1, 1994, final rule (59 FR 45341), we stated our intention to improve the classification and relative weights of the DRGs that apply to newborns, children, and maternity patients. Because the Medicare population does not include many of these individuals, the original DRG classification system was developed from analysis of claims data representative of the total inpatient population. Non-Medicare discharge records from Maryland and Michigan hospitals were used to calculate the original Medicare weights for the DRGs to which newborns, children, and maternity patients are classified. Since that time, because of the lack of Medicare data, these low-volume DRGs have not been analyzed and refined, and the relative weights assigned to them may no longer be entirely reflective of the resources needed to treat patients.

Accordingly, we have acquired hospital claims data representative of the total inpatient population for analysis and evaluation. These data, collected and formatted by the Urban Institute under contract with HCFA (Contract 500–92–0024), represent claims for non-Medicare payers from 19 States. The data base contains approximately 17 million discharge records. Using these data, we are evaluating possible modifications to MDC 15 that would better address the requirements for an all-patient population.

As we have not yet completed this evaluation, we did not propose an MDC 15 DRG reclassification structure for FY 1996. However, we did propose to adjust the DRG relative weights for 36 Medicare low-volume DRGs (defined as those DRGs with fewer than 10 cases). These DRGs are generally those assigned to patients age 0–17, many of the neonate and newborn MDC 15 DRGs, and one DRG in MDC 14 (Pregnancy, Childbirth and Puerperium). The proposed DRG relative weights for these low-volume DRGs were calculated based on the non-Medicare data we acquired from the 19 States. We note that, based on the June 1995 update to the FY 1994 MedPAR file, there are only 34 low-volume DRGs in the final recalibration.

During the year, we have received suggestions from the public concerning improvements for the neonate DRG classifications. Among these suggestions have been recommendations concerning specific diagnoses that are currently considered significant problems in determining the assignment of a neonate case to DRG 390 (Neonate with Other Significant Problems) rather than DRG 391 (Normal Newborn). Another issue is the assignment to MDC 15 of discharges with a principal diagnosis of certain congenital defects regardless of the age of the patient. Because the MDC 15 modifications that we are considering should resolve these concerns, we did not propose to revise the assignment of these diagnoses and conditions. Rather, we indicated that we would incorporate the necessary and appropriate assignment of these cases with our overall modification of the neonate DRGs.

Comment: We received two comments on our proposal to base the relative weights for low-volume DRGs on all patient data, both of which supported our proposal. However, one of these commenters objected to the proposed assignment of a weight of 0.1460 to DRG 391 (Normal Newborn), the only DRG within MDC 15 for which the proposed relative weight decreased compared to the previous year's weights. This commenter stated that changes to the relative weight of DRG 391 should be postponed until our evaluation of claims data has been completed.

Response: In previous years, we computed the weight for the low-volume DRGs by adjusting the original weights of these DRGs as calculated based on 1981 bills by the percentage change in the average weight of the cases in the remaining DRGs. Thus, the weight for these DRGs was not based solely on actual experience and was, in some cases, artificially inflated. Using empirical data from more recent actual claims resulted in figures that more accurately reflect current utilization and resource use. We note that of the final 34 low-volume DRGs, only 8 experienced an increase in relative weight based on the all-patient data. Of these eight DRGs, four are in MDC 15. The decrease in the relative weight for DRG 391 is the one exception within that MDC. The decrease in weight is a function of the expanded data base and the difference between applying an automatic percentage increase and calculating a relative weight using an averaging process as we do for the other DRGs. Taking into account the changes in practice for treating normal newborns that have taken place over the last several years, it is not surprising that the weight for DRG 391 has decreased.

In any case, we see no reason why we should adjust all the low-volume weights to the new data except DRG 391. Therefore, we will proceed with the proposed methodology for updating these weights.

4. MDC 24 (Multiple Significant Trauma)

Several years ago, we created a new MDC 24 to classify cases of multiple significant trauma. In order to be assigned to this MDC, a patient must have a principal diagnosis of trauma and at least two significant trauma diagnosis codes from two different body sites reported as either principal or secondary diagnoses. We recognize eight different body site categories: head, chest, abdomen, kidney, urinary, pelvis and spine, upper limb, and lower limb.

It was brought to our attention that diagnosis code 851.06 (Cerebral cortex contusion with loss of consciousness of unspecified duration) was excluded from the list of diagnoses that count as principal or secondary diagnoses in the significant head trauma section of MDC 24. Because this code is clinically similar to those already on the list of principal or secondary diagnoses that cause assignment to DRG 487 (Other Multiple Significant Trauma), we proposed to add this diagnosis to the significant head trauma list effective with discharges occurring on or after October 1, 1995.

The one comment we received in response to this proposal stated that the change was appropriate. Thus, we have

[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 of patients who are age 0–17. Occasionally, a pair of DRGs is split on age >17 and age 0–17.

included this change in the final DRG classifications.

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 ''coronary bypass'' consists of two DRGs (DRGs 106 and 107). 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, therefore, 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, and 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, which may sometimes occur in cases involving multiple procedures, this result is unavoidable.

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

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

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy as set forth below:

- In MDC 2 (Diseases and Disorders of the Eye), we proposed to reorder Extraocular Procedures Except Orbit (DRGs 40 and 41) above Retinal Procedures (DRG 36).
- In MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), we proposed to reorder Major Thumb or Joint Procedures or Other Hand or Wrist Procedures with CC (DRG 228) above Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC (DRG 223).

We received one comment in support of both surgical hierarchy changes. In addition, based on a test of the proposed changes using the most recent MedPAR file and the revised GROUPER software, we have found that the changes are still supported by the data and no additional changes are indicated. Therefore, we are now incorporating the proposed surgical hierarchy as final.

6. Refinement of Complications and Comorbidities List

a. Addition or Deletion of CCs. There is a standard list of diagnoses that are considered complications or comorbidities (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 preparing the original CC list, a substantial CC was defined as a condition that, because of its presence with a specific principal diagnosis, would increase the length of stay by at least 1 day for at least 75 percent of the patients.

Based upon clinical review by our medical consultants and analysis of charge data, we proposed to revise the list of diagnoses that are considered CCs as follows:

- We proposed to add diagnosis code 008.49 (Bacterial enteritis) to the CC list. This diagnosis would be considered a CC for any principal diagnosis not shown in Table 6f, Addition to the CC Exclusions List (see discussion of CC Exclusions list in section V of the addendum below).
- We proposed to delete diagnosis code 276.8 (Hypopotassemia) from the CC list. This diagnosis would no longer be considered a CC for any principal diagnosis.

Comment: We received one comment that supported our addition of diagnosis code 008.49 to the list of CCs. However, two commenters disagreed with our proposal to remove diagnosis code 276.8 from the list. The commenters state that hypokalemia, which is one of the conditions coded to 276.8, is a serious medical condition that can complicate a patient's treatment and increase the length of stay.

Response: We agree that severe cases of hypokalemia can affect a patient's clinical course. However, based on our analyses and the judgment of our expert medical advisors, we believe that when a patient has a case of hypokalemia severe enough to affect the clinical course of treatment, there will be additional manifestations of the condition. Thus, we expect that in such cases, in addition to an abnormal laboratory report finding of low potassium, the patient will have other manifestations of this condition, many of which are coded to diagnoses considered to be CCs. Therefore, we believe that a patient with severe hypoalemia will be classified to a CC DRG based on his other secondary diagnoses. However, an abnormal

laboratory finding of low potassium, which is one of the conditions coded to 276.8, does not by itself generally result in increased resource use.

Comment: One commenter requested that we add the following diagnoses to the CC list:

008.45 Clostridium difficile
331.0 Alzheimer's disease
423.9 Unspecified disease of the pericardium
348.5 Cerebral edema
333.4 Huntington's chorea
458.0 Orthostatic hypotension
458.9 Hypotension, not otherwise specified

In addition, the commenter suggested that the following diagnoses be added as CCs for DRGs 121 and 122 only:

434.xx Occlusion of cerebral arteries
436 Acute but ill-defined, cerebrovascular disease

Response: Our analysis of FY 1994 MedPAR data did not support granting CC status to these diagnoses. However, we have limited Medicare data on several of these codes. We will reevaluate these codes as part of our DRG analysis for FY 1997.

b. CC Exclusion List. We proposed a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1995, as well as the proposed CC changes in Section II.B.6.a. described above. (See section II.B.8 for a discussion of the diagnosis coding system changes.) The proposed revisions were made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in section V of the addendum to this final rule contain the revisions to the CC Exclusions List that will be effective for discharges occurring on or after October 1, 1995. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges occurring on or after October 1, 1995, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges occurring on or after October 1, 1995, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $84.00, plus $6.00 for shipping and handling and on microfiche for $20.50, plus $4.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service; U.S. Department of Commerce; 5285 Port Royal Road, Springfield, VA 22161; or by calling (703) 487–4650.

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

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 13.0, which includes the changes set forth in this final rule, is available for $195.00, which includes $15.00 for shipping and handling. Manuals may be obtained by writing 3M/HIS at: 100 Barnes Road; Wallingford, CT 06492; or by calling (203) 949–0303.

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

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

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

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.2 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, and September 1, 1994, we moved several other procedures from DRG 468 to 477. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, and 59 FR 45336, respectively.)

a. Adding Procedure Codes to MDCs. We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. This year's review did not identify any necessary changes; therefore, we did not propose to move any procedures from DRG 468 or DRG 477 to one of the surgical DRGs.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. We also reviewed the list of procedures that produce assignments to each of DRG 468, 476, and 477 to ascertain if any of those procedures should be moved to one of the other DRGs 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 proposed to move a limited number of procedures.

In reviewing the list of OR procedures that produce DRG 468 assignments, we analyzed the average charge and length of stay data for cases assigned to that DRG to identify those procedures that are more similar to the discharges that currently group to either DRG 476 or 477. We identified several procedures that are significantly less resource intensive than the other procedures assigned to DRG 468. These procedures occur in the same ''family'' (that is, they relate to procedures on the same body part or system) and at least one of this family of codes is already present within DRG 477. Therefore, we proposed to move the following procedures to the list of procedures that result in assignment to DRG 477:

18.21 Excision of preauricular sinus
18.31 Radical excision of lesion of external ear
18.39 Other excision of external ear
18.5 Surgical correction of prominent ear
18.6 Reconstruction of external auditory canal
18.71 Construction of auricle of ear
18.72 Reattachment of amputated ear
18.9 Other operations of external ear

We conducted a similar analysis of the procedures that are assigned to DRG 477 to determine if any of those procedures might more appropriately be classified to DRG 468. Again, we analyzed charge and length of stay data to identify procedures that were more similar to discharges assigned to DRG 468 than to those classified in DRG 477. We did not identify any procedures in DRG 477 that should be assigned to DRG 468.

Comment: We received one comment that objected to our proposed move of procedure codes 18.21, 18.31, 18.39, 18.5, 18.6, 18.71, 18.72, 18.9 from DRG 468 to DRG 477. The commenter did not indicate the basis of the objections.

Response: In analyzing the procedures that produce assignments to each of DRG 468, 476, and 477 for possible reassignment, we evaluate both average charge and length of stay, as well as clinical evaluation to determine the appropriate classification. These procedure codes were significantly less resource intensive than other procedures assigned to DRG 468, and more closely resembled the average charge and length of stay for procedures classified to DRG 477. Our data continue to support the reclassification of these procedures to DRG 477. Therefore, we are reassigning these procedures from DRG 468 to DRG 477 as proposed.

All of the reassignments of procedures in DRGs 468 and 477 will be effective with discharges occurring on or after October 1, 1995.

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

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

The Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in *Volume 1—Diseases: Tabular List* and *Volume 2—Diseases: Alphabetic Index,* while HCFA has lead responsibility for the ICD–9–CM procedure codes included in *Volume 3—Procedures: Tabular List and Alphabetic Index.*

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

The Committee presented proposals for FY 1996 coding changes at public meetings held on May 5 and December 1 and 2, 1994, and finalized the coding changes after consideration of comments received at the meetings and in writing within 30 days following the December 1994 meeting. The initial meeting for consideration of coding issues for implementation in FY 1997 was held on May 4, 1995. Copies of the minutes of these meetings may be obtained by writing to one of the co-chairpersons representing NCHS and HCFA. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Sue Meads, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Rm. 9–58; 6525 Belcrest Road; Hyattsville, MD 20782.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Office of Hospital Policy; Division of Prospective Payment System; Room C5–06–27; 7500 Security Boulevard; Baltimore, MD 21244–1850.

The ICD–9–CM code changes that have been approved will become effective October 1, 1995. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section V of the addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we solicited comments on the proposed DRG classifications only.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes, other codes, or have been deleted, are in Table 6c (Invalid Diagnosis Codes). The procedure codes that have been replaced by expanded codes or have been deleted are in Table 6d (Invalid Procedure Codes). These invalid diagnosis and procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 1995. The corresponding new or expanded codes are included in Tables 6a and 6b. Revisions to diagnosis and procedure code titles are in Tables 6e (Revised Diagnosis Code Titles) and 6f (Revised Procedure Code Titles), which also include the DRG assignments for these revised codes.

There are three new procedure codes that were previously included in codes

classified as operating room procedures even though the specific procedures specified by the new codes may not be routinely performed in an operating room. The three codes are as follows:

48.36 [Endoscopic] polypectomy of rectum
59.72 Injection of implant into urethra and/or bladder neck
92.3 Stereotactic radiosurgery

In the proposed rule, these three new codes were classified as non-OR procedures that affect DRG assignment and are indicated as such in Table 6b—New Procedure Codes. We will continue to assign these three codes to the surgical DRGs to which they are currently assigned.

Comment: We received over 700 comments requesting that we assign cases involving the insertion of a coronary artery stent along with percutaneous transluminal coronary angioplasty (PTCA) to a different DRG than conventional PTCA. These cases are all currently assigned to DRG 112 (Percutaneous Cardiovascular Procedures). The commenters stated that hospital costs for inserting coronary stents along with an angioplasty are significantly greater than those for conventional angioplasty alone and the clinical results of the stent implantation are significantly better, leading to a reduction in the need for repeat interventions and to improved quality of care. These comments are based on two studies that were published in the August 25, 1994, *New England Journal of Medicine* as well the results of an analysis commissioned by the manufacturer of one of the two stent devices currently approved by the Food and Drug Administration (FDA).

In this latter analysis, the contractor used the Medicare cases reported to DRG 112 in the FY 1994 MedPAR file and information provided voluntarily by 19 hospitals on interventional catheter procedures performed between July 1, 1994, and September 30, 1994, including information on coronary stent implantation. By matching the individual hospital data to the MedPAR file, the contractor identified 655 cases of PTCA, 68 of which involved insertion of a stent device. The following are the findings of the analysis:

- The difference between the average length of stay for the stent cases and the non-stent cases is 2.8 days (7.7 days versus 4.9 days).
- The difference between the average standardized charges for stent cases and non-stent cases was approximately $8,500 ($22,500 versus $14,000).
- The contractor projects that approximately 10 percent of the PTCA cases assigned to DRG 112 during FY 1996 will receive a stent, resulting in approximately 10,000 stent cases.

One commenter stated that section 1886(d)(4)(C) of the Act gives HCFA the authority to adjust the DRG classifications and relative weights annually to ''reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.'' Because insertion of the coronary stent is both a new technology and a change in treatment patterns, the commenter believes that we have a duty to revise the DRG classification for this procedure.

The commenter also noted that we have used this authority in the past, citing two other changes made in response to technology changes. Effective for discharges occurring in FY 1993, we reclassified certain automatic implantable cardiac defibrillator (AICD) cases from DRG 120 (Other Circulatory System OR Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure). (See 57 FR 39749, September 1, 1992.) The commenter stated that this change was made in response to complaints that hospitals were not adequately compensated for these procedures. Also, effective for discharges occurring in FY 1987, we reclassified all extracorporeal shockwave lithotripsy (ESWL) cases to DRG 323 (Urinary Stones with CC and/or ESWL) even in the absence of a CC (which would have resulted in classification to DRG 324 (Urinary Stones without CC)). (See 51 FR 31485, September 3, 1986.) The commenter stated that we made this change even though we did not conduct an analysis of Medicare data and instead relied on an outside source for the analysis. Thus, the commenter believes that HCFA could make a change in the assignment of stent cases even though HCFA cannot, at this time, conduct a complete analysis based on Medicare data. The commenter requested that a separate DRG be created for coronary stent implantation and that payment be established at a level that is appropriate for the cost of the procedure.

We received one comment supporting our proposed assignment of coronary stent implant as non-OR. The commenter stated that the published studies that were the basis for FDA approval do not show an overwhelming improvement in any clinical event when a stent was used in place of balloon PTCA. Thus, the commenter believes that it is obvious that coronary stenting is not a ''good buy,'' and further studies are needed.

Response: Currently, the insertion of coronary stents are included in the codes for PTCA (procedure codes 36.01, 36.02, and 36.05). That is, there is no separate code to indicate that a coronary stent was inserted during a PTCA procedure. Therefore, at this time, we cannot identify which PTCA cases in the MedPAR file include insertion of a stent. Effective October 1, 1995, a new procedure code for insertion of a coronary stent (code 36.06) will be introduced. We have designated this code as non-OR and have not assigned it to a specific DRG (see Table 6b in section V of the addendum to this final rule). However, since it is always performed in connection with PTCA, the cases will continue to be assigned to DRG 112.

When a new code is introduced, our longstanding practice is to assign it to the same DRG category as its predecessor code. One compelling reason for this practice is our inability to move the cases associated with a new code to a new DRG assignment as part of DRG reclassification and recalibration. We have discussed this policy in several previous rules, most recently in the September 1, 1994, final rule (59 FR 45340).

Since coronary angioplasty with stent is currently assigned currently to the same DRG as those without stent, this classification will continue until data on the new procedure code are available. Hospitals will begin coding claims with procedure code 36.06 beginning with discharges in FY 1996. Therefore, the resource use and other data associated with that code will be available to us for analysis as part of the FY 1998 DRG changes. We will evaluate the DRG assignment of coronary stent insertion at that time.

We agree with the commenter who stated that section 1886(d)(4)(C) of the Act gives HCFA the authority to adjust DRG classification and relative weights. In fact, that section of the law *requires* that the Secretary adjust the DRG classifications and relative weights annually. However, we virtually always limit our adjustments to those that are supported by Medicare data we have collected through the claims submittal process. Although the change in DRG assignment for AICD procedures was requested by commenters because they did not believe that the payment associated with DRG 120 was adequate compensation, the revision in DRG assignment was based on our analysis of the FY 1991 MedPAR data. In fact, we had conducted other analyses of these cases in several previous years that did not support a DRG change. (See final rules published September 1, 1989 (54

FR 36465), September 4, 1990 (55 FR 36023), and August 30, 1991 (56 FR 43216).)

Concerning the change for ESWL cases made effective October 1, 1986, we note that this revision was made in response to a ProPAC recommendation and was based on ProPAC's analysis, which found that payment under DRG 324 substantially understated the cost of ESWL. As discussed in detail in the September 3, 1986 final rule, a commenter had requested that the ESWL cases be assigned to a separate DRG based on a study conducted by the National Health Services and Practice Pattern Survey (51 FR 31486). Our response was that we are generally opposed to the creation of a single procedure DRG and that ''. . . this avenue should be employed only if there is substantial evidence of inequity through classification in any of the existing clinically consistent groupings.'' In addition, we stated that we intended ''. . . to monitor ESWL closely as Medicare data become available. If it becomes apparent that reclassification is necessary in the future, we will consider the alternative of developing a specific DRG for ESWL among the options for reclassification.'' We note that, since 1986, the assignment of ESWL has never been revised.

We intend to maintain the non-OR designation of procedure code 36.06 until we have collected claims data from all hospitals performing this procedure, which will be available in 1997. We will carefully examine these data as part of our analysis of DRG changes for FY 1998 and we will discuss our findings in the FY 1998 proposed rule.

9. DRG Refinements

For several years, we have been analyzing major refinements to the DRG classification system to compensate hospitals more equitably for treating severely ill Medicare patients. These refinements, generally referred to as severity of illness adjustments, would create DRGs specifically for hospital discharges involving very ill patients who consume far more resources than do other patients classified to the same DRGs in the current system. This approach has been taken by various other groups in refining the Medicare DRG system to include severity measurements, most notably the research done for Yale, the changes incorporated by the State of New York into its all patient (AP) DRG system, and the all-patient refined (APR) DRGs, which are a joint effort of 3M/HIS and the National Association of Children's Hospitals and Related Institutions.

In the May 27, 1994, proposed rule, we announced the availability of a paper we had prepared that describes our preliminary severity DRG classification system as well as the analysis upon which our proposal was formulated. Comments were due to HCFA by September 30, 1994. We received 99 individual letters commenting on the DRG refinements. Many of the commenters supported the change in theory, but there were numerous specific comments on the methodology.

Our plan was to incorporate comments and suggestions we received and to consider proposing the complete revised DRG system as part of the FY 1996 prospective payment system proposed rule. However, as the final rule published on September 1, 1992 (57 FR 39761) indicated, we would not propose to make significant changes to the DRG classification system unless we were able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG changes may have on coding behavior, or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments.

Besides the mandate of section 1886(d)(4)(C)(iii) of the Act, which provides that aggregate payments may not be affected by DRG reclassification and recalibration changes, we do not believe it is prudent policy to make changes for which we cannot predict the effect on the case-mix index and, thus, payments. Our goal is to refine our methodology so that we can fulfill, in the most appropriate manner, both the statutory requirement to make appropriate DRG classification changes and to recalibrate DRG relative weights (as mandated by section 1886(d)(4)(C) of the Act) as well as to make DRG changes in a budget neutral manner.

One approach to this problem would be to maintain the average case weight at 1.0 after recalibration, thereby eliminating the process of normalization. In other words, after recalibration, we would not scale the new relative weights upward to carry forward the cumulative effects of past case-mix increases. We would, instead, make an adjustment or include in the annual update factor a specific allowance for any real case-mix change that occurred during the previous year. This is a relatively simple and straightforward system for preventing the effects of year-to-year increase in the case-mix index from accumulating in the DRG weights and to account for expected changes in coding practice. In addition, we are exploring a means of estimating anticipated case-mix change due to changes in coding practice that are a result of DRG classification revisions. (See section VII.E of this preamble for a more detailed description of this process in response to a ProPAC recommendation.) However, since we have not yet resolved these issues, we were unable to propose our refined DRG severity system for FY 1996. We will continue to analyze the comments we received and validate our previous research with later MedPAR data. We remain committed to proposing our revised system as soon as possible.

We received several comments on our plan to introduce refinements to the DRG classification to include a measure of severity. In general, these comments were supportive of the concept of a severity-adjusted DRG system to improve compensation for the treatment of severely ill patients.

Comment: One commenter supported HCFA's decision to postpone a final proposal until all related issues were resolved. Another commenter stated we should not postpone new refinements on the basis of political reasons that arise due to shifts in payments. Other commenters, while stating appreciation of our desire to predict beforehand the effect of severity changes on coding behavior, urged us to resolve the issues regarding the effect of severity-adjusted DRGs on case mix, payment, and budget neutrality. One commenter stated we should set standards for ''predictive accuracy'' that are reasonable and attainable.

Response: We continue to maintain our position that, until we can improve our ability to predict coding changes, or prevent inflationary effects of coding change through methodological changes to DRG recalibration, we will not propose any significant changes to the DRG classification system. However, we note that we have continued to evaluate approaches to resolve this issue.

One approach to improving our ability to predict coding changes is to develop a data base of abstracted medical records to be used to estimate the real and coding components of case-mix change and to forecast future coding improvements. As we stated in the proposed rule (60 FR 29247), HCFA has recently implemented a record reabstracting process being conducted by two clinical data abstraction centers (CDACs) under contract with the Health Standards and Quality Bureau (HSQB). This will provide a data base consisting of 30,000 records per year. When we have evaluated the results of this reabstracting effort, we will determine if it is suitable for predicting coding

behavior. We believe we are proceeding at an appropriate pace that will result in both reasonable and attainable predictive standards.

As to the statement that HCFA should not postpone DRG refinements because of political reasons due to payment shifts, we note that we are constricted by the mandate of section 1886(d)(4)(C)(iii) of the Act, which provides that aggregate payments may not be affected by DRG reclassification and recalibration changes. We have experienced severe inflationary effects in prior years (see the September 1, 1989, final rule for a discussion of the inflationary effect of the FY 1987 DRG changes (54 FR 36468)), and reiterate our position that it would not be prudent payment policy to make changes for which we cannot predict nor control the effects.

Comment: One commenter recommended that HCFA issue a GROUPER that includes the severity refinements for review and comment by the industry.

Response: We believe it would be neither cost effective nor efficient to issue a GROUPER preliminary to a decision to proceed with the severity refinements. Thus, because the severity methodology is still in the preliminary planning stages, we have not prepared a public use GROUPER for release. The figures used in the initial analysis will be subject to change based on more current data and to modification based on comments received. At such time as the severity-adjusted methodology is officially implemented, a GROUPER will be made available. This is consistent with HCFA policy on the availability of GROUPER software for other modifications to the DRG classification system. We note that we made a complete FY 1992 MedPAR file with the current and revised (severity) DRG designations available to the public as part of the May 27, 1994 proposed rule (59 FR 27756).

10. Other Issues

a. Epilepsy (DRGs 24, 25, and 26).

Comment: We received two comments concerning the classification in DRGs 24, 25, and 26 (Seizure and Headache) of patients with intractable epilepsy, specifically those admitted for neurodiagnostic monitoring. The commenters believe that a revision to the existing DRGs is necessary to account for the greater resource use and length of stay for these patients. The commenters stated that the financial risk is greatest in DRG 25, the DRG most commonly used by specialized centers to evaluate patients, and that these patients are typically under age 40.

The commenters referred to an analysis conducted by HCFA based on FY 1993 Medicare data that indicated that the charges for cases assigned to DRG 25 were twice as great per patient for intractable epilepsy patients with monitoring than for all other patients in that DRG. This analysis was discussed in the September 1, 1994, final rule (59 FR 45343). Based on these results, the commenters argue that a change in the DRG classification system for FY 1996 is imperative, using the following criteria to classify patients into a separate DRG:

- A diagnosis of intractable epilepsy (diagnosis codes 345.0 through 345.9, with a 5th digit of 1); and
- Procedure code 89.19 for video and radio-telemetered monitoring.

In addition, one commenter noted that the relatively low volume of cases of intractable epilepsy with telemetered monitoring (fewer than 500) is not a valid objection to establishing a separate DRG for these cases because there are currently over 70 DRGs with 500 or fewer cases.

Response: The epilepsy treatment community has for some time expressed concern that the resources used to treat intractable epilepsy patients far exceeded those needed for other patients in the same DRGs, and that Medicare payment is inadequate to meet these costs. We have addressed the issue of Medicare payment for intractable epilepsy cases for the past 4 years. As a result of our previous analyses, we concluded that although intractable epilepsy patients incur higher average charges than other patients in the same DRGs, there is neither sufficient differential in the charges nor sufficient volume to warrant a DRG change.

We updated our most recent study and evaluated the March 1995 update of the FY 1994 MedPAR file. We identified 2,385 intractable epilepsy cases with an average charge of $9,084, compared to an average charge of $7,636 for all patients in the same DRGs (that is, DRGs 24, 25, and, 26).

We note that, although the incidence of inpatient admissions for all cases of epilepsy decreased nearly 30 percent in FY 1993, in FY 1994 intractable epilepsy inpatient admissions increased by a little over 4 percent, with nonintractable epilepsy admissions continuing to decrease (down 21 percent). The largest increase in admissions occurred in DRG 25, up more than 16 percent. Nonintractable epilepsy cases incurred an average charge of $7,458, for 10,536 cases.

The following table summarizes our most recent epilepsy analysis findings, comparing the average charges between epilepsy and other cases assigned to the same DRG (the number of cases is included in parentheses):

DRG	Intractable epilepsy	Nonintractable epilepsy	All epilepsy	All cases
24	$11,083	$8,626	$8,937	$8,649
	(1,065)	(7,342)	(8,407)	(58,726)
25	7,471	4,762	5,555	4,946
	(1,320)	(3,190)	(4,510)	(22,121)
26	0	$13,060	$13,060	7,834
	(0)	(4)	(4)	(43)
All cases	9,084	7,458	7,758	7,636
	(2,385)	(10,536)	(12,921)	(80,890)

Based on the recommendation of the commenters, we focused our analysis on DRG 25, with and without video-telemetered monitoring (procedure code 89.19). Our results parallel the expectations of the commenters. That is, patients with intractable epilepsy who receive monitoring incur charges significantly higher than both intractable cases without monitoring and nonintractable cases with monitoring. Also, this differential is greatest in DRG 25, with an average charge of $11,088 for intractable patients with monitoring compared to $5,397 for intractable patients not receiving monitoring. We note that the number of intractable epilepsy inpatient admissions has increased over last year; the number of cases with monitoring has increased almost 34 percent in DRG 25. Thus, it would appear that access to care is not being jeopardized, particularly in this area over which

commenters expressed the greatest concern. It is notable, also, that the charges for treating intractable epilepsy patients with monitoring increased 9 percent, while the cost of treating these patients without monitoring decreased 2 percent. The results of our analysis of DRG 25 are summarized in the following table:

DRG	Intractable epilepsy	Nonintractable epilepsy
24 with 89.19	$14,299	$9,826
	(107)	(35)
24 without 89.19	10,724	8,620
	(958)	(7,307)
25 with 89.19	11,088	7,454
	(481)	(88)
25 without 89.19	5,397	4,685
	(839)	(3,102)
26 with 89.19	0	0
	(0)	(0)
26 without 89.19	0	13,060
	(0)	(4)

As we did last year, we evaluated the experience of intractable epilepsy patients under age 65 in DRG 25. These patients qualify for Medicare benefits on the basis of disability rather than age. We focused our analysis on DRG 25 because patients admitted for neurodiagnostic monitoring must be relatively healthy and, thus, do not usually have any complicating conditions. Again, we found that those patients under 65 years of age with intractable epilepsy and telemetered monitoring (454 cases) incurred higher average charges ($11,330) than similar patients (27 cases) over 65 ($7,030).

The results of our analysis of DRG 25 by age category are as follows:

DRG 25	Age <65	Age ≥65	All ages
All Epilepsy	$6,002	$4,911	$5,555
	(2,659)	(1,851)	(4,510)
All Intractable	7,757	5,383	7,470
	(1,161)	(159)	(1,320)
Intractable with 89.19	11,330	7,030	11,088
	(454)	(27)	(481)
Intractable without 89.19	5,464	5,046	5,397
	(707)	(132)	(839)
All Nonintractable	4,643	4,867	4,762
	(1,498)	(1,692)	(3,190)
Nonintractable with 89.19	7,679	5,699	7,454
	(78)	(10)	(88)
Nonintractable without 89.19	4,476	4,862	4,685
	(1,420)	(1,682)	(3,102)

We also reviewed the intractable cases where sphenoidal electrodes were inserted and identified 62 cases, with an average charge of $12,220. It is interesting to note that while there was more than a 14 percent increase in the incidence of these cases, the average charge actually decreased. These patients continue to incur higher charges than those with video-telemetered monitoring.

We note that, as a group, the intractable epilepsy cases are not the most resource intensive set of cases assigned to DRGs 24, 25, and 26. The highest volume of epilepsy cases are coded 345.3 (Epilepsy, Grand Mal status), with 5,608 cases and an average charge of $12,054. Of the epilepsy diagnoses, the average charge for grand mal epilepsy is exceeded only by intractable epilepsy partialis continua (diagnosis code 345.71) with an average charge of $13,095, but only 94 cases.

In response to the commenters' contention that epilepsy centers are at financial risk, we also evaluated the distribution of epilepsy cases across hospitals. There were 740 hospitals treating intractable epilepsy patients: approximately 55 percent treated only one patient; an additional 20 percent treated 2 patients; and 7 percent treated 3 patients. Of the providers treating 10 or more cases of intractable epilepsy (7 percent or 52 hospitals), 34 treated more than 20 intractable cases (approximately 5 percent of the total providers). Recognized epilepsy specialty centers accounted for about 3 percent of total intractable admissions (24 epilepsy center providers). As in our prior analyses, we found that among the high volume hospitals, charges for these cases were normally distributed, with only 21 percent incurring charges greater than the average charge for intractable epilepsy cases with telemetered monitoring, and 33 percent above the average for all epilepsy cases. Accounting for those cases that fall within the average range, 69 percent of the providers incurred average charges below the overall average for intractable cases with monitoring, and 61 percent incurred charges below the average for all epilepsy cases.

Of the 30 recognized epilepsy treatment centers, only 24 reported any intractable epilepsy discharges in FY 1994. Approximately 71 percent (17 of 24 centers) treated 10 or more cases. However, of the total 2,385 intractable epilepsy cases, only 20 percent (477 cases) were treated at epilepsy centers. There were 16 centers (67 percent) with average charges at or below the average charge of $9,084 for all intractable epilepsy cases; only 8 centers incurred average charges above the intractable average charge for treating intractable epilepsy cases.

As we have stated in previous final rules, we acknowledge that, even though the volume of hospitals is small, many hospitals treating high numbers of intractable epilepsy patients may incur charges above the average. This is particularly true for the specialized treatment centers. However, we note that these hospitals are, for the most part, large urban or teaching hospitals or both and, as such, receive some of the highest Medicare payment rates.

We are not recommending any DRG modification for epilepsy cases at this time. Although the intractable epilepsy cases, especially those using procedure 89.19, result in higher charges than other cases in the same DRGs, neither the volume nor the differential in average charges is sufficient to justify a separate DRG for these patients.

Concerning the comment that there are over 70 DRGs with fewer than 500 cases, we note that the vast majority of these lower volume DRGs (59 out of 89 for FY 1994) are for patients age 0 to 17 years, or are located in MDC 14 (Pregnancy, Childbirth, and Puerperium) or MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). None of these is reflective of the Medicare population, who are primarily

age 65 or older. Many of the remaining lower volume DRGs are for cases that are generally no longer performed in the hospital inpatient setting. That is, they are assigned to surgical procedures that have moved from being generally performed in the inpatient setting to being performed in an outpatient setting. A few remaining DRGs were established during the initial classification of cases and were determined to have no other clinically appropriate DRG assignment (for example, DRG 43 (Hyphema)). This is not true for epilepsy cases, which are clinically similar to other cases in the DRGs to which they are currently assigned.

Comment: One commenter expressed concern that, in order to ensure access to care, DRG revisions must occur to account for the higher charges incurred by intractable epilepsy patients receiving neurodiagnostic monitoring.

Response: We believe that the increase in the number of intractable epilepsy cases overall (up 4 percent) and the 27 percent increase in intractable epilepsy admissions for video-telemetered monitoring are evidence that access to care is adequate for these patients. Also, a hospital may not refuse to provide a covered service to a Medicare beneficiary if it provides that service to other patients. Specifically, the Medicare regulations at 42 CFR 489.53(a)(2) provide that HCFA may terminate a hospital's Medicare provider agreement if it finds that the hospital places restrictions on the persons it accepts for treatment and fails to apply them to Medicare beneficiaries the same as to all other persons seeking care.

Comment: One commenter noted that many other payers utilize Medicare's DRG classification system, causing an even greater financial loss attributable to treating intractable epilepsy patients because of an arguably inadequate DRG payment.

Response: We have regularly cautioned against the use of the DRG classification system for populations other than the one for which it was designed. Medicare serves a predominantly elderly population, and, thus, the assignment of cases reflects the unique needs and conditions of this age group. To attempt to classify other populations within this structure may result in inappropriate designation of cases. We do not believe that we should develop a system that reflects the experience of another patient group and expect to apply such categorizations to the elderly population. Nor can we assume responsibility for other payers who may attempt to use the Medicare classification system for populations for which it was not intended.

b. Cochlear Implants (DRG 49).

Comment: We received one comment regarding cochlear implants. The commenter expressed concern that the proposed weight for DRG 49 (Major Head and Neck Procedures) is insufficient to compensate hospitals for the cost of providing the cochlear implant to Medicare patients. The commenter is concerned that this will exacerbate a growing access problem for those who need the device. The commenter stated that several hospitals each year have determined that the loss suffered in providing the cochlear implant to the Medicare population makes an ongoing cochlear implant program unsustainable. The commenter quotes utilization figures for the past 4 years, indicating a steady decline in Medicare patient volume.

Because the cochlear implant is a technology-intensive rather than a labor-intensive procedure, the commenter believes that the current system, designed to encourage hospitals to control their costs, suppresses the diffusion of the cochlear implant among the Medicare population. In the absence of a payment policy that the commenter believes will adequately reimburse technology intensive procedures, they requested the following:

- Cochlear implant procedures be placed in DRG 1 (Craniotomy Age >17 except for Trauma).
- HCFA allow separate payment of the speech processor which is not provided during the hospital stay.
- A separate, temporary DRG be created, with a weight of at least 3.0, until such time that a more acceptable policy for technology-intensive DRG's is implemented.

Response: Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49 (Major Head & Neck Procedures), the highest weighted surgical DRG in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat). Since that time, the cochlear industry has contended that the weight of DRG 49 is too low and does not adequately reflect the resources necessary for the cochlear implant procedure. In response to these concerns, we have analyzed Medicare data every year since 1986.

Our latest analysis, using FY 1994 Medicare claims data, identified a total of 76 cochlear implant cases. Of these cases, 67 were assigned to DRG 49 (9 cases were assigned to DRG 468, Extensive OR Procedure Unrelated to Principal Diagnosis), representing 3.3 percent of all cases in DRG 49. These 67 cases incurred an average charge of $21,793, compared to an average charge of $15,938 for all cases in DRG 49. The average charge for cochlear implant cases is down slightly from FY 1993 claims ($22,386) while the average charge for all cases in DRG 49 shows a small increase (up from $15,679). This increase is most likely a function of the reclassification, effective October 1, 1993, of the low charge procedure, partial glossectomy, from DRG 49 to DRGs 168 and 169 (Mouth Procedures).

Although there is a higher charge for the 67 cochlear cases than for many of the other cases in DRG 49, we note that the cochlear cases are distributed across 44 hospitals, with no more than 6 cases at any one hospital. The majority of hospitals (30 of 44 hospitals, or 68 percent) have only one case.

We have repeatedly addressed the recommendation that we assign cochlear implants to DRG 1, most recently in the September 1994 prospective payment final rule (59 FR 45342). Our rejection of this suggestion continues to be based on our conclusion that the diagnosis code associated with cochlear cases (diagnosis code 389, hearing loss) is not clinically coherent with the diagnosis codes assigned to MDC 1. A basic premise of DRG classification is the assignment of clinically similar discharges within categories based on a common body system or organ system. To reassign cochlear implant cases to MDC 1, we would have to move the principal diagnosis code 389 from MDC 3, the clinically appropriate MDC.

The commenter requested that HCFA allow separate payment of the speech processor, which is typically provided to the patient 4 to 6 weeks after the surgery, thus ''unbundling'' these costs from other inpatient supplies and services to be billed by the surgeon or audiologist to Medicare Part B. Prior to implementation of the prospective payment system, it was a practice for certain nonphysician services and supplies furnished to hospital inpatients to be billed directly to patients under Medicare Part B. However, with the enactment of Public Law 98–21 and the implementation of the prospective payment system, several statutory changes concerning the bundling policy were made. Specifically, section 1862(a)(14) of the Act provides that, to qualify for Medicare payment, all nonphysician services (with limited exceptions) furnished to hospital inpatients must be provided directly or arranged for by the hospital. Thus, these services become inpatient hospital services payable under Medicare Part A. Section 1833(d) of the Act, in turn, provides that services payable under

Part A may not be paid for under Part B. Therefore, all the services provided to a Medicare beneficiary as part of the inpatient hospital stay are covered under Part A and may not be billed under Part B. This includes the external components of the cochlear device that are implanted during an inpatient stay covered under Part A. Therefore, we do not allow separate Part B payment for part of the cochlear device.

In response to the recommendation submitted by the commenter to assign cochlear implant cases to a new DRG with a weight of at least 3.0, we believe the process for assigning cases as well as calculating DRG relative weights needs to be clarified. HCFA does not assign weights to DRGs arbitrarily, but, rather, calculates the weight for each DRG based on the resources necessary to treat patients assigned to that DRG relative to all other DRGs. A DRG weight cannot be adjusted or a new DRG created without affecting the weight of other DRGs. It would be inappropriate and inadvisable for us to create a new DRG with a specified weight assigned, as such action would impact the weight and, therefore, the payment, for other DRGs. The process by which DRG weights are recalibrated is described in detail below in section II.C of this preamble.

We acknowledge that the Medicare payment for cochlear implant patients has been an issue for several years. However, we find no justification for creating a special DRG for cochlear implants. We have consistently classified clinically similar patients in DRGs who use approximately the same amount of hospital resources. In addition, we prefer to maintain DRGs with enough cases to ensure a normal distribution and relative stability over time.

Although some technologies may not be flexible in their costs, and thus, not lend themselves readily to cost control techniques, there are other areas within the hospital's control that are responsive to cost containment. Thus, the incentive to the hospital is to treat a mix of patients and to manage its operations in such a way to offset lower payment-to-cost cases with those where the payment is in excess of cost.

We continue to believe that the low volume of these cases does not justify the establishment of a new DRG specific to cochlear implants. Nor do we generally create DRGs that are specific to a single technology, especially those available through a single source manufacturer.

In response to the commenter's concern that cochlear implants may not be available to Medicare beneficiaries in the future, as stated above in section II.B.10.a of this preamble, we note that a hospital may not refuse to provide a covered service to a Medicare beneficiary if it provides that service to other patients. Specifically, the Medicare regulations at § 489.53(a)(2) provide that HCFA may terminate a hospital's Medicare provider agreement if it finds that the hospital places restrictions on the number of Medicare beneficiaries it will accept for a particular treatment without placing the same restriction on the other populations it treats.

c. Bipolar Hip Replacement (DRG 209). We received a comment concerning the DRG assignment of certain cases in MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue).

Comment: The commenter believes that cases of bipolar hip replacement should be assigned to DRGs 210, 211, and 212 (Hip and Femur Procedures Except Major Joint) rather than to its current assignment, DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity). The commenter stated that procedure code 81.52 (partial hip replacement) is very similar to procedure code 79.35 (open reduction of fracture of the femur with internal fixation), which is already assigned to DRGs 210, 211, and 212. Further, the commenter believes that partial hip replacement patients are generally more frail individuals as compared to the population that elects total hip replacement surgery, and that they should, therefore, not be assigned to the same DRG.

Response: In recent years, we have conducted several analyses of the procedures assigned to the surgical DRGs in MDC 8. In the final rules dated September 4, 1990 (56 FR 43205) and September 1, 1993 (58 FR 46286), we addressed two of those analyses in detail. Although the specific issues that concern the commenter were not addressed, the result of our analyses was to retain the current DRGs 209, and 210, 211, and 212 classifications. We will, however, reexamine these assignments as part of our annual update and revision process for FY 1997.

d. Add-On Payment for Blood Clotting for Hemophiliacs. We received one comment regarding payment for blood clotting factors administered to hemophilia inpatients.

Comment: The commenter questioned why there was no reference in the proposed rules to the continuation of the add-on payment for blood clotting factors administered to Medicare hemophilia patients. The commenter believes that if this additional payment program is not continued, then some other mechanism should be developed to help alleviate the financial burden of treating these patients.

Response: We did not include a discussion of the payment for blood clotting factors provided to hemophilia inpatients in the proposed rule because the legislation that required this add-on payment expired effective with discharges beginning on or after October 1, 1994.

Section 6011 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), as amended by section 13505 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), provided that prospective payment hospitals receive an additional payment for blood clotting factors furnished to Medicare hospital inpatients who are hemophiliacs for discharges occurring on or after June 19, 1990, and before October 1, 1994.

We discussed the issue of payment for Medicare inpatients with hemophilia who require blood clotting factors in detail in the September 1, 1992 final rule in response to a ProPAC recommendation that the add-on payment was no longer necessary. Briefly, ProPAC found that, even though hemophiliacs were more costly to treat than the average case within a given DRG, there were insufficient data to indicate that these differences were due to the administration of the clotting factor. In addition, ProPAC found that not only was there a low volume of patients receiving the blood clotting factor, there were very few hospitals with a significant number of cases. Analyses performed by HCFA resulted in similar findings. Thus, we agreed with ProPAC's conclusion that this add-on payment for blood clotting factors is not necessary.

e. Stem Cell Transplant. Comment: We received one comment requesting that we classify procedure code 41.04 (autologous hematopoietic stem cell transplant) as an OR procedure. The code was effective beginning October 1, 1994, and was classified as a non-OR procedure at that time. The commenter believes that we should reconsider this policy based on the resource use associated with stem cell transplant. In addition, the commenter requested that the code be assigned to DRG 481 (Bone Marrow Transplant) along with the other codes in category 41.0 (bone marrow transplant).

Response: As discussed in the September 1, 1994, final rule in response to a similar comment, prior to the creation of procedure code 41.04 for stem cell transplants, this procedure

was included in procedure code 99.73 (therapeutic erythrocytapheresis), a non-OR procedure (59 FR 45340). As we have noted several times, our practice is to assign a new code to the same category as its predecessor code. Because we could not separately identify the stem cell transplant cases from the other cases coded with 99.73 in order to reclassify them and their charges to another DRG, we were unable to predict the resources required for this code and unable to calculate the new weights of both the DRG in which this code was classified and the DRG to which it would be assigned. Therefore, we were prevented from redesignating code 41.04 as an OR procedure and assigning it to another DRG.

Although it was requested that this code be reassigned to DRG 481, we note that the procedure represented by this code is not a bone marrow transplant procedure. While it may consume hospital resources similar to those transplant procedures, we will be unable to verify that assumption until we can evaluate the newly coded stem cell transplant cases in the FY 1995 MedPAR file. That file will be available in calendar year 1996 and we will analyze the cases with procedure code 41.04 as a part of our DRG agenda for FY 1997.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 1996 recalibration as we did for FY 1995. (See the September 1, 1994, final rule (59 FR 45347).) That is, we proposed to recalibrate the weights based on charge data for Medicare discharges. However, we proposed to use the most current charge information available, the FY 1994 MedPAR file, rather than the FY 1993 MedPAR file. The MedPAR file includes fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights were constructed from FY 1994 MedPAR data, based on bills received by HCFA through December 1994, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1994 MedPAR file at that time included data for approximately 10.9 million Medicare discharges. The MedPAR file updated through June 1995 includes data from approximately 11 million discharges and is the file used to calculate the weights set forth in Table 5 of the addendum to this final rule.

Although we are using the same basic methodology for recalibration, we are making two revisions which are described below. The methodology used to calculate the DRG relative weights from the FY 1994 MEDPAR file is as follows:

- To the extent possible, all the claims were regrouped using the DRG classifications discussed above in section II.B of this preamble. As noted in section II.B.4, due to the unavailability of final GROUPER software, we must simulate some classification changes to approximate the placement of cases under the revised reclassification. However, there are some changes that cannot be modeled.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers. In computing the FY 1995 weights, we eliminated all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG. For the FY 1996 relative weights, we proposed to eliminate a case only if it met the current criterion and also was outside of 3.0 standard deviations from the mean log of distribution of charges per day. We believe that this refinement to the methodology reduces the risk of eliminating cases with unusually low or high total charges that are nevertheless accurately reported. For example, a case with extremely high charges and a corresponding extremely long length of stay would be less likely to be eliminated under the revised methodology.

We received no comment on this refinement and we have identified the statistical outliers in the final recalibration using this methodology.

- 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. The second revision we proposed to make is in the treatment of transfer cases. In past recalibrations, we have counted transfer cases as full cases. This may distort the average standardized charges, particularly in DRGs with a high percentage of transfer cases, because the charges associated with a transfer case often do not reflect the resources necessary for a complete course of treatment. Therefore, in calculating the proposed FY 1996 relative weights, a transfer case was 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 was counted as 0.5 of a total case.

We received one comment concerning this methodology, which supported our change. Therefore, we have included it in the final recalibration.

- We established the relative weight for heart and liver transplants (DRGs 103 and 480) 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 and liver transplant centers that have cases in the FY 1994 MedPAR file. (Medicare coverage for heart and liver transplants is limited to those facilities that have received approval from HCFA as transplant centers.) Similarly, we limited the lung transplant cases we used to establish the weight for DRG 495 (Lung Transplant) to those hospitals that are established lung transplant centers. (As discussed in detail in the final notice with comment period of Medicare coverage of lung transplants published in the **Federal Register** on February 2, 1995 (60 FR 6543), payment for lung transplants is limited to Medicare-approved facilities, effective July 31, 1995.)
- Acquisition costs for kidney, heart, 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); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We proposed to use that same case threshold in recalibrating the DRG weights for FY 1996. Using the final FY 1994 MedPAR data set, there are 34 DRGs that contain fewer than 10 cases. As discussed in detail in section II.B.3 of this preamble, we computed the

weight for the 34 low-volume DRGs using the non-Medicare cases from 19 States.

The weights developed according to the methodology described above, using the 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 assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.b of the Addendum to this final rule, we are making a budget neutrality adjustment to implement that the requirement of section 1886(d)(4)(C)(iii) of the Act.

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 by this provision, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs) issued by the Office of Management and Budget (OMB). In addition, as discussed below, we adjust the wage index to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

Section 1886(d)(3)(E) of the Act also requires that the wage index be updated annually beginning October 1, 1993. This section further 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 data with respect to the wages and wage-related costs incurred in furnishing skilled nursing services.

For determining prospective payments to hospitals in FY 1996, the wage index is based on the data collected from the Medicare cost reports submitted by short-term, acute care hospitals for cost reporting periods beginning in FY 1992 (that is, cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992). The FY 1996 wage index includes wages and salaries paid by a hospital, home office salaries, fringe benefits, and certain contract labor costs. The current computation for the wage index excludes salaries and wages associated with nonhospital-type services, such as skilled nursing facility services, home health agency services, or other subprovider components that are not subject to the prospective payment system.

As discussed in detail below, we proposed to use updated wage data to construct the wage index as required by section 1886(d)(3)(E) of the Act. Set forth below is a discussion of that update as well as a discussion of other wage index issues. In addition, we proposed to change certain guidelines for hospital reclassification used by the Medicare Geographic Classification Review Board (MGCRB). That change is discussed in section III.E of this preamble.

B. FY 1996 Wage Index Update

We proposed to base the FY 1996 wage index, effective for hospital discharges occurring on or after October 1, 1995 and before October 1, 1996, on the data collected from the Medicare cost report (Worksheet S–3, Part II) submitted by hospitals for cost reporting periods beginning in FY 1992.

We proposed to use all of the categories of data collected from Worksheet S–3, Part II. Therefore, the FY 1996 wage index reflects the following:

- Total short-term, acute care hospital salaries and hours.
- Home office costs and hours.
- Fringe benefits associated with hospital and home office salaries.
- Direct patient care related contract labor costs and hours.
- The exclusion of salaries and hours for nonhospital services such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

Although we did not propose any changes in the reporting of hospital wage index data, we received some comments on this issue.

Comment: One commenter noted that, in early 1995, HCFA distributed special audit instructions to the fiscal intermediaries that defined ''direct patient care'' as ''hands on care.'' The commenter believes that the ''hands on'' definition will create problems because it may be subject to various interpretations. Also, the commenter objects to a recent HCFA statement that ''travel time'' in connection with contract labor is excluded in costs and hours if the information is specifically identified, but otherwise is included. Again, the commenter believes there will be inconsistencies when travel time cannot be identified. Rather than continually refining the definition of direct patient care, the commenter suggested that we adopt a different approach, such as ''chargeable services'' or ''services provided in revenue producing cost centers.'' In addition, the commenter recommends that HCFA consult with industry representatives before any special data requests or audit instructions are issued that involve large numbers of hospitals.

Response: Before FY 1994, the wage index did not include any costs associated with contract services because the data collected on contract services as part of the 1988 wage survey were unreliable. (See the September 1, 1993 final rule, 58 FR 46295.) However, many hospitals indicated that they were inappropriately disadvantaged because they were forced to contract out for nurses and technicians due to shortages of these services in their areas. To alleviate this problem, we revised the cost report effective for FY 1990 to collect the data associated with any direct patient care service contracts such as service contracts for nurses, therapists, and diagnostic imaging technicians. We specifically excluded any Part B services, Part A physician services, management contracts, or any contract for services not directly involved with patient care.

The contract labor definition is limited to those services directly related to hands-on patient care. This definition was adopted to address the main concern expressed by hospitals with respect to the inclusion of contract labor

in the wage index, that is, that many hospitals have problems hiring nurses in areas experiencing nursing shortages and must rely on contract labor sources. We believe that defining direct patient care as ''chargeable services'' or ''services provided in revenue producing cost centers'' would result in confusion on the part of hospitals attempting to exclude nonlabor-related expenses such as payments for equipment and supplies and nonpatient care contract services such as management and housekeeping services.

Regarding the exclusion of travel time in connection with contract labor, we believe that it is appropriate to exclude from the wage data those nonlabor costs associated with contract services that are billed separately. Contract labor typically involves negotiating a dollar amount for labor to be provided. This negotiated amount may include other costs involved in providing the labor, such as travel costs for lodging, mileage, and time. However, if these nonlabor costs are billed separately from the negotiated contract, they are not to be included in the contract labor wage data.

We believe that our definition of direct patient care is accurate and clear. Special audit instructions were issued earlier this year because we were receiving many inquiries regarding contract labor for services such as pharmacy and clinical laboratory. In the instructions, which were issued in February 1995, we provided all fiscal intermediaries with written guidelines concerning our policy to exclude payments and hours not attributable to direct patient care-related contract services, which would include pharmacy and clinical laboratory services.

We believe it is appropriate to issue clarifying instructions to our fiscal intermediaries on policies without industry input, but we agree with the commenter that we should consult with industry representatives before making changes in the types of costs that are included in the wage index. In fact, virtually all our recent proposals were made in response to requests from hospital and industry representatives. In addition, we have conducted special surveys and task forces to address these issues. One example of our efforts to involve industry representatives before making a change in policy is the summer 1993 survey concerning which costs should be recognized as fringe benefit costs. (See the September 1, 1994 final rule (59 FR 45356).)

Comment: The national representative of a group of fiscal intermediaries requested that the February 1995 special instruction be distributed to all fiscal intermediaries.

Response: The February 1995 instruction on direct patient care related contract services was distributed to all fiscal intermediaries. Therefore, there should be consistent application of this policy in future data collection.

Comment: One commenter noted that the wage index for seven out of eight MSAs in one State decreased between FY 1995 and the proposed FY 1996 values while other areas of the country experienced significant increases. The commenter suggested that HCFA review in detail those MSAs that experience significant increases in their wage index values from the prior year in order to maintain consistency and equity of the payment system.

Response: HCFA does review the percent change in the updated wage index from the prior year wage index, by MSA and by urban and rural hospital location. In addition, we review the wage data for any area that experiences a wage index change of 10 percent or more to determine the reason for the fluctuation. When necessary, we contact the appropriate fiscal intermediary to ensure the validity of the data or to obtain an explanation for the change. We note that none of the MSAs referred to by the commenter experienced a change of 10 percent or more. Therefore, they were not subject to any special review.

We also analyze the impact of the updated wage index on hospitals using categories such as census division, teaching status, and geographic reclassification status. This impact analysis is located in section VI.C of Appendix A to this final rule. We include this impact analysis in both the proposed and final rules.

1. Verification of Wage Data from the Medicare Cost Report

The data for the FY 1996 wage index were obtained from Worksheet S–3, Part II, of the HCFA–2552 form submitted and certified for accuracy by short-term, acute care hospitals for cost reporting periods beginning during FY 1992 (October 1, 1991 through September 30, 1992). The wage data are reported electronically to HCFA through the Hospital Cost Report Information System (HCRIS). As in past years, we initiated an intensive review of the wage data submitted by hospitals and performed numerous edits to ensure quality and accuracy. Medicare intermediaries were instructed to transmit any revisions in wage data made as a result of their review through HCRIS by early January 1995. In the proposed rule, we discussed in detail our review of the wage data as well as the process that hospitals could use to verify their wage data and to submit corrections if necessary (60 FR 29211).

The wage file used to construct the proposed wage index included data obtained in late January 1995 from the HCRIS data base and subsequent changes we received from intermediaries through March 21, 1995. To allow sufficient time to process changes, we instructed hospitals to submit requests for corrections to their intermediaries by May 15, 1995. To be reflected in the final wage index, wage data corrections had to be reviewed, verified, and transmitted to HCFA through HCRIS on or before June 15, 1995 (except for tabulation or data entry errors). All data elements that failed edits have been resolved and are reflected in this final rule.

Comment: One commenter stated that the fiscal intermediaries should not be given as much discretion to make determinations regarding which costs should be allowed as wage data for purposes of calculating the wage index. The commenter believes that HCFA should clearly define allowable items, and intermediaries should be required to use those definitions. It is the commenter's opinion that this action would greatly improve the comparability of wage data from one MSA to another.

Response: We promote consistency in the treatment of allowable wage costs to the extent possible. We have provided the intermediaries with the wage data cost report instructions and guidelines for allowable wage data in the desk review, but it is not possible to define every allowable wage data item. (See the September 1, 1993 final rule, 58 FR 46299.) We believe that the fiscal intermediaries are generally in the best position to make determinations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. We note that, effective October 1, 1994, hospital cost reports were revised to further promote equitable and consistent treatment of wage-related costs (59 FR 45357, September 1, 1994).

Comment: One commenter is concerned that HCFA's edits are not adequate to ensure consistent treatment of the wage data by the fiscal intermediaries and to produce wage index values that reflect the true labor market situation. The commenter is also concerned about delays in making changes to improve the wage index.

Response: In response to concerns voiced in the past about inconsistent treatment of wage data, we have taken steps that we believe should eliminate

most inconsistencies. Specifically, in November and December of each year, the fiscal intermediaries perform desk reviews on the wage data reported by each hospital. These reviews are conducted based on reasonableness parameters (edits) established by HCFA. HCFA also edits the wage data using additional edits, such as comparing each hospital's current year wage data to the prior year wage data, comparing each hospital's wage data to its MSA's data, and reviewing aggregate data such as all hospitals with average hourly wages below the second percentile for all hospitals nationally. The FY 1992 data that were used to calculate the FY 1996 wage index were subjected to a total of 55 edits. We have also instructed fiscal intermediaries to contact HCFA when questions arise. In addition, if a hospital disagrees with how a fiscal intermediary deals with a particular issue, the hospital is encouraged to bring it to our attention.

Regarding the fluctuations in the wage index by area, as discussed in a previous response, we analyze the impact of the updated wage index and review the data for any area that experienced a wage index value change of 10 percent or more to determine the reason for the fluctuation. When necessary, we contact the intermediary to determine the validity of the data or to obtain an explanation for the change.

Regarding changes to improve the wage index, we note that the cost report form for reporting wage data has been revised effective for FY 1995 (that is, for cost reporting periods that begin on or after October 1, 1994 and before October 1, 1995). Because this revised cost report form and instructions are more specific, we expect that the reporting of wage data and the review of that data will be more consistent across hospitals and fiscal intermediaries. However, because of the 4-year time lag between improved data reporting and the use of those data in the wage index, there is a necessary delay before the changes can affect the wage index.

2. Requests for Wage Data Corrections

In the proposed rule, we noted that we would make a diskette available in mid-August that would contain the finalized raw wage data used to construct the wage index values in this final rule. As with the diskette made available in March 1995, HCFA made the August diskette available to hospital associations and the public. The August diskette is 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 result from the process described above, not for the initiation of new wage data correction requests (60 FR 29212).

If, after reviewing the data in the August diskette or in this final rule, a hospital believes that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and HCFA. These letters should outline why the hospital believes an error exists. These requests must be *received by* the intermediary and HCFA no later than September 21, 1995 to allow inclusion in the wage index values effective October 1, 1995. Requests should be sent to: Office of Hospital Policy; Attention: Nancy Edwards, Director; Division of Prospective Payment System; Room C5–06–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. The intermediary will review requests upon receipt, and, if it is determined that an intermediary or HCFA error exists, the fiscal intermediary will notify HCFA immediately.

As noted in the proposed rule, after mid-August, we will make changes to the hospital wage data 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 August diskette. Specifically, neither the intermediary nor HCFA will accept the following types of requests in conjunction with this mid-August process: requests for wage data corrections that were submitted too late to be included in the data transmitted to the HCRIS system on or before June 15, 1995; requests for correction of errors made by the hospital that were not, but could have been, identified during the hospital's review of the March 1995 data; or 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 made as a result of an intermediary or HCFA error received timely (that is, by September 21, 1995) will be effective October 1, 1995.

We believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors made by the hospital during the preparation of Worksheet S–3 to the intermediary's attention. Moreover, because hospitals had access to the raw wage data in mid-August, they will have had the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the implementation of the prospective payment rates on October 1. We believe that if hospitals avail themselves of these opportunities, the wage index implemented on October 1 should be free of such errors. Nevertheless, in the unlikely event that such errors should occur, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(s)(2), we may make midyear corrections to the wage index only in those limited circumstances where a hospital can show: (1) that the intermediary or HCFA made an error in tabulating its data, and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 1996 (that is, by the September 21, 1995 deadline). As indicated earlier, since a hospital will have the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be made prospectively from the date the correction is made. We received several comments concerning the collection and verification of the wage data.

Comment: One commenter is concerned that the definition of ''HCFA or intermediary error'' related to requests for wage data corrections has been modified to mean only those errors relating to the entry or tabulation of the wage data. The commenter also stated that it is not clear if this would remove inconsistent applications or interpretations of HCFA policy by the intermediary from the definition of an error. The commenter disagrees with excluding an inconsistent application of policy from the definition of errors.

Response: In the proposed rule, we stated that, after mid-August, we would make changes to the hospital wage data 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 diskette we made available in August (60 FR 29212). We specified that after the May 15 deadline for submission of requests for corrections, hospitals would not be able to request that we reconsider factual determinations or policy interpretations made by the intermediary or HCFA. We believe that hospitals had sufficient opportunities to raise these types of issues, including review of the March 1995 data. Thus, after May 15, correctable errors to the wage data are limited to data entry or tabulation errors made by HCFA or the intermediary.

Comment: One commenter believes that any wage data and wage index changes made for one hospital after the final rule is published should not have a negative impact on other hospitals. While acknowledging budget neutrality limitations, the commenter stated that, last year, several MSAs were subject to wage index changes even though only one MSA had a hospital that made a mistake in reporting certain data.

Response: We do not believe it is appropriate to make a ''partial correction,'' that is, correcting a hospital's wage data but not incorporating the effects of the correction into the wage index value for all hospitals in the MSA. We note that we make both types of corrections—those that decrease the wage index value of an MSA as well as those that result in an increase in the wage index value.

Comment: One commenter requested that we specify a date by which intermediaries must notify hospitals regarding determinations on wage data correction requests. The commenter believes the rules should be changed to specify a date prior to the June 15 deadline, in order to give hospitals the opportunity to appeal the intermediary decision to HCFA.

Response: In order to allow sufficient time to review and process the wage data so that the final wage index and prospective payment rates can be published by September 1, it is necessary that the intermediary transmit any wage data corrections to HCFA through HCRIS on or before June 15. The raw hospital wage data become available to the public in mid-March, and we allow hospitals 2 months to review their wage data and submit wage data corrections, including all documentation necessary to support the requested change. We then allow the intermediary 1 month in which to review, verify and submit revised data in response to these correction requests. We do not believe that it would be appropriate to shorten the time available to the intermediaries for these determinations.

In each of the past two years, a commenter has suggested that we establish a formal appeals process for disputes over corrections submitted by hospitals to intermediaries (58 FR 46301 and 59 FR 45351). We continue to believe that a formal appeals process is neither necessary nor feasible. We believe that maintaining the current timeframes gives hospitals more flexibility in their review. We encourage hospitals to submit their wage data correction requests to the fiscal intermediary as soon as possible in order to allow the intermediary sufficient time to review the request prior to June 15.

Comment: One commenter requested changes in the format of the wage data diskette that we make available to the industry. The commenter believes that HCFA should provide additional information on the wage data diskette, such as each hospital's MSA, redesignated MSAs, and inflation factors. This would allow purchasers of the diskette to group hospitals by MSA in order to make comparisons and to verify the published wage index.

Response: The purpose of the diskette that HCFA makes available is to allow each hospital to review its wage data in order to verify that it is correct before it is used in the calculation of the final wage index. We agree with the commenter that the hospital's MSA should be included in the diskette and we will revise the format accordingly. However, we are unable to add any other data elements to the diskette because of space limitations. That is, we would be forced to expand to two diskettes, requiring the purchase of both diskettes to obtain all wage data. We are, however, considering the possibility of providing all of the requested data elements electronically (that is, on-line). In the meantime, we note that there is a Payment Impact file available for both the proposed and final rules. This file contains the data used to estimate payments, and we suggest that members of the public who wish to make comparisons order this disk. See our June 2, 1995 proposed rule for ordering information (60 FR 29250).

3. Effect of Judicial Reversal of Wage Data Denial

It has been our longstanding policy to make midyear revisions to wage index data prospectively only (see, for example, 49 FR 258 (January 3, 1984); 54 FR 36478 (September 1, 1989)), and we continue to believe that, to the extent that midyear wage data revisions are appropriate, those revisions should be made prospectively only. Some hospitals whose requests for wage data revisions have been denied by HCFA have sought relief in the Federal courts. While no court has yet reversed an HCFA decision denying a hospital's wage data revision request, these cases have the potential to present the question of what effect we would give to such a final judicial decision.

Because we had not previously addressed this question in any rulemaking, we proposed to clarify our position regarding the temporal effect of a final judicial decision reversing an HCFA denial of a hospital's request for a wage data revision. We proposed to add a new § 412.63(s)(5) to clarify that such a decision has limited retroactive effect. If a final judicial decision reverses an HCFA denial of a hospital's wage data revision request, we proposed to treat the hospital as if HCFA's decision on the hospital's wage data revision request had been favorable rather than unfavorable. HCFA would pay the hospital by applying a revised wage index that reflects the revised wage data at issue. The revised wage data would not be considered for purposes of revisiting past adjudications of requests for geographic reclassification under section 1886(d)(10) of the Act. Under the statutory scheme established by Congress, decisions on applications for MGCRB reclassification must be finalized prior to the Federal fiscal year for which the reclassifications would take effect.

In some Federal fiscal years, wage data revision requests were initially reviewed by the fiscal intermediaries and forwarded to HCFA for a determination of whether a revision should be made. In other years, the fiscal intermediaries themselves have made determinations on wage data revision requests (with input from HCFA when necessary). The latter is our current policy. In the foregoing discussion, the phrases ''HCFA denial of a hospital's wage data revision request'' and ''HCFA decision on the hospital's wage data revision request'' mean the decision by either HCFA's Office of Hospital Policy or the intermediary denying a hospital's request for a wage data revision.

We considered proposing to apply a strict policy of prospectivity to final judicial decisions reversing HCFA denials of wage data revision requests—that is, adopting a policy to apply such judicial decisions prospectively from the date they are made. While we continue to believe that prospective-only changes are most appropriate under a prospective rate-setting system such as the hospital inpatient prospective payment system, we also recognize that hospitals have sought, and will continue to seek, judicial review of unfavorable HCFA decisions on hospitals' requests for wage data revisions. Applying a policy of strict prospectivity to final judicial decisions reversing HCFA denials of wage data revision requests might be viewed, in some cases, as frustrating the purpose of judicial review, since such a decision might not be made until after the close of the fiscal year or years at issue. Therefore, on balance, we believe the better policy is the one we proposed,

under which we would give effect to a final judicial decision reversing a HCFA denial of a hospital's wage data revision request by applying a revised wage index that reflects the revised wage data as if HCFA's decision had been favorable rather than unfavorable.

No comments were received on this proposal. Therefore, we will implement the change as proposed effective beginning FY 1996, that is, October 1, 1995.

4. Computation of the Wage Index

As noted above, we are basing the FY 1996 wage index on wage data reported on the FY 1992 cost report. The final wage index is based on data from 5,269 hospitals paid under the prospective payment system and short-term, acute care hospitals in waiver States. The method used to compute the FY 1996 wage index is as follows:

Step 1—We gathered data from each of the non-Federal short-term, acute care hospitals for which data were reported on the Worksheet S–3, Part II of the Medicare cost report for the hospital's cost reporting periods beginning on or after October 1, 1991, and before October 1, 1992.

Each hospital was assigned to its appropriate urban or rural area prior to any reclassifications under section 1886(d)(8) or 1886(d)(10) of the Act. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1991 and had reported a cost reporting period exceeding 52 weeks. The data were included because no other data from these hospitals would be available for the cost reporting period described above, and particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1992 data.

Step 2—For each hospital, we subtracted the excluded salaries (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system) from gross hospital salaries to determine net hospital salaries. To the net hospital salaries, we added hospital contract labor costs, hospital fringe benefits, and any home office salaries and fringe benefits reported by the hospital to determine total salaries plus fringe benefits.

Step 3—For each hospital, we inflated or deflated, as appropriate, the total salaries plus fringe benefits resulting from Step 2 to a common period to determine total adjusted salaries. To make the wage inflation adjustment, we used the percentage change in average hourly earnings for each 30-day increment from October 15, 1991 through September 14, 1993, for hospital industry workers from Standard Industry Classification 806, Bureau of Labor Statistics Employment and Earnings Bulletin. The annual inflation rates used were 5.6 percent for FY 1991, 4.8 percent for FY 1992, and 3.6 percent for FY 1993. The inflation factors used to inflate the hospital's data were based on the midpoint of the cost reporting period as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/91	11/15/91	1.059411
11/14/91	12/15/91	1.055280
12/14/91	01/15/92	1.051165
01/14/92	02/15/92	1.047066
02/14/92	03/15/92	1.042983
03/14/92	04/15/92	1.038916
04/14/92	05/15/92	1.034865
05/14/92	06/15/92	1.030830
06/14/92	07/15/92	1.026810
07/14/92	08/15/92	1.022806
08/14/92	09/15/92	1.018818
09/14/92	10/15/92	1.014845
10/14/92	11/15/92	1.011859
11/14/92	12/15/92	1.008881
12/14/92	01/15/93	1.005912
01/14/93	02/15/93	1.002952
02/14/93	03/15/93	1.000000
03/14/93	04/15/93	0.997057
04/14/93	05/15/93	0.994123
05/14/93	06/15/93	0.991197
06/14/93	07/15/93	0.988280
07/14/93	08/15/93	0.985372
08/14/93	09/15/93	0.982472

For example, the midpoint of a cost reporting period beginning January 1, 1992 and ending December 31, 1992 is June 30, 1992. An inflation adjustment factor of 1.026810 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 1992 and covers a period of less than 360 days or greater than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 4—For each hospital, we subtracted the reported excluded hours from the gross hospital hours to determine net hospital hours. We increased the net hours by the addition of any reported contract labor hours and home office hours to determine total hours.

Step 5—As part of our editing process, we deleted data for 37 hospitals for which we lacked sufficient documentation to verify data that failed edits because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. We retained the data for other hospitals that are no longer participating in the Medicare program because these hospitals contributed to the relative wage levels in their labor market areas during their FY 1992 cost reporting period.

Step 6—Within each urban or rural labor market area, we added the total adjusted salaries plus fringe benefits obtained in Step 3 for all hospitals in that area to determine the total adjusted salaries plus fringe benefits for the labor market area.

Step 7—We divided the total adjusted salaries plus fringe benefits obtained in Step 6 by the sum of the total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus fringe benefits obtained in Step 3 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $18.9296.

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.

Comment: One commenter noted that Flagstaff, Arizona, a new MSA, was not designated as an MSA for either wage index or hourly wage purposes in the proposed rule. The commenter requested that we reflect this change in the final rule.

Response: After publication of the proposed rule on June 2, Office of Management and Budget (OMB) Bulletin Number 95–04 established two new MSAs effective June 30, 1995: Flagstaff, Arizona-Utah MSA (comprising Coconino County, Arizona and Kane County, Utah) and Grand Junction, Colorado MSA (comprising Mesa County, Colorado). The bulletin also changed the name of the Hickory-Morganton, North Carolina MSA to Hickory-Morganton-Lenoir, North Carolina MSA. These new MSAs and the revised designation are incorporated in the final wage index (see Tables 4a and 4d).

Comment: One commenter requested that we establish a wage index floor for each of the labor market areas in Puerto Rico equal to the level of the wage index at the time Puerto Rico became subject to the prospective payment system (October 1, 1987). An alternative proposal made by the commenter was to

establish a wage index floor based on the current wage index for rural Mississippi. The commenter also suggested that, after making either of the two recommended wage index changes, we should adjust the Puerto Rico standardized amounts to reflect the higher wage index values leading to a decrease in the labor share percentage of the Puerto Rico standardized amounts.

Response: At this time, we do not believe it would be appropriate to set up a floor level for the wage index. The wage index measures relative hospital wage levels, so that labor market areas that experience slower wage growth than the national average wage growth (on a percentage basis) experience wage index decreases while those who experience faster growth receive wage index increases. Since the wages in Puerto Rico have increased at a significantly slower level than national wages, Puerto Rico's wage index values have decreased accordingly. The average hourly wage for rural Puerto Rico has increased 51.7 percent (from $5.40 to $8.19) from FY 1984 to FY 1992, while the national average hourly wage has increased 94.0 percent (from $9.76 to $18.93). Consequently, the wage index for rural Puerto Rico has decreased from 0.5536 in FY 1988, which is based on the FY 1984 data, to 0.4326 in FY 1996, which is based on the FY 1992 wage data.

While we are concerned about the fall in the wage index values in Puerto Rico, the implementation of a wage index floor would create new problems. For example, we also must consider that the introduction of a wage index floor would have to be executed in a budget neutral manner. Thus, any wage index floor would deprive hospitals with wage index values above the floor level of their appropriate payment level through lower standardized amounts. We will continue to study this issue in the hope of finding a solution that is equitable to hospitals in all areas. Since we do not believe a wage index floor is appropriate, we will not be making any changes to the labor share percentage for Puerto Rico standardized amounts.

Comment: One commenter suggested that we eliminate the Puerto Rico Rural Area classification and classify those hospitals to their nearest geographic area (that is, one of the urban Puerto Rico areas). The commenter's suggestion is based on the belief that there is no socioeconomic difference between the rural hospitals and any other hospital on the island.

Response: We do not believe it is appropriate to offer special treatment for any rural area. Unless and until we decide to adopt a new method for defining labor market areas, we will continue to use rural areas for hospitals in counties that are not designated as part of MSAs. We note that the Puerto Rico rural wage index value has increased since publication of the proposed rule based on corrections we have received. The final rural area wage index value is 0.4326, an increase of 11 percent over the proposed value of 0.3888, and only a slight decrease from the FY 1995 wage index value.

C. Allocation of General Service Salaries and Hours to Areas Excluded From the Wage Index

In constructing the wage index, we exclude the direct wages and hours associated with certain subprovider components of the hospital, such as skilled nursing facilities and home health agencies. The cost reporting form used to collect the FY 1992 wage data also includes within the definition of excluded areas any rehabilitation and psychiatric distinct part units of the hospital that are excluded from the prospective payment system. Thus, the wage index is constructed by including only the direct wages and hours associated with those areas of the hospital subject to the prospective payment systems. However, the general service hours associated with excluded areas are not currently excluded from the wage index calculation.

In the May 26, 1993 proposed rule, we discussed our analysis of our first attempt to allocate overhead salaries and hours to areas of the hospital that are excluded from the prospective payment system (58 FR 30237). This analysis was prompted by several suggestions from hospital representatives that, in addition to excluding the direct salaries and hours for subprovider components of the hospital, HCFA should also exclude the general service, or overhead, wages and hours that are associated with these areas. For example, we currently include all of the wage costs associated with housekeeping in the wage index data, even if a facility has excluded subprovider components that receive housekeeping services. As we discussed in detail in the May 26, 1993 proposed rule, we identified several problems with the data collected that led us to the conclusion that it would be inappropriate to use the data in allocating the overhead wages and hours. Thus, we did not allocate general service salaries and hours to the excluded areas of hospitals in calculating the FY 1994 wage index.

In the September 1, 1993 final rule, we indicated that we would revisit this issue when the data for cost reporting periods beginning in FY 1992 became available (58 FR 46298). We believed that the retroactive determination of overhead hours for the FY 1990 cost reports may have caused some of the problems with the data. We stated that the FY 1992 cost report might allow a more accurate allocation since both overhead salaries and overhead hours would be directly reported on the cost report.

In calculating the FY 1996 wage index, we used data for cost reporting periods beginning in FY 1992. We received general service hour data for 4,356 of the 4,441 hospitals that reported excluded salaries. We analyzed these data to determine whether we could reasonably allocate the overhead wages and hours to the excluded areas of the hospital. First, we determined the total general service wages (including fringe benefits) from Worksheet A of the cost report. We then developed a ratio of total indirect costs (net of capital costs) allocated to the excluded areas of the hospital to total noncapital general service costs (using Worksheet B, Parts I, II, and III from the cost report). We call this the ''indirect cost ratio.'' We computed the general service salaries and hours allocated to the excluded areas by multiplying the indirect cost ratio by the total general service salaries and by the total general service hours reported by the hospital on the cost report.

For example, if 10 percent of a hospital's total indirect costs were allocated to excluded areas, we allocated 10 percent of its overhead salaries and 10 percent of its overhead hours to the excluded areas.

In the June 2, 1995 proposed rule (60 FR 29214), we discussed in detail our analysis of the general service allocation. We found that after we completed the data edits, 4,199 hospitals still had overhead allocations. Of these, 71 percent (2,978) had average hourly wages that were lower after the overhead allocation was made to the excluded areas. The average difference between the pre- and post-allocation average hourly wage was −0.14 percent. Eighty-six hospitals had a percentage change of more than 10 percent in their average hourly wage, of which 45 were decreases. An additional 158 hospitals had a percentage change of between 5 and 10 percent, of which 104 were decreases. Thirty-seven of 49 rural labor market areas would experience decreases in their wage index value if we performed the allocation, while 195 of 317 urban areas would experience decreases. The average wage index value for all hospitals would decrease

0.08 percentage points if we performed the overhead allocation.

Thus, we again concluded that it would not be appropriate to perform the allocation of overhead salaries and hours to excluded areas of the hospital in computing the wage index. The data still have the same variations that were prevalent when we declined to use this methodology in the proposed rule for FY 1994: many hospitals were removed due to the edits, many have large swings in their average hourly wages, and many more hospitals' average hourly wages would decrease as a result of the allocation than would increase, particularly for rural hospitals. As we noted in the September 1, 1993 final rule (58 FR 46297), if these allocations are accurate, it would mean that for the majority of hospitals with excluded areas, the average hourly wage for the overhead areas (such as laundry and housekeeping) is higher than that for patient care areas (such as nursing). We do not believe that this could be the case for such a large number of hospitals, and we have therefore concluded that the reported data regarding overhead hours are inaccurate. As a result, we decided not to employ the allocation of general service salaries and hours to excluded areas of the hospital in constructing the FY 1996 wage index.

We note that hospital representatives that support the allocation of overhead salaries to excluded areas do so because they believe that, for those hospitals with excluded areas, the current average hourly wage is artificially weighted downward. (See the September 1, 1994 final rule (59 FR 45359).) They believe that the current methodology, which removes the higher nursing costs in excluded areas from the hospital's direct salaries, but leaves in the lower general services salaries, distorts wages downward. The reported data, however, are not consistent with this concern.

While we continue to believe that an allocation of overhead salaries and hours to the excluded subprovider components may be appropriate, it would not benefit the hospital industry or the Medicare program to implement an allocation that is not reliable. Clearly, the overhead hours reported by many hospitals did not accurately reflect the salaries reported. In addition, we realize that the allocation method described above may not necessarily be the most accurate method to make this allocation. We invited public comment concerning alternative methods that might produce a more accurate and uniform allocation method and at the same time impose little or no additional reporting burden on the hospital industry. We noted that, under any acceptable allocation method, we would require that the method be used by all hospitals with excluded areas and that the intermediary be able to verify the accuracy of the reported data.

The cost report effective for FY 1995 (that is, for cost reporting periods that begin on or after October 1, 1994 and before October 1, 1995) will collect overhead data, both paid hours and the related salaries, by general service area. These data will be used to construct the wage index for FY 1999. We proposed to reevaluate an allocation of overhead salaries and hours to excluded areas of the hospital once the data from this new cost report are available or possibly earlier if we receive comments or suggestions from the public or otherwise determine alternative methods to better allocate overhead salaries.

Comment: Three commenters expressed support for the exclusion of overhead salaries and hours associated with excluded areas of the hospital and made suggestions regarding allocation methods. One commenter stated that HCFA's allocation method had merits in terms of modeling the impact and collectability of the data and requested that we continue to apply the same methodology in future studies. Another commenter suggested that HCFA incorporate in this final rule the collection of data on overhead dollars and hours separately and the exclusion of overhead salaries and hours associated with excluded subprovider components. A third commenter suggested a stepped-down cost finding basis for the allocation of salaries and hours from general service areas. This commenter believes that the data necessary to perform the step-down would be readily available to the intermediary and recommended that HCFA add cost center hours to Worksheet B–1 of the HCFA 2552–89 to facilitate data collection.

Response: As discussed above, while we agree with the commenters that an allocation of overhead salaries and hours to the excluded subprovider components may be appropriate, we believe that it would not benefit the hospital industry or the Medicare program to implement at this time an allocation that is not reliable.

Both the commenters who suggested a change in methodology based that change on the collection of new data. We do not agree with one commenter's suggestion to employ an allocation method based on stepped-down cost finding as it would impose additional reporting burden on the hospital industry. The approach would require a new or revised cost reporting form to allocate overhead hours and salaries to all of a hospital's cost centers. In addition, hospitals would have to adopt uniform statistics for allocating costs to cost centers to ensure data comparability. As we noted above, any method we use should impose little or no additional reporting burden. At this time, we do not believe the merits of an allocation of general service salaries and hours to excluded areas warrant the additional reporting burden. We have implemented new cost reporting instructions concerning overhead data. We will wait to evaluate those data (which will be available for the FY 1999 wage index) before imposing any additional data collections.

D. 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 Metropolitan Statistical Areas (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, pursuant to 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 reduces the MSA wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the MSA 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 the wage index value of the area that results from including the wage data of the

redesignated hospitals (the ''combined'' wage index value). However, the wage index value for the redesignated hospitals cannot be reduced below the wage index value for the rural areas of the State in which the hospitals are located.

• Rural areas whose wage index values would be reduced by excluding the data for hospitals that have been redesignated to another area continue to have their wage index calculated as if no redesignation had occurred. Those rural areas whose wage index value increases as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index calculated exclusive 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 for an urban area below the Statewide rural average, provided the wage index prior to reclassification was greater than the Statewide rural wage index value.

• A change in classification of hospitals from one area to another may not result in the reduction in the wage index for any urban area whose wage index is below the rural wage index for the State. This provision also applies to any urban area that encompasses an entire State.

We note that, except for those rural areas where redesignation would otherwise reduce the rural wage index value, and for urban areas whose wage index values are already below the rural wage index and would otherwise be reduced by redesignations, the wage index value for each area is computed exclusive of the data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, several MSAs listed in Table 4a have no hospitals remaining in the MSA. This is because all the hospitals originally in these MSAs have been reclassified to another area by the MGCRB. For those areas, we have listed the Statewide rural wage index value.

Comment: We received one comment on our policy of assigning the Statewide rural wage index value to MSAs where all of the hospitals have been reclassified to another area. The commenter believes that our policy is unfair to new hospitals that open in such an MSA, because they would be automatically assigned the Statewide rural wage index value, which is generally much lower than the pre-reclassified value for the MSA. The commenter stated that the Statewide rural wage index value would not reflect the labor costs in the labor market in which the hospital would be operating. Therefore, the commenter requested that we revise this policy and assign the MSA's pre-reclassified wage index value to the empty MSA.

Response: We adopted our current policy in response to comments as part of the August 30, 1991 final rule (56 FR 43222). Upon reconsideration, we agree with the commenter that the wage levels a new hospital must pay may be better reflected by the pre-reclassified wage index value for the area than the State-wide rural wage index value. Therefore, effective October 1, 1995, we will assign the pre-reclassified wage index value for an MSA to any MSA where all of the hospitals have been reclassified to another area. That value would apply as long as the MSA remains empty or until the new hospital has reported wage data that are used to calculate a wage index value (approximately 4 years). This change has been incorporated into the final wage index tables.

The final revised wage index values for FY 1996 are shown in Tables 4a, 4b, and 4c of the addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. For some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one State are included in the group of redesignated hospitals, and one State has a higher Statewide rural wage index value 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 based on the FY 1992 wage data. In addition, Table 3c (Hospital Case-Mix Indexes for Discharges) includes the average hourly wage for each hospital based on the FY 1992 data. Hospitals may use the average hourly wage published in this final rule for purposes of applying to the MGCRB for wage index reclassifications in FY 1997.

We note that in adjudicating these wage reclassification requests during FY 1996, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 1996 wage index. The FY 1996 wage index values incorporate all hospital redesignations for FY 1996. At the time the final wage index was constructed, the MGCRB had completed its review. Any changes to the wage index that resulted from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process are incorporated into the wage index values published in the final rule. For FY 1996, 420 hospitals are redesignated for purposes of the wage index (including hospitals redesignated under both sections 1886(d)(8)(B) and 1886(d)(10) of the Act).

E. Changes to the MGCRB Guidelines

1. Limitations on Hospital Reclassification (§§ 412.230, 412.232, and 412.234)

a. Elimination of Individual Hospital Reclassification From Rural to Other Urban Areas for Purposes of the Standardized Amount. Section 1886(d)(10)(C)(i)(I) of the Act requires the MGCRB to consider applications of hospitals requesting reclassification for purposes of the standardized amount. Section 1886(d)(10)(D)(i)(II) of the Act requires that the MGCRB utilize guidelines published by the Secretary for determining whether the county in which a particular hospital is located should be treated as being a part of a particular MSA. Accordingly, the MGCRB allows reclassifications for purposes of the standardized amount for individual hospitals that meet the guidelines under § 412.230, and for groups of rural and urban hospitals that represent an entire county and that meet the guidelines under §§ 412.232 and 412.234 respectively.

As required by section 1886(d)(3)(A)(iii) of the Act, effective for discharges occurring on or after October 1, 1994, the average standardized amount for hospitals located in a rural area was made equal to the average standardized amount for hospitals located in other urban areas. The standardized amount effective for those areas is now known as the standardized amount for ''other areas.'' Large urban areas continue to receive a separate, higher standardized amount. The effect of this provision is that in FY 1995 or later, hospitals reclassified from rural to other urban areas for purposes of the standardized amount receive no increase in their standardized payment amount, since the two rates are now the same.

However, we continue to receive applications from individual hospitals seeking to be reclassified from rural to other urban areas for the standardized amount because of certain payment advantages that accompany the urban designation. When an individual hospital reclassifies from a rural to an urban area for purposes of the standardized amount, we consider the hospital urban for all purposes except the wage index. For some rural hospitals, the urban designation enables them to qualify as a disproportionate share hospital (DSH) and to receive special payment adjustments. For other

rural hospitals that already qualify for DSH payments, the urban designation qualifies them for a higher DSH adjustment than they would receive as a rural hospital.

We proposed to provide under new § 412.230(a)(5)(ii) that a hospital may not be reclassified for purposes of the standardized amount if the area to which the hospital seeks reclassification does not have a higher standardized amount than that currently received by the hospital. This change would be effective for hospital applications due October 2, 1995, requesting reclassification for FY 1997. (Since October 1 is a Sunday, the MGCRB will accept applications through October 2, 1995.)

We note that, under this change, individual rural hospitals could continue to receive reclassifications to large urban areas, since the standardized amount for large urban areas is greater than that of rural (or other urban) areas. Also, group applications from all hospitals in a rural county for reclassification to urban areas would not be affected, since these hospitals are required to meet a different ''metropolitan character'' criterion under § 412.232(b) and would receive the other area's wage index.

We received 15 comments in response to our proposal to eliminate standardized amount reclassifications for individual hospitals from a rural area to an other urban area. All of the commenters were opposed to our proposed change. Four of the comments we received were from individual hospitals that stated that they would no longer qualify for higher DSH payments as a result of the change.

Comment: Several commenters raised questions about whether the statute gives us the authority to eliminate standardized amount reclassifications from rural to other urban areas and whether we are interpreting the MGCRB provisions of the statute correctly. One commenter stated that the statute contains no language that modifies or limits the areas to which hospitals may seek reclassification, or restricts the types of hospitals that may seek changes in the standardized amount. The commenter believes that, because section 1886(d)(10)(C)(i) of the Act provides that the MGCRB *shall* consider applications of hospitals seeking reclassification, rather than stating that the MGCRB *may* consider such applications, the MGCRB is obligated to consider applications from hospitals seeking to be reclassified from rural areas to other urban areas. The commenter argues that the statute gives the Secretary the authority only to establish guidelines for evaluating hospital-specific facts, not to preclude specific classes of hospitals from being reclassified. Another commenter stated that since Congress had not specifically provided in legislation that rural to other urban standardized amount reclassification would no longer be allowed after the rural and other urban rates were made equal, HCFA does not have the statutory authority to make this change.

Response: We believe the proposed policy of eliminating individual hospital reclassifications from rural areas to other urban areas for purposes of the standardized amount is fully consistent with the language and purpose of the Medicare statute. Although the statute states that the MGCRB ''shall'' consider applications for reclassification, the statute does not require the Board to consider a reclassification request for any purpose whatsoever. Instead, the relevant terms of the statute provide that the Board ''shall consider'' applications for reclassification ''for purposes of determining * * * the hospital's average standardized amount.'' Accordingly, the statute *requires* the Board to consider requests for standardized amount reclassification only if the ''purpose'' of the request is for the hospital to receive the other area's standardized amount. Since the standardized amount for rural areas now equals the standardized amount for other urban areas, there is no reason for a rural hospital to be reclassified to another urban area ''for purposes of'' the standardized amount itself.

Under the proposed policy, qualifying rural hospitals (and other urban hospitals too) may continue to seek standardized amount reclassification to large urban areas because large urban areas have a different standardized amount (base payment rate). Thus, consistent with the statute, the Board ''shall consider'' applications for standardized amount reclassification from hospitals seeking to receive the other area's (higher) standardized amount. As explained further below, we also believe that the proposed change is consistent with the purpose of the statute, as well as the language of the statute.

Comment: Several commenters argued that the proposed policy is contrary to the purpose of the geographic reclassification system. Some commenters believe that our proposal is contrary to congressional intent that geographic reclassification be available to hospitals to address competitive inequities. One commenter stated that HCFA had previously interpreted the purpose of geographic reclassification as addressing those situations where a hospital is more like the hospitals in a geographic adjacent area than the hospitals in its own geographic area, and that the proposed policy of not allowing rural hospitals to be reclassified to other urban areas contravened the agency's interpretation of the statute and placed those hospitals at a competitive disadvantage. Another commenter stated that we were changing our standard as to the purpose of geographic reclassification from providing hospitals with a more appropriate geographic classification to providing only a more appropriate standardized payment rate.

One commenter suggested that HCFA was interpreting the statute very narrowly in this instance, but in other cases, such as allowing rural to rural reclassification, HCFA had been more liberal. Another commenter acknowledged that the statute addressed only the wage index and standardized amount as reasons for reclassification, but said that the intent of the MGCRB provisions was to provide an opportunity for rural hospitals sharing certain characteristics with urban hospitals to partially escape the disadvantage of their rural status. Still another commenter believes Congress intended that, if a rural hospital satisfied HCFA's criteria for standardized amount reclassification to an other urban area, the hospital should be considered urban for purposes of disproportionate share payments as well because the hospital had proved that it was similar to urban hospitals.

Response: We believe the proposed policy is fully consistent with the purpose of the statute, as well as the language. The geographic reclassification process enables hospitals to be reclassified to another geographic area for purposes of receiving the other area's standardized amount or wage index, the two major components of a hospital's prospective payment rate. As indicated in the June 4, 1991 final rule implementing the reclassification process, ''we believe geographic reclassification should be limited to those hospitals which are disadvantaged by their current geographic classification because they compete with the hospitals that are located in the geographic area to which they seek to be reclassified.'' (56 FR 25469.)

For purposes of determining an appropriate standardized amount, a hospital is not disadvantaged by its ''current geographic classification'' if the area to which it seeks reclassification has the same

standardized amount. Rural hospitals requesting reclassification to another urban area would receive the same standardized amount. We believe it is appropriate to limit reclassifications ''for purposes of'' the standardized amount to hospitals seeking reclassification to an area with a higher standardized amount. We note that the statute confers broad authority on the Secretary to determine the circumstances under which reclassification is appropriate.

In essence, the commenters are arguing that hospitals should be allowed to seek reclassification solely for purposes of the DSH adjustment. However, the statute specifies only two purposes for which hospitals may seek reclassification—the standardized amount and the wage index, the two major components that determine a hospital's base prospective payment rate. We believe that, if it is appropriate not to reclassify a hospital for purposes of the base payment rate itself, as contemplated by the statute, it is appropriate not to reclassify the hospital solely for purposes of the DSH adjustment to the base payment rate.

In response to the arguments that our proposed policy would place rural hospitals unable to receive higher DSH payments at a competitive disadvantage, any hospital unable to satisfy the criteria for reclassification could claim it was placed at a competitive disadvantage. For example, rural hospitals slightly beyond the qualifying mileage requirement of 35 miles do not qualify for reclassification even if they have costs like those of an urban hospital. Almost every rural hospital in the country could argue that it shares some characteristics with urban hospitals. However, a rural hospital cannot argue now that it is disadvantaged because it is unable to receive the standardized amount of an adjacent other urban area.

Since all hospitals pay for geographic reclassification through the budget neutrality process, it is HCFA's responsibility to develop guidelines to determine when reclassification is appropriate. We believe it is appropriate not to reclassify individual rural hospitals to other urban areas for purposes of the standardized amount.

Comment: Some commenters stated that the proposed change was inconsistent with our previous policy of allowing rural hospitals to reclassify to other urban areas and considering them urban for all purposes (except the wage index). Many of the commenters were concerned about the equity of our proposal since rural hospitals located near large urban areas could continue to reclassify for the standardized amount and receive higher DSH payments if they qualified, but rural hospitals located next to other urban areas could not. Some of the commenters also stated that since rural hospitals have proved that their costs are similar to those of other urban hospitals they should be eligible for any payments and adjustments that those hospitals receive.

Response: We believe that our proposed policy is consistent with the previous policy of allowing rural hospitals to reclassify to other urban areas for purposes of the standardized amount and considering such hospitals urban for all purposes, including DSH payments. It is important to consider the circumstances underlying each policy. At the time the previous policy was implemented, the standardized amount for rural areas was different from the standardized amount for other urban areas, so it was appropriate to reclassify qualifying rural hospitals to other urban areas and to consider them urban for purposes of the standardized amount. We decided that, once a hospital was reclassified as urban for purposes of the standardized amount, the hospital would also be considered to be urban for all purposes (except the wage index).

As this analysis suggests, there is a two-step inquiry in determining whether a rural hospital should be considered urban for a purpose *other than* the standardized amount. The first, and threshold, question is whether it is appropriate to reclassify the hospital for purposes of the standardized amount itself, as contemplated by the statutory language? Only if this threshold question is answered affirmatively does one reach the second question: should the hospital be considered urban for other purposes as well?

Applying this analysis, rural hospitals seeking standardized amount reclassification to other urban areas would now receive the same standardized amount. Therefore, as explained earlier, we believe it is appropriate not to reclassify these rural hospitals as urban ''for purposes of'' the standardized amount. Since there is now no reason to consider these hospitals as urban for purposes of the standardized amount, we do not reach the second question of whether the hospitals should be considered urban for other purposes as well.

We recognize that there may be some possible inequity between rural hospitals seeking reclassification to other urban areas and rural hospitals seeking reclassification to large urban areas. However, the statute does not mandate that hospitals reclassified as urban for purposes of the standardized amount also be considered urban for purposes of DSH. We could have decided initially that rural hospitals reclassified to large urban areas for purposes of the standardized amount would *not* be considered urban for other purposes. But then arguably there would be some inequity between hospitals located in urban areas and rural hospitals reclassified as urban for purposes of the standardized amount.

As explained above, we believe the most appropriate policy is to first address the threshold question: whether it is appropriate to reclassify certain rural hospitals for purposes of the standardized amount. If the answer is yes, then we reach the second question: whether the hospitals should be considered urban for other purposes. We believe that all of our policies are consistent with this analysis.

Comment: One commenter suggested that we were continuing to allow rural hospitals adjacent to large urban areas to seek reclassification because the large urban standardized amount is much higher than the other standardized amount and few hospitals would be able to qualify for such reclassification.

Response: As stated earlier, we believe, consistent with the statutory language and purpose, that it is appropriate for hospitals to seek reclassification from rural areas to large urban areas for purposes of the standardized amount because the other area has a higher standardized amount.

Comment: Two commenters mentioned the impact that this change would have on rural referral centers. One commenter stated that many hospitals had voluntarily relinquished their rural referral center status in order to qualify for higher DSH payments and that HCFA had previously acknowledged the benefit of such reclassification to these hospitals. The commenters also stated that 18 hospitals eligible for rural referral center status were reclassified to other urban areas in FY 1995 and would lose $13.8 million if the proposal were implemented.

Response: While we recognize that many hospitals voluntarily relinquished their rural referral center status in the past to qualify for DSH as an urban hospital and we are sympathetic to the financial impact that the loss of higher DSH payments will have on these hospitals, we believe it is appropriate not to allow these hospitals to be reclassified for purposes of the standardized amount to another area with the same standardized amount. Eligible hospitals may seek to have rural referral center status reinstated. Although these hospitals would not be considered urban for purposes of DSH

payments, we note that, under section 1886(d)(5)(F)(iv) of the Act, rural referral centers receive special treatment for purposes of DSH. In addition, we have previously recognized the role that sole community hospitals and rural referral centers play in preserving access to care for rural Medicare beneficiaries by means of the MGCRB special access rule, which waives the mileage requirement for such hospitals seeking reclassification. (*See* 42 CFR 412.230(a)(3).)

Comment: One commenter claims that our proposed change contravenes the rationale behind HCFA's requirement that DSH be included in the standardized amount reclassification test. The commenter asserts that since HCFA has noted that DSH payments change depending on whether or not a hospital is urban or rural and should be included in the standardized amount calculation, hospitals that can qualify to reclassify based upon including their DSH payments and costs should be allowed to do so.

Response: Again, there is a two-step analysis: first, is it appropriate to reclassify rural hospitals to other urban areas (or large urban areas) for purposes of the standardized amount; second, if the answer to that threshold question is yes, then should the hospitals be considered urban for purposes other than the standardized amount? As indicated above, we believe it is appropriate not to reclassify a rural hospital to an other urban area for purposes of the standardized amount because the hospital would receive the same standardized amount. In contrast, it is appropriate to reclassify rural hospitals to large urban areas for purposes of the standardized amount, and when a rural hospital qualifies to be considered urban for purposes of the standardized amount, we believe it is appropriate to consider the hospital urban for purposes of DSH. Applying this policy in determining the geographic area (rural or large urban) to which a hospital should be classified for purposes of the standardized amount, we believe that applicable DSH payments and costs should be included in the qualifying cost test because they reflect the costs and payments of the hospital under the alternative scenarios.

After considering the comments, we have decided to adopt the change as proposed.

b. Reclassification for Purposes of the Wage Index. Section 1886(d)(10)(C)(i)(II) of the Act requires the MGCRB to consider the application of any prospective payment hospital for purposes of changing its applicable wage index. Sections 412.230, 412.232, and 412.234 set forth the types of individual and group reclassifications that are currently allowed. An individual rural hospital may reclassify to another rural area or to an urban area. An individual urban hospital may reclassify to another urban area for purposes of the wage index, the standardized amount or both. A rural group may reclassify to an urban area and an urban group may reclassify to another urban area, but only for purposes of both the wage index and the standardized amount. In the proposed rule we stated that we do not believe it is appropriate for hospitals to seek reclassification to an area with a lower wage index in an effort to use the MGCRB system inequitably (60 FR 29217).

Therefore, under the proposed rule, a hospital that seeks to reclassify for the purpose of the wage index may apply for reclassification only to an area that has a higher pre-reclassified average hourly wage than the pre-reclassified average hourly wage in the hospital's original geographic area. We proposed revisions to §§ 412.230, 412.232, and 412.234 to reflect these changes.

For group reclassifications, we proposed that either the pre-reclassified average hourly wage or the standardized amount of the area to which the hospitals seek reclassification must be higher than the corresponding figure of the area in which the hospitals are located for the group to qualify for reclassification. These revisions are effective for applications for reclassification due by October 2, 1995, for reclassifications effective October 1, 1996. We received two comments on our proposal to prohibit a hospital from reclassifying to an area in which the pre-reclassification average hourly wage is lower than the pre-reclassification average hourly wage in the hospital's current area, both of which agreed with our changes. Therefore, we will implement this requirement beginning with MGCRB applications due October 2, 1995, effective for reclassifications for FY 1997.

Comment: Although we made no proposal regarding the 108 percent criterion, two commenters wrote to state their concern about the impact of that criterion in relation to hospital reclassification for wage index purposes. The current regulations require that among other criteria, a hospital that seeks to be reclassified must have an average hourly wage that equals or exceeds 108 percent of the average hourly wage of the area in which it is located. One commenter believes that this test is inappropriate, especially for hospitals that are the predominant wage payers in an area. The commenter states that as a hospital's wage influence in a labor market area increases, it becomes proportionately less likely to satisfy the 108 percent rule.

Response: We continue to believe that the 108 percent test is a reliable measure for determining whether hospitals are truly aberrant within their labor market areas and merit reclassification. We also do not believe that it would be appropriate to exclude a hospital from its labor market area in order for the hospital to qualify for reclassification. Our policy has been that the wage data for all hospitals located in a labor market area is to be used when determining reclassification qualification. If one hospital is so dominant as to affect the labor market area to the extent noted by the commenter, the resulting average hourly wage (and thus the wage index value of the area) is also affected by that hospital. Removing the dominant hospital's data from the hourly wage calculation for purposes of meeting the 108 percent test would, in our view, lead to inappropriate reclassifications.

2. Hospital Requests for Wage Data from HCFA

Currently, regulations at § 412.266 provide that a hospital may request from HCFA certain wage data that are necessary for a complete reclassification application to the MGCRB. The regulations also set forth dates by which HCFA must respond to such requests. Before 1994, hospitals needed to obtain data on average hourly wages directly from HCFA, since the data were not available from any other source. Beginning with the May 27, 1994, proposed rule, we have included the average hourly wage data for each hospital in the proposed and final rules as part of Table 3c. Therefore, hospitals no longer need to contact HCFA to obtain the data necessary to apply for reclassification. Thus, we are revising § 412.266 to indicate that hospitals are to obtain the necessary data from the **Federal Register** document. We received no comments on this change and are adopting it as proposed.

3. Elimination of the MGCRB

As discussed above, under section 1886(d)(10) of the Act, the MGCRB is charged with reviewing and making decisions on hospital requests for geographic reclassification. Since implementation of this process 5 years ago, many changes have been made to the criteria that hospitals must meet in order to qualify for reclassification. The majority of these criteria are now

objective standards that are easily assessed. However, the MGCRB application process remains essentially unchanged. We solicited comments concerning alternatives for revising and simplifying the reclassification system (60 FR 29218) including the possibility of eliminating the MGCRB and transferring its decisionmaking authority to HCFA. In addition, we suggested that if the reclassification process was revised and simplified, it might be possible to use more current wage data in making reclassification decisions.

Comment: We received seven comments in response to our suggestion that the MGCRB could be eliminated. Five of the commenters were opposed to this suggestion and two stated that they were not opposed to such a change. One of the latter two commenters agreed with us that the criteria for reclassification are essentially mechanical and can be applied unambiguously by an administering agency.

The commenters opposed to the elimination of the MGCRB believe that the Board remains the appropriate entity for reviewing reclassification applications and should be preserved. Commenters stated that the independent administrative review offered by the MGCRB is necessary to counterbalance the authority that HCFA holds over the process through its implementation of strict numerical standards and the statutory prohibition on judicial review of MGCRB and Administrator decisions. Several commenters requested that, rather than eliminate the Board because of the more mechanical nature of its review, HCFA should restructure the qualifying criteria for reclassification to allow the MGCRB the ability to consider a wide range of hospital-specific facts in determining whether geographic reclassification would be appropriate for a particular hospital or group of hospitals.

One commenter stated that in proposing to use more current wage data HCFA must not have examined its own time line. Using more current data would require either not allowing hospitals time to review their wage data prior to reclassification, or moving the fiscal intermediary review of wage data to earlier in the wage data verification process. The commenter believes that it is essential not to limit the amount of time hospitals have to review their own wage data before it is implemented.

Another commenter noted that it might be possible to improve the MGCRB process without transferring the Board's functions to HCFA. The commenter stated that they would support a legislative proposal to change the March 30 deadline for MGCRB decisions if it would allow for the improvement of the process and the use of more accurate data.

Response: We will take the commenters' suggestions into account as we consider whether to pursue statutory changes in the law governing the reclassification process. Regarding the comments that eliminating the Board would grant too much authority to HCFA, we believe that instituting a process in which HCFA rather than the MGCRB makes the geographic reclassification decisions would not result in a significantly different outcome. This is because of the basically objective nature of the current reclassification criteria and provision for the Administrator's discretionary review as set forth in the regulations at § 412.278(c). In addition, we believe that a process that is handled entirely by HCFA could lead to some administrative simplification in the application process. We understand the concerns about using more recent wage data that has not been thoroughly verified through the process described in section III. B of this preamble and will bear these concerns in mind as we further analyze potential changes.

4. MGCRB Address Change

The MGCRB has recently moved its offices to a new location. Therefore, hospitals that wish to apply to the MGCRB for geographic reclassification for FY 1997 should submit their applications to the following new mailing address: MGCRB; P.O. Box 31713; Baltimore, MD, 21207–8713. The address for deliveries is: MGCRB; 7500 Security Boulevard; Room C1–09–13; Baltimore, MD 21244–1850.

F. Alternative Labor Market Areas

In the proposed rule, we summarized our position with regard to further research into changing labor market areas and summarized the major comments we received in response to last year's proposals for potential revisions to labor market areas. There was no consensus among the commenters on the potential options for new labor market areas. Many individual hospitals that commented expressed dissatisfaction with all of the proposals.

One of the options for revising labor market areas was a blended wage index that used the MSA-based system but generally gave a hospital's own wages a higher weight than under the current system. Under this option the wage index of each hospital would be based on a average of that hospital's own average hourly wages and the average hourly wages of other hospitals in its labor area (either an MSA or Statewide rural area). We stated that while we believed a blended wage index might have merit, we were not planning to propose it given the generally negative comments we received on changes in the labor market areas.

Comment: We received two comments in response to our summary of labor market comments in the proposed rule. One commenter endorsed our statement that there was no clear ''best'' labor market option to pursue. The commenter also stated that the current wage areas coupled with the reclassification process best measures hospital labor market areas. The other commenter expressed disappointment that we had decided not to endorse an alternative labor market classification system such as the blended wage index. This commenter asserted that a blended wage index, in which a hospital's wages would generally be given greater weight in developing the hospital's wage index than under the current system, would not cause hospitals to increase their wages in order to increase payments. The commenter also expressed disappointment that we did not propose a method for redefining the Boston New England County Metropolitan Area (NECMA) which the commenter believes is too large to encompass the actual Boston labor market area.

Response: The Boston NECMA was expanded by OMB as part of its revised MSA definitions based on 1990 data. As we noted in the September 1, 1993 final rule (58 FR 46292) in response to a similar comment, pursuant to our broad discretion under section 1886(d)(3)(E) of the Act, we currently define labor market areas for purposes of the wage index on the basis of MSAs and NECMAs. Thus, until alternative labor market areas are established we believe the MSA definitions should be applied consistently for purposes of the wage index. Since there does not appear to be a consensus among hospitals on new labor market areas, we have not made any proposals in this area. As we stated in the proposed rule, we are willing to conduct additional research if we receive recommendations of feasible options that we have not explored previously.

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

A. Payment for Transfer Cases (Section 412.4)

The prospective payment system distinguishes between ''discharges,''

situations in which a patient leaves an acute-care hospital after receiving complete treatment, and ''transfers,'' situations in which the patient is transferred to another acute-care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation irrespective of the length of time the patient spent in the ''sending'' hospital before transfer, this would create a strong incentive to increase transfers, thereby unnecessarily endangering patients' health. Therefore, the regulations at § 412.4(d) provide that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Currently, the per diem rate paid to a transferring hospital is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the geometric mean length-of-stay for the DRG into which the case falls. Transferring hospitals are also eligible for outlier payments for cases that meet the cost outlier criteria established for all cases (nontransfer and transfer cases alike) classified to the DRG. They are not, however, eligible for day outlier payments. Two exceptions to the transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) or DRG 456 (Burns, Transferred to Another Acute Care Facility), which are not paid on a per diem basis but instead receive the full DRG payment.

In the May 27, 1994 proposed rule, we proposed to revise our payment methodology for transfer cases. Under the proposal, for the first day of a transfer, the per diem amount would be doubled, while a flat per diem amount would be paid for each succeeding day, up to the full DRG payment (59 FR 27734). We also proposed at that time to change our definition of a transfer case to include cases transferred from an acute-care setting paid under the prospective payment system to a hospital or unit excluded from the prospective payment system. When we published the September 1, 1994 final rule with comment period, we withdrew these proposals for FY 1995 (59 FR 45362) based on negative comments and further analysis. In that final rule, however, we stated our intention to continue to evaluate the appropriateness of our transfer policy.

For FY 1996, we again proposed to adopt a graduated per diem payment methodology for transfer cases. Again, under this methodology, we would pay double the per diem amount for the first day and the per diem amount for subsequent days (up to the full DRG amount). We did not propose to revise our definition of transfers. However, we noted that we were concerned about an accelerating trend toward earlier discharges to postacute settings. Therefore, we solicited public comments regarding this trend and the implications this has for the design of our payment systems. In its March 1, 1995 report, ProPAC supported our proposed payment methodology (Recommendation 11) and expressed its concern ''about the continuity of care across treatment settings.'' The Commission also indicated its willingness to work with the Secretary to explore this issue. The following discussion describes our change to the transfer payment methodology and some of the issues identified by our further analysis of transfer cases.

1. Payment for Transfer Cases

As part of a study of Medicare transfer cases funded by HCFA (''Transfers of Medicare Hospital Patients under the Prospective Payment System'', PM–191–HCFA, January 1994), RAND found that among cases transferred before reaching the geometric mean length-of-stay, 1-day stays cost 2.096 times the per diem payment amount for cases in nonsurgical DRGs and 2.576 times the per diem for surgical DRGs (based on FY 1991 data). Among nonsurgical transfer cases, the costs of 2-day stays were about 1.215 times the per diem payment amount, and cases transferred after 2 days cost about 10 percent more than the applicable per diem amount. Among surgical cases, the costs of stays of 2 or more days were actually about 7 percent below the applicable per diem amount.

In order to pay hospitals more appropriately for the treatment they furnish to patients before transfer, we proposed to revise § 412.4(d)(1) to pay transfers twice the per diem amount for the first day of any transfer stay plus the per diem amount for each of the remaining days before transfer, up to the full DRG amount. (Our concerns about basing the gradation of the per diem scale on the actual coefficients as estimated by RAND were described in last year's proposed and final rules, as referenced above.) This change will apply uniformly for both medical and surgical transfer cases; although surgical transfer cases appear to be more costly on average for the first day, they are relatively less costly for the second day and beyond.

If the patient is transferred again before final discharge, then, under this change, all sending hospitals involved would be paid using the graduated per diem methodology rather than the flat per diem rate they currently receive. For example, a case transferred from a community hospital to a tertiary care hospital for a procedure that is not performed at the community hospital, may subsequently be transferred back to the community hospital, which ultimately discharges the patient home. In such a case, the community hospital and the tertiary care hospital would be paid using the transfer payment methodology for the first two phases of the hospitalization, and the community hospital would also receive a DRG amount for the final phase when it discharges the patient. This is our current policy, as well. Each phase of the hospitalization is assigned a DRG based on the diagnosis and procedures applicable to that particular phase; therefore, a different DRG could be assigned to each phase.

Transfer cases would continue to be eligible for additional payments as cost outliers. In the September 1, 1993 final rule, we set forth revised qualifying criteria for transfer cases to be eligible for cost outlier payments (58 FR 46305). Before that change, transfer cases were required to meet the same criteria to qualify for cost outliers as were discharges. The revised policy adjusts the outlier threshold for transfer cases to reflect the fact that transfer cases were receiving a reduced payment amount under the per diem methodology. Last year, when we revised the cost outlier qualifying criteria so that it was based on a fixed loss threshold, the qualifying criteria for transfers continued to reflect the fact that their payment amounts are reduced relative to the full DRG amount. Although we did not state this explicitly in the September 1, 1994 final rule, it is the policy we have employed, and intend to continue to employ, since the fixed loss threshold was implemented October 1, 1994. In the proposed rule, we described the cost outlier threshold for transfer cases as equal to the fixed loss amount (for FY 1995, the prospective payment rate for the DRG plus $20,500), divided by the geometric mean for the DRG, multiplied by the length of stay before transfer. In order to maintain the correct relationship between the payment received under the new graduated per diem methodology and the outlier threshold, for FY 1996, the per diem outlier threshold should be multiplied by the length of stay before transfer plus one day. Of course, the threshold is limited

to the prospective payment rate for the DRG plus the fixed loss amount.

Using the graduated per diem methodology, RAND estimated the payment-to-cost ratio of transfer cases that were transferred before reaching the geometric mean length of stay would be 0.9321. While this is somewhat less than the payment-to-cost ratio for nontransfer cases (0.9645), it represented a significant improvement over the current ratio for transfer cases (0.7224). Using more recent data (FY 1993 MedPAR) and payment policies (FY 1995), we estimated the improvement in the payment-to-cost ratio for transfer cases to be from 0.7548 under the current flat per diem policy to 0.9701 under the graduated per diem policy.

Section 109 of the Social Security Act Amendments of 1994 (Public Law 103–432), which amended section 1886(d)(5)(I) of the Act, authorized the Secretary to make adjustments to the prospective payment system standardized amounts so that adjustments to the payment policy for transfer cases do not affect aggregate payments. In light of this authority, we believe the benefits of the graduated per diem methodology now outweigh the concerns that we expressed in the September 1, 1994 final rule. Our methodology for applying this adjustment was described in section II of the Addendum to the proposed rule and is included in this final rule as well.

Finally, we proposed to revise the DRG recalibration methodology so that transfer cases are treated as a proportion of a full case based on the transfer payment amount (as discussed above in section II.C of this preamble). Specifically, we proposed to weight transfer cases as less than a full discharge based on the proportion of the total DRG amount the hospital receives under the graduated per diem transfer payment methodology. This has the effect of increasing the relative weights of the DRGs with a high number of short-stay transfer cases.

Comment: All of the comments we received regarding our revision to the transfer payment methodology were in support of the proposal. ProPAC wrote that ''(t)his policy will improve payment equity for hospitals that must transfer a large number of patients to other hospitals.''

Response: All of the comments favored our proposal, and we have adopted the proposal without change. We appreciate ProPAC's valuable contribution to the analysis of the transfer payment methodology. We share its conclusion that this change will appropriately benefit hospitals that transfer large numbers of patients.

2. Definition of a Transfer Case

Under current policy, cases that are transferred from an acute-care hospital paid under the prospective payment system to another type of provider or unit are considered to be discharges (as opposed to transfers) from the acute-care hospital. As a discharge, payment for the case is the full DRG amount.

As noted above, we are concerned that the current trend of declining average lengths of stay as hospitals transfer Medicare patients into alternative health care settings (other than acute care) in less time may result in a misalignment of payments and costs under our existing payment systems. In particular, we are concerned that hospitals paid under the prospective payment system may be shifting costs (for which they are compensated through the DRG payments) to alternative settings, which in turn may be paid on a cost basis.

In the September 1, 1994 final rule, we explained our rationale for proposing to consider patients transferred to excluded hospitals or units as transfers rather than discharges. Briefly, our proposal was ''based upon the premise that an increasing number of patients are being transferred to excluded hospitals or units and that these patients are still in the acute care phase of treatment when they are transferred.'' (See 59 FR 45364.) We also explained our reason for continuing to consider patients going to a skilled nursing facility (SNF) as discharges. In that regard, we stated that ''(w)e did not propose to consider discharges to SNFs as transfers because we do not consider SNFs to be hospital settings; thus, there is generally little overlap with acute care hospitals in the services provided.'' Based upon further analysis of patient discharge trends and research on the type and outcomes of care provided in SNFs, as well as anecdotal evidence drawn from the health care industry, we no longer believe there is a clear distinction between the type of care provided in SNFs and the type of care provided in hospitals or units excluded from the prospective payment system, such as rehabilitation and long-term care facilities.

Therefore, we considered proposing to expand our definition of transfers to include not only cases going from one hospital paid under the prospective payment system to another but also cases transferred to excluded hospitals and units as well as SNFs. However, as discussed below, our analysis has identified problems that need to be addressed. Nevertheless, once we are convinced these problems can be effectively handled, we intend to proceed with implementing policy changes designed to remedy this issue.

First, our analysis (as well as anecdotal evidence) indicates that the settings where acute care is now being delivered are rapidly expanding and evolving. To the extent that payment is affected by where a patient goes after an acute hospitalization, it is critical to understand the clinical capabilities of different types of settings, so that the incentives created by the payment system do not unduly influence the choice of where to send a patient for postacute care. That is, all like provider settings should be treated equally in terms of payment incentives. Currently, the settings that are considered as alternatives to acute care are expanding rapidly, and we want to be sure that we do not create unforeseen financial incentives toward one alternative over another by any redefinition of transfers.

In addition, as discussed in last year's final rule, hip replacement cases (which, as a group, constitute one of the largest sources of Medicare cases moving from acute to postacute settings) would be systematically underpaid under either the current or the proposed per diem methodology. This is because the cost of the surgery including the prosthetic device, which is incurred in the first day or two of the stay, constitutes a large percentage of the total cost of the stay. A graduated per diem would have to be skewed greatly toward the first day to approximate the daily cost distribution.

We, therefore, solicited public comment with regard to these issues. Specifically, we were interested in suggestions on how best to adapt our payment methodologies for hospitals and units (both acute care paid under the prospective payment system and those excluded from this system), SNFs, and home health agencies in response to the evolving integrated delivery systems. We were particularly interested in comments and suggestions on how to design a comprehensive payment system that better matches payments with the costs providers actually incur in furnishing care (that is, reducing hospital payments when a significant phase of a patient's acute episode is treated in other than an acute hospital inpatient setting). A major issue in developing such an integrated payment system is to neutralize the incentives that arise in terms of where patients are treated. For example, hospitals should continue to be adequately compensated for acute inpatient hospitalization where appropriate, so that there will not

be an adverse incentive to move patients prematurely to alternative settings.

We appreciate the numerous comments we received in response to this solicitation. Many of them shed new light on our understanding of the complicated issues involved, and will serve to enhance our analysis as we grapple with these issues in the future.

Comment: Many commenters misinterpreted our discussion related to the definition of transfer cases as a proposal to expand the definition to include patients moving from an acute care hospital to a hospital or unit excluded from the prospective payment system or to an SNF.

Response: We wish to make clear that we did not propose a change to the definition of transfers. We identified an expanded definition (one that would encompass patients going to SNFs) as one possible approach. We went on, however, to discuss why we were not proposing to make such a change to the definition at this time. Furthermore, we did not suggest that we would pay postacute care providers on the basis of the hospital DRGs.

Comment: The majority of the commenters who discussed an expanded definition of transfers as one approach to address the blurring distinction between different sites of care were opposed to it. Several commenters argued that there remains a clear distinction between the care provided in acute care hospitals and that provided by postacute care providers, and therefore it would be inappropriate to consider these cases as transfers. The point was also raised that defining these cases as transfers would create a financial incentive to hold them in the acute care hospital longer, in order to avoid a reduction in payment. On the other hand, some commenters pointed to ''perverse incentives'' under the current system that encourage early discharges.

Some commenters who argued against last year's proposal wrote to support a redefinition of transfers that includes SNFs. These commenters indicated they were in favor of an expanded definition if it included cases going to SNFs as transfers. Conversely, several commenters opposed including cases going to SNFs, arguing that ''HCFA will *not* accomplish its goal since it will effectively remove any incentive for hospitals to move patients into a more cost-effective setting for subacute care.'' Not surprisingly, opinions on whether any redefinition of transfers should include cases going to SNFs divided along lines of whether the commenter represented SNFs or excluded hospitals.

Response: We would like to make clear that we recognize the importance of rehabilitative care as a necessary and distinct phase of the episode of care for many patients. Similarly, we recognize the historical distinctions between different providers of postacute care, as evidenced, for example, by our different payment policies for excluded hospitals and SNFs. Nevertheless, we are convinced these distinctions have recently become increasingly ill-defined. Part of the difficulty in addressing this issue, however, is that, while some providers have taken great strides toward integrating their health care delivery systems, many others continue to operate under the more traditional approach, with clear distinctions existing between the providers at different phases of patients' care.

We have repeatedly indicated our belief that the incentives created by our payment policy should be neutral in terms of the settings where patients receive care. That is, the payment received should correspond to the costs of the care provided, so that decisions regarding the appropriate site of care are based on clinical, not economic, concerns. As noted above, our concern stems from increasing indications that in certain contexts our present payment system no longer reflects provider costs as accurately as it once did. On the other hand, we believe that, for the most part, our per diem payment methodology for transfer cases does meet this test. Although payments for transfer cases are reduced relative to full discharges, they reflect the reduction in resources hospitals commit to these cases (particularly under our graduated per diem methodology). However, one of the issues of expanding this transfer payment methodology to cases going to excluded hospitals and units, as well as SNFs, is the underpayment for hip replacements. To the extent that the transfer payment is below costs, economic considerations are more likely to enter into the decision of when to release a patient and to which type of setting.

Finally, with regard to whether any redefinition of transfers should or should not include SNFs, we noted in the proposed rule (and reiterated above) that patients appear to be going to SNFs sooner from acute care settings. On the whole, the comments we received reinforced this belief. We will, however, continue to evaluate this issue.

Comment: Some commenters indicated that the redefinition of transfers should apply only to hospital-based distinct part units or in the case of long-term care hospitals, to a ''hospital within a hospital,'' where the incentive to transfer early is strongest. In the words of two commenters: ''(t)his perverse situation is becoming more common as States make it easier for hospitals to circumvent the normal health planning process to convert excess acute care beds to cost-based, distinct part units.''

Response: We share many of the concerns expressed in these comments regarding the special potential for abuse that exists in such situations, and have addressed some of the potential abuses inherent in the ''hospital within a hospital'' arrangements in section IV of this preamble. However, we have historically recognized that many of the distinct part unit situations arise from legitimate efficiency incentives on the part of hospital administrators. In addition, implementing such a proposal would likely multiply the types of problems arising in the ''hospital within a hospital'' issue, as hospitals devise new relationships for postacute care.

Comment: It was suggested that, if we redefine transfers to include cases moving to excluded hospitals and units as well as SNFs, one State should be exempted because, among other reasons, the State's hospitals cannot establish exempt units without receiving a State Certificate of Need.

Response: One of the major factors leading us to pursue refinements with respect to this issue is the fact that not all areas of the country have equal access to postacute care alternatives. Currently, among those DRGs experiencing the most dramatic declines in length of stay, the relative weights are declining as the resources expended for these cases by acute care hospitals around the country decline. Because, effective for FY 1996, for purposes of recalibrating the DRGs, transfer cases are weighted in proportion to their payments, expanding the definition of transfer cases would alleviate some of the downward impact these cases have on the DRG weights. Hospitals lacking the opportunity to decrease their lengths of stay by transferring patients to postacute care settings would thereby benefit.

Comment: A number of commenters suggested that the appropriate means to address the issue of declining lengths of stay was through the DRGs and the prospective payment system, not the definition of a transfer. One commenter, for example, correctly asserts that the reduced resources attributable to cases discharged early from the acute hospital would ultimately result in lower DRG weights. Others called for the system to be rebased in order to capture the savings from the shorter lengths of stay.

Many commenters argued that it would be inappropriate to reduce payments for cases discharged prior to the mean without simultaneously increasing payments for cases discharged after the mean.

Response: An integral concept of the prospective payment system is that a predetermined payment can be made for an identifiable and distinct phase of care. To the extent that hospitals can provide this acute phase of patients' care at costs below average, they profit under this system. In response to this incentive, lengths of stay declined dramatically in the first few years after implementation of the prospective payment system.

Our concern regarding the misalignment of payments and costs arises when the acute phase of care may no longer be completed within the hospital. At that point, it is no longer sufficient to rely on the recalibration of the relative weights of the DRGs to correct the balance between payments and costs. Recalibration is, by definition, a budget neutral process. While payments will decline for the DRGs with cases that are being moved earlier out of the hospital, this decline will necessarily be offset by relative increases for other DRGs. The net result is that total payments systemwide are the same despite the cost reductions.

One way of potentially capturing these reductions would be to rebase the standardized amounts using more recent cost data. We are not convinced at this time, however, that such a dramatic approach is warranted. In addition, due to the need to use audited cost data in any such rebasing, it is questionable to what extent rebasing at this time would capture these savings, since this trend has apparently begun to accelerate only in the last year or two.

We disagree with the comments that it is inappropriate to reduce payments for cases discharged prior to the mean without simultaneously increasing payments for cases discharged after the mean. Cases with long lengths of stay may be eligible for outlier payments. In addition, as we pointed out in last year's final rule, generally fewer than 10 percent of cases in the DRGs most likely to receive postacute care leave the acute care hospital before the geometric mean length of stay, minus one day, and would therefore receive payment under the per diem methodology (59 FR 45365).

Comment: Several commenters noted that our current payment methodologies are predominately fee-for-service, and that this method of paying for health care will become much less prevalent in the near future. These commenters suggested that under a Medicare capitated payment methodology many of the issues with which we are concerned will resolve themselves.

Response: We agree that issues pertaining to properly allocating payments among service providers is significantly a function of our fee-for-service payment systems, which are largely required by the Medicare law. Nevertheless, given the amount of money currently paid through our fee-for-service systems, and the projections from the Office of the Actuary regarding the Medicare Trust Fund, the need to address this issue is pressing. Therefore, given the uncertainty about major legislative changes to our payment systems, we intend to pursue a solution that can be implemented relatively soon.

Comment: In response to our request, we received numerous suggestions for alternative approaches to address the evolving integration of the various phases of a patient's care across different provider settings. In the timeframe we are under to publish this final rule, we cannot appropriately analyze and respond to all of them. Additional comments we received included the following:

- There is no current infrastructure to accommodate a bundled payment system for acute and postacute care.
- HCFA should rely on the utilization review process to identify individual abusive providers and deal with them on an individual basis.
- HCFA should pursue its stated intention to better understand the clinical capabilities of various postacute settings.
- All types of providers of inpatient rehabilitation services should be under the same payment system (the Functional Related Groups concept was suggested).
- Hospital outpatient services should be included in the analysis of postacute care.
- HCFA should establish a commission to consider both the financial and clinical aspects of postacute care.
- A new discharge status code should be established for patients transferred for subacute, rather than postacute, care.

A number of revisions to SNF payment policy were also recommended, including a more stringent review of cost limit exception requests, a cap on exceptions based on like providers, elimination of the 3-day hospital stay requirement for Medicare SNF coverage, permitting providers to establish multiple distinct parts, and applying the hospital-based routine cost limits to freestanding SNFs.

Response: As noted above, we appreciate the many suggestions we received and will take each into consideration as we pursue our options. In addition, we anticipate that we will continue to work with the hospital industry as we proceed in our efforts to address this problem.

B. Physician Attestation (Section 412.46)

Under current Medicare regulations at § 412.46(a), physicians are required to sign an attestation statement for each hospital discharge before the claim can be submitted to the intermediary for payment. With this attestation, the physician is certifying the accuracy of the principal and secondary diagnoses and the major procedures performed for each patient during the inpatient stay. Because this information dictates which DRG is assigned to a case, it is extremely important that it be correct so that proper Medicare payment can be made.

The attestation statement the physicians sign reads as follows:

> I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge. (§ 412.46(a).)

Although a hospital official is required to certify on each Medicare claim form that all the data are correct, when the prospective payment system was first implemented, we believed that we needed a clear statement for each claim concerning the validity of that data. At the time, we believed that the physician was in the best position to attest to the information.

The hospital must also have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

> Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patients, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. (§ 412.46(c)(1).)

We implemented these requirements to ensure a means of holding hospitals and physicians accountable for the information they submit on the Medicare claims form. At the time, we believed that these statements were valuable tools for ensuring the validity of DRG claims.

Over the years, we have received many complaints from both hospitals

and physicians concerning the administrative burden of completing the attestation and acknowledgement statements. In a final rule with comment period published in the **Federal Register** on March 9, 1994 (59 FR 11003), we revised the regulations to require that a physician need sign the acknowledgement statement only upon receiving admitting privileges at a hospital and no longer was required to sign the statement every year.

In practice, review of attestation statements by the Peer Review Organizations (PROs) as a part of DRG validation review has resulted in less than a 0.01 percent denial rate of sampled claims. Therefore, in an effort to reduce burden, we are revising the regulations to eliminate the physician attestation requirement.

We believe that this will reduce the burden on both physicians, who must sign an attestation on each of the approximately 11 million Medicare inpatient claims a year, and on hospitals, which are responsible for obtaining the signatures before they can submit completed claims for payment. In addition, the hospital claim form (UB–92), which must be signed by a hospital representative, contains a certification statement that reads as follows:

> Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal or State law.

Because the hospital remains responsible for certifying that the hospital claim is accurate, we believe that we can hold the hospital responsible for the accuracy of the diagnostic and procedural information. We are revising revise § 412.46 by eliminating paragraphs (a), (b), (d), and (e). We note that on January 20, 1995, HCFA notified its Regional Offices that the PROs would no longer be responsible for performing attestation review.

Although this revision was not included in the proposed rule, we did receive many comments requesting that we eliminate the physician attestation requirement. In addition, this change was announced in July by Vice President Albert Gore, as one of the Administration's health care regulatory reforms.

C. Rural Referral Centers (Section 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 payment rate rather than the rural payment rate. As of that date, the other urban and rural payment rates are the same. However, rural referral centers continue to receive special treatment under both the disproportionate share hospital payment adjustment and the criteria for geographic reclassification.

One of the criteria under which a rural hospital may qualify as a 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 (number of discharges and case-mix index) and at least one of three optional criteria (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. In determining the proposed national and regional case-mix index values, we followed the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value included all urban hospitals nationwide, and the proposed regional values were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

The values in the proposed rule were based on discharges occurring during FY 1994 (October 1, 1993 through September 30, 1994) and included bills posted to HCFA's records through December 1994. Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status or to meet the triennial review standards for cost reporting periods beginning on or after October 1, 1995, a hospital's case-mix index value for FY 1994 would have to be at least—

- 1.3165; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located. (See the table set forth in the June 2, 1995 proposed rule at 60 FR 29222.)

Based on the latest data available (FY 1994 bills received through June 1995), the final national case-mix value is 1.3184 and the median case-mix values by region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2135
2. Middle Atlantic (PA, NJ, NY)	1.2077
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3141
4. East North Central (IL, IN, MI, OH, WI)	1.2288
5. East South Central (AL, KY, MS, TN)	1.2814
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1892
7. West South Central (AR, LA, OK, TX)	1.2986
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3630
9. Pacific (AK, CA, HI, OR, WA)	1.3300

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 1994 case-mix index value in Table 3C in section V of the addendum to this final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, we proposed to update the regional standards. The proposed regional standards were based on discharges for

urban hospitals' cost reporting periods that began during FY 1993 (that is, October 1, 1992 through September 30, 1993). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status or to meet the triennial review standards for cost reporting periods beginning on or after October 1, 1995, the number of discharges a hospital must have for its cost reporting period that began during FY 1994 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the June 2, 1995 proposed rule at 60 FR 29222.)

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

Region	No. of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6815
2. Middle Atlantic (PA, NJ, NY)	8618
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7500
4. East North Central (IL, IN, MI, OH, WI)	7155
5. East South Central (AL, KY, MS, TN)	5582
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5135
7. West South Central (AR, LA, OK, TX)	4464
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8179
9. Pacific (AK, CA, HI, OR, WA)	5594

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1995, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1994 would have to be at least 3,000.

3. Retention of Referral Center Status

Section 412.96(f) states the general rule that each hospital receiving the referral center adjustment is reviewed every 3 years to determine if the hospital continues to meet the criteria for referral center status. To retain status as a referral center, a hospital must meet the criteria for classification as a referral center specified in § 412.96 (b)(1) or (b)(2) or (c) for 2 of the last 3 years, or for the current year. A hospital may meet any one of the three sets of criteria for individual years during the 3-year period or the current year. For example, a hospital may meet the two mandatory requirements in § 412.96(c)(1) (case-mix index) and (c)(2) (number of discharges) and the optional criterion in paragraph (c)(3) (medical staff) during the first year. During the second or third year, the hospital may meet the criteria under § 412.96(b)(1) (rural location and appropriate bed size).

A hospital must meet all of the criteria within any one of these three sections of the regulations in order to meet the retention requirement for a given year. That is, it will have to meet all of the criteria of § 412.96(b)(1) or § 412.96(b)(2) or § 412.96(c). For example, if a hospital meets the case-mix index standards in § 412.96(c)(1) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards would have to be met in the same year.

In accordance with § 412.96(f)(2), the review process is limited to the hospital's compliance during the last 3 years. Thus, if a hospital meets the criteria in effect for at least 2 of the last 3 years or if it meets the criteria in effect for the current year (that is, the criteria for FY 1996 outlined above in this section of the preamble), it will retain its status for another 3 years. We have constructed the following chart and example to aid hospitals that qualify as referral centers under the criteria in § 412.96(c) in projecting whether they will retain their status as a referral center.

Under § 412.96(f), to qualify for a 3-year extension effective with cost reporting periods beginning in FY 1996, a hospital must meet the criteria in § 412.96(c) for FY 1996 or it must meet the criteria for 2 of the last 3 years as follows:

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the **Federal Register** on
1995	1993	1993	September 1, 1994.
1994	1992	1992	September 1, 1993.
1993	1991	1991	September 1, 1992.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1993. The hospital has fewer than 275 beds. Its 3-year status as a referral center is protected through June 30, 1996 (the end of its cost reporting period beginning July 1, 1995). To determine if the hospital should retain its status as a referral center for an additional 3-year period, we will review its compliance with the applicable criteria for its cost reporting periods beginning July 1, 1993, July 1, 1994, and July 1, 1995. The hospital must meet the criteria in effect either for its cost reporting period beginning July 1, 1996, or for two out of the three past periods. For example, to be found to have met the criteria at § 412.96(c) for its cost reporting period beginning July 1, 1994, the hospital's case-mix index value during FY 1992 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 1, 1993 final rule with comment period. The hospital's total number of discharges during its cost reporting year beginning July 1, 1992, must have equaled or exceeded 5,000 or the regional standard as published in the September 1, 1993 final rule with comment period.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96(b)(1)(i) and (ii) (that is, rural location and at least 275 beds), we will look at the number of beds shown for indirect medical education purposes (as defined at § 412.105(b)) on the hospital's cost report for the appropriate year. We will consider only full cost reporting periods when determining a hospital's status under § 412.96(b)(1)(ii). This definition varies from the number of beds criterion used to determine a hospital's initial status as

a referral center because we believe it is important for a hospital to demonstrate that it has maintained at least 275 beds throughout its entire cost reporting period, not just for a particular portion of the year.

Comment: One commenter noted that the American Osteopathic Hospital Association had changed its name to the American Osteopathic Healthcare Association and requested that § 412.96(c)(2)(B)(ii) be revised to reflect this change.

Response: Section 412.96(c)(2)(B)(ii) specifies that a rural osteopathic hospital that is recognized by the American Osteopathic Hospital Association can meet the number of discharges criterion at § 412.96(c)(2) if it has at least 3,000 discharges for the hospital's most recently completed cost reporting period. As requested, we are revising § 412.96(c)(2)(B)(ii) to reflect the organization's new name. To qualify as an osteopathic hospital, the hospital must be recognized by the American Osteopathic Healthcare Association (or any successor organizations).

D. Determination of Number of Beds Used in Calculating the Indirect Medical Education Adjustment (Section 412.105)

In the September 1, 1994 final rule (59 FR 45373), in an effort to clarify our policy, we amended the regulations at § 412.105(b), that describe how to determine the number of beds in a hospital for purposes of the indirect medical education adjustment. At that time, we added language to the regulations that specifically excludes ''nursery'' beds assigned to newborns ''that are not in intensive care areas'' from the bed count. This change was supposed to clarify that, with regard to infants, only beds in a nursery used for newborns (see section 2815 of the Provider Reimbursement Manual-Part 2) are excluded from the count. As we stated in the May 27, 1994 proposed rule (59 FR 27741), we made this revision ''to exclude specifically only beds assigned to newborns *in the nursery*'' (emphasis added). Furthermore, when we published the final rule, we added the reference to nursery beds directly into the text of § 412.105(b) ''(t)o prevent any future confusion about the term 'newborn' '' (59 FR 45374).

Although we received no comments in response to the May 27, 1994 proposed rule as to whether beds occupied by sick infants in areas other than a neonatal intensive care area or a nursery could be counted, we continue to receive questions on this issue. Therefore, in the June 2, 1995 proposed rule, we proposed to revise § 412.105(b) to further clarify our bed counting policy. This year, rather than specifically identifying intensive care beds occupied by infants as eligible to be counted, we proposed to delete that phrase and insert the phrase ''beds in the healthy newborn nursery.'' As we stated in the June 2 proposed rule, our policy is and has been that only beds in a healthy, or regular, baby nursery are excluded from the count. All other beds available for occupancy by a newborn are to be counted. We received a number of comments on our policy clarification.

Comment: Several commenters believe that, rather than a policy clarification, the proposed language represents a policy shift in how we count beds. Several of these commenters indicated that the proposed language was not supported within the construct of current regulations and manual instructions. Specifically, commenters stated that the current § 412.105(b) and the manual instructions at section 2202.7.II of the Provider Reimbursement Manual-Part 2 (which defines intensive care units) indicate that the only beds assigned to infants that are to be counted are those in a neonatal intensive care unit.

Response: This change to the regulation language does not represent a policy shift. While the manual section referenced by the commenters does distinguish explicitly between neonatal intensive care units and a regular well-baby unit, this distinction clearly is not exhaustive of all of the possibilities for counting beds assigned to infants. In fact, the same manual section goes on to indicate that subintensive care type units, that is, those not meeting the criteria for intensive care units, are considered as general routine care areas. Although this discussion does not specifically mention neonatal subintensive care units, we believe it is applicable for these units as well.

In addition, section 2815 of the Provider Reimbursement Manual-Part 2 has long included a definition of newborn inpatient days that indicates that our policy for including inpatient days attributable to sick infants is not restricted to the neonatal intensive care unit in describing the days that are to be included in the completion of Worksheet D–1 of the Provider Cost Reporting Form 2552.

''Newborn inpatient days are the days that an infant occupies a newborn bed in the nursery. Include [as inpatient days] an infant remaining in the hospital after the mother is discharged who does not occupy a newborn bed in the nursery, an infant delivered outside the hospital and later admitted to the hospital but not occupying a newborn bed in the nursery, or an infant admitted or transferred out of the nursery for an illness in inpatient days. Also, include an infant born in and remaining in the hospital and occupying a newborn bed in the nursery after the mother is discharged in newborn inpatient days.''

Total inpatient days reported on that form exclude those days applicable to newborn days. However, as clearly stated, days of care for newborns outside the nursery are not considered to be newborn days.

We believe this decades-old manual instruction (in place since 1975) supports our position that all references to the exclusion of the costs, days, or beds of nursery units refer only to the regular, healthy baby nursery, and that the proposed language represents a clarification rather than a shift in policy. We recognize that some of these references may not have been as precise as they could have been when they refer only to ''newborn beds'' or ''nursery beds,'' and this imprecision occasionally has led to confusion both within and outside the agency. However, where the instructions are specific, these terms are sufficiently well-defined so that they can reasonably be interpreted to refer only to a regular, healthy baby nursery.

Comment: Commenters suggested that past practice on the part of Medicare's fiscal intermediaries with regard to counting these beds has been inconsistent. That is, some intermediaries have allowed hospitals to exclude only those days that a newborn is in the nursery, while other intermediaries have allowed hospitals to exclude any day a newborn is not in a certified-intensive care unit. Therefore, the commenters believe it would be improper to begin to exclude them now. Commenters questioned whether we would require intermediaries to adjust unsettled past cost reports where these beds were excluded incorrectly. It was suggested that doing so would constitute retroactive rulemaking.

Response: We recognize that there have been inconsistencies in the application of this policy. We believe this has stemmed from the absence of a specific provision in the instructions on the treatment of subintensive/intermediate care beds, which this clarification should remedy. In light of these previous inconsistencies, we expect that all fiscal intermediaries that have not been correctly counting newborn beds consistent with our policy, as clarified in this final rule, must ensure that they revise their practices effective for cost reporting periods beginning on or after October 1, 1995. We expect that those fiscal

intermediaries that have been applying our policy appropriately will continue that practice.

Comment: Several commenters questioned whether the costs of these neonatal intermediate units were included in the calculation of the prospective payment system standardized amounts. They stated that unless we could demonstrate that the costs of these units were included in the base year used to calculate the standardized amounts, there is no basis for counting these beds when determining the resident-to-bed ratio.

Response: As indicated above in a previous response to comment, our policy to include the days, costs, and beds of these units predates the prospective payment system, as well as the base year (1981) that was used to set the standardized payment amounts. Consequently, we disagree that we should be prohibited from clarifying this policy due to apparent inconsistencies in its implementation.

Comment: Additional comments related specifically to how we differentiate between healthy baby nursery beds and special care beds. Commenters requested guidance on the status of those beds that are occasionally used to treat less healthy newborns, but that are actually located within a regular, healthy baby nursery. The commenters noted that currently there is no clear definition in the regulations or manual instructions that could be used to identify an intermediate level of special care between a healthy, or regular, nursery and a neonatal intensive care unit. Finally, one commenter suggested that we consider licensure criteria for distinguishing between treatment units.

Response: Our bed counting policy essentially is determined by our policies for including or excluding costs and days from the calculation of Medicare costs on the cost report. These policies have consistently followed the general principle that we do not attribute costs or days to individual beds, but rather to units or departments. Therefore, individual beds that are occasionally used to treat less healthy infants, but that are located within a regular, healthy baby nursery, continue to be treated as part of the unit in which they are located, that is, as part of the healthy baby nursery. In considering whether the beds used to treat sick infants constitute an intermediate neonatal care unit, one must consider the cost center concept. Section 2302.8 of the Provider Reimbursement Manual-Part 2 describes a cost center ''as an organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated * * *.'' A regular, healthy baby nursery serves as a custodian of healthy infants, whereas the intermediate or subintensive neonatal care unit provides medical care to sick infants with very different types of costs being incurred. Therefore, the appropriate cost center with which to count the beds of an intermediate neonatal care unit is the Adults and Pediatrics cost center.

While there is a great deal of variation in the types of units that exist to care for infants, the Medicare fiscal intermediaries have been required for some time to distinguish between nurseries and intermediate units for cost reporting purposes.

Also, concerning the suggestion that we rely on licensure designations to differentiate between units, we do not believe this would be a feasible alternative due to variations in licensing criteria across the country.

Comment: A representative of a group of Medicare's fiscal intermediaries requested that we retain the language in § 412.105(b) specifically including neonatal intensive care beds in the bed count. This commenter also pointed out that what we refer to as beds are often referred to instead as bassinets, and that we should include both phrases in the regulations. Finally, we were asked to clarify our policy regarding the counting of beds or bassinets kept in the mother's room, for example, in an alternative birthing center.

Response: We proposed deleting the reference to the inclusion of neonatal intensive care unit beds from the regulations because we believe that reference led to confusion concerning the beds excluded from the hospital bed count. We continue to believe that the proposed wording, combined with the policy clarification published in last year's proposed and final rules, sufficiently defines our intentions as to which beds are to be excluded. We agree that ''bassinets'' should be included in the definition for determination of the number of beds. Therefore, we are revising § 412.105(b) accordingly.

With regard to beds placed in the mother's room rather than in a healthy baby nursery, these beds or bassinets are not counted in addition to the mother's bed already present in that room. We do not believe, however, that it is necessary at this time to add a reference to this issue in § 412.105. Nevertheless, we will continue to evaluate the policy implications of these arrangements in the future.

E. Disproportionate Share Adjustment (Section 412.106)

Section 1886(d)(5)(F) of the Act provides for additional payments for hospitals that serve a disproportionate share of low income patients. A hospital's disproportionate share adjustment is determined by calculating two patient percentages (Medicare Part A/Supplemental Security Income (SSI) covered days to total Medicare covered days, and Medicaid but not Medicare Part A covered days to total inpatient hospital days), adding them together, and comparing that total percentage to the hospital's qualifying criteria. These calculations are done by HCFA and the fiscal intermediary on a Federal fiscal year basis. However, § 412.106(b)(3) currently states that if a hospital prefers that HCFA use its cost reporting period instead of the Federal fiscal year, it must furnish to its intermediary, in machine-readable format as prescribed by HCFA, data on its Medicare Part A patients for its cost reporting period. These data take the place of the Federal fiscal year MedPAR file data in obtaining the Medicare Part A/SSI percentage. To ensure that the hospital is reporting actual Medicare Part A patient days, we match the hospital's data to the HCFA MedPAR data. In addition, we have required that a hospital accept the recalculated percentage, even if it is lower than the Federal fiscal year percentage.

In the last few years, this process has proven to be unsatisfactory for several reasons. First, it is an administrative burden for the hospital to prepare a tape that includes all its Medicare Part A inpatient days. In addition, the hospital's tape data have seldom exactly matched the MedPAR data. In that case, we can use only the data that match. Finally, and probably often due to this second problem, the resulting disproportionate patient percentages are invariably lower than the original HCFA determined percentage. We proposed to alleviate these problems by continuing to provide hospitals an alternative to base their percentage on their cost reporting year, but relieving them of the tape requirement.

Therefore, we proposed that if a hospital wishes a recalculation based on its cost reporting period, the hospital would notify HCFA in writing of its request that the Medicare Part A/SSI percentage be calculated based on its own cost reporting year. The hospital would be required to provide HCFA with its name, provider number, and cost report period end date. HCFA, in turn, would use all MedPAR records for that hospital from the requested time

period, as opposed to only those records that matched between the MedPAR file and the hospital's tape data. This should provide hospitals with more appropriate Medicare Part A/SSI percentages.

In addition, we proposed to process these requests on a quarterly basis. Processing these individual requests for recalculation on a flow basis has become an administrative burden on the available HCFA computer processing resources. Therefore, we believe it is necessary to batch these requests and run the MedPAR data on a set schedule. This will be much more efficient and predictable.

Accordingly, we proposed to revise § 412.106(b)(3) to provide that HCFA will accept a hospital's written request, transmitted through its fiscal intermediary, for a recalculation of its Medicare Part A/SSI percentage based on its cost reporting period. The written request should include the hospital's name, provider number, and cost report period end date. We would perform a recalculation only once per hospital per cost report period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

Comment: We received three comments, all of which supported our proposal to use the MedPAR file data to recalculate Medicare Part A/SSI percentages rather than continuing the requirement that hospitals submit a tape of their Medicare Part A data based on their cost reporting periods. However, one commenter was concerned that HCFA provide an opportunity for hospitals to verify the data, and another commenter requested that we add a provision that would hold a hospital harmless if the Medicare Part A/SSI percentages decreased when this alternative was requested. The latter commenter suggested that a hospital affected by the ''hold harmless'' provision be subject to a processing fee for the unused cost reporting period.

Response: Since there was no opposition to the proposed change, we are adopting it in this final rule. Because the SSI data used in the calculation are protected by the Privacy Act, we cannot provide an opportunity for hospitals to verify these data. The data that the Social Security Administration (SSA) uses to determine the Medicare Part A/SSI percentage are not released to HCFA and therefore we are unable to produce these data for hospitals. We must accept the data that are officially collected and compiled by the SSA on a monthly basis. The SSA is responsible for administering the SSI program and keeps track, on a monthly basis, of those individuals who receive SSI benefits.

Concerning the request for a ''hold harmless'' provision, it has been our consistent policy that a hospital that requests a recalculation of its Medicare Part A/SSI percentage based on its cost reporting period must accept the result of that calculation in place of the Federal fiscal year calculation. We believe that this policy prevents hospitals from taking advantage of the opportunity to request this procedure merely so that they can choose the higher percentage. Ideally, a hospital will request a recalculation only if it has not qualified for a disproportionate share adjustment but believes it is close to qualifying.

F. Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs) (Sections 412.109, 413.70, 424.15, 485.603, 485.606, 485.614, 485.620, and 485.639, 485.645)

On May 26, 1993, we published a final rule to implement the EACH program (58 FR 30630). The rule set forth the requirements for designating certain hospitals as EACHs or RPCHs, the conditions that an RPCH must meet to participate in Medicare, and the rules for Medicare payment for services furnished by EACHs and RPCHs. The final rule implemented section 1820 of the Act, as added by sections 6003(g) and 6116(b)(2) of Public Law 101–239 and revised by section 4008(d) of Public Law 101–508. The amendments were intended to promote regionalization of rural health services in grant States, improve access to hospital and other health services for rural residents, and enhance the provision of emergency and other transportation services related to health care.

Section 102 of the Social Security Act Amendments of 1994, Public Law 103–432 (SSAA '94), made significant changes in the provisions of the Medicare law governing the EACH/RPCH program. To implement these changes, we proposed to revise the regulations as follows:

1. Designation of Urban Hospitals as EACHs (Section 412.109)

Section 1820(e) of the Act previously provided that only rural facilities could be designated as EACHs, and all EACHs were to be paid as sole community hospitals (SCHs). Section 102(b)(1) of SSAA '94 revised section 1820(e) of the Act to allow hospitals located in urban areas to be designated as EACHs if they have entered into network agreements with RPCHs and meet other applicable requirements. As EACHs, these urban facilities may qualify for EACH grants. However, they are not eligible for the special payment methodology afforded rural EACHs. For payment purposes, rural EACHs are treated as sole community hospitals (SCH). Section 1886(d)(5)(D) of the Act was amended to clarify that only hospitals designated as EACHs *and* located in rural areas are treated as SCHs for payment purposes. Urban EACHs will therefore continue to be paid at the applicable urban rates.

To implement this provision, we proposed to revise § 412.109 to remove the current rural location requirement for EACH designation, and to provide that payment as an SCH is limited to EACHs in rural areas. As explained below, we also proposed to revise that section to allow a State that has received an EACH grant to designate an otherwise qualified hospital in an adjoining State as an EACH.

In conjunction with this change, we proposed to make a technical correction to a reference in § 485.603.

We received no comments in response to these proposals, and are, therefore, adopting them as proposed.

2. Designation of EACHs and RPCHs in States Adjoining Grant States (Sections 412.109 and 485.606)

Section 1820(c) of the Act previously provided that hospitals could be designated as EACHs only if they were located in States receiving EACH grants. Section 1820(i)(2) of the Act did authorize designation of RPCHs outside the grant States; however, the number of facilities designated under this authority was limited to 15 nationally, and only the Secretary, not individual grant States, could make the designation. Section 1820(i)(2) of the Act further requires the Secretary, in making the special designations, to give preference to facilities that have entered into network agreements with other facilities in grant States, thus indicating a strong preference for designation of RPCHs in States adjoining grant States. Section 102(b)(2) of SSAA '94 amended section 1820 of the Act to authorize the individual grant States to make designations of both EACHs and RPCHs in adjoining States, if the facilities so designated are otherwise qualified and have entered into network agreements with EACHs or RPCHs in the grant State. The legislation does not limit the number of such designations. To implement this change, we proposed to revise §§ 412.109 and 485.606 to permit these new designations of EACHs and RPCHs by adjacent States that have received grants. We proposed that hospitals designated in this way will be required to meet other applicable requirements, and we plan to make such designations subject to review and

approval by the HCFA regional offices on the same basis as designations of facilities in the grant State. That is, the designation will not result in recognition of a facility as an EACH or RPCH for Medicare or Medicaid purposes until HCFA has determined that the requirements are met.

We received no comments in response to these proposals, and are, therefore, adopting them as proposed.

3. Designation of EACHs and RPCHs by States That Have Received Grants (Sections 412.109 and 485.606)

Section 1820(a)(1) of the Act establishes a program under which the Secretary makes grants available to not more than seven States to carry out certain activities, including designating hospitals or facilities in the State as either an EACH or an RPCH. Because there is no assurance that funding of this grant program will continue, some or all of the seven States may not receive grants under section 1820(a)(1) of the Act in the future. Since States may not continue to ''receive'' grants, we proposed to revise the regulations pertaining to EACHs and RPCHs by replacing references to ''States receiving grants'' with references to ''States that have received grants'' or ''a State that has received a grant,'' as appropriate. Specifically, we proposed to revise the designation of EACHs and RPCHs under current § 412.109(b) and (c), and § 485.606, respectively, to include these revised references. Should the grant program expire, these proposed revisions would prevent any uncertainty that may arise as to the status of designations made by States that have received grants.

We received no comments in response to these proposals, and are, therefore, adopting them as proposed.

4. Change in Payment for Outpatient RPCH Services (Section 413.70)

Previously, section 1834(g) of the Act provided that payments to RPCHs for outpatient services under the cost-based facility fee plus professional charges method were to be determined under section 1833(a)(2)(B) of the Act. That section states that payment is to be made at the lesser of the reasonable cost of the services or the customary charges for the services. (This is commonly referred to as ''LCC,'' that is, the lesser of costs or charges.) Current regulations at § 413.70(b)(2)(i) require that payment to RPCHs under the cost-based facility fee plus professional services be made in accordance with the LCC principle. This principle is set forth under § 413.13.

Section 102(e)(2) of SSAA '94 amended section 1834(g)(1) of the Act to provide that payment for outpatient RPCH services under the cost-based facility fee plus professional charges method are to be determined without regard to the amount of the customary charge. To implement this change, we proposed to amend § 413.70(b)(2)(i) to provide that for payment for RPCH outpatient services made under the cost-based RPCH payment plus professional services method, the principle of the lesser of costs or charges does not apply.

We received no comments in response to these proposals, and are, therefore, adopting them as proposed.

5. Content of Required Physician Certification (Section 424.15)

Section 1814(a)(8) of the Act previously provided that Medicare Part A could pay for inpatient RPCH services only if a physician certified that the services were required to be furnished immediately on a temporary, inpatient basis. Section 102(a)(3) of SSAA '94 deleted this requirement and provided instead that Medicare Part A will pay for the inpatient RPCH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the RPCH. We proposed to revise § 424.15 to reflect the new requirement.

We received no comments in response to this proposal, and are, therefore, adopting it as proposed.

6. Length-of-Stay Requirement for RPCHs (Sections 485.614 and 485.620)

Section 1820(f)(1)(F) of the Act previously allowed all RPCHs to keep inpatients no longer than 72 hours before discharging them or transferring them to a full-service hospital, unless discharge or transfer was precluded by inclement weather or other emergency conditions. Section 102(a)(1) of SSAA '94 removed the per-stay limitation and substituted for it a provision under which the Secretary may terminate the designation of a facility as an RPCH if the Secretary finds that the average length of stay in the preceding year exceeded 72 hours. The provision further states that periods of stay in excess of 72 hours that occurred because discharge or transfer were precluded by inclement weather or other emergency conditions are not to be taken into account in computing a facility's average length of stay for this purpose.

To implement this change, we proposed to revise §§ 485.614 and 485.620 to delete the current per-stay limitation, and to replace it with a requirement for a facility-wide average length of stay that does not exceed 72 hours, excluding parts of stays in excess of 72 hours that occurred because of inclement weather or other emergencies. In the case of a currently participating RPCH, termination of the RPCH designation can be made effective only by ending Medicare participation. Therefore, we proposed to revise § 489.53 to authorize termination of the provider agreement of an RPCH if HCFA finds that it does not maintain the required average length of stay.

We received no comments in response to these proposals, and are, therefore, adopting them as proposed.

7. Restriction on Scope of Surgical Services to RPCH Inpatients (Section 485.614 and new Section 485.639)

Before the Social Security Act Amendments of 1994 were enacted, there were no explicit restrictions on the type or extent of surgical activity that could be performed in a RPCH. These facilities and their practitioners were, however, required to conform to applicable State licensure and scope of practice laws. Section 102(a)(1) of SSAA '94 added an explicit restriction on surgical activity by RPCHs. Specifically, a State may not designate a facility as an RPCH if the facility provides inpatient hospital services consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A) of the Act), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services. The procedures specified by the Secretary under section 1833(i)(1)(A) of the Act are those that are performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (ASC) or in a hospital outpatient department. Implementing regulations for section 1833(i)(1)(A) of the Act are set forth at § 416.65. HCFA also publishes a list of covered surgical procedures in Addendum A to Part 3 of the *Medicare Carriers Manual.*

To implement this change, we proposed to revise § 485.614 to reflect the new statutory provision. We note that the law still does not limit the scope of surgical procedures that can be performed for RPCH outpatients, and that both hospitals and ASCs, the other two facilities in which ASC procedures can be performed, are subject to specific health and safety rules on administration of anesthesia and performance of the surgery. To ensure

adequate health and safety protection for RPCH patients and to apply Medicare standards uniformly to ASC-type procedures, we also proposed to add, at § 485.639, a new RPCH condition of participation for surgical services. We note that the new condition would apply the same rules in the RPCH as now apply in an ASC, and that it would apply to both inpatient and outpatient surgery. Given the similarities between RPCHs and ASCs and the fact that identical procedures can be performed in each, we believe uniform health and safety rules are needed.

We received no comments in response to these proposals, and are, therefore, adopting them as proposed.

G. New Provision Subject to Public Comment To Allow Provision of Skilled Nursing Facility (SNF) Services by RPCHs (Section 485.645)

When we issued regulations (§ 485.645) to implement the RPCH provisions in section 1820 of the Social Security Act (see 58 FR 30630, May 26, 1993), we made a number of interpretations or elaborations to deal with situations that were not explicitly dealt with by the statute. Among them were these two policies: an RPCH with a swing-bed agreement could have no more than 12 beds for the use of inpatients (§ 485.645(a)(1)); and all 12 beds could ''swing,'' that is, could be used to furnish both RPCH-level (acute) care as well as a SNF-level of care, as the individual patient required.

Congress changed those policies when it enacted section 102 of the Social Security Act Amendments of 1994. First, Congress rejected the 12-bed limit. Section 102(c) of SSAA '94 amended section 1820(f)(3) of the Act to provide instead that in the case of a hospital with a swing-bed agreement under section 1883 of the Act that applies to become a RPCH, the number of beds that the RPCH can use for furnishing SNF-level services may not exceed the total number of beds that were licensed beds at the time the hospital applies to become an RPCH, minus the number of inpatient RPCH beds. (Thus, the number of beds an RPCH may have for SNF-level care could be more or fewer than 12.)

Second, amended section 1820(f)(3) now refers only to ''the number of beds used [by the RPCH] for the furnishing of such [SNF-level] services.'' This language does not also refer to using those beds to furnish such SNF-level services along with RPCH-level services.

Third, Congress provided that the six RPCH-level beds could not also be used to furnish SNF-level services. Specifically, section 1820(f)(3) now explicitly states that the number of beds an RPCH can use for furnishing SNF-level services must be calculated ''minus the number of inpatient beds used for providing inpatient [RPCH-level (acute)] care.'' The latter indicates that Congress did not anticipate the six RPCH-level beds would also be used to furnish SNF-level services.

Further, in section 102(g) of SSAA '94, Congress enacted a number of conforming technical amendments to make explicit that various provisions applicable to hospitals should also be applicable to RPCHs. In doing so, however, it conspicuously failed similarly to amend section 1883 of the Act, ''Hospital Providers of Extended Care Services.'' That is the provision that permits hospitals to have swing beds. Not amending section 1883 is consistent with our conclusion that Congress intended to permit certain RPCHs to have a limited number of beds for furnishing SNF-level services, but not dual-purpose swing beds.

We believe these Congressional policy changes are based on sound policy reasons. First, the six-bed limit for inpatient RPCH-level care is reconfirmed. That was a major element in Congress' decision in the original legislation to encourage small rural hospitals to convert from being full service hospitals to become limited purpose facilities. Second, all RPCHs are now treated the same with respect to the limit on the number of RPCH-level inpatient beds. Third, hospitals that had swing-bed agreements can continue to furnish SNF-level services when they become RPCHs, without interfering with the other RPCH provisions.

As noted, although section 1820 of the Act, as amended by section 102(c) of SSAA '94, does not provide for an RPCH to continue to use its beds interchangeably to provide RPCH-level and SNF-level services, it does provide for an existing swing-bed hospital to be designated as an RPCH (with up to 6 beds used exclusively for inpatient RPCH-level services) and retain its remaining beds to be used exclusively for SNF-level services. Payment for the RPCH-level care provided by the RPCH would be determined in accordance with 42 CFR 413.70(a). In establishing the payment methodology for the SNF-level services provided by the RPCH, we have concluded that since SNF-level services provided by the hospital had previously been paid under the methodology specified for swing-bed hospitals at 42 CFR 413.114, it is consistent with sound application of these reasonable cost principles to continue to pay for those services under that methodology.

In this final rule, we are revising § 485.645 accordingly to set forth the eligibility and payment policies described above. We recognize that there may be concerns about the implementation of this provision with respect to facilities originally designated as RPCHs before the effective date of the new amendments, and are providing a 60-day public comment period on the § 485.645 changes only. (As discussed above in section IV.F of this preamble, the other changes needed to implement section 102 of SSAA '94 were included in the proposed rule and, in the absence of public comment, are being adopted without change.) Because we did not include these changes in the proposed rule, we considered delaying the implementation of section 102(c) further in order to allow time for full notice-and-comment rulemaking. However, the statutory effective date is October 31, 1994, and several facilities have indicated an interest in being designated as RPCHs under the new provisions. Moreover, we believe these changes may be necessary to assure access to SNF-level care in rural areas. In this context, we believe it would be contrary to the public interest to further delay implementation by the amount of time needed for proposed rulemaking. We will consider carefully all comments we receive, and make any further changes needed as the result of them in a final rule. We also are considering whether other, more stringent health and safety rules may be needed in light of the new provisions, and may propose further changes in this area in the future.

H. Rebasing the Hospital Market Basket

Our practice has been to update or rebase the market basket about every 5 years. Occasionally, we have adjusted this timing to coincide with the Department of Commerce, Bureau of Economic Analysis' schedule for updating the interindustry model of the United States (U.S.) economy, which is released every 5 to 7 years. The interindustry model includes detailed cost analyses of the entire U.S. economy including the hospital industry. In developing the current market basket, effective beginning October 1, 1990, we used 1987 hospital data from the American Hospital Association's (AHA's) 1988 Annual Survey for six major expense categories (wages and salaries, employee benefits, professional fees, depreciation, interest, and a residual ''all other'' category). We used AHA's Hospital Administrative Services (HAS) data from 1987 to derive the weights for professional liability

insurance, food, and pharmaceutical products. Weights for most of the remaining subcategories were derived from Department of Commerce, Bureau of Economic Analysis data trended forward to 1987. For a detailed description of the rebased market basket effective October 1, 1990, see the September 1, 1990 final rule (55 FR 36043).

Although it has been 5 years since the most recent rebasing of the market basket, in the proposed rule we announced our intention to schedule market basket rebasing for FY 1997. We believe that a 1-year delay in the usual schedule is advantageous for the following reasons. First, it provides an opportunity to review and incorporate two important new data sources that are not available at this time. The first of these, the FY 1992 and 1993 Medicare cost report data, contain more detailed data on labor-related and capital-related costs. We are planning on replacing the AHA Annual Survey data with Medicare cost report data for the main operating and capital cost weights. In the next several months, we are planning to compare and analyze the impact of this change to ensure the validity and consistency of the rebased market baskets for operating and capital costs. We believe that using the Medicare data would be an improvement since these data are reported directly to HCFA by Medicare participating hospitals, are readily available to us in a timely manner, and would free us from relying on data that is collected by outside organizations.

The second new data source we anticipate obtaining and analyzing is the 1992 Bureau of the Census' Assets and Expenditures Survey, which will be available later this year. The Census survey will provide much more detailed operating and capital cost data, and we anticipate that we will be able to use this survey to allocate the main cost category weights into more detailed subcategory weights for both operating and capital costs.

In addition to using the market basket to update the payment rates, we also use the percentages of the labor-related items (that is, wages and salaries, employee benefits, professional fees, business services, computer and data processing, blood services, postage, and all other labor-intensive services) to determine the labor-related portion of the standardized amounts. The labor-related portion of the standardized amounts is that portion that is subject to adjustment by the hospital wage index. In order to estimate if postponement of the market basket rebasing would adversely affect hospital payments due to a potential change in the labor-related portion of the payment amounts, we conducted an analysis using the 1987 index rebasing methodology (with 1992 equivalents of the data sources used in 1987). This analysis indicates only a minor difference in the 1987 and 1992 AHA cost shares for compensation costs, which are the major portion of labor-related costs. Therefore, we believe that delaying the market basket rebasing until FY 1997 will not disadvantage hospitals and will allow us to use more detailed and current data. We did not receive any comments opposing this plan, and we intend to rebase the market basket as a part of our FY 1997 changes to the prospective payment system.

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

A. Update Framework for Prospective Payment System for Inpatient Hospital Capital-Related Costs and Possible Revisions to the Federal Rate (Section 412.308(c)(1)(ii))

1. Introduction

For FY 1992 through FY 1995, § 412.308(c)(1) provides that the update for the capital prospective payment rates (Federal rate and hospital-specific rate) will be based on a 2-year moving average of actual increases in Medicare inpatient capital costs per discharge. The regulations provide that, beginning in FY 1996, HCFA will determine the update in the capital prospective payment rates based on an analytical framework that will take into account (1) changes in the price of capital (which we will incorporate into a capital input price index), and (2) appropriate changes in capital requirements resulting from development of new technologies and other factors (such as existing hospital capacity and utilization). The objective of the capital update framework is to determine a rate of increase in aggregate capital prospective payments that, along with a rate of increase in DRG operating payments, ensures a flow of capital and operating services for efficient and effective care for Medicare patients.

In the June 2, 1995 proposed rule we presented a formal proposal for an update framework for the prospective payment system for hospital inpatient capital-related costs (60 FR 29227). The proposal followed a series of preliminary models of an update framework in our FY 1992, FY 1993, FY 1994, and FY 1995 rulemaking documents. We received numerous public comments on the proposed framework, and we present our responses to those comments below.

The proposed update framework included a capital input price index (CIPI) that parallels the operating input price index. The CIPI measures the pure price changes associated with changes in capital-related costs (prices x ''quantities''). The composition of capital-related costs is maintained at base-year FY 1987 proportions in the CIPI. As such, the composition of capital reflects the underlying capital acquisition process. We employ FY 1987 as the base year for this preliminary CIPI for consistency with the operating input price index. We will periodically update both the operating and the capital input price indexes to reflect the changing composition of inputs for capital and operating costs.

The proposed capital update framework, like the operating update framework, incorporated several policy adjustments in addition to the CIPI. We proposed to adjust the CIPI rate of increase for case-mix index-related changes, for intensity, and for error in previous CIPI forecasts. We also discussed a possible adjustment for the efficient and cost-effective use of capital (such as movable equipment, buildings and fixed equipment) in the hospital industry.

In the proposed framework, we attempted to maximize consistency with the current operating framework, in order to facilitate the eventual development of a single prospective payment system update framework. We also attempted to promote the goals that motivated the adoption of the capital prospective payment system, especially the goals of promoting more effective and efficient utilization of capital resources in the hospital industry and establishing incentives for hospitals to make cost-effective decisions regarding acquisition of new capital resources.

We invited comments and recommendations on all aspects of the proposed framework. We expressed interest in suggestions regarding the CIPI, the proposed policy adjustment factors, and alternative methodologies for deriving the factors. We were especially interested in comments on a possible efficiency adjustment.

2. ProPAC Recommendation for Updating the Capital Prospective Payment System Federal Rate

In its March 1, 1995 report to Congress, ProPAC recommended the use of an update framework that includes a capital market basket component. The ProPAC market basket measures 1-year changes in the purchase prices of a fixed basket of capital goods purchased by

hospitals. The ProPAC framework also includes several policy adjustment factors. A forecast error correction factor adjusts payment rates so that the effects of past errors are not perpetuated. A financing policy adjustment accounts for the effects of substantial deviations from long-term trends in interest rates on hospital capital costs. The ProPAC capital update framework also includes adjustments for scientific and technological advances, productivity, and case-mix change similar to those employed in the ProPAC operating update framework. ProPAC also recommends the adoption of a single update framework for adjusting operating and capital prospective payment rates when the transition to full Federal rate capital payments is complete. ProPAC believes that using a simplified approach comparing annual price changes in capital would facilitate the development of such a unified framework.

Our long-term goal is to develop a single prospective payment system update framework. We will soon begin to study development of a unified framework. In the meantime, we will continue to maintain as much consistency as possible with the current operating framework in order to facilitate the eventual development of a unified framework.

The ProPAC and HCFA update frameworks share certain goals. The goal of each framework is to provide a rate of increase in capital prospective payments that, along with the rate of increase in operating prospective payments, will ensure a flow of capital and operating resources that will allow for efficient and effective care for Medicare patients. Both frameworks are designed to provide increases for the purchase of quality-enhancing new technologies. Both frameworks provide for case-mix adjustments to remove the effects of upcoding and to adjust for changes in within-DRG severity. Both frameworks also seek to encourage efficient capital spending behavior. Although the frameworks adopt different methodologies for promoting some of these goals, they are compatible to the degree that they share these goals.

The major difference between the ProPAC and HCFA frameworks concerns the purpose and structure of the capital input price index, or market basket. ProPAC's framework is based on the premise that capital prospective payments are only for future capital purchases and should not reflect the vintage nature of capital. Thus, ProPAC's proposed capital market basket reflects the projected increase in the purchase price of capital goods from one year to the next. HCFA's framework is based on the premise that capital prospective payments are for hospitals' capital-related expenses, which include the expenses related to future capital-related purchases. That is, HCFA's framework addresses the input price component of expenses associated with hospitals' given stock of capital in a particular fiscal year; ProPAC's framework ignores hospitals' present stock of capital and focuses on changes in input prices associated with capital purchases that hospitals will make in a particular fiscal year.

The HCFA CIPI projects the price changes associated with the accounting or vintage costs of capital assets. The HCFA CIPI is based on a definition of capital-related expenses and associated capital-related prices derived from accounting practice (including required HCFA prospective payment system accounting practice) and consistent with economic theory. HCFA believes that the concept of capital-related prices incorporated into the HCFA CIPI is more appropriate than the concept incorporated into the ProPAC market basket because the consumption of capital is not just what is purchased in one year. The consumption of capital has a time-dimension: Capital is not used up immediately but rather over time. This feature of capital is reflected in the accounting definition of capital cost, and it should be reflected as well in the concept of capital prices in the CIPI. The transition from reasonable cost reimbursement to payment under a prospective system does not cancel the applicability of general accounting practice or the HCFA accounting practice derived from it. Thus the concepts of capital-related expenses and capital-related prices continue to be appropriate. Furthermore, the base capital rates were computed on the basis of accounting costs. HCFA believes that it is more consistent to update those rates on the basis of the changes in prices associated with those costs rather than on the basis of changes in current year purchase prices alone.

The HCFA CIPI captures the vintage feature of capital price by using a vintage average approach, that is, weighted averages of purchase prices and interest rates up to and including the current year. The use of vintage averages as the measure of price changes tracks the flow of consumption of capital. The vintage approach better reflects what hospital cash-flow needs are as new assets are brought on, since hospitals still bear the costs of older assets as the new assets are brought on.

HCFA believes that the CIPI appropriately reflects the prices associated with past and current period purchases of capital. Under the HCFA approach, the price change associated with the capital costs for any year is a weighted average of the prices associated with depreciation, interest and other capital costs for that year. The prices associated with the depreciation costs during the year are an average of the prorated purchase prices for the assets in use during that year (25 years for buildings and fixed equipment, 10 years for movable equipment, including current year purchases). The prices associated with the interest costs during the year are an average of the interest rates on debt instruments in effect during that year (22 years, including debt instruments that are new in the current year). Capital-related costs for insurance have an annual time dimension, and therefore the prices associated with those expenses are current year prices only.

In addition to the disagreement over whether the CIPI should reflect the vintage nature of capital, HCFA and ProPAC also disagree over the treatment of interest. ProPAC proposes to account for interest rate changes through a separate financing policy adjustment that would account for significant changes in long-term interest rates. This adjustment would increase the update in case of significant long-term interest rate increases, and decrease the update in cases of significant interest rate decreases. (ProPAC has not identified the threshold that constitutes ''significant'' interest rate changes.)

HCFA believes that there must be an interest rate component in a capital input price index. Sound accounting practice includes interest, along with depreciation, as a component of capital cost. The interest and depreciation components of capital cost track the flow of consumption of capital inputs. Price is a component factor of cost (that is, cost is the product of price and quantity), and capital cost has both depreciation and interest components. There must therefore be an interest component of capital price just as there is an interest component of capital cost.

Furthermore, ProPAC's treatment of interest assumes that only current year interest rate changes need to be measured to capture the relevant price effects of interest rate changes. HCFA believes that the price aspects of interest costs, like the price aspects of depreciation costs, have a time dimension that must be captured in the CIPI. Whether the current year interest rate reflects a net lower price of financing to the hospital depends not on comparison of the current year's interest rate to the previous year's interest rate,

but on the effect of the current year interest rate on all the hospital's debt instruments. For example, assume that the previous year's interest rate was 8 percent, and the current year's interest rate is 5 percent. However, as the hospital enters new financing arrangements at the current rate of 5 percent, it retires debt instruments from 20 years earlier that bore an interest rate of 3 percent. The price effect of the current year's interest rate is thus higher, not lower, as new debt instruments at 5 percent replace old debt instruments at 3 percent. HCFA believes it to be a great advantage of its CIPI that it directly tracks price effects such as these.

Finally, the pure price aspects of interest costs (that is, the interest rate and the purchase price that is represented in the amount of loan principal) are typically beyond the control of the hospital industry. To be sure, the actual decision to purchase capital assets or acquire debt is a ''quantity'' decision and typically is discretionary for a particular span of time. However, in measuring the actual expected price per unit of real capital, independently of any evaluation of the propriety of any actual purchase decisions, it is essential to recognize that the industry has some control over the amount of capital it purchases but little or no control over the price it pays for capital. Thus, the pure price aspect of interest cost changes must be incorporated into the CIPI. Otherwise, the CIPI will not accurately reflect the prices faced by hospitals who must borrow to finance necessary capital acquisitions. Limitations on the quantity of capital are appropriately implemented through policy adjustment factors. The ProPAC approach artificially eliminates pure price changes related to interest costs from the CIPI and incorporates them into a discretionary adjustment factor. The HCFA CIPI retains all price components of increases in interest costs as one measure of inflation in capital-related expenses. It thereby keeps price and quantity aspects distinct, allowing separate analysis of each factor of increases in capital expenses.

We do not agree with the ProPAC that the approach of comparing annual price changes in capital is more conducive to a single update factor. We believe that price changes in current hospital capital expenses are analogous to price changes in current hospital operating expenses. The HCFA CIPI measures the price change in capital expenses, and is, therefore, the appropriate analog to the input price index used to update operating payments under prospective payment. We provide further comments on particular ProPAC recommendations in section V.A.3 of this preamble.

3. Measurement of Capital Input Price Increases

a. Introduction. HCFA discussed a capital input price index as one component in developing future update factors for the Federal rate in the September 1, 1992 **Federal Register** (57 FR 40016). We have presented revised versions of the capital input price index in the May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), and September 1, 1994 (59 FR 45517) issues of the **Federal Register**.

In the June 2, 1995 proposed rule (60 FR 29229), we formally presented a capital input price index for public comments prior to adoption of this final rule. The proposed CIPI parallels the operating input price index. Both the CIPI and the operating input price index are designed to measure input price changes for hospitals' current year expenses, that is, to separate pure price changes from quantity and expenditure changes. The operating sector input price index measures input price changes for operating-related expenses. The capital input price index measures input price changes for capital-related expenses, which include depreciation, interest, and other expenses (such as insurance related to capital goods).

b. HCFA Capital Input Price Index Methodology. The CIPI is based on the following assumptions:

- The Federal rate is based on the concept of capital-related expenses of capital assets used for patient care in the fiscal year and, therefore, any change in the Federal rate should take into account expected changes in the input price aspects of capital-related expenses.
- Capital-related expenses are defined as the sum of depreciation expense, capital-related interest costs, and other capital-related costs, including insurance and leases.
- The input prices related to capital-related expenses are typically beyond the control of the hospital industry (that is, the hospital is a price-taker, not a price-setter).

These assumptions lead directly to a definition of a CIPI that takes into account the price aspects of changes in depreciation expense, interest costs, and other capital-related costs. Thus, the CIPI includes three categories of capital-related expenses: depreciation, interest, and other capital-related costs (such as insurance). Further, the assumptions lead directly to input prices for depreciation and interest costs that, unlike operating costs, have a time dimension that must be captured in the CIPI.

Comment: A commenter suggested that the HCFA CIPI is flawed because it relies excessively on assumptions that could cause the update to be more likely to overstate or understate the true changes in prices than an input price index measuring year-to-year changes.

Response: We believe that the HCFA CIPI appropriately and accurately reflects the ''pure'' price change in capital expenses for the current year as well as other years or vintages. The CIPI was developed based on accepted accounting definitions of capital expenses and conceptually sound methodologies using appropriate data. We have continually improved the index by using more relevant data, as well as implementing comments received on three prior rulemaking documents. The assumptions we have made regarding price proxies, base year weights, and expected lives have been explained thoroughly and refined in the prospective payment system rulemaking documents for the last three fiscal years. These assumptions are based on accepted accounting, economic, and financial reasoning. Thus, we believe that those assumptions lead to valid results.

Current depreciation costs represent the summed depreciation for all purchases of capital assets that are still depreciable in the current period. The input prices associated with these depreciation expenses are the purchase prices attached to all past and current capital purchases for capital still depreciable in the current period. A weighted average of these purchase prices thus represents the input price associated with depreciation expenses in the current period. Thus, the depreciation input price for the current period measures price aspects of current depreciation expenses for capital, just as the operating input price index for the current period measures price aspects of current operating expenses for labor and non-capital goods and services. The depreciation input price appropriately differs from the operating input price in that the depreciation input price is a vintage-weighted composite of all past capital purchase prices, while the operating index input price measures purchase prices for current periods only.

Comment: Two commenters contended that HCFA's vintage-weighting approach will not provide sufficient updates to allow for replacement of capital. They conclude that the CIPI should therefore include only increases in current year purchase

prices. One of the commenters submitted a detailed technical analysis concluding that the HCFA CIPI will allow HCFA to match payment increases for depreciation and interest with increases in depreciation and interest expenses, but will not allow HCFA to match increases in replacement costs of assets. This commenter questioned whether a focus solely on depreciation and interest is a necessary requirement for *prospective* payment for capital. The other commenter implied that the non-vintage approach will provide sufficient capital reimbursement to replace needed capital assets, while the HCFA CIPI looks at the current capital stock that has already been acquired and paid for.

Response: We concur with the comment that the HCFA CIPI captures increases in the price component of depreciation expenses, and, under reasonable assumption, will match price increases in interest rates. The issue of providing for replacement of capital assets is a difficult one. We agree with the commenters that an adequate update framework should be able to provide updates to payment rates sufficient to fund replacement of capital assets, where it is appropriate to do so. We do not necessarily believe, however, that it is appropriate for the Medicare program to support full replacement of assets where excess capital capacity exists.

As in the case of other issues regarding the update framework, the issue of replacement costs has both price and quantity aspects. Full replacement cost involves increases reflecting both price and quantity sufficient to replace existing assets. In this section, we discuss the replacement issue from the price aspect: that is, whether the vintage-weighting approach in the HCFA CIPI can provide, where appropriate, updates sufficient to fund full replacement. In this analysis, we make the assumption that it is appropriate to set the policy adjustments within the update framework at levels to provide for the quantities necessary to provide full replacement. In section V.A. below, we discuss our continuing analysis of capital cost increases during the period just prior to the implementation of prospective payment for capital. During that period, the Medicare program paid for operating costs on a prospective basis, but hospitals continued to receive cost-based payment for capital. That analysis suggests that an excess capacity of capital assets over efficient levels may exist. If that is the case, then adjustments to provide for less than full replacement of capital assets may be appropriate since underused capacity implies inefficient use of social resources.

We do not agree with the suggestion that the HCFA CIPI cannot adequately provide for replacement of assets. The HCFA CIPI provides increases in the price component of replacement costs for new capital by adequately reflecting price increases in capital expenses. Medicare's payment for capital has changed from retrospective cost-based reimbursement to prospective payment for an efficient level of capital. However, the concept of paying for capital expenses remains the same under capital prospective payment, just as the concept of paying for operating expenses has not changed. That is, under prospective payment, hospitals will be paid for an efficient level of operating and capital expenses.

The HCFA CIPI provides a conceptually sound measure of price changes associated with the capital expenses incurred by hospitals. The level of capital expenses incurred by a hospital in a given year is not a function merely of the annual percent change in the new capital purchase prices, but rather of the purchase prices and interest rates associated with all capital assets that are still in use for patient care and that are not yet fully depreciated. Because of the vintage nature of the CIPI, the percent change in the CIPI can appropriately be above, below, or equal to the annual percent change in capital purchase prices in any given year.

Analysis by the HCFA Office of the Actuary suggests that the CIPI should provide updates adequate to finance replacement of capital under reasonable assumptions about prudent hospital financial management. Industry sources and Medicare cost report data indicate that capital is not typically paid for in full when it is acquired. Rather, debt funding is the major form of capital financing used by hospitals. Actual cash outlays for capital thus consist primarily of payments for principal and interest on loans. The interest component inherent in the capital prospective payment system should cover interest costs for an efficient hospital.

The issue concerning replacement of assets is thus whether the depreciation component implicit in the prospective capital payment can, assuming an allowance for replacement of the full quantity of assets, cover the principal costs of debt for an efficient hospital while allowing accumulation of a reserve adequate to provide the necessary down payment for future capital purchases. In the early years of debt repayment, principal payments are relatively small. During that period, the portion of the rate payment related to depreciation in excess of principal costs of debt can be accumulated in a sinking fund. Sound financial management suggests that payments for capital expenses (depreciation and interest) that are in excess of the hospital's actual capital cash outlays (principal and interest) be accumulated and invested to provide for adequate replacement of assets. In other words, prudent hospitals would invest the sinking fund to earn interest. Based on examination of historical relationships and projected trends, we believe that accumulation of the sinking fund over the life of the asset will, on average, provide an adequate amount for asset replacement.

Current interest expenses represent the total interest costs for all still-active past debt instruments associated with past and current purchases of all capital assets currently used for patient care. The input prices associated with these interest expenses are the interest rates associated with all past debt instruments that are still active in the current period. A weighted average of these interest rates thus represents the input price associated with interest expenses in the current period. Thus, the interest input price for the current period measures price aspects of current interest expenses, just as the operating input price index for the current period measures price aspects of current operating expenses for labor and non-capital goods and services. The interest input price appropriately differs from the operating input price in that the interest input price is a vintage-weighted composite of all interest rates for debt instruments that are still active in the current period, while the operating index input price measures purchase prices for current periods only.

Comment: A commenter agreed with HCFA's inclusion of interest in the CIPI. However, the commenter did not agree with the HCFA vintage approach to determining the interest component. The commenter instead recommended measuring annual price changes in financing costs.

Response: We agree with this commenter that the price increases in interest are an integral and accepted component of capital costs and therefore should be included in the CIPI. However, we do not believe that using *annual* price changes in interest rates will appropriately measure the price change for interest expenses that have a vintage nature. The HCFA CIPI measures the price aspects associated with current interest expense, which include interest costs for all still-active past debt instruments appropriately

weighted. It would be inappropriate to update the interest expense component of the CIPI by the annual change in the current year interest rate when current year interest expense reflects interest rates on debt in various years, or vintages. Also, using the change in the current year interest rate would create a volatile series in the CIPI that would lack predictability, as well as inappropriately measure price increases in current year interest expense. The HCFA CIPI should include a vintage-weighted interest component, appropriately weighted, to validly measure price increases in current year interest expense.

Comment: One commenter stated that once the negative interest adjustment proposed by HCFA is eliminated, ProPAC's CIPI and HCFA's CIPI show very little difference.

Response: HCFA has not proposed a negative adjustment for interest, but merely requires that the price aspect of interest expense be appropriately measured in the CIPI. In the most recent historical and forecasted periods, it is true that the interest component is negative; however, it is correctly negative because the effect of interest rate decreases in recent years has been to decrease the interest price faced by hospitals for all the debt instruments that are still in effect. In addition, the commenter's contention about the result of removing the interest component from the CIPI is erroneous. In many of the years from 1979 to 1994, removal of the interest component creates larger differences between the HCFA CIPI and the ProPAC CIPI.

Our original version of the CIPI employed proportional annual weights in determining the moving averages of the purchase prices associated with depreciation and interest. A commenter on a previous version of the CIPI recommended that proportional annual vintage weights for capital price proxies be replaced by non-proportional annual vintage weights that reflect the relative vintage purchases of capital. The commenter pointed out that annual purchases of real capital tend to increase over time. As annual purchases of real capital increase, the later years in the moving average of depreciation and interest costs should be weighted more heavily than the earlier years. We agree with this comment. Accordingly, a special data base was prepared to provide appropriate historical vintage weights for depreciation and interest input prices. The non-proportional vintage weights in the CIPI appropriately reflect the relative contributions of current capital purchase prices and current interest rates to total capital price in the current year.

Current year other capital-related expenses (for example, insurance) have an annual time dimension and, therefore, prices associated with these expenses are, like operating input prices, current year prices only.

Comment: One commenter recommended that HCFA use a more recent year as the base year for the CIPI to increase consistency with current hospital capital expenditure patterns. Another commenter agreed that delaying the rebasing will improve the market basket and, therefore, is appropriate.

Response: We agree that using a more recent base year is desirable and, as we discussed in the June 2, 1995 (60 FR 29229) proposed rule, we have done preliminary research into the effects of changing the base year from FY 1987 to FY 1992. The initial results from currently available data sources have shown small differences between the FY 1987 and FY 1992 base year weights, resulting in a minimal effect on the CIPI. We intend to use expanded capital-related data in the FY 1992 and FY 1993 Medicare cost reports in the rebasing effort. The expanded capital-related data is available beginning with FY 1992 cost reports; therefore, we are examining the data thoroughly for reliability and accuracy using FY 1993 as a validity check. To ensure that the data is reasonable, we plan to compare data from other sources, some of which are not available at this time, to the expanded capital-related data in the Medicare cost reports. Exercising this added discretion before using the expanded capital Medicare data will not only produce more representative and reliable data, but would also ensure that the data are less subject to interpretation and error. It is for these reasons that we delayed the rebasing originally planned for FY 1996.

The FY 1987 composite data base starts with financial variables from the American Hospital Association (AHA) Panel Survey. These data are augmented by data from the Medicare cost reports and from the Department of Commerce Capital Expenditure Survey. The composite data base provides annual estimates of nominal purchases for building and fixed equipment and for movable equipment. Leasing amounts were distributed among building and fixed equipment and movable equipment nominal purchases by first computing the percentage of total owner-operated nominal purchases attributable to each type of equipment, and then applying these percentages to total leasing amounts. Nominal purchases were then converted to annual real (that is, constant dollar) purchases by dividing nominal expenditures by an appropriate purchase price proxy.

Expected life for building and fixed equipment and for movable equipment were derived from Medicare cost reports by dividing the book value of assets by current year depreciation amounts. The relative distribution of real capital purchases within the respective life for building and fixed equipment (25 years) and for movable equipment (10 years) were derived from the special data base. These relative distributions are shown in Table 1. Relative distributions for a number of different time periods were averaged to obtain the distributions in Table 1. These distributions were all very similar regardless of the periods chosen and, therefore, we selected an average of the distributions in order to simplify the calculations.

TABLE 1.—RELATIVE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Building and Fixed Equipment Expected Life: 25 years:	
1	0.015
2	0.019
3	0.022
4	0.024
5	0.023
6	0.022
7	0.020
8	0.021
9	0.025
10	0.030
11	0.033
12	0.034
13	0.034
14	0.035
15	0.038
16	0.043
17	0.049
18	0.053
19	0.056
20	0.057
21	0.060
22	0.066
23	0.071
24	0.075
25	0.077
Total	1.000
Movable Equipment Expected Life: 10 years:	
1	0.064
2	0.072
3	0.077
4	0.085
5	0.095
6	0.101
7	0.109
8	0.122
9	0.132
10	0.142
Total	1.000

TABLE 1.—RELATIVE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES—Continued

Interest Expected Life: 22 years:	
1	0.007
2	0.009
3	0.010
4	0.011
5	0.013
6	0.015
7	0.017
8	0.020
9	0.023
10	0.027
11	0.032
12	0.038
13	0.043
14	0.050
15	0.057
16	0.064
17	0.074
18	0.083
19	0.090
20	0.098
21	0.105
22	0.114
Total	1.000

Source: Health Care Financing Administration, Office of the Actuary (Medicare Cost Reports, AHA Panel Survey, Securities Data Inc.)

Table 2 shows the historical, annual percentage changes in the capital-related price proxies employed in the CIPI prior to vintage-weighting. These proxies are as follows: the institutional construction index maintained by Boeckh for the unit prices of fixed assets; the machinery and equipment component of the Producer Price Index (PPI–11) for movable equipment; the average yield on domestic municipal bonds from the Bond Buyer index of 20 bonds (Muni); the average yield on Moody's corporate bonds (AAA); a composite of Muni and AAA indexes (Combined Muni/AAA); and the residential rent component of the Consumer Price Index (CPI Rent) for other capital costs.

We previously used the Engineering News-Record (ENR) building cost index as a price proxy for the unit price of fixed assets. However, we believe that the Boeckh institutional construction index is more applicable to the industry. The variation between the two indexes is minimal.

We applied the relative vintage depreciation weights from Table 1 to the appropriate non-vintage weighted historical, annual index levels (base year FY 1987) of depreciation price proxies to generate the current year, vintage-weighted component index levels for the CIPI depreciation sector. The annual percentage change between the non-vintage weighted historical, annual depreciation index levels are listed in Table 2. The annual percentage changes between the annual, vintage-weighted depreciation component index levels (base year FY 1987) are listed in Table 3. For example, the FY 1996 movable equipment index component percentage change of 1.8 percent in Table 3 was computed as the percentage change between the FY 1995 and FY 1996 vintage-weighted movable equipment component index levels. The FY 1996 movable equipment component index (base year FY 1987) represents the weighted-average of the index levels in the movable equipment price proxy (PPI–11 in Table 2) for the previous 10 years (that is, FY 1987 through 1996), weighted by the relative vintage weights listed for movable equipment in Table 1. These calculations are slightly different than prior versions of the CIPI in the **Federal Register**, and reflect a more refined weighting methodology.

TABLE 2.—ANNUAL PERCENT CHANGES FOR NON-VINTAGE WEIGHTED CAPITAL INPUT PRICE PROXIES, FISCAL YEARS 1949 TO 2000

[Proxy name—BOECKH—institutional construction, PPI–11–machinery and equipment, Muni—average yield on domestic municipal bonds—bond buyer (20 bonds), AAA—average yield on moody's AAA corporate bonds, CPI rent (all urban)—residential rent]

Fiscal year	BOECKH	PPI–11	Muni	AAA	Combined Muni/AAA	CPI rent
1949	3.3	7.4	−4.4	−3.1	−4.2	4.4
1950	1.4	0.5	−9.4	−4.2	−8.4	3.9
1951	8.6	13.6	−5.8	7.1	−3.4	3.7
1952	3.7	1.6	12.9	5.7	11.4	4.2
1953	3.5	0.8	25.9	7.3	22.2	4.7
1954	1.5	2.7	−8.2	−6.3	−7.9	4.8
1955	1.8	1.9	−0.4	1.1	−0.1	1.4
1956	4.8	7.5	7.8	7.6	7.8	1.7
1957	3.6	8.0	24.0	18.0	23.0	1.9
1958	1.8	3.2	−3.7	−1.1	−3.3	1.9
1959	3.1	1.6	11.5	13.3	11.8	1.3
1960	2.7	1.5	1.7	4.9	2.3	1.6
1961	1.1	−0.3	−3.1	−3.2	−3.2	1.3
1962	2.2	0.0	−6.4	0.8	−5.1	1.3
1963	2.3	0.0	−3.4	−2.8	−3.3	1.0
1964	2.8	0.9	3.2	3.3	3.2	1.0
1965	3.1	0.6	−0.5	1.6	−0.1	1.0
1966	3.8	2.7	16.5	11.0	15.4	1.2
1967	5.3	3.8	2.4	8.3	3.5	1.7
1968	7.3	2.8	14.7	14.5	14.6	2.4
1969	8.4	3.3	21.5	9.8	19.2	2.8
1970	7.0	4.2	22.2	18.0	21.4	4.1
1971	8.7	4.2	−13.9	−4.9	−12.3	4.7
1972	8.0	2.2	−5.8	−3.8	−5.4	3.6
1973	6.0	2.6	−1.8	0.8	−1.3	4.0
1974	8.0	9.9	12.6	12.5	12.6	4.9
1975	11.1	19.5	19.2	7.9	16.9	5.2
1976	7.6	6.7	−1.2	−3.2	−1.5	5.3
1977	8.5	6.0	−15.8	−6.4	−14.1	5.8
1978	6.6	7.6	1.1	5.6	2.0	6.7
1979	7.5	8.7	7.3	8.9	7.6	7.1
1980	8.6	11.5	26.9	22.9	26.1	8.6
1981	9.8	10.6	32.9	20.7	30.5	8.8

TABLE 2.—ANNUAL PERCENT CHANGES FOR NON-VINTAGE WEIGHTED CAPITAL INPUT PRICE PROXIES, FISCAL YEARS 1949 TO 2000—Continued

[Proxy name—BOECKH—institutional construction, PPI–11–machinery and equipment, Muni—average yield on domestic municipal bonds—bond buyer (20 bonds), AAA—average yield on moody's AAA corporate bonds, CPI rent (all urban)—residential rent]

Fiscal year	BOECKH	PPI–11	Muni	AAA	Combined Muni/AAA	CPI rent
1982	9.6	7.1	16.2	5.5	14.2	8.0
1983	7.0	3.2	−22.5	−17.7	−21.7	6.3
1984	5.2	2.3	4.8	6.9	5.1	5.0
1985	2.0	2.2	−5.3	−7.1	−5.6	5.9
1986	1.6	1.5	−18.1	−19.6	−18.4	6.2
1987	2.1	1.5	−5.5	−5.3	−5.5	4.5
1988	2.3	2.2	7.1	9.9	7.6	3.8
1989	3.6	3.5	−6.7	−4.8	−6.3	3.8
1990	2.5	3.1	−1.2	−2.0	−1.3	4.2
1991	2.7	2.2	−2.7	−2.6	−2.7	3.9
1992	3.1	0.5	−7.4	−8.2	−7.5	2.6
1993	2.4	0.4	−10.6	−8.9	−10.3	2.4
1994	2.8	0.8	0.0	0.2	0.0	2.3
1995	3.1	1.4	6.2	8.1	6.5	2.7
1996	2.8	3.0	−6.9	−6.0	−6.7	3.0
1997	3.4	2.4	4.2	1.5	3.7	2.2
1998	3.4	2.5	−2.3	1.3	2.1	3.6
1999	3.2	2.4	−1.3	−0.6	−1.2	2.5
2000	3.2	2.5	0.5	0.6	0.5	2.7

Source: DRI/McGraw-Hill HCC, 2nd Qtr 1995; @USSIM/TRENDLONG0595; @CISSIM/CCONTROL952.
Released By: HCFA, OACT, Office of National Health Statistics.

TABLE 3.—HCFA CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1979 TO 2000

Fiscal year	Total	Depreciation			Interest	Other
		Total	Building and fixed equipment	Movable equipment		
Weights (FY1987)	1.0000	0.6510	0.3054	0.3456	0.3274	0.0216
Price Changes						
1979	5.6	7.4	6.9	7.7	2.6	7.1
1980	7.1	7.9	7.2	8.6	5.6	8.6
1981	8.8	8.4	7.6	9.1	9.5	8.8
1982	9.3	8.5	7.9	9.0	10.6	8.0
1983	6.7	8.0	7.8	8.1	4.7	6.3
1984	6.3	7.2	7.5	6.9	4.8	5.0
1985	5.1	6.2	6.7	5.7	3.3	5.9
1986	3.7	5.5	6.1	5.0	0.4	6.2
1987	3.1	4.9	5.6	4.3	−0.5	4.5
1988	3.0	4.5	5.3	3.8	0.1	3.8
1989	2.7	4.3	5.1	3.6	−0.7	3.8
1990	2.4	3.9	4.8	3.2	−1.0	4.2
1991	2.1	3.6	4.5	2.7	−1.3	3.9
1992	1.7	3.2	4.3	2.1	−2.1	2.6
1993	1.3	2.9	4.1	1.8	−2.9	2.4
1994	1.3	2.8	4.0	1.6	−2.7	2.3
1995	1.5	2.7	3.9	1.6	−1.9	2.7
1996	1.5	2.8	3.8	1.8	−2.5	3.0
1997	1.7	2.8	3.7	1.9	−2.0	2.2
1998	1.9	2.8	3.6	2.0	−1.5	3.6
1999	1.9	2.8	3.5	2.0	−1.4	2.5
2000	1.9	2.8	3.5	2.0	−1.2	2.7

Source: DRI/McGraw−Hill HCC, 2nd Qtr 1995; @USSIM/TRENDLONG0595; @CISSIM/CONTROL952.
Released By: HCFA, OACT, Office of National Health Statistics.

As we have discussed in connection with previous versions of the CIPI, stability is an important criterion for evaluating such an index. Stability is an inherent characteristic of capital because of its vintage nature; since capital assets are consumed over time, they are replaced at a relatively slow rate. An input price index for capital

should reflect the relative stability of capital assets themselves. Furthermore, excessive volatility in a price index deprives the index of predictability, thus inhibiting the ability of institutions to plan for changes in capital payments resulting from changes in the CIPI. We graphically demonstrated (using the projections available at that time) the stability of the annual HCFA vintage-weighted CIPI compared to annual changes in non-vintage-weighted capital purchase prices in Figures 1 and 2 in our discussion of May 27, 1994 (59 FR 27882).

ProPAC recommends a capital input price index based on annual changes in current capital purchase prices excluding consideration of weighted historical capital purchase prices (that is, not vintage weighted). We previously argued that the ProPAC index was not consistent with the operating input price index that is currently used to assist in updating DRG payment rates. We would add that the greater volatility in annual purchase prices would introduce an unacceptable degree of volatility in prospective capital payments and does not reflect the inherent stability that comes from the vintage nature of capital.

Comment: One commenter contended that the HCFA CIPI is excessively complicated, considering that its purpose is to update just a small portion (approximately 10 percent) of payments to hospitals for inpatient services. The commenter recommended that a simpler approach be adopted.

Response: Capital expenses for prospective payment hospitals are expected to be about $7.8 billion in FY 1996, a significant amount that warrants an appropriate input price index. While the HCFA CIPI does include vintage-weighting of both depreciation and interest prices, the HCFA CIPI is actually a simplification of the complicated capital accumulation process it is measuring. It would not be appropriate to accept an index that does not measure capital prices as well just because it is simpler. The HCFA CIPI is complicated only to the point that it accurately measures price increases for capital purchased in a financial world that is itself inherently complicated by the vintage nature of capital. Despite its necessary complexities, the HCFA CIPI provides an accurate, less volatile measure of price increases than annual price changes, providing hospitals with the ability to plan for changes in capital payments. As stated earlier, the vintage nature of capital requires that the index reflect the stability of capital assets.

Another commenter on a previous version of the CIPI recommended that data from Securities Data Corporation be incorporated into the CIPI interest computations. This source provides information on hospital issuances of municipal and commercial bonds. From this data base, we incorporated information showing that the average expected life of hospital bond debt instruments (that is, the time interval between the issue date and the maturation date) was about 13 years for municipal serial bonds and about 25 years for municipal term bonds. The weighted average life for the 2 types of bonds was 22 years.

The relative nominal capital purchases within various 22-year periods provided appropriate vintage weights for annual changes in interest rates. Not all capital purchases are funded by debt. Medicare cost reports suggest that about 80 percent of new capital acquisitions are financed by debt and about 20 percent by equity financing. However, if the proportion of total purchases financed by debt does not change substantially from year to year, then it is irrelevant whether we use the full amount or a constant proportion of the full amount of nominal capital acquisitions as weights for relative amounts of the debt instruments still active in the current period.

A third commenter on a previous version of the CIPI recommended that we investigate the effects on interest rate changes of changing structures of hospital bond ratings. If bond ratings are deteriorating, hospitals incur higher interest rate charges; if bond ratings improve, hospitals incur lower interest rates. Our CIPI currently recognizes only changes in pure interest rates and does not recognize changes in effective interest rates due to changes in bond ratings.

We reviewed a hospital municipal-bond data base from Securities Data Corporation to examine that issue. The data showed that serial bonds continue to dominate short-term financing and that term bonds dominate long-term financing. We classified all bond amounts by ratings found in the data base for years 1980 to 1993. The distribution of those issues described with a Moody's Quality Rating, shown in Table 4 (portions are applied to dollar amount of debt issued), indicates a trend toward higher quality issues since 1984. Although the annual, aggregate issue amounts in Moody's quality range Aaa through A have remained approximately constant since 1980, issue amounts in the highest quality band have become substantially higher since inception of the prospective payment system. Both issue amounts in the Aaa–Aa3 ranges and those in the Aaa–A range are greater in 1993 than at any time since 1980. We conclude there is not sufficient evidence to justify a component for deteriorating bond ratings in the CIPI.

TABLE 4.—PERCENT DISTRIBUTION OF HOSPITAL MUNICIPAL BOND AMOUNTS BY MOODY'S QUALITY RATING.*

	Pre-prospective payment system	Post-prospective payment system	
	1980–1983	1984–1988	1989–1993
	(percent)	(percent)	(percent)
Aaa–Aa3	7.1	36.8	49.0
Aa–A	50.6	24.1	21.7
Baa1–Ba	9.6	3.6	8.0
Not Rated	31.0	32.7	17.9

*Distributions do not sum to 100 percent due to a residual category of missing data.

Notes:

(1) Aggregate issues from Aaa–A have remained fairly constant since 1980.

(2) Issue amounts in the highest quality band have become substantially higher since inception of the prospective payment system.

(3) Both issue amounts in the Aaa–Aa3 ranges and those in the Aa–A ranges are greater in 1993 than at any time since 1980.

Relative vintage interest weights derived from our procedure are shown in Table 1. When combined with index levels (base year FY 1987) of annual, non-vintage weighted interest rate proxies, the relative interest weights provide current year, vintage-weighted component index levels for interest rates in the CIPI. The annual percentage change between the non-vintage-weighted historical, annual interest index levels are listed in Table 2. The annual percentage change between the annual, vintage-weighted interest component index levels (base year FY 1987) are listed in Table 3. Thus, for example, the interest rate component change of −2.5 percent in Table 3 for FY 1996 represents the annual percentage change between the 1995 and 1996 vintage-weighted interest component index levels. The 1996 interest component index level (base year FY 1987) is computed as the vintage-weighted average of the previous 22 years in the interest rate proxy index level (Combined Muni/AAA) in Table 2, weighted by the interest weights listed in Table 1. We use an index level for a combined municipal and AAA commercial bond interest rate (percent changes shown in Table 2 as Combined Muni/AAA), giving the municipal rate an 85 percent weight and the AAA rate a 15 percent weight, reflecting the relative hospital debts of the government/non-profit hospital sector and the for-profit sector.

Although Medicare cost reports show that only 60 percent of current hospital debt is in the form of notes or bonds (about 40 percent is in the form of mortgages), we assumed that the relative annual weights for all debt and the relative annual changes in interest rates for all debt were the same as bond-related weights and price changes. We are still searching for an appropriate source of information on hospital commercial mortgage data. We do not expect that the discovery of such data will materially alter our current conclusions about trends in effective interest rates over time.

c. Projection of the CIPI for Fiscal Year 1996. DRI projects a 1.5 percent increase in the CIPI for FY 1996 (Table 3). This is the outcome of a 2.8 percent increase in projected weighted depreciation prices in FY 1996, partially offset by a 2.5 percent decline in vintage-weighted interest rates in FY 1996.

d. ProPAC Input Price Index.

i. Introduction. Three major differences distinguish ProPAC's CIPI from HCFA's CIPI:

- The ProPAC CIPI measures changes in capital asset purchase prices in the year the asset is purchased (that is, not vintage-weighted). HCFA's CIPI is designed to measure changes in a vintage-weighted composite of capital asset purchase prices.
- The ProPAC CIPI uses the Marshall and Swift hospital equipment index as the movable equipment purchase price proxy while HCFA uses the Producer Price Index for machinery and equipment.
- The ProPAC CIPI has no interest component. ProPAC treats interest rate changes as an optional separate update policy adjustment factor.

Through 1996, for example, ProPAC expects that long term interest rates will remain relatively stable and, therefore, believes that it is not appropriate to adjust capital input prices for forecasted changes in interest rates in the target year.

HCFA incorporates a vintage-weighted composite of interest rates in its CIPI for the target year.

ii. Depreciation. ProPAC states that its CIPI is analogous to the prospective payment operating price index. We disagree. The components of the operating index represent price changes in ongoing hospital expenses for labor and non-capital goods and services. The analogous capital expenses in this context are current depreciation costs, interest costs, and other capital-related expenses (such as insurance). Current depreciation and interest costs, according to HCFA, IRS, and accounting principles, are a cumulative composite of segments of expenses incurred in current and prior periods. Current interest costs are a cumulative composite of segments of past and current year debt costs. Since both depreciation and interest costs have a vintage component, the price aspect of these costs must have a vintage component as well. The HCFA CIPI attempts to capture these vintage components.

Differences between HCFA and ProPAC with respect to choices for annual non-vintage-weighted rates of change in alternative price proxies for movable equipment are small for much of the historical period. (We illustrated this fact in Figure 8 (Inset) in the May 27, 1994 proposed rule (59 FR 27890), using earlier projections.) As noted in our September 1, 1992 final rule, one basic criterion for accepting price proxies is public availability of documentation on data sources and methodology (57 FR 40018–40019). Despite repeated efforts, neither we nor Data Resources Inc. have been able to obtain documentation on the movable price proxy recommended by ProPAC (Marshall and Swift hospital equipment index) that explains how it is derived and what sampling frame and sampling error attach to the estimates. In the absence of such information we cannot adopt the ProPAC alternative.

HCFA's assumption is that prices for movable equipment purchased by hospitals change at about the same rate as prices for machinery and equipment generally. This assumption is justified in part by the fact that not all movable equipment purchased by hospitals is medical equipment; it stands to reason that the prices for non-medical movable equipment purchased by hospitals, such as automobiles, desks, chairs, etc., would change at about the same rate as prices for all machinery and equipment. To examine this assumption further, we measured the rate of change in the HCFA movable price proxy relative to prices for medical equipment only by preparing a composite index of medical prices from the Bureau of Labor Statistics Producer Price Index (PPI) for two commodity categories—medical instruments/equipment and X-ray/electro-medical equipment. The two PPI commodity indexes were then merged using their respective PPI weights. Price changes for this index are not available for years prior to 1984. Annual price changes for medical equipment follow the annual HCFA price proxy more closely than the ProPAC price proxy for most of the historical period. We will continue to monitor trends in these indexes to ensure that appropriate price proxies are incorporated in the CIPI.

iii. Interest. ProPAC has proposed to project annual interest rates to future periods and then to decide whether to allow an add-on to the Federal capital rate depending on the magnitude of the projection. ProPAC has presented no objective criteria for determining when an interest adjustment is appropriate. We previously noted that a single-year projection for interest rates is conceptually inappropriate since interest costs must be vintage-weighted. In addition to this conceptual problem, the ProPAC approach is impractical because future annual interest rates are volatile, vulnerable to unpredictable market forces, and subject to exogenous influences (such as Federal Reserve Board decisions) that are difficult to anticipate. Thus, any projection of future annual interest rates is likely to be inaccurate, resulting in underpayment or overpayment of the Federal capital rate relative to the capital-related expenses that the rate is supposed to reflect. The resulting uncertainty in payments under future Federal capital rates further complicates future capital expenditure decisions by hospitals. On the other hand, the

projected HCFA CIPI interest component for the target year is the weighted average change over 22 years of interest rate history, of which 20 years experience in the non-vintage weighted price proxy is appropriately historical. The projected annual, non-vintage weighted experience in the price proxy for the most recent 2 years may be as inaccurate as any ProPAC projection, but any error will have minimal effects on Federal rates due to the appropriately weighted effect of the historical data in the HCFA CIPI. This stability in the interest rate component of the HCFA CIPI provides hospital planners with a degree of certainty about future Federal rate payments, other things remaining equal.

iv. The Composite CIPI. Annual percentage changes in the historical and projected HCFA and ProPAC CIPIs differ markedly as shown in Table 5. The 2.9 percent increase for the ProPAC capital market basket in Table 5 for FY 1996 is lower than the 4.1 percent increase presented in ProPAC's March 1995 Report and Recommendation to the Congress. In the ProPAC March report, ProPAC used the 4th quarter 1994 DRI forecasts, while the figure in this final rule represents 2nd quarter 1995 DRI forecasts. Between 4th quarter 1994 and 2nd quarter 1995, DRI revised its forecast downward by 1.2 percentage points to reflect slower price growth in 1996 than originally expected. A lower forecast for the movable equipment price proxy (Marshall and Swift) was responsible for roughly 60 percent of the 1.2 percentage point decline between forecasts. The remaining 40 percent of the decline was the result of lower forecasts in the fixed equipment price proxy (Boeckh) and the other capital-related expenses price proxy (CPI-residential rent), which accounted for roughly 23 percent and 12 percent, respectively. We emphasize that the later forecast was not available when ProPAC released its March report.

The ProPAC CIPI is much more volatile than the HCFA CIPI in the historical period through 1994 because it does not reflect vintage-weighted capital input price factors for depreciation. Further, the ProPAC CIPI omits conceptually relevant interest rates. The cumulative effect of declining interest rates for all debt instruments in recent years has driven the rate of change in the HCFA vintage-weighted interest rate component downward, a trend projected by DRI into future rate years. The declining interest rate component appropriately brings the HCFA CIPI below the ProPAC CIPI in the projection period. Other things being equal, the ProPAC index would result in overpayment through the Federal rate because anticipated actual capital-related expenses will be less than ProPAC projects due to the effects of lower interest rates on capital-related expenses.

TABLE 5.—ANNUAL PERCENT CHANGES IN HCFA CAPITAL INPUT PRICE INDEX AND THE PROPAC CAPITAL MARKET BASKET, 1979 TO 2000

Fiscal year	HCFA capital input price index	ProPAC capital market basket
1979	5.6	8.3
1980	7.1	9.2
1981	8.8	10.0
1982	9.3	7.7
1983	6.7	4.6
1984	6.3	3.9
1985	5.1	2.2
1986	3.7	1.7
1987	3.1	2.1
1988	3.0	3.5
1989	2.7	4.6
1990	2.4	2.3
1991	2.1	3.0
1992	1.7	2.2
1993	1.3	2.1
1994	1.3	2.8
1995	1.5	3.4
1996	1.5	2.9
1997	1.7	3.4
1998	1.9	3.3
1999	1.9	3.2
2000	1.9	3.4

Source: DRI/McGraw-Hill HCC, 2nd Qtr 1995; @USSIM/TRENDLONG0595; @CISSIM/CONTROL952.
Released By: HCFA, OACT, Office of National Health Statistics.

ProPAC believes that Medicare program payments should reflect both savings from low interest rate levels on new debt instruments and the additional costs of high interest rate levels. As explained above, the Commission has proposed accomplishing this through an interest policy adjustment. However, ProPAC has neither presented a threshold level for making an interest adjustment nor established a process for determining the amount of the adjustment. The HCFA CIPI, on the other hand, automatically registers the price effects of interest rate changes on new debt instruments that carry over into future periods, although those effects are appropriately registered only very gradually.

When interest rate levels decline, hospitals may refinance their existing debt. Refinancing has a price effect as new debt instruments with lower prices (interest rate levels) replace older debt instruments with higher prices (interest rate levels). ProPAC believes its interest policy adjustment can and should capture this behavior. In this way, Medicare can share in the savings from refinancing. The HCFA CIPI does not now automatically register the price effects of refinancing. Whether to do so or not is a policy judgment concerning whether HCFA should share in refinancing savings or allow hospitals to realize the full effects of refinancing. A refinancing adjustment would not only reflect actual hospital behavior, but would also add to the existing incentives of a rate-based system for hospitals to replace high interest debt instruments with lower interest debt instruments. However, the absence of a refinancing adjustment could allow individual hospitals to refinance and keep the savings, just as individual hospitals who become relatively more efficient in furnishing care for specific DRGs are rewarded for the more efficient behavior.

Since refinancing is a price matter, the adjustment would appropriately be on the price side of the framework, rather than on the policy adjustment side, which deals with quantities. However, the adjustment would not be included directly within the CIPI because the price effect of refinancing involves a shift in the vintage weights applied to index levels. That is, interest expense associated with prices (interest rate levels) in the year the debt is originated would be shifted to reflect interest expense associated with prices in the year the debt is refinanced. This essentially would reduce the relative vintage weights for interest in the CIPI (Table 1) in some years and increase the relative vintage weights for interest in other years. Yet by definition, the fixed-weight CIPI holds all weights constant. However, a discretionary adjustment could be made on the relative vintage weights. This is analogous to the separate adjustments for real case-mix changes in the update framework.

In the June 2, 1995 proposed rule we invited comments on whether to incorporate a refinancing adjustment within the HCFA framework. A refinancing adjustment would present specific problems because HCFA has not been able to obtain data to accurately determine refinancing amounts. Whether HCFA can ultimately propose a refinancing adjustment depends upon whether the necessary data can be obtained.

Comment: Two commenters stated that a proposed refinancing adjustment is not necessary. One commenter indicated that hospitals should be rewarded by keeping savings from

efficient behavior such as refinancing high interest debt. The other commenter indicated that it would not be proper for hospitals to be penalized or rewarded based on a theoretical refinancing threshold that would trigger an adjustment.

Response: These comments are useful in analyzing the merits and technical difficulties of including a refinancing adjustment in the HCFA update framework. We are continuing to determine whether a refinancing adjustment is appropriate, and, if so, how to implement one. We will provide any additional findings in upcoming notices. We encourage comments and suggestions, like those we have received, or recommendations of any studies or data sources that would be useful in assessing and/or implementing a refinancing adjustment.

4. Case-Mix Adjustment and Adjustment for Forecast Error

We proposed that the update framework contain adjustments for changes in the case-mix index and for forecast error.

The case-mix index (CMI) 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 CMI corresponds to an equal percentage increase in hospital payments.

The CMI can change for any of several reasons: because the average resource use of Medicare patients changes (''real'' case-mix change); because changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and because 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 CMI. 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 CMI-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1992 DRG reclassification and recalibration as part of our FY 1994 update recommendation.) The operating adjustment consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change that we determine is due to real case-mix change rather than coding modifications, and an adjustment for the effect of prior DRG reclassification and recalibration changes. We proposed to adopt this CMI adjustment as well in the capital update framework.

For FY 1996, we are projecting a 0.8 percent increase in the case-mix index. We estimate that real case-mix increase will equal projected case-mix increase in FY 1996. We do not anticipate any changes in coding behavior in our projected case-mix change. The proposed net adjustment for case-mix change in FY 1996 is therefore 0.0 percentage points.

The −1.0 percent figure used in the ProPAC framework represents ProPAC's projection for observed case-mix change. ProPAC projects a 0.8 percent increase in real case-mix change across DRGs and a 0.2 percent increase in within-DRG complexity. ProPAC's net adjustment for case mix is therefore zero.

We estimate that FY 1994 DRG reclassification and recalibration resulted in a 0.3 percent increase 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. ProPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation.

The current operating 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 following year. In any given year there can be unanticipated price fluctuations that can result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. We continue to believe that the capital update framework should include a forecast error adjustment factor. In setting a prospective payment rate under the proposed framework, we proposed to make an adjustment for forecast error only if our estimate of the capital input price index rate of increase for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. Thus, for example, we would adjust for a forecast error made in FY 1996 through an adjustment to the FY 1998 update.

We received no comments on our proposed adjustments for case-mix increase and for forecast error. In this final rule, we are therefore adopting those adjustments as proposed.

5. Policy Adjustment Factors

The capital input price index measures the pure price changes associated with changes in capital-related costs (prices × ''quantities''). The composition of capital-related costs is maintained at base-year 1987 proportions in the capital input price index. We proposed to address appropriate changes in the amount and composition of capital stock through the policy adjustment factors.

The current update framework for the prospective payment system for operating costs includes factors designed to adjust the input price index rate of increase for policy considerations. Under the revised operating framework, we adjust for service productivity (the efficiency with which providers produce individual services such as laboratory tests and diagnostic procedures) and intensity (the amount of services used to produce a discharge). The service productivity factor for the operating update framework reflects a forward-looking adjustment for the changes that hospitals can be expected to make in service-level productivity during the year. A hospital retains any productivity increases above the average.

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 proposed that the intensity adjustment factor in the operating framework be adopted in the capital update framework. Under the operating update framework, 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 proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. We therefore proposed to incorporate the intensity adjustment from the operating update framework into the capital update framework. In the absence of 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 proposed to assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The proposed capital update framework would thus provide 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.

Comment: Several commenters objected that we derive the estimate of allowable intensity as a function of observed intensity, so that any level of intensity is presumptively 100 percent too high.

Response: Our analysis does derive allowable intensity from observed intensity. However, we do not believe that doing so involves an assumption that any level of intensity increase is 100 percent too high. In our analysis, and in determining the level of the intensity adjustment in the framework, we assume that half of observed intensity is due to the combination of quality-enhancing new technology and within-DRG complexity, and half to ineffective practice patterns. We adopted this assumption in the absence of any estimates of the comparative contributions of those factors to the observed level of intensity increases. Under such circumstances, we believe the assumption that half of observed intensity is allowable to be reasonable because it minimizes error.

We have decided to adopt the intensity measure as proposed. For FY 1996, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1990–1994. In determining case-mix constant intensity, we found that observed case-mix increase was 2.2 percent in FY 1990, 2.8 percent in FY 1991, 1.5 percent in FY 1992, 0.8 percent in FY 1993, and 0.8 percent in FY 1994. For FY 1990 through FY 1992, we estimate that 1.0 to 1.4 percent of the case-mix increase was real. (This estimate 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 rather 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.) We assumed that all of the observed case-mix increase of 0.9 percent for FY 1993 and 0.8 percent for FY 1994 was real. (This assumption is consistent with the FY 1996 CMI projections described above.) If we assume that real case-mix increase was 1.0 percent per year during FY 1990 through FY 1992 (but 0.9 percent in FY 1993 and 0.8 percent in FY 1994), case-mix constant intensity declined by an average 1.2 percent during FY 1990 through FY 1994, for a cumulative decrease of 6.1 percent. If we assume that real case-mix increase was 1.4 percent per year during FY 1990 through FY 1992 (but 0.9 percent in FY 1993 and 0.8 percent in FY 1994), case-mix constant intensity declined by an average 1.5 percent during FY 1990 through FY 1994, for a cumulative decrease of 7.2 percent. Since we estimate that intensity has declined during the FY 1990–1994 period, the intensity adjustment for FY 1996 is 0.0 percent.

In our discussion of a possible efficiency adjustment, we suggested that such an adjustment should take into account two considerations. One is that capital inputs, unlike operating inputs, are generally fixed in the short run. The productivity target in the revised operating framework operates on a short-term, year-to-year basis. Targets for capital efficiency and cost-effectiveness, however, must operate on a longer term basis. The other consideration is that, prior to the adoption of the capital prospective payment system, Medicare payment policy for capital-related costs, as well as the policies of other payers, did not provide sufficient incentives for efficient and cost-effective capital spending. Economic theory suggests that an industry with a guaranteed return on capital (such as the hospital industry prior to prospective payment for capital-related costs) would have a tendency to be overly capitalized relative to more competitive industries. This is because the incentive for firms in such an industry is to compete on the basis of more capital-intensive production processes than firms in other industries. As a result, capital costs per case, and therefore base year prospective capital rates, may be higher than would have been consistent with capital acquisition policy in more efficiency-oriented markets. A guiding principle in devising an efficiency adjustment is therefore that Medicare capital prospective payment rates should not provide for maintenance of capital in excess of the level that would be produced in an efficiency-oriented competitive market.

To examine this issue, we analyzed the change in actual Medicare capital cost per case for FY 1986 through FY 1992 in relation to the change in the capital input price index (which accounts for change in the input prices for capital-related costs), and the other adjustment factors that we were then proposing to include in the framework. (The other adjustment factors are the increase in real case mix and the increase in intensity due to quality-enhancing technological change and within-DRG complexity.) We found rates of increase in actual spending per case that exceeded the rate of increase attributable to inflation in capital input prices, quality-enhancing intensity increases, and real case-mix growth.

Our analysis was designed to examine whether hospitals had in fact responded to the incentives of the cost-based payment system for capital by expanding beyond what was necessary for efficient and cost-effective delivery of services. The analysis confirmed that volume and intensity of capital acquisition far outpaced the increase in capital input prices during the years between the implementation of the prospective payment system for operating costs and the introduction of the capital prospective payment system. Even accounting for real CMI increases and increases in intensity attributable to cost-increasing but quality-enhancing new technologies, there remains a large excess of capital-related spending.

The following table shows the results of our most recent analysis, based on the most current data available and the most recent projections. Differences between this table and the tables in previous discussions in the **Federal Register** reflect updated figures for average capital cost per case increases, based on the most recent data and projections, and our revised CIPI. This analysis encompasses all but 1 year of the period from the implementation of the prospective payment system for operating costs to the implementation of the prospective payment system for capital costs. (For FY 1984, sufficient data is not available to compute capital cost per case increases and intensity increases.) The results of the analysis in Table 6 are substantially similar to the results of previous analyses. In Table 6, real case-mix increase is assumed to be 1.0 percent annually.

TABLE 6.—CUMULATIVE PERCENTAGE CHANGE IN CAPITAL-RELATED COST PER CASE DUE TO INFLATION, REAL CMI, AND INTENSITY, 1985–1992

Year	CIPI [1]	Real CMI [2]	Allowable intensity [3]	Resulting increase [4]	Percent change cost/case [5]	Residual [6]
1985	5.1	1.0	3.7	10.1	12.5	2.2
1986	3.7	1.0	2.1	6.9	19.9	12.2
1987	3.1	1.0	2.5	6.7	14.9	7.6
1988	3.0	1.0	1.5	5.5	7.1	1.5
1989	2.7	1.0	0.5	4.3	7.8	3.4
1990	2.4	1.0	0.2	3.6	6.9	3.1
1991	2.1	1.0	0.1	3.2	5.5	2.3
1992	1.7	1.0	0.1	2.8	4.6	1.8
Cumulative (compounded)				52.0	111.3	39.0

[1] Figures from Table 1, section V.A.3 of this preamble.
[2] Assuming that real CMI increase is 1.0 percent annually.
[3] One half of observed intensity increase, as determined by the joint operating/capital intensity measure.
[4] The increase attributable to inflation, real CMI, and allowable intensity, calculated as the product of the rates of increase of those factors (that is, $1.031 \times 1.01 \times 1.025 = 1.067$ for 1987).
[5] Figures supplied by HCFA's Office of the Actuary.
[6] The actual increase in average cost per case divided by the increase attributable to inflation, real CMI, and allowable intensity (that is, 1.149 /1.067 = 1.076, a 7.6 percent residual for 1987).

We believe that an adjustment for capital efficiency and cost-effectiveness should take into account the efficiency and effectiveness of the capital resources present in the base year for the capital prospective payment system. We do not believe that Medicare capital payment rates should provide for maintenance of capital in excess of the level that would be produced in an efficiency-oriented competitive market. A capital efficiency adjustment should be designed to give hospitals an incentive to reduce inefficiency and ineffectiveness in capital resources. The analysis in Table 6 suggests that, in order to restore the Federal rate to the level at which it would have been if capital costs had not been excessive in the years before the implementation of capital prospective payment, a cumulative reduction in the rate of as much as 28.1 percent (1.52/2.113=0.7194, or −28.1 percent) would be necessary.

We stated in the proposed rule that we were considering a range of options for such an efficiency adjustment. In particular, we have considered whether to provide, in the design of such an adjustment, for eventually reducing the rate by the entire 28.1 percent suggested by the above analysis. Alternatively, the eventual reduction to the rate could reflect some part, but not all, of the excess of actual capital cost increases over the identified factors. We have also considered the appropriate rate at which an adjustment based on the above analysis should be applied to the update factors. On the assumption that the updates to the rate should be reduced by the full 28.1 percent, such an adjustment could be accomplished over a shorter or longer period of time. For example, HCFA could adjust the updates to the rate over a period of 20 years at the rate of 1.4 percent per year. Similarly, the adjustment could be made over 5 years at the rate of 5.6 percent per year.

We proposed that HCFA have the discretion to apply an efficiency adjustment to the capital input price rate of change in determining the annual update factor. We invited comment on the advisability of such an adjustment, on the proportion of the residual that should be employed in adjustments to the update, and on the rate at which such an adjustment should be applied. We also solicited information on possible sources of data that would be useful in developing or refining such an adjustment, and on the possible effects of such an adjustment on various segments of the hospital industry.

Comment: Many commenters objected to a possible efficiency adjustment. Several commenters asserted that such an adjustment would be punitive because it would inappropriately punish hospitals for behavior in response to the incentives of the cost-based system. One of those commenters recommended that HCFA adopt positive incentives to motivate future behavior rather than an adjustment based on past behavior.

Response: We do not believe that an efficiency adjustment based on the analysis we have presented would necessarily be punitive. Hospitals received reasonable cost payments based on the costs we examined during the period just prior to the introduction of prospective payment for capital. We believe that the capital rates should not permanently reflect a level of cost in excess of an efficient use of capital inputs. However, we also believe that an adjustment to return the rates to a level reflecting greater efficiency in capital resources should not necessarily involve a drastic and precipitous reduction of the rates. We note for example, that with the expiration in FY 1996 of the requirement that capital prospective payments equal 90 percent of what would have been payable on a reasonable cost basis, the Federal rate is projected to increase by 22.59 percent. Thus, a substantial efficiency adjustment could be made without a net reduction in the Federal rate.

Comment: One commenter objected that the assumptions behind the analysis were not identified. Other commenters argued the analysis behind the proposed adjustment did not sufficiently account for the costs of quality improvements and other factors such as the need for design changes and features that attract patients. Several commenters objected that the analysis provided no empirical evidence that inefficiency accounts for capital expenses in excess of the expected levels.

Response: We attempted to explain all the assumptions behind our analysis. The basic assumption, which derives from economic theory, is simply that cost-based payment for capital, or any input, provides an incentive for the use of inefficiently high levels of that input. We also presented the available empirical data concerning capital cost per case increases during the period prior to the introduction of prospective payment for capital. The result of comparing actual capital cost increases during that period with the identifiable factors that contribute to cost increases, is consistent with that assumption: Cost

increases exceeded the level that can be accounted for on the basis of price increases, intensity increases, and case-mix increases. We believe the factors that we have identified already account for quality increases, design changes, and the other factors mentioned by commenters. Our intensity measure, for example, accounts for any factor that affects the level of hospital charges. Presumably, hospitals account for the costs, including quality improvements and design changes to attract patients, that they face when they set the level of charges. As we discuss below, a large residual remains even when we allow for all the measured intensity changes during the period we examined. We believe that this analysis is certainly suggestive of a significant measure of inefficiency in capital costs in the pre-prospective payment period.

Comment: Several commenters from states with certificate of need (CON) requirements argued that those requirements prevent inefficient capital purchases.

Response: Our analysis was based on national figures, and it did not consider regional differences, such as the existence of CON requirements in various States, since we are evaluating an efficiency adjustment in the Federal rate.

Comment: Several commenters objected that rate reductions of the size contemplated in the discussion of a possible efficiency adjustment would jeopardize the ability of many hospitals to meet obligations entered under the existing rate levels. One commenter objected that the proposed 27.7 percent reduction in capital payments would have a devastating impact on hospitals.

Response: We did not suggest that capital payments would be reduced by 27.7 percent. Our proposal, in fact, called for a 20.5 percent increase in payments in FY 1996 compared to FY 1995. We did suggest that the rate of increase in the rates, and hence in payments, might appropriately be reduced by an adjustment to account for inefficiency in the level of costs on which the rates were based.

Comment: One commenter contended that the prospective payment system already has sufficient measures to promote efficiency and restrain the growth in capital expenditure.

Response: We agree that there are substantial incentives under the capital prospective payment system to promote efficiency and to restrain the growth of capital expenditures. However, the existence of these incentives does not resolve the problem that motivated our discussion of a possible efficiency adjustment. That problem is that the level of the capital prospective rates may reflect an inefficiently high level of capital costs. We do believe that the rates should not permanently reflect a level of capital costs in excess of an efficient use of capital inputs.

Comment: Several commenters objected that the estimate of inefficiency partially derives ''efficient'' capital growth due to allowable intensity as a function of observed intensity, so that any level of intensity is presumptively 100 percent too high.

Response: Our analysis does derive allowable intensity from observed intensity. However, we do not believe that doing so involves an assumption that any level of intensity increase is 100 percent too high. In our analysis, and in determining the level of the intensity adjustment in the framework, we assume that half of observed intensity is due to the combination of quality-enhancing new technology and within-DRG complexity, and half to ineffective practice patterns. We adopted this assumption in the absence of any estimates of the comparative contributions of those factors to the observed level intensity increases. This assumption does not undermine the validity of our analysis of capital cost increases before the introduction of the capital prospective payment system. On the contrary, varying our assumption about the level of allowable intensity increases yields substantially the same result. If we allow 100 percent of observed intensity increases, there remains a residual of 25.7 percent, as the following table shows:

TABLE 7.—CUMULATIVE PERCENTAGE CHANGE IN CAPITAL-RELATED COST PER CASE DUE TO INFLATION, REAL CMI, AND INTENSITY, 1985–1992

Year	CIPI [1]	Real CMI [2]	Allowable intensity [3]	Resulting increase [4]	Percent change cost/case [5]	Residual [6]
1985	5.1	1.0	7.4	14.0	12.5	−1.3
1986	3.7	1.0	4.1	9.0	19.9	10.0
1987	3.1	1.0	5.0	9.3	14.9	5.1
1988	3.0	1.0	2.9	7.0	7.1	0.1
1989	2.7	1.0	1.0	4.8	7.8	2.9
1990	2.4	1.0	0.4	3.8	6.9	2.9
1991	2.1	1.0	0.1	3.2	5.5	2.3
1992	1.7	1.0	0.2	2.9	4.6	1.7
Cumulative (compounded)	.....	.....	.....	68.0	111.3	25.7

[1] Figures from Table 1, section V.A.3 of this preamble.
[2] Assuming that real CMI increase is 1.0 percent annually.
[3] Total observed intensity increase, as determined by the joint operating/capital intensity measure.
[4] The increase attributable to inflation, real CMI, and allowable intensity, calculated as the product of the rates of increase of those factors (that is, $1.031 \times 1.01 \times 1.05 = 1.093$ for 1987).
[5] Figures supplied by HCFA's Office of the Actuary.
[6] The actual increase in average cost per case divided by the increase attributable to inflation, real CMI, and allowable intensity (that is, 1.149/1.093 = 1.051, a 5.1 percent residual for 1987).

Therefore, even under the assumption that all intensity increases are allowable, this analysis suggests that, in order to restore the Federal rate to the level at which it would have been if capital costs had not been excessive in the years before the implementation of capital prospective payment, a cumulative reduction in the rate of as much as 20.5 percent (1.68/2.113=0.7951, or −20.5 percent) would be necessary.

Comment: One commenter denied that cost-based payment for capital would influence the decision to purchase capital assets. According to the commenter, the decision to add capital resources is driven primarily by patient care needs, and not by the availability of additional reimbursement. At the same time, the

commenter asserted that low payment rates for capital often force hospitals to defer needed capital investments.

Response: The commenter's assertion that cost-based payment would not influence the decision to purchase capital assets is inconsistent with widely accepted economic theory. Several other commenters, in fact, agreed that economic theory does suggest incentives for overuse of capital under cost-based reimbursement.

Comment: Several commenters agreed that economic theory would suggest incentives for the overuse of capital during a period in which capital was paid on a cost basis while operating costs were paid on the basis of a prospective rate. However, the commenters contended that economic theory would also suggest that, if hospitals overpurchased capital, they conversely had to underemploy operating inputs. As a result, the commenters believe that reductions to the capital Federal rate to account for the inefficient overuse of capital should be matched by increases in the operating rates to account for inefficient underutilization of operating inputs.

Response: We agree with the commenters that the conjunction of rate-based payment for operating costs and cost-based payment for capital encouraged hospitals to substitute capital inputs for labor and other operating inputs. However, we do not agree that an inefficiently *high* level of capital inputs under those conditions necessarily implies an inefficiently *low* level of operating inputs. Rather, the conjunction of rate-based payment for operating costs and cost-based payment for capital could also lead to the substitution of inefficient capital inputs for inefficient operating inputs. Indeed, our previous analysis of efficient operating costs for hospitals during FY 1985 through FY 1991 (57 FR 40014), indicates that operating prospective payments during that period were sufficient for the efficient and cost-effective delivery of quality care. In conjunction with the analysis of capital spending during FY 1985 to FY 1992, these results suggest that hospitals may indeed have responded to the existing incentives by substituting an inefficiently high level of capital inputs for inefficient operating inputs. Under these circumstances, it would not be appropriate to increase operating rates in conjunction with a decrease in capital rates. Decreased capital rates, along with the existing level of operating rates, would provide the appropriate incentives for hospitals to achieve efficient levels of both capital and operating inputs.

Comment: One commenter objected that it is inappropriate to evaluate hospital behavior during a period of cost-based reimbursement for capital on the basis of standards characteristic of a more efficiency-oriented market system. Prior to the capital prospective payment system, hospitals operated within a system that did not reward efficiency. Providers should not be penalized by reducing future rates to account for their response to poor incentives in the past.

Response: We understand the commenter's concern about the use of a retrospective standard. At the same time, we do not believe that the Medicare program should necessarily base payments permanently on rates that reflect a known level of inefficiency in the use of capital inputs. We believe a solution that is fair both to hospitals and to the Medicare program can be found within the available range of options. As we have stated, an efficiency adjustment need not remove all the identified residual from the rates, nor need it do so precipitously.

Comment: One commenter argued that, since capital expenditures are associated with binding legal contracts that fix payments for capital assets, hospitals would actually be forced to reduce costs in areas other than capital in response to reductions in capital rates. The result, according to the commenter, would not be capital efficiency, but inefficiently low levels of spending in other areas. In addition, the commenter contended that rate reductions would result in inefficiencies on the capital side as hospitals delayed needed capital improvements.

Response: Implementation of an inefficiency adjustment would not necessarily produce an actual decrease in Medicare payments for capital. Rather, an efficiency adjustment could be implemented gradually so that the rate of increase in the rates and payments is reduced. Under those circumstances, the consequences that the commenter describes would not arise.

Comment: Several commenters suggested that the excess of actual capital costs over the levels accounted for in our analysis may be the result of substitution of debt financing for equity. Such substitution may have occurred as a response to negative margins under the prospective payment system. Debt financing may have increased capital costs, and the commenters urged that we test this possibility empirically.

Response: Cost report data (along with data from other sources) suggest that hospitals steadily have financed approximately 80 percent of their capital acquisitions by debt, and the remaining 20 percent by equity. We have seen no evidence that these proportions have been changing in recent years. We will continue to monitor the data, however.

Comment: ProPAC expressed concern about implementing a retroactive standard of efficient capital spending, and about the absence of a widely accepted definition of hospital efficiency.

Response: We recognize that there is not a widely accepted definition of hospital efficiency. However, we believe that the analysis we have presented suggests a significant measure of inefficiency in capital costs in the pre-prospective payment period. Nevertheless, we have decided not to implement an efficiency adjustment at this time. We will, however, continue to study the issue and attempt to refine the analysis we have presented. We continue to believe that an adjustment for capital efficiency, parallel to the productivity adjustment employed in the operating framework, would be an appropriate feature of the capital framework.

6. FY 1996 Update Factor

Table 8 summarizes HCFA's FY 1996 update factor under the framework adopted in this final rule, in comparison with the recommendation of ProPAC.

In its March 1995 report to Congress ProPAC recommended a 4.1 percent update for FY 1996. Based on more recent projections, ProPAC's recommended update would be 2.9 percent. On the basis of the projections and data available for this final rule, HCFA's update is 1.2 percent. As Table 5 shows, the different update methodologies adopted by ProPAC and HCFA, respectively, can be expected to result in higher ProPAC update recommendations during some years, and higher HCFA update recommendations during other years.

TABLE 8.—HCFA'S FY 1996 UPDATE FACTOR AND PROPAC'S RECOMMENDATIONS

	HCFA update factor	ProPAC recommendation
Capital input price index	1.5	2.9
Policy adjustment factors:		
Productivity	.....	(1)
Efficiency	(2)	.....
Intensity:	0.0	.....
Science and technology	.....	(1)
Intensity	.....	(3)
Real within DRG change	.....	(4)
Subtotal	0.0	0.0
Case mix adjustment factors:		
Projected case Mix change	−0.8	−1.0
Real across DRG change	0.8	0.8
Real within DRG change	(5)	0.2
Subtotal	0.0	0.0
Effect of FY 1994 reclassification and recalibration	−0.3	.....
Forecast error correction	0.0	0.0
Total update	1.2	2.9

[1] Adjustments for scientific and technological advance and productivity offset each other. No specific values were recommended.
[2] Efficiency adjustment may be adopted after public comment.
[3] Included in ProPAC's Productivity Measure.
[4] Included in ProPAC's Case Mix Adjustment.
[5] Included in HCFA'S Intensity Factor.

7. Possible Adjustments to the Federal Rate and the Hospital-Specific Rates

In the June 2, 1995 proposed rule, we discussed the effects of the expiration of the statutory budget neutrality provision on rates and aggregate payments under the capital-prospective payment system. Under that provision, we set the capital-prospective payment system rates during FY 1992 through FY 1995 so that payments would equal 90 percent of estimated Medicare payments that would have been made on a reasonable cost basis for the fiscal year. As a result of the provision's expiration, both the capital-prospective payment system rates and payments under the transition system will increase significantly. The proposed FY 1996 Federal rate was 21.3 percent higher than the FY 1995 Federal rate. We estimated that payments under the proposed rule would increase by 20.45 percent in FY 1996 compared to FY 1995, and that FY 1996 payments would exceed projected FY 1996 Medicare hospital inpatient capital costs by 4.52 percent.

In the proposed rule, we presented a discussion of possible revisions to the capital-prospective payment rates that would moderate these substantial increases in payments. These revisions could be made in conjunction with, or in place of, an update framework adjustment to account for possible inefficiency in capital spending prior to the capital-prospective payment system base period. While these possible revisions to the rate are not, strictly speaking, elements of the update framework, we presented them within the context of the proposed update framework in order to allow commenters the opportunity to consider all the possible rate revisions that might affect the future levels of rates and payments. We solicited comment on whether to make any of the possible revisions that we discussed. We expressed our belief that reductions in Medicare spending should be addressed in the context of health care reform.

Under § 412.308 of the regulations, HCFA determined the standard Federal rate, which is used to determine the Federal rate for each fiscal year, on the basis of an estimate of the FY 1992 national average Medicare capital cost per discharge. The FY 1992 national average Medicare capital cost per discharge was estimated by updating the FY 1989 national average Medicare capital cost per discharge by the estimated increase in Medicare inpatient capital cost per discharge. As we discussed in the August 30, 1991 capital prospective payment system final rule (56 FR 43366–43384), HCFA used the July 1991 update of HCRIS data to estimate an FY 1989 national average Medicare cost per case of $527.22. HCFA then updated that amount to FY 1992 by using an actuarial projection of a 31.3 percent increase in Medicare capital cost per discharge from FY 1989 to FY 1992. The standard Federal rate was thus based on an estimated FY 1992 national average Medicare capital cost per discharge of $692.24 (before the application of a transfer adjustment and a payment parameter adjustment).

Section 13501(a)(3) of Public Law 103–66 amended section 1886(g)(1)(A) of the Social Security Act to require that, for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent. As we discussed in the September 1, 1993 final rule for FY 1994 (58 FR 46316), the purpose of that reduction was to reflect revised inflation forecasts, as of May 1993, for the increases in Medicare capital cost per discharge during FY 1989 through FY 1992. By that time, the estimate of increases in Medicare inpatient capital costs per discharge from FY 1989 through FY 1992 had declined from 31.3 percent to 21.57 percent. The 7.4 percent reduction to the Federal rate was calculated to account for these revised forecasts (1.2157/1.313=.926, a 7.4 percent decrease). That provision of Public Law 103–66 also required that, for cost reporting periods beginning on or after October 1, 1993, the Secretary redetermine which hospital payment methodology should be applied under the capital prospective payment system transition rules to take into account the 7.4 percent reduction to the Federal rate.

As a result of the reduction required by Public 103–66, the standard Federal rate is now based on an estimated FY 1992 Medicare inpatient capital cost per case of $641.01 ($692.24×0.926). At the

time of the Public Law 103–66 reduction to the Federal rate, actual cost report data on the FY 1992 Medicare capital cost per discharge were not yet available. The reduction was based on cost report data for FY 1990 and FY 1991, and a revised projection of the rate of increase in Medicare capital costs per discharge during FY 1992.

We now have extensive cost report data for FY 1992. The December 1994 update of HCRIS data showed an audit-adjusted FY 1992 Medicare inpatient capital cost per discharge of $593.15, or 7.47 percent lower than the estimate (reflecting the 7.4 percent reduction mandated by Public Law 103–66) on which the Federal rate is currently based. We do not believe that the Federal rate should necessarily remain at a level that reflects a known over-estimation of base year costs. We therefore invited comment on the appropriateness of an estimated 7.47 percent reduction to the unadjusted standard Federal rate to account for that over-estimation. (The June 1995 update of HCRIS data shows an audit-adjusted FY 1992 Medicare inpatient capital cost per discharge of $596.28, or 6.98 percent lower than the estimate on which the Federal rate is currently based.)

Under § 412.328, HCFA determined the FY 1992 hospital-specific rate by using a process similar to the process for determining the FY 1992 Federal rate. The intermediary determined each hospital's allowable Medicare inpatient capital cost per discharge for the hospital's latest cost reporting period ending on or before December 31, 1990. The intermediary then updated each hospital's FY 1990 allowable Medicare capital cost per discharge to FY 1992 based on the estimated increase in Medicare inpatient capital cost per case. As in the case with the Federal rate updates, current data demonstrate that the estimates used to update the hospital specific rates from FY 1990 to FY 1992 were overstated. On the basis of the data available in the proposed rule, we indicated that we were also considering whether to correct for the original rate of increase estimates by prospectively decreasing the hospital-specific rates by 8.27 percent. Such a reduction would not apply to hospital-specific rates that have been redetermined for a later cost reporting period. This is because the rate of increase estimates were not employed for redeterminations after FY 1992.

Finally, we suggested that the analysis of capital cost increases prior to the implementation of the prospective payment system for capital-related costs could be the basis for an immediate adjustment to the Federal rate to compensate for the effects of the expiration of budget neutrality. At the time of the proposed rule, the available data suggested that a reduction to the Federal rate of up to 27.7 percent would be necessary to restore the rate to the level at which it would have been if capital costs had not exceeded the level that can be accounted for on the basis of known factors. (As discussed in section V.A.5 above, the current data suggest that a reduction of up to 28.1 percent would be necessary to restore the Federal rate to that level.) Such an adjustment could be accomplished gradually over a number of years within the context of the update framework. We suggested in the proposed rule that some large part of the residual could be removed from the rate in a single adjustment. For example, we suggested that retaining the FY 1995 budget neutrality adjustment of 0.8432 in the standard Federal rate would have the effect of recapturing a large part of the residual of capital cost increase over the identifiable factors. The remainder of the residual, if appropriate, could be removed from the rate on a gradual basis through an adjustment to the update factor, as discussed in section V.A.6 above. We therefore requested comments on the appropriateness of such measures, particularly on the appropriateness of retaining the FY 1995 budget neutrality adjustment in the rate as an efficiency measure.

Comment: Many commenters objected to possible measures to reduce the Federal rate. Some commenters contended that the error in forecasting the FY 1992 cost per case likely resulted from a substantial decline in the rate of growth in capital expenditures as hospitals anticipated the introduction of prospective payment for capital. Under these circumstances, the commenters contended, reduction to the rates would punish providers for responding to the new incentives of prospective payment.

Response: Current cost report data show a modest decline in the rate of increase in Medicare capital cost per case immediately before the introduction of the capital prospective payment system. (See Table 6 above.) From the information at our disposal, however, it is impossible to determine the degree to which this modest decline is due to behavioral changes induced by anticipation of prospective payment for capital as opposed to other factors. For example, during the last years under reasonable cost payment, the payment for capital costs was discounted; that is, the program paid 85 percent of Medicare capital costs. It is likely that the discounting of reasonable cost payment contributed to the modest decrease in the rate of increase in capital cost during that time. In any event, we intended to base the Federal capital rate on the FY 1992 Medicare capital cost per case. We do not believe it is reasonable to expect that the rate permanently reflect the level of cost that would have existed if the poor incentives that existed prior to the implementation of capital prospective payment had remained in place.

Comment: Other commenters contended that continued retrospective lookbacks to FY 1992 are inappropriate in a prospective payment system.

Response: The core notion of prospective payment is that the payment rate be set in advance of the actual payment. None of the measures that we discussed would violate that principle. In each case, rate revisions would apply prospectively, that is, only to payments in the future. Under a prospective system, prior period rates are the basis for determining rates in subsequent years. However, we believe that future rates should not be based permanently on initial estimates that we now know to be incorrect. Our intention was always to base the capital rates on FY 1992 costs per case. At the time of the final rule establishing the prospective payment system for capital-related costs, we estimated FY 1992 costs on the basis of the best data and projections then available.

Comment: Several commenters argued that retaining the FY 1995 budget neutrality adjustment in the rate would disadvantage hospitals after they have responded to the incentives under the capital prospective payment system.

Response: The purpose of retaining the FY 1995 budget neutrality adjustment in the rate would be to address a known overestimation in the costs used to establish the rate, and possibly excessive costs that may be inappropriate to include permanently in the rate. While it is true that hospitals should be able to gain from responding to the incentives of prospective payment, it does not follow that this should include permanent benefit from excessively high rate levels.

Comment: Several commenters contended that it would be illegal for HCFA to retain the FY 1995 budget neutrality adjustment in the base rate. These commenters observed that Congress mandated the sunset of budget neutrality for capital, and asserted that retaining the budget neutrality adjustment in the rate was a covert way of attempting to extend the provision beyond the statutory sunset.

Response: The purpose of the measure we discussed would not be to extend the budget neutrality provision. Rather

it would be to set the rate at an appropriate level in the light of information that is now available concerning cost increases in the years up to and including FY 1992. Retaining the budget neutrality adjustment factor would simultaneously address our original overestimation of FY 1992 costs and some significant proportion of the inefficiency represented in the FY 1992 cost per case. The use of the FY 1995 budget neutrality adjustment factor would merely accomplish a major rate revision in a manner that provides substantial stability in the level of payments. As such, the adjustment would not be a budget neutrality adjustment per se, but rather an adjustment to address past estimates. Section 1886(g) of the Social Security Act confers broad authority on the Secretary to establish a prospective payment system for capital-related costs.

Comment: A number of commenters contended that the reductions discussed in the proposed rule would jeopardize the ability of many hospitals to meet current obligations and reduce their ability to meet future capital needs.

Response: The measures discussed in the proposed rule would not necessarily result in actual reductions in capital payments compared to the level of FY 1995. For example, the reduction to account for the overestimation of FY 1992 costs per case would still allow annual increases in rates and payments of over 10 percent in FY 1996, and approximately 3 to 5 percent per year through the rest of the transition.

Comment: One hospital association observed that Congress may choose to enact one or more of the measures discussed in the proposed rule. The commenter suggested that any measures to reduce the growth of Medicare expenditures would create the need for HCFA to increase the protections for hospitals that undertake major capital projects during the transition period to fully prospective capital payment. The commenter emphasized that its recommendation was budget neutral.

Response: We do not yet know what if any action Congress will take with respect to the capital prospective payment system. Thus, it would be premature to consider proposals that, under a budget neutrality provision, would involve redistribution of funds from hospitals generally to those hospitals that might benefit from expanded exceptions protection.

Comment: Several commenters contended that it would be illegal for HCFA to implement any of the identified reductions to the rates (including an efficiency adjustment). Two commenters characterized the rate reduction options as thinly disguised attempts to rebase hospitals' base year capital costs, and asserted that Congress has not given the Secretary of Health and Human Services the authority to rebase hospital capital costs. One commenter stated that the rate revisions discussed in the proposed rule would violate a fundamental principle of prospective payment: that the system provide certain and predictable payment rates.

Response: Section 1886(g) of the Social Security Act requires payment for capital-related costs under a prospective payment system ''*established by the Secretary*.'' (Emphasis added.) The statute prescribes only that the system provide for payment on a per discharge basis, employ appropriate weighting of payment rates by classification of discharge, and reduce payments during FY 1992 through FY 1995 by an amount estimated to equal 10 percent of what would have been paid on the basis of reasonable costs. The statute gives the Secretary wide discretion in determining the particular features of the system, including the appropriate level of payment rates. We believe that any rate revision implemented prospectively would satisfy the principle of certainty and predictability under a prospective system.

Comment: One commenter argued that reducing the rate to account for overestimation of FY 1992 cost per case amounts to rebasing the capital rates from FY 1989 to FY 1992. The commenter contended that such a measure would amount to more than a technical correction and would, in fact, require revisiting the entire discussion that gave rise to prospective payment for capital. Finally, the commenter objected that there is no evidence that FY 1992 represents a typical year in capital spending as opposed to a ''trough'' in capital expenses.

Response: The methodology that we adopted in the September 1, 1992 final rule provided for using the FY 1989 cost per case as the basis for estimating the FY 1992 cost per case. We used FY 1989 as the basis for estimating because it was at that time the most recent year for which substantial cost report information was available. Thus FY 1992, not FY 1989, has always been the base year for the rate. The issue is not rebasing the rate but only the appropriateness of addressing previous estimates of base year costs. We believe that the commenter's concern about whether FY 1992 was a ''trough'' year in capital spending is misguided. The Medicare accounting rules, which were used to determine the capital costs on which the capital Federal rate is based, count depreciation costs for all capital still in use and interest on loans for depreciable assets. Current year purchases thus have only a small effect on the accounting of capital costs for the year. Capital costs for FY 1992 include depreciation and interest costs related to capital purchases over many previous years. There is no evidence that the period up to FY 1992 represented a ''trough'' in capital spending.

Comment: One commenter objected that making the rate reductions under consideration would be inconsistent with HCFA's refusal over the years to ''make up'' for shortfalls in actual outlier payments compared to estimates.

Response: We believe that we have been completely consistent in our policies regarding rate-setting and issues of revising prior year payments under the prospective payment system. As discussed earlier, we believe that prospective adjustments to the rates may be appropriate to address errors in estimating base year costs that would otherwise be built into the rates for future fiscal years. In contrast, any difference between actual outlier payments and estimated outlier payments are not built into the rates for future years; thus, for example, if actual outlier payments in a fiscal year were 4.0 percent rather than the projected 5.1 percent, the 1.1 percent difference does not mean that prospective payment rates would be 1.1 percent lower than if we had accurately projected outliers.

The case of the outlier offset cited by the commenter is more analogous to the budget neutrality adjustments under the capital prospective system than it is to the reductions to the base capital rate that we discussed. In the cases of outliers and budget neutrality, temporary annual adjustments to the rates have been made to meet certain payment targets (that is, a designated percentage of outlier payments, in the one case, and 90 percent of what would have been paid for capital costs on a reasonable cost basis, in the other). In both cases, we have refused to make any changes in the level of the rates or payments during subsequent years to account for differences between actual and estimated payments. Thus, we have not decreased subsequent year payments to account for actual payments that have apparently exceeded the payment target of 90 percent of estimated capital costs under the expiring budget neutrality provision. We do, however, examine past experience for purposes of refining the estimation methodology used to set the outlier offsets and budget neutrality adjustments for subsequent years.

As in the case of outlier payments and budget neutrality, none of the rate changes that we discussed in the proposed rule would ''make up'' for past payments. In making any of those revisions, we would instead be employing better data that is now available in order to set the permanent base rate more accurately for future years.

Comment: ProPAC commented that the large increase in rates with the expiration of budget neutrality raises two sets of questions. First, it raises the issue of an appropriate update mechanism, about which HCFA and ProPAC have conducted a vigorous discussion. (See section V.A above.) The second and perhaps more important issue is the need to determine the appropriate base rate to which the update is to be applied. ProPAC believes that, because updates during the first four years of the prospective payment system were based on historical cost increases rather than on an analytical framework reflecting current factors, the updated payment rates grew more rapidly than estimated reasonable costs. The result was a widening gap between the updated base rate and the rates actually used for payment under the budget neutrality provision. The expiration of budget neutrality thus results in a 21 percent increase in both rates and payments. ProPAC believes that the appropriate level of the base payment rate is an issue that merits attention by the Secretary and Congress. The Commission identifies several possible approaches to setting the base rate at an appropriate level, including those identified in this year's proposed rule. They identify one approach that we did not discuss: updating actual FY 1992 costs to FY 1996 on the basis of an analytical framework, rather than actual cost increases.

Response: We agree with ProPAC that the appropriate level of the capital base payment rate is an important issue. We presented the discussion of possible rate revisions in the proposed rule precisely in order to initiate a discussion of that issue.

Comment: Several commenters contended that rate revisions with the potential magnitude of those discussed in the proposed rule should not be implemented through rulemaking. The commenters argued that proposals of this scope should require enabling legislation.

Response: We do not believe that it would be inappropriate for HCFA to implement rate revisions of the kind under discussion after appropriate notice and comment rulemaking. As we have previously stated, the statute gives the Secretary broad discretion in the design of the system in general and in the determination of the appropriate rate level in particular. Nevertheless, it is clear that Congress will be considering major changes in the Medicare program, including substantial budget savings proposals, during the coming months. Under the circumstances, we have decided not to proceed at this time with any possible capital rate revisions through the rulemaking process while Congress considers whether to include any such measures within more comprehensive legislation dealing with Medicare and the Federal budget.

B. Adjustment to the Capital Prospective Payment System Federal Rate for Capital-Related Taxes

In our June 2, 1995 proposed rule, we discussed an adjustment to the capital prospective payment system for capital-related tax costs. As we noted in that discussion, such an adjustment would be designed to remove a possible inequity in the capital prospective payment system. While capital-related taxes constitute a cost imposed on an identifiable group of hospitals, those costs are currently reflected in the Federal capital rate paid to all hospitals. Since the inception of the prospective payment system for capital-related costs, several commenters have pointed out that all hospitals are thus being reimbursed for costs that only some hospitals pay.

In the proposed rule, we presented a proposal for an adjustment for capital-related tax costs. However, we noted in the proposed rule that introducing an adjustment posed several serious problems which we had not been able to resolve. These issues involve equity to hospitals that may become subject to capital-related taxes in the future. They also involve our responsibility to protect the Medicare Trust Fund from possible manipulation as well as from any new open-ended commitments to increase Medicare payments. We presented a formal proposal in order to facilitate discussion of the merits of implementing a special tax adjustment. We believed that presentation and analysis of a proposal provided the best opportunity for a full and public discussion of all the issues surrounding a possible adjustment for capital-related tax costs. We presented our proposal in the hope that the process of public comment would produce a solution that could simultaneously protect the Trust Fund and satisfy the equity concerns of all hospitals.

In order to facilitate discussion of the issues surrounding the treatment of capital-related taxes, we proposed to provide for a special adjustment for the capital-related tax costs of hospitals that paid such taxes for cost reporting periods beginning in FY 1992. The tax costs of those hospitals were included in the computation of the capital Federal rate. Under our proposal, hospitals that began operation after FY 1992 would also be eligible for an adjustment. We further proposed an adjustment of the Federal rate to offset the amount of capital-related tax costs originally included in the computation of the rate. In this way, adoption of the tax adjustment would be budget neutral: Aggregate capital payments would neither increase nor decrease merely because of the tax adjustment.

For those hospitals that would be eligible for an adjustment, we proposed to apply a hospital-specific Medicare tax cost per discharge amount to the Federal rate portion of each payment for each discharge from the hospital, beginning October 1, 1995. Under our proposal, the hospital-specific Medicare tax cost per discharge was to be determined on the basis of the updated FY 1992 base year cost.

Some of the serious issues that arose in connection with the implementation of a tax adjustment concern hospitals whose tax-paying status has changed since FY 1992. Some hospitals that paid capital-related taxes in FY 1992 may no longer be subject to such taxes (for example, because they converted to non-proprietary status in a taxing jurisdiction that does not tax non-proprietary hospitals). Other hospitals may have been in operation during FY 1992, but have only become subject to tax payments since that time, either by a change in status (that is, from non-proprietary to proprietary) or by the action of State or local authorities to impose capital-related taxes on entities that had not previously been subject to such taxes.

Hospitals that subsequently become subject to taxes through the action of State or local authorities pose the most serious issues of equity and protection of the Trust Fund. On the one hand, it may seem unfair to prohibit hospitals on whom a tax cost is imposed *after* FY 1992 from receiving an adjustment available to hospitals on whom a tax cost was imposed *in* FY 1992. On the other hand, a capital Federal rate tax adjustment should not be vulnerable to possible efforts by state or local authorities to gain revenues from increased Medicare payments to hospitals. Nor should a tax adjustment provide an open-ended commitment to increase the overall level of Medicare capital payments as State and local

governments extend taxation to previously tax-exempt facilities. The capital Federal rate tax adjustment that we proposed reflected only the FY 1992 capital-related tax costs included in the original computation of the Federal rate. It could not reflect costs imposed on hospitals by the extension of State and local capital-related taxes after FY 1992. Therefore, in the absence of some additional budget neutrality provision, extending the tax adjustment to hospitals that become subject to capital-related taxes after FY 1992 could significantly increase the overall level of Medicare capital payments.

We proposed that hospitals would not qualify for the adjustment if they became subject to tax payments because of state or local action to change tax laws (for example, by extending taxation to non-proprietary hospitals) since FY 1992. We did so both to prevent the possibility that State and local authorities could inappropriately gain revenues through increased Medicare payments, and to prevent the adoption of a tax adjustment from producing large increases in Medicare capital payments if additional jurisdictions impose taxes on non-proprietary hospitals. We recognized, however, that this policy might be viewed as penalizing newly taxed hospitals for changes in circumstances over which they have no control. We invited comment on the appropriateness of this proposal, which raised issues of equity between hospitals subject to capital-related taxes in FY 1992 and those newly subject to such taxes after FY 1992. We specifically invited suggestions and comments on other approaches to dealing with the situation of hospitals that become subject to taxes after FY 1992. We stated our belief that any proposal to deal with the situation of such hospitals should protect the Medicare Trust Fund against an open-ended commitment to increase Medicare payments in order to reimburse hospitals for Medicare's share of newly imposed capital-related tax obligations.

In particular, we invited comment on the possibility of providing an adjustment to such hospitals on a budget-neutral basis. Under such an approach, an annual tax adjustment budget neutrality factor would be applied to the Federal rate to account for the estimated cost of the tax adjustment over and above the costs attributable to capital-related taxes in the FY 1992 base year. In this way, aggregate payments, including tax adjustments to hospitals that have become subject to taxes since FY 1992, would not exceed the amount of payments in the absence of extending the adjustment to such hospitals. Such an approach would prevent the tax adjustment from becoming an open-ended drain on the Medicare Trust Fund. However, such an approach necessarily involves reducing the Federal rate beyond the level accounted for by the capital-related tax costs originally included in the rate computation. In other words, such a budget neutrality adjustment would reduce the amount of other capital-related costs incorporated in the original rate computation. Under such an approach, the reductions in payments to hospitals that do not pay taxes would exceed the amount of capital-related taxes included in the original rate computation; arguably, then, this approach would inappropriately disadvantage hospitals that do not pay capital-related taxes.

With regard to the situation of other hospitals whose tax status has changed since FY 1992, we stated our belief that hospitals that are no longer subject to capital-related taxes should not receive an adjustment to their capital Federal rate payments. Therefore, we proposed that a hospital (or a related organization) must be directly subject to capital-related taxes in order to qualify for the capital Federal rate tax adjustment.

In addition, we proposed that no adjustment would be made for hospitals whose status changed from non-proprietary to proprietary after FY 1992. The decision to change status to a proprietary hospital is a voluntary decision of the hospital's management, and we therefore believe that an adjustment to allow special payment for additional taxes that result from such a decision is not warranted.

However, we also proposed that hospitals that were not in operation in FY 1992 should be able to qualify for the adjustment. We therefore provided that intermediaries should accept data on capital-related tax payments from hospitals that have begun operation since FY 1992. Such hospitals were to contact their intermediaries as soon as possible, but in any case no later than July 31, 1995, to submit the appropriate data and documentation.

Comment: In Opposition: We received comments opposed to the proposed property tax adjustment from six associations representing a large number of hospitals and from two individual providers. These commenters were opposed to a tax adjustment for several related reasons. Several commenters argued that tax-exempt hospitals incur substantial costs for services they must provide to maintain tax-exempt status. They pointed out that the Internal Revenue Code requires tax-exempt hospitals to satisfy a community benefit standard. This standard requires the operation of a full-time emergency room open to all persons without regard to their ability to pay. It also requires provision of care for every person in the community regardless of ability to pay. The commenters asserted that costs faced by hospitals to provide these services may be higher than property tax levels. They objected that our proposal did not offer any special adjustment to compensate for the cost of community benefit services.

One commenter characterized the proposal as an attempt to address a perceived inequity for one group of hospitals that in turn creates new inequities for many other hospitals. In particular, the commenter objected to our suggestion that extending the adjustment to hospitals newly subject to taxes could be financed by further reducing the Federal rate paid to all hospitals. The commenter suggested that, in light of the acknowledged problems in treating all hospitals equitably in implementing an adjustment, the most equitable solution would be to maintain the integrity of the prospective payment system by refusing to provide special treatment for this cost.

Another commenter objected that the proposed tax adjustment would shift payments from hospitals that exist to serve the needs of the community to those whose primary purpose is to return a profit to its shareholders. The commenter expressed concern that this shift could aggravate existing access problems.

Several commenters objected to the proposal based on reasons related to Medicare reimbursement principles. One commenter argued that the proposed tax adjustment contradicted an established policy of the Medicare program, that organizational decisions made by a hospital should not affect payments. Another commenter contended that the proposed adjustment would subsidize the decision to become a for-profit entity. The same commenter termed the proposed adjustment a return to a cost-based reimbursement system, and thus a retreat from the principles of prospective payment. Another commenter contended that tinkering with a prospective payment system to reflect a specific component of cost may invite requests for further adjustments. One commenter specifically requested that we provide an adjustment for capital-related interest costs in the same manner as we proposed to adjust for capital-related property taxes.

Several commenters raised questions of fairness among tax-paying and tax-exempt providers. The commenter contends that for-profit hospitals do not share equally in the burden of providing care to indigent patients. Furthermore, payment reductions will affect the ability of the non-profit hospitals to maintain current service levels to Medicare beneficiaries.

Several commenters recommended either that we drop the proposal to institute a capital-related property tax adjustment, or that we introduce a tax adjustment only in conjunction with an adjustment for the costs of charity care.

In Favor: We also received numerous comments in favor of the proposed adjustment for capital-related property taxes. Most comments (129) came from tax-paying proprietary hospitals who supported the tax adjustment as proposed. Another 38 commenters supported the concept of the proposed rule, but advocated revisions to the proposal, such as expansion of the eligibility criteria.

Two hospital associations responded generally in favor of the proposed adjustment, but also requested some modifications of the proposed provisions. In particular, those commenters requested the inclusion of hospitals that did not pay property taxes in 1992, but are now paying property taxes. To prevent gaming, the commenters suggested the adoption of a 3-year waiting period before hospitals newly subject to taxes could become eligible for an adjustment. To protect the Trust Fund, the commenters recommended that future capital rate updates be reduced to provide the funds for extending the adjustment to hospitals newly subject to taxes. The commenters also suggested that hospitals should only qualify for an adjustment if they pay bona-fide taxes that apply to all businesses in an area.

Other commenters contended that we should include taxes paid on leased property or equipment in the adjustment, at least in cases where the lease provided for direct payment to taxing authorities. One commenter agreed that a level playing field exists for leases on fixed equipment, but recommended that an adjustment be provided for taxes paid on leased facilities. Another commenter requested that we allow an adjustment for municipal hospitals that have city services allocated to their facility rather than a direct property tax bill.

Two commenters pointed out that they provide charity care and community services, as the tax-exempt hospitals do, but they must also pay taxes.

Response: We have decided not to proceed with implementation of a tax adjustment at this time. Two considerations motivated this decision. First, we have not been able to resolve the problems with implementing a tax adjustment that we identified in the proposed rule. Those commenters in favor of an adjustment did suggest several means for preventing gaming by states and to protect the Medicare Trust Fund from expenditure increases. Several of the suggestions for preventing gaming have some merit. We agree with the commenters, for example, that requiring hospitals newly subject to taxes to wait 3 years before qualifying for an adjustment may reduce the possibilities for gaming. At the same time, we are concerned that some of their other suggestions, such as the adoption of rules to determine *bona fide* taxes, would prove difficult to administer. Even if these measures could prevent gaming, however, we have not been able to determine a method for protecting the Trust Fund that does not create possible new inequities. Commenters in favor of a tax adjustment have suggested reducing future rate updates by an amount sufficient to fund the extension of adjustments to hospitals newly subject to taxes. Under such a measure, however, hospitals that do not pay taxes would necessarily receive lower payments than they would in the absence of a tax adjustment. (Even some hospitals that pay taxes would receive lower payments, if the amount of the Federal rate reduction exceeds the amount of the hospital-specific adjustment.) If the problem that motivated our consideration of an adjustment is an inequity, such a measure would certainly create an inequity as well. As several commenters noted, it would not be appropriate to proceed with a proposal that replaces one possible inequity with another.

The second consideration in our decision not to implement a tax adjustment at this time is that, in the light of the comments, we believe the proposed adjustment may be incompatible with a prospective payment system for capital-related costs. Prospective payment involves an averaging system under which differences in costs among hospitals are generally not accorded special treatment. Many hospitals and groups of hospitals can cite costs which may be unique to them. Among the commenters on the proposed adjustment, for example, some claimed that capital-related tax costs deserve special treatment because they are unique to one group, while others cited charity care as a unique cost to another group of hospitals. By ignoring such differences, a prospective system provides incentives for realizing greater efficiency in the provision of services than can be achieved under a cost-based payment system. Such a system is not inequitable as long as it is consistent in rejecting special treatment for specific costs.

It is true, as the commenters in favor of a tax adjustment pointed out, that the prospective system does provide adjustments for several costs. For example, adjustments are provided under both the operating and capital systems to those hospitals that have graduate medical education programs for the costs associated with that activity. However, the adjustment for the indirect cost of graduate medical education (as well as the disproportionate share adjustment) ultimately reflects a decision specifically to encourage the activity associated with those costs. As several commenters pointed out, adoption of a tax adjustment would have amounted to subsidizing a decision about hospital organizational structure (that is, the choice of proprietary status). While many nonproprietary hospitals would have qualified for a tax adjustment, our final data showed that those hospitals would have received, on average, a capital-related tax adjustment of $6.42 per discharge. As a result, tax-paying nonproprietary hospitals would, on average, have gained only slightly more from the tax adjustment than they would have lost from the reduction to the Federal rate. This is because the amounts that voluntary hospitals pay in taxes is relatively small. In contrast, tax-paying proprietary hospitals would have received, on average, a tax adjustment of $70.47 per discharge. As a result, those hospitals would have gained much more from the adjustment than they would have lost from the reduction to the Federal rate. A tax adjustment would have subsidized proprietary hospitals that pay capital-related taxes at the expense of all other groups. Therefore, we believe that the proposed tax adjustment may not be consistent with the principles behind prospective payment.

We recognize that many hospitals that might have benefited from the implementation of a tax adjustment have been inconvenienced by the time and effort required to comply with our requests for documentation of their tax costs. Because of our decision, those hospitals will now receive no benefit in return for complying with our requests. We regret that it was not possible to

make a final determination about the merits of implementing a tax adjustment before proceeding with data collection and verification. It was necessary to collect and verify data on tax costs in order to determine the dimensions of the issue before proceeding with any proposal to make an adjustment. Without verified data, we would not have been able to inform interested parties of the estimated size of the change in payments for hospitals that do not pay taxes. Once we published the proposal, it was necessary to complete data collection and verification in order to be prepared for possible implementation of the adjustment following comments. On the one hand, then, we could not proceed with a proposal without data. On the other hand, we also could not decide to implement the proposal in the final rule simply because the data had been collected. It would be inconsistent with the integrity of the rulemaking process to allow preparations necessary for the possible implementation of a proposal to dictate the results of the notice and comment process.

The issue of taking capital-related tax payments into account when determining capital-related prospective payments is an important one in the effort to create a payment system that is both fair and feasible. Providers that submitted data needed in the analysis of this issue and for the design of a payment system made an indispensable contribution toward informing the debate, influencing the formulation of this important public policy, and reaching the decision that the proposed change in the capital-related prospective payment system should not be made at this time.

As noted, we received numerous other comments about the specific features of a possible tax adjustment. Since we have decided not to proceed with such an adjustment, we will not respond to those comments at this time.

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

A. New Requirements for Certain Long-Term Care Hospitals Excluded From the Prospective Payment Systems (§§ 412.23(e))

1. Effect of Change of Ownership on Exclusion of Long-Term Care Hospitals

As discussed in the June 2, 1995 proposed rule, some questions have arisen as to whether a hospital's compliance with the length-of-stay requirement for long-term care (LTC) hospitals is affected by its sale to a new owner. After reviewing this issue, we concluded that if a change of ownership occurs at the start of a cost reporting period, or at any time during the 6 months immediately preceding the start of that period, the hospital should not be required to begin a new qualifying period. Therefore, we proposed to clarify current regulations by specifying under § 412.23(e)(2) that if a hospital undergoes a change of ownership at the start of a cost reporting period, or at any time within the preceding 6 months, it may be excluded from the prospective payment system as an LTC hospital if it is otherwise qualified and maintained an average length of stay in excess of 25 days, under both current and previous ownership, for that 6-month period (60 FR 29244). To qualify for the exclusion, the hospital must have been continuously in operation for all of the qualifying period and participated continuously in Medicare as a hospital. That is, periods during which the hospital was closed or did not participate in Medicare could not be counted toward the required experience.

We received no public comments on this proposal and are, therefore, adopting the regulations as proposed.

2. Revised Criterion on Purchase of Services by LTC ''Hospitals Within Hospitals''

Recently, some entities began to organize themselves under what they refer to as the ''hospital within a hospital'' model. Under this model, an entity may operate in space leased from a hospital and have most or all services furnished under arrangements by employees of the lessor hospital. The newly organized entity may be operated by a corporation formed and controlled by the lessor hospital, or by a third entity that controls both. In either case, the new entity seeks State licensure and Medicare participation as a hospital, demonstrates that it has an average length of stay of over 25 days, and seeks to obtain an exclusion from the prospective payment systems. As explained in the rulemaking documents for FY 1995, we believe it would be inappropriate to extend the LTC hospital exclusion to what is for all practical purposes a LTC hospital unit.

To avoid granting LTC hospital exclusions inappropriately to hospital units while still allowing adequate flexibility for legitimate networking and sharing of services, we set forth additional exclusion criteria for these ''hospitals within hospitals'' in our September 1, 1994 final rule (59 FR 45389–45393). These regulations provide that, in addition to meeting the other LTC hospital exclusion requirements set forth in § 412.23, to be excluded from the prospective payment systems, a hospital located in the same building or in one or more entire buildings located on the same campus as another hospital must have a separate governing body, a separate chief medical officer, a separate medical staff, and a separate chief executive officer. These criteria are stated in regulations at §§ 412.23(e)(3)(i)(A) through 412.23(e)(3)(i)(D). In addition, the hospital must either perform most basic hospital functions without any assistance from the hospital with which it shares space (or from a third entity that controls both) (§ 412.23(e)(3)(i)(E)) or receive at least 75 percent of its inpatient referrals from a source other than the other hospital during the period used to demonstrate compliance with the length-of-stay criterion (§ 412.23(e)(3)(ii)). The criterion under § 412.23(e)(3)(i)(E) does permit a hospital seeking exclusion to obtain certain services from a hospital occupying space in the same building, including food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment.

Since publication of the September 1, 1994 final rule, hospital representatives have stated that there are some situations in which basic hospital services other than those related to dietetic, housekeeping and maintenance functions could be furnished in a more cost-effective manner, or more conveniently for patients, if they were provided by the hospital in which the LTC hospital is located. As discussed in the June 2, 1995 proposed rule, we recognize the need to allow LTC hospitals within hospitals greater discretion to purchase services like these from their ''host'' facilities, when it is done in a cost-effective and convenient way. However, it is also important that the LTC hospital exclusion criteria be clear and definite enough to limit LTC exclusions to bona fide separate hospitals. To balance these competing objectives, we proposed to revise the exclusion criteria to describe the scope of services that can be obtained from the host hospital in financial terms, rather than by type of service (60 FR 29244).

Under our proposal, an otherwise qualified hospital could obtain a LTC hospital exclusion if the operating cost of services that it furnishes directly or obtains from a source other than the hospital with which it shares a building or campus (or from a third entity which controls both hospitals) constitutes at least 85 percent of its total inpatient operating costs. This test would be applied with respect to the cost

reporting period or other time period used to establish the hospital's compliance with the length of stay criterion. (If a period other than a full cost reporting period is used, the LTC hospital must provide HCFA with verifiable information on its costs for that part of the period.)

We proposed a criterion of 85 percent of total inpatient operating costs as an appropriate test of separateness based on the level of dietetic, housekeeping, and maintenance expenses incurred by a small sample of LTC hospitals for which we have readily available data. Our review showed that these expenses generally ranged from 5 to 17 percent of total inpatient operating costs for the periods under review. By setting the maximum acceptable level at 15 percent, we believe that we would allow hospitals an adequate margin for purchase of a limited range of services, without encouraging a level of dependence that calls into question the LTC hospital's status as a separate institution.

To implement this policy, we proposed to specify under § 412.23(e)(3)(i)(E) that the costs of any services a hospital obtains under contract or other agreements with a hospital occupying space in the same building or campus, or with a third entity that controls both hospitals, may not exceed 15 percent of the hospital's total inpatient operating costs, as defined under § 412.2(c). Thus, a LTC hospital would be permitted to obtain dietetic, housekeeping, maintenance or other services from another hospital with which it shares a building or campus (or from a controlling third entity), provided that the aggregate cost of these services is no more than 15 percent of its total inpatient operating costs.

Public comments on this proposal are addressed below.

Comment: One commenter objected to an exclusion criterion for LTC hospitals within hospitals that is stated in terms of the cost, rather than the type, of services purchased from the host facility. This commenter stated that hospitals within hospitals are units of acute care hospitals and should be treated as such. The commenter also stated that the proposed criterion will further complicate an already complex system, encourage more facilities to reorganize themselves in an attempt to gain exclusions from the prospective payment system, and increase Medicare administrative costs. For all of these reasons, the commenter recommended that we not only abandon the proposed change but also revise the regulations to prohibit LTC hospitals within hospitals from being excluded from the prospective payment system.

Response: Although we share the commenter's concern about possible abuse of the exclusion provisions, we do not believe that either our current regulations or our proposals encourage inappropriate exclusions. On the contrary, the current regulations provide reasonable assurance that facilities excluded as LTC hospitals are functioning as separate hospitals, and we believe that our proposed changes will preserve our ability to achieve this result. Moreover, we expect that the shift from a type-based to a volume-based standard will reduce, rather than add to, the complexity and cost of our regulations. Thus, we do not agree that it is necessary to prohibit all LTC hospitals within hospitals from being excluded from the prospective payment system, nor do we believe that the proposed changes will encourage more facilities to pursue exclusions. For these reasons, we did not adopt this commenter's suggestions.

Comment: One commenter stated that hospitals within hospitals typically are set up to serve only the LTC needs of patients of the host hospital, and are unlikely to receive referrals from other sources. A hospital of this type also may have a low occupancy level, thus leading to very high per-stay costs, which will be paid for by Medicare. To prevent this situation from occurring, the commenter recommended that the 75 percent alternative criterion in § 412.23(e)(3)(ii) be made a basic requirement for exclusion. Under this commenter's recommendation, a hospital within a hospital would be excluded as a LTC hospital only if it met the 75 percent criterion and also provided all basic services without assistance from the host hospital. The commenter argued that this approach will limit the exclusion of LTC hospitals within hospitals to those that meet legitimate community needs.

Response: Although we agree that an approach of this kind might help to prevent abuse of the exclusion provisions, we are concerned that such a standard might deny exclusion to some legitimately separate institutions. We believe that the revised criteria are sufficiently rigorous to identify only situations when exclusion is appropriate, yet flexible enough to recognize legitimate variations in the ways hospitals obtain needed services and supplies. Therefore, we did not adopt this comment.

Comment: Several commenters expressed support for our proposal to focus on the volume, rather than the type, of services purchased from the host hospital. However, these commenters also stated that a criterion set at 15 percent of total inpatient operating costs is too restrictive. One commenter favored setting the criterion at 25 percent of the LTC hospital's total inpatient operating costs, with an exception for higher levels of purchases where the LTC hospital can show that obtaining services in this way is cost-effective. Another commenter suggested setting the criterion at 35 percent of total inpatient operating costs. Still another commenter favored retaining the requirement that hospitals provide most basic hospital services but allowing some percentage of basic hospital services, as measured by cost, to be purchased from the host hospital.

Several commenters expressed concern about the range of costs considered in arriving at the 15 percent figure. One commenter stated that the 15 percent threshold is too low because it does not include those services that were prohibited in the prior years, and recommended eliminating any limit on the type or cost of services that a LTC hospital can purchase from its host hospital. Another commenter asked for more detailed information on how the 15 percent figure was derived and how the measurement will be implemented. The commenter believes the 15 percent figure is necessarily too low since several categories of costs (telephone, administrative and general, laundry and linen, social services, and physical, recreational, and respiratory therapy costs) were not included in the costs sampled to arrive at that figure. One commenter stated that the methodology used to arrive at the 15 percent figure appears to be inadequate, in that it assessed only dietetic, housekeeping, and maintenance expenses, and did not take into account services such as hyperbaric oxygen therapy, surgical services, physical therapy, and security, which can often be obtained most cost-effectively from the host hospital. Because of concern about these issues, the commenter recommended that we revise the regulations to base exclusion on the level of patient needs, rather than the volume of costs, met by services obtained from the host hospital. Two commenters recommended that the regulations be revised to state that the inpatient operating costs to which the 15 percent criterion is applied will not include any costs of leased space or of equipment rental, maintenance, or utilities for the space.

Finally, one commenter noted that some new hospitals have structured their operations for their initial 6-month period of operation to comply with the requirement that they furnish basic

hospital services without assistance from the host facility, and have not held the inpatient operating costs of services purchased from the host hospital within the 15 percent ceiling allowed by the proposed regulations. The commenter stated that by shifting to a cost-based standard, we would in effect be denying exclusion to facilities that operated in compliance with the exclusion criteria in effect when they began to provide services. To avoid this scenario, the commenter suggested that we delay the effective date of the 15 percent rule by an additional year (that is, until cost reporting periods beginning on or after October 1, 1996) for hospitals meeting the criterion related to provision of basic hospital services without assistance from the host hospital.

Response: These comments appear to reflect some misunderstanding of the purpose of our proposed change to an exclusion criterion based on volume of services (as measured by costs) rather than type of services. The purpose of the proposal is not to identify the most cost-effective way for a hospital within a hospital to obtain services, but to describe a pattern of functioning that provides reasonable assurance that a facility seeking to be excluded from the prospective payment system as a LTC hospital actually functions as a separate hospital. Clearly, when a facility operates within another institution, it may be more cost-effective in many cases to obtain services from the surrounding institution. It may be even more cost-effective to integrate the governance and medical direction of the hospital and the entity. A hospital component that wishes to organize itself in this way may do so, but it would not constitute a separate hospital under section 1886(d)(1)(B) of the Act, which provides for the exclusion of LTC hospitals, but not LTC units, from the prospective payment system.

In assessing the level of dietetic, housekeeping, and maintenance expenses incurred by a sample of LTC hospitals, our goal was not to set the criterion at a level that could easily be met by all potential hospitals within hospitals, but to assess the proportion of costs that a separate hospital may need to spend for the range of services it can buy under current exclusion rules. Thus, our intent was to devise a criterion that would properly assess the level of independence of a hospital within a hospital, but would allow more discretion as to the types of services to be supplied by the host facilities. We recognize that not all hospitals located within hospitals may be able to meet the criterion, and that in some cases hospitals may need to reduce their level of purchases from host facilities to qualify for exclusion under the criterion.

In response to the comments asking for the basis for establishing the threshold at 15 percent, the proposed 15 percent criterion was based on our analysis of the best available data. The Hospital Cost Report Information System (HCRIS), the automated cost report data base submitted by the fiscal intermediaries, does not contain cost data for the specific general service cost centers, such as dietary, housekeeping and maintenance costs, that represent a large portion of the costs of shared services. As a result, we instead analyzed cost report data from the hard copies of cost reports that we had on file. Specifically, we analyzed data for LTC hospitals that had requested a review of costs in relation to the TEFRA limits. This data showed that the aggregate of these specific operating costs, in comparison to total operating costs, ranged from a low of 5 percent to a high of 17 percent. Based on this range, we concluded that 15 percent was a reasonable level at which to establish the standard, as we proposed in our June 2, 1995 rule.

In response to public comments on this proposal, we conducted further analysis of the cost reports aimed at estimating more precisely the proportion of total inpatient operating costs that is attributable to basic hospital services. To do so, we refined our analysis to include additional costs (that is, maintenance and repairs, operation of plant, and laundry and linen services), to account for ancillary costs of inpatient hospital services, and to exclude ancillary costs related to nonhospital components of the institution, such as distinct part skilled nursing facilities. The new analysis indicated a range of 7 percent to 27 percent, with an average of slightly below 15 percent.

Thus, based on this analysis, we continue to believe that a 15 percent standard represents a valid and reasonable basis for identifying hospitals within hospitals that actually function independently. However, we are concerned that some hospitals that have been excluded appropriately under criteria related to the types of services they provide independently from their hosts may not be able to meet the new criterion by the time it becomes effective (that is, by the start of cost reporting periods beginning on or after October 1, 1995). To avoid this problem as well as to widen, as appropriate, the range of compliance options available to hospitals within hospitals, we have decided to make the 15 percent standard an alternative to, rather than a replacement for, our current criterion on provision of basic hospital services. This approach will enable hospitals the flexibility to buy whatever services they wish from the host, subject to the 15 percent limit, but will not require hospitals that qualify for exclusion under current rules to alter their operations to meet a new requirement. We note that because we are making the 15 percent rule an alternative to the current criterion rather than a replacement for it, a new hospital that has organized itself to meet the current requirements will not be disadvantaged. Thus, there is no need to delay application of the 15 percent rule.

With respect to the costs to which the 15 percent criterion will apply, we are clarifying proposed § 412.23(e)(3) to state that the criterion apply to total inpatient operating costs, as defined under § 412.2(c), except that, for purposes of the prospective payment system exclusion provisions, the costs of preadmission services are those specified at § 413.40(c)(2), not those described in § 412.2(c). Costs incurred under leases or rental agreements are taken into account only to the extent they fall within the § 412.2(c) definition of operating costs.

Finally, concerning the suggestion on patient needs, we note that those needs often can be defined only subjectively, and we believe that any test or measurement used for exclusion should be an objective one that is susceptible to verification by both the provider and HCFA. Thus, we did not adopt this suggestion.

Comment: One commenter stated that current rules relating to the types of services obtained by an LTC hospital within a hospital from its host are clear and adequate for distinguishing a separate hospital from a hospital unit, and that a separate rule relating to the volume of services is not needed. This commenter suggested that instead of shifting to a volume-based standard, another way to allow greater flexibility for cost-effective purchasing from the host hospital would be to allow specific types of basic hospital services, such as laboratory services, to be purchased from the host facility. Another commenter recommended that the 15 percent limitation be applied only to basic hospital services as defined under current regulations, and that an LTC hospital within a hospital be allowed to buy other services without limitation from the host hospital.

Response: We agree that either proposed approach would increase hospital flexibility. However, the types of services available from host facilities

and from other sources vary from one community to another, and from hospital to hospital within a community, and it would be difficult to specify a range of basic hospital services that could acceptably be obtained from the host facility in all cases, without permitting so many types of services to be obtained from the host facility that the criterion would no longer be a useful measure of independent functioning. With regard to the second comment, we are concerned that applying the 15 percent criterion only to basic hospital services would effectively lower the level of independent functioning necessary for a hospital to qualify for exclusion, relative to our current requirements, and thus might permit inappropriate exclusions. Therefore, we are not adopting either of these suggestions.

Comment: A commenter suggested that the creation of a hospital within a hospital is potentially abusive only where the LTC hospital is operated by a corporation owned and controlled by the host hospital, or by a third entity that controls both the host and the LTC hospitals. The commenter recommended that the 15 percent rule be applied only where operational control of this kind exists.

Response: We do not agree with this commenter that simply satisfying the structural criteria (those related to having a separate governing body, medical staff, chief executive officer, and chief medical officer) and average length of stay criteria should be sufficient to support exclusion of an LTC hospital within a hospital. On the contrary, we believe it is essential for such an entity to show that it actually functions as a separate hospital. If the two facilities meet only the separate control criteria but the LTC facility either receives fewer than 75 percent of its inpatients from sources other than the host or receives more services, or different types of services, from the host than allowed under our regulations, we question the validity of excluding the facility from the prospective payment system as a separate LTC hospital. Under these circumstances, the facility would in reality be a unit of the host hospital. Therefore, we did not adopt this comment.

Comment: Two commenters stated that the regulations on hospitals within hospitals should be revised to apply only when an LTC hospital wishes to share a building or campus with a prospective payment hospital, not to comparable situations involving a long-term care hospital and a rehabilitation hospital.

Response: Although the ''hospital within a hospital'' rules were designed primarily in response to situations involving LTC and prospective payment hospitals, the possibility of inappropriate exclusion of a hospital unit can also arise if an excluded hospital such as a psychiatric or rehabilitation hospital seeks to set up an LTC hospital within itself. In both situations, our concern is that an entity that is in essence a hospital unit may seek to obtain an inappropriate exclusion from the prospective payment system. Section 1886(d)(1)(B) of the Act provides for exclusion of LTC hospitals but not of LTC units. Because newly created hospitals within hospitals are eligible for a separate TEFRA target rate and may be eligible for a new hospital exemption from the rate-of-increase ceiling under § 413.40(f), we believe it is important to prevent inappropriate exclusions in all circumstances, not merely those involving prospective payment hospitals. Thus, we do not believe it is appropriate to limit the criteria as the commenter suggested.

Comment: One commenter recommended that we revise the regulations to include a ''grandfather'' clause under which LTC hospitals within hospitals that were excluded from the prospective payment system before October 1, 1994, would not need to meet the current exclusion criteria in order to continue to qualify for exclusion.

Response: The adoption of the 15 percent criterion as an alternative to the existing exclusion criteria under § 412.23(e) gives hospitals within hospitals three alternatives for showing that they function as separate hospitals. Moreover, § 412.23(e)(4) specifies that the criteria concerning the performance of basic hospital functions (under § 412.23(e)(3)) do not apply to any previously excluded hospital until the hospital's first cost reporting period beginning on or after October 1, 1995. In view of the three options available to hospitals for establishing eligibility to be excluded from the prospective payment system, and the delayed effective date already provided for in regulations, we believe we have established equitable policies for previously excluded LTC hospitals within hospitals. Thus, a grandfather clause is unnecessary. Moreover, we are concerned that indefinitely exempting a set of previously excluded hospitals from the regulations would be both inequitable to newer hospitals, and difficult to administer, since similar facilities would be subject to different payment rules, based only on their initial date of exclusion. Finally, it would be contrary to the statutory scheme to exclude LTC units from the prospective payment system. Thus, we have not adopted this suggestion.

Comment: One commenter asked whether the revised criterion on purchase of services would apply to the initial qualifying period of 6 months that is used to establish length of stay for a new LTC hospital.

Response: As stated in proposed § 412.23(e)(3)(i)(E), the new criterion on purchase of services applies to the same period of at least 6 months used to determine compliance with the length-of-stay criterion in § 412.23(e)(2).

Comment: One commenter stated that if an acute care hospital is allowed to set up a LTC hospital within a hospital, it may have a financial incentive to discharge patients prematurely from the acute hospital to the long-term care hospital. The commenter suggested that we adopt further regulations limiting the acute care hospital's ability to discharge a patient to a LTC hospital that it owns or controls.

Response: We understand and share this commenter's concern, and the LTC exclusion criteria are designed to prevent inappropriate exclusions. However, HCFA has no authority to restrict the range of hospitals to which a patient may be referred following discharge from acute care. We intend to review this issue, and may propose further payment changes to avoid financial incentives for inappropriate placement of patients.

B. Clarifying Changes for Excluded Hospitals and Units (§§ 412.23, 412.29, 412.30 and 412.130)

For clarity, we proposed to revise § 412.23(e)(3) to state more clearly that a hospital sharing space with another can qualify for exclusion only if it meets all of the requirements of paragraphs (e)(3)(i)(A) through (e)(3)(i)(D) of that section and, in addition, those in *either* paragraph (e)(3)(i)(E), which deals with separate performance of services, or § 412.23(e)(3)(ii), which deals with the source of the hospital's patients.

In addition, we proposed to restate the rules in §§ 412.29 and 412.30 to differentiate more clearly between criteria that apply when a hospital seeks exclusion of a rehabilitation unit that is created through an addition to its existing bed capacity, and the criteria that apply when a hospital seeks exclusion of a unit that has been created by converting existing bed capacity from other uses. We also proposed to clarify the rules that apply when a hospital expands an existing rehabilitation unit by increasing its bed capacity or by converting existing capacity. These

revisions were developed in response to complaints from some hospital representatives that the current regulations do not state our criteria clearly. We emphasized that these proposals merely restate, and do not change, existing rules. In conjunction with this proposed change, we also stated that we would make a technical change to a reference in § 412.130.

Comment: One commenter objected to the provision of § 412.30(c)(1)(ii) under which the beds a hospital seeks to add to its existing rehabilitation unit will be considered new only if over 50 percent of the beds represent newly licensed and certified beds. The commenter stated that this represents a substantive change in the rules which inappropriately restricts the ability of a hospital to convert acute care capacity to uses excluded from the prospective payment system.

Response: As the commenter noted, § 412.30(b) does not deal explicitly with situations in which a hospital seeks to expand an excluded rehabilitation unit by adding bed capacity that is made up partly of newly licensed capacity and partly of existing capacity. One purpose of the revision was to clarify our policy on this issue. However, § 412.30(a)(2) does state explicitly that ''a unit that includes some beds that were previously licensed and certified and some new beds is recognized as new only if more than one half of the beds are new.'' Thus, the revision merely restates a current rule as to what will be considered ''new'' when an existing facility adds a mixture of newly licensed and existing capacity.

C. Changes to the Regulations Addressing Limitations on Reimbursable Costs (§§ 413.30 (e) and (f), and 413.35(b))

We proposed to remove obsolete material from the regulations. Specifically, we proposed to remove § 413.30 (e)(1), (e)(3), and (e)(4), since sole community hospitals, risk-basis HMOs, and rural hospitals with less than 50 beds are included under 42 CFR part 412, which governs the prospective payment system for operating costs. In addition, we proposed to remove § 413.30(f)(5), (f)(6), (f)(7) (a reserved paragraph), and (f)(9), concerning exceptions for hospital routine care, essential community hospital services, and hospital case-mix changes for cost reporting periods beginning before October 1, 1983. In conjunction with these proposed changes, we stated that we would incorporate the exemption requirements for new providers into paragraph (e) of § 413.30, redesignate subparagraphs under paragraph (f) of § 413.30, and make technical changes to references in §§ 413.30(f) and 413.35(b)(2).

We received no comments on these proposals, and are therefore adopting the changes as proposed.

D. Payment Window for Hospitals and Hospital Units Excluded from the Prospective Payment Systems (§ 413.40(c))

On January 12, 1994, we published an interim final rule with comment period to specify that inpatient hospital operating costs include costs of certain preadmission services furnished by the hospital (or by an entity that is wholly owned or operated by the hospital) to the patient up to 3 days before the date of the patient's admission to the hospital (59 FR 1654). The interim final rule implemented section 4003 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), which amended section 1886(a)(4) of the Act. Because the definition of inpatient operating costs in section 1886(a)(4) of the Act applies to both prospective payment system hospitals and hospitals excluded from the system, the January 12, 1994 interim final rule revised the regulations governing excluded hospitals as well as those governing prospective payment hospitals. Specifically, we revised § 413.40(c)(2) of the regulations to reflect the 3-day payment window as required by the statute. We received 11 comments in response to this issue. Although we stated in the proposed rule that we intended to address these comments in this final rule, we have revised our plans. We will instead issue the final rule addressing the 3-day payment window as a separate document to be published in the **Federal Register**.

On October 31, 1994, Congress enacted the Social Security Act Amendments of 1994. Section 110 of that legislation amended section 1886(a)(4) of the Act to state that, for hospitals excluded from the prospective payment system, the preadmission services to be included are those furnished during the 1 day (not 3 days) before a patient's admission.

To implement this provision, we proposed to revise § 413.40(c)(2) to provide for a 1-day payment window for hospitals and hospital units excluded from the prospective payment system. We note that the term ''day'' refers to the calendar day immediately preceding the date of admission, not the 24-hour time period that immediately precedes the hour of admission.

We received no comments on this proposal, and are therefore adopting the changes as proposed.

E. Ceiling on the Rate of Increase in Hospital Inpatient Costs (§ 413.40(e) and (g))

We proposed to revise § 413.40(e)(1) to clarify that a request for a payment adjustment must be *received* by a hospital's fiscal intermediary no later than 180 days from the date of the notice of program reimbursement (NPR). Currently, this section states that a request must be ''made'' rather than ''received.'' We have consistently interpreted the word ''made'' to mean ''received by the fiscal intermediary'' since the original regulation was promulgated (47 FR 43282, September 30, 1982). However, use of the word ''made'' in § 413.40(e)(1) has resulted in varying interpretations of the timely filing requirement by hospitals and their fiscal intermediaries. In the interest of a uniform and consistent application of our policy, we proposed to clarify the regulation by substituting ''received by the hospital's fiscal intermediary'' for ''made'' in § 413.40(e)(1).

In § 413.40(g)(1), we proposed to clarify the determination of the amount of payment made to a hospital that receives a TEFRA adjustment. Since October 1, 1991, a hospital with operating costs in excess of its ceiling has been paid the ceiling plus an additional amount, as provided at § 413.40(d)(3). For these cost reporting periods, a hospital receives some payment for costs in excess of the ceiling. We also proposed to add a sentence to clarify that the amount of payment made after a TEFRA adjustment may not exceed the difference between a hospital's operating costs and the payment previously allowed.

Comment: We received two comments requesting that the postmark date of the request be used as the determinant of whether the comment is received timely. One commenter expressed concern about problems with the intermediary's delivery procedures and delays in the mail room. Both commenters requested that we use the postmark date to determine timely filing of an exception request because it provides ''incontrovertible proof'' that a request was made timely and is consistent with a final rule published in the **Federal Register** on June 27, 1995 (60 FR 33137) with regard to timely filing of the cost report.

One of the commenters also objected to our proposed policy of using the receipt date by the intermediary, stating that HCFA often takes 18 months or longer to respond to exception requests. The commenter added that a request based on sound merits should be

considered whether it is received on the 180th or 181st day after the notice of program reimbursement.

Response: The commenter's statement regarding the use of a postmark date for determining whether cost reports are considered timely filed is based on language from our response to a comment in a final regulation published in the **Federal Register** on June 27, 1995 (60 FR 33139) that extended the due dates for filing cost reports to five months from the end of the cost reporting period. In that response, we explained that we use the postmark date in the cost report context in accordance with section 2219.4C of the Medicare Intermediary Manual.

In the appeals context, however, there are certain statutes and regulations that impact on our decision as to when payment exceptions must be requested to be considered timely. While section 1886(b)(4)(A) of the Act, which provides the Secretary with the authority to grant exceptions to the per discharge limit, does not specify requirements with regard to timely filing of an exception request, we believe it is appropriate to examine section 1878 of the Act. That section addresses timely filing of a hearing request with the Provider Reimbursement Review Board (PRRB). Such a request, like an exception request, involves a provider seeking reimbursement in addition to that set forth in its notice of program reimbursement. For that reason, we believe that our policy with regard to the timely filing of an exception request should be consistent with section 1878 of the Act.

Section 1878(a)(3) of the Act states that if a provider files a request for a hearing within 180 days after notice of the intermediary's final determination, the provider can obtain a hearing with the PRRB. We note that *Black's Law Dictionary* defines the term ''file'' as follows:

> To deposit in the custody or among the records of a court. To deliver an instrument or other paper to the proper officer or official for the purpose of being kept on file by him as a matter of record or reference in the proper place.

Accordingly, we are continuing to use the date received by the intermediary to determine timely filing of an adjustment request by a provider. Under this policy, intermediaries will date stamp requests upon receipt, and we will consider the date stamped on the exception request by the intermediary as the receipt date to determine timely filing, unless the provider demonstrates that the intermediary received the request on some other date. For example, a provider may mail through an overnight delivery service a request that is not stamped until the day after delivery. Where the provider can show that it was delivered on the previous day the request will be considered timely.

With regard to the comment that HCFA often takes 18 months or longer to respond to exception requests, we regret these delays, which have resulted from the significant volume of exception requests we have received. We are making efforts to reduce the backlog and expedite processing of exception requests. However, we do not agree that all exception requests should be evaluated on their merits regardless of whether they are received on the 180th or 181st day after the NPR. To ensure effective administration of the program, intermediaries must consistently apply the timely filing requirements.

Comment: One commenter interprets our proposal to clarify that the amount of payment made after a TEFRA adjustment may not exceed the difference between a hospital's operating costs and the payment previously allowed to mean that the TEFRA penalty payment would not apply.

Response: The commenter's interpretation is not correct. Our proposal was intended only to ensure that total payments to an excluded hospital or unit that receives an exception do not exceed total inpatient operating costs. Currently, hospitals with costs above the TEFRA limit receive their per discharge limit plus 50 percent of costs in excess of the limit, up to 110 percent of the target amount. If the hospital receives an adjustment to its TEFRA target amount, the amount of penalty payment is recalculated based on the adjusted target amount. Under our policy, the hospital could continue to receive the TEFRA penalty payment and any additional adjustment amounts, but only up to its total inpatient operating costs. Accordingly, the total payment would not exceed total inpatient operating costs.

VII. ProPAC Recommendations

As required by law, we reviewed the March 1, 1995 report submitted by ProPAC to Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our response to that recommendation, we have not repeated the recommendation and response in the discussion below. Recommendations 1, 4, and 5, concerning the update factors for inpatient operating costs, the update factor for hospitals paid on the basis of hospital-specific rates, and the update factor for hospitals excluded from the prospective payment system and distinct-part units, respectively, are discussed in Appendix C to this final rule. Recommendations 2 and 3, concerning the update factors for inpatient capital costs and the single operating and capital update factor, respectively, are discussed in Section V of this final rule. Recommendation 11, concerning improving Medicare transfer payment policy, is discussed in section IV.A of the preamble. The remaining recommendations on which we received comments are discussed below.

A. Update to the Composite Rate for Dialysis Services (Recommendation 6)

Recommendation: For FY 1996, the composite rate for dialysis services should be updated to account for the following:

- The projected increase in the market basket index for dialysis services, currently estimated at 3.7 percent;
- A net adjustment of zero percentage points for scientific and technological advances and productivity; and
- A negative discretionary adjustment of 3.7 percentage points to reflect the relationship between payments and estimated fiscal year 1995 costs.

This would result in an update of zero percent.

Response in the Proposed Rule: We agree with ProPAC's recommendation not to propose a payment rate increase for dialysis services. ProPAC's cost analysis indicates that, in aggregate, Medicare payments to independent dialysis facilities were about 12 percent higher than their Medicare allowable costs, and thus there is no basis to increase the composite rate. Furthermore, ProPAC concludes that without documented explanations for reported higher costs in hospital-based facilities, it cannot justify a differential update for these facilities.

ProPAC's analysis of the 1993 unaudited cost data shows that Medicare allowable costs for independent facilities are less than their payment rate. Since 1983, the number of independent facilities has continued to increase in response to growing patient demand, even though payment rates have remained constant. As noted by ProPAC, the margin between

independent facilities' composite payment rates and their Medicare allowable costs continues to decrease. Because of this trend, we will closely monitor the costs of dialysis treatments as reported by facilities on their cost reports. Further, if Medicare's conditions of coverage are revised to include an adequacy of dialysis standard, we will examine the need to adjust composite payment rates. The current composite payment rates are mandated by statute.

To improve the quality of the cost report data and to address concerns about the cost report, we have revised the independent facilities' cost report, Form HCFA 265–94. The new cost report eliminates the allocation of the facility's overhead to the drug recombinant human erythropoietin (EPO). In addition, we are revising the independent cost reports edits. These edits would screen cost report data to ensure that data elements outside edit ranges are investigated by intermediaries.

Comment: One commenter asserted that the difference in cost levels between freestanding facilities and hospital-based renal facilities is obvious; hospital-based renal facilities treat a more resource intensive and complicated patient base. The commenter recommended updating the composite payment rates using the hospital market basket index.

Response: ProPAC addressed this issue in its report. Its analysis did not attribute the difference in cost to factors such as patient mix, for which the composite payment rate system should compensate renal facilities. Rather, it showed that the higher cost per treatment in hospital-based facilities was due to higher labor expenses and the method by which costs are allocated between inpatient and outpatient departments. Differences between independent and hospital-based facilities in quality of care and patient outcomes have not been demonstrated. Patient data showed in the aggregate that there is no difference between hospital and independent renal patient medical populations. For renal facilities treating an atypical patient population, there is an exception process. This process gives renal facilities an opportunity, on a case by case basis, to demonstrate that their payment rates should be adjusted to account for higher costs attributable to differences in patient mix.

Comment: ProPAC commends the Secretary's efforts to improve the quality of cost report data by eliminating the allocation of facilities' overhead to the drug recombinant human erythropoietin (EPO) and by revising the independent cost report edits to screen cost report data more effectively. The Commission believes, however, that annual audits are necessary to develop the quality data needed to monitor dialysis costs over time and to ensure that payments for dialysis services are updated appropriately.

Response: Audits are important to ensure the quality of cost reporting data and would improve the quality of the data. However, audits are expensive for HCFA and for renal facilities, and they only correct the data being audited. The best way to improve the quality of cost data is through education, such as that being conducted by the National Renal Administrator Association. We are in the process of developing a national standard to measure the adequacy of dialysis. We will conduct audits once this standard is implemented. These audits should then document the costs associated with improved dialysis care.

B. Level of the Indirect Medical Education (IME) Adjustment to Prospective Payment System Operating Payments (Recommendation 7)

Recommendation: For FY 1996, the IME adjustment to prospective payment system operating payments should be reduced by 13 percent, from a 7.7 percent to a 6.7 percent increase for every 10 percent increment in teaching intensity. Ultimately, the IME adjustment should be reduced by about 40 percent, to a 4.5 percent increase for every 10 percent increment in teaching intensity.

Response in the Proposed Rule: ProPAC's IME estimate of 4.5 percent represents a significant acceleration in the downward trend of its estimates in the last several years (5.7 percent in 1992, 5.4 percent in 1993, and 5.2 percent in 1994). Coupled with FY 1993 cost report data showing major teaching hospitals' Medicare operating margins (difference between payments and costs as a percentage of payments) rising to over 11 percent, this declining IME estimate adds to the argument that the current adjustment is too high. Legislation would be required to reduce the IME adjustment. However, savings proposals of this sort would only be appropriate in the context of health care reform.

Comment: ProPAC's comment largely reiterated the discussion contained in its March 1995 report. ProPAC did indicate that, contrary to our assertion that its IME estimate of 4.5 percent represents an acceleration in the downward trend of its recent estimates, this apparent downward trend reflects its ''continuing efforts to improve both the methods used to analyze this relationship and the accuracy of the resulting estimates.'' The Commission's comment goes on to indicate that, applying its current estimating methodology to prior year's data, ''the results do not vary much from the current 4.5 percent estimate.

Response: We agree that, in our June 2, 1995 response to ProPAC's recommendation, we may have misinterpreted ProPAC's most recent IME estimates as indicating an accelerating downward trend. Upon further discussion with ProPAC, it appears that, rather than a declining relationship over time, the decline in the most recent estimate results from a change in how ProPAC controls for cost differences resulting from hospital location (that is, large urban, other urban or rural). Specifically, in its most recent estimate, ProPAC included dummy variables in the regression to indicate that a hospital is located in a large or other urban area, rather than standardizing the dependent variable costs per discharge for differences in the standardized amounts.

C. Making DRG Payment Rates More Accurate (Recommendation 9)

Recommendation: The Secretary should implement, as soon as practicable, the DRG severity refinements developed by HCFA. At the same time, she should improve the accuracy of basic DRG payment rates and outlier payments by changing the methods used to calculate the DRG relative weights. The weights should be based on the national average of hospital-specific relative values for all cases in each DRG, rather than the national average standardized charge per case.

Response in the Proposed Rule: In the May 27, 1994 proposed rule (59 FR 27716), we announced the availability of a paper we prepared that describes our preliminary severity DRG classification system and the analysis upon which our proposal was formulated. Based on the 100 comments we received on that paper, we are further analyzing and adjusting the severity DRG classifications. We are also examining the stability of the severity classifications over time. We agree with the Commission's judgment that adopting the severity DRGs would tend to reduce current discrepancies between payments and costs for individual cases and thereby improve payment equity among hospitals. We therefore remain committed to implementing the severity DRG classification system as soon as possible. (See discussion in Section II.B of this preamble.)

We also agree with the Commission that basing DRG weights on standardized charges results in weights that are somewhat distorted as measures of the relative costliness of treating a typical case in each DRG. The Commission notes several sources of distortion, including the following: systematic differences among hospitals in cost-to-charge ratios; variation in mark-ups for services across hospitals; variation among DRGs in the average mark-up implicit in case level charges; standardization factors that inaccurately represent cost differences among hospitals; and the absence of adjustments to account for factors such as variations in practice patterns and efficiency. We recognize that the hospital-specific relative value method of setting weights may reduce or eliminate distortions from these sources, and we are studying its effect on DRG weights and hospital payments.

The Commission also addresses two issues regarding current outlier financing policies: (1) how to account for outlier payments in setting a DRG weight that accurately reflects the relative costliness of treatment for typical cases; and (2) how to finance outlier payments so that the burden of treating such cases is spread fairly among all hospitals. We are studying these issues and look forward to working with ProPAC to find solutions.

Because the effects on DRG weights of implementing DRG severity refinements and changing the methods used to calculate DRG relative weights are interactive, we believe that appropriate changes should be adopted concurrently. However, as stated in the final rule published on September 1, 1992 (57 FR 39761) and in subsequent rules, as well as in this rule, we would not make significant changes to the DRG classification system unless we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG changes may have on coding behavior, or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments. (See comment and response following Recommendation 10 below).

D. Improving Annual Update Policies (Recommendation 10):

Recommendation: The Secretary should be given authority to adjust the standardized amounts if anticipated coding improvements would increase aggregate payments by more than 0.25 percent during the coming year. This adjustment should be separate from the annual update. It should be based on findings from empirical analysis of the new HCFA data base of reabstracted medical records. Once sufficient data are available, the Secretary should also make a correction if there is more than a 0.1 percentage point error in a previous adjustment.

Response in the Proposed Rule: We agree with ProPAC that anticipated coding changes should be taken into account and that the most appropriate method for recognizing valid increases in case mix as a result of improved coding practices is within the framework of the standardized payment amount. We acknowledge, with ProPAC, that shifts in the mix of cases among DRGs may result from changes in practice patterns, new technology, or variations in the incidence of illness, as well as changes in the coding of diagnoses and procedures.

As ProPAC states, under section 1886(d)(4)(C) of the Act, we are required to make DRG reclassification and recalibration changes in a budget neutral manner. To meet this requirement, we normalize the DRG relative weights so that, for the discharges in the data base, the average DRG weights before and after reclassification and recalibration are equal. The recalibration of the DRG weights is accompanied by a budget neutrality adjustment to the standardized payment amount to ensure that estimated aggregate payments remain unchanged.

We share ProPAC's concern that introduction of any major modification to the DRG classification system will result in major shifts in the distribution of cases among the DRGs. Because the severity refinements to the DRGs would create many new DRGs with relatively high weights, there will be increased incentive to hospitals to report those secondary diagnoses that result in assignment to the higher weighted DRG. We agree with ProPAC that this is not inappropriate and is indeed anticipated. We further agree that we need to ensure that hospitals are fairly compensated for increases in costs that reflect real increases in the level of severity of illness of their patient population.

In order to protect the Medicare program from payment increases that are a consequence of improved coding practices that do not reflect a real increase in case mix, we have developed a methodology that would recalibrate the DRG relative weight to 1.0 each year, thus eliminating the normalization process and the concomitant inflationary adjustment to the DRG weights. This would prohibit upcoding and other coding improvements from having an impact on the DRG relative weight. To account for real case-mix increases, we have recommended an annual upward adjustment to the standardized amounts equal to the lesser of the total observed case-mix increase or 1.0 percent. Anticipated case-mix change due to upcoding would be accounted for through a prospective adjustment to the standardized amounts. This adjustment would be for one year at a time and would not be cumulative.

ProPAC recommends that an ongoing data base of reabstracted medical records be used to estimate the real and coding components of case-mix change and provide the basis for forecasting future coding changes. HCFA has recently implemented a record reabstracting process being conducted by two clinical data abstraction centers (CDACs) under contract with the Health Standards and Quality Bureau (HSQB). The CDACs will review a national random sample of 30,000 records per year from the National Case History file, gathered on a monthly basis. Registered Record Administrators (RRAs) and Associate Record Technicians (ARTs) will reabstract the medical record and perform complete record medical coding, which will be stored with the original coding.

We will evaluate the results of this reabstracting process before making a decision to base adjustments for anticipated coding changes only on this data base. Our estimate of an annual real case-mix increase of 1.0 percent is supported by past studies of case-mix change by the Rand Corporation. The most recent study by RAND, ''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), uses medical records from those Federal fiscal years, using consistent standards, to determine real case-mix change.

As we pursue options and alternatives to payment adjustments to account for real case-mix increases, we will take into consideration ProPAC's recommendations to limit adjustments to those occasions in which coding changes would increase aggregate payments by more than 0.25 percent or when forecasts differ from observed, actual experience by more than 0.1 percent. We note, also, that we are considering a number of related modifications to the calculation of the DRG relative weights that will have an impact on the prospective payment rates. (See response to ProPAC Recommendation 9, above.)

Comment: In its comment on our response to ProPAC Recommendation 9

and 10 (Improvements in the DRG Payment Rates and Annual Update Policies), the Commission indicated that it continues to believe that refinements to the DRG definitions and relative weights should be implemented as soon as possible. While the Commission agrees that adopting the refined DRGs could lead to changes in hospital coding behavior, it states that recalibrating the weights annually to 1.0 in not necessary to protect Medicare from the effects of coding change. ProPAC believes this may actually interfere with reducing the program's financial risk if it is perceived as an arbitrary means of reducing spending. Additionally, it does not believe that limiting future increases in payments to the lesser of the measured real change or 1.0 percent is plausible if the real change turns out to be higher.

The Commission, although stating appreciation of our desire to evaluate the new reabstracted data base, states that this data base exceeds the size and representativeness of any data base previously used to determine adjustments for coding change. ProPAC reiterates its recommendation that an adjustment, separate from the annual update, be applied in situations when changes in coding, anticipated in response to major revisions in the DRG definitions or the relative weights, are expected to lead to an increase in aggregate payments of at least 0.25 percent. The projected effect of changes in coding would be based on empirical analysis of the reabstracted medical records available to HCFA, and corrections would be made when significant forecast errors are detected.

Response: Although we agree with the Commission that these policy changes will improve equitable payment across hospitals, we believe it would be irresponsible for HCFA to implement the severity adjustment to the DRGs before we are able to predict or control the impact of coding changes on final DRG assignment and, thus, on payment. We do not agree that recalibration of the DRG relative weights to 1.0 will be perceived as arbitrary. With sufficient understanding of the rationale and results, as well as of the other modifications to the payment rate and DRG weights, the health care community should appreciate our efforts to identify and measure real case-mix increases. Nor do we agree that our rationale for limiting adjustments to the standardized amounts for real change in case mix to the lesser of the measured real change or 1.0 percent is not plausible. As stated in the proposed rule (60 FR 29247), our estimate of annual real case-mix increase of 1.0 percent is supported by past studies of case-mix change by RAND. We are willing to re-examine this issue, if empirical evidence provided through analysis of the reabstracted data from the clinical data abstraction centers (CDACs) demonstrates that real case-mix change is significantly more or less than 1.0 percent.

As discussed in section II.B. of this preamble, collection of data from the CDACs has recently been implemented, and we will evaluate the results of this reabstracting process. Only through this evaluation will we be able to confirm the reliability and validity of these data as a basis for predicting case-mix increases. We will consider ProPAC's recommendations to adjust the standardized amount only when coding changes increase aggregate payments by more than 0.25 percent. However, we believe it is prudent and responsible policy to defer DRG changes, as well as adjustments in anticipation of coding changes, until such adjustments can be based on empirical analysis of the reabstracted medical records. As noted by ProPAC in its recommendations, the current statute prevents us from making any adjustment to the standardized amount to account for coding improvements.

VIII. Other Required Information

A. Paperwork Reduction Act

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

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the two information collection requirements discussed below.

As discussed in detail in section IV.B of this preamble, we are eliminating the requirement under § 412.46(a) that a physician sign an attestation statement for each Medicare patient discharged from a hospital. When the prospective payment system for hospitals was established in 1983, we believed that the physician attestation statement was a valuable tool for ensuring the validity of DRG claims. Over the years, however, we have received many complaints from both hospitals and physicians concerning the administrative burden of completing the attestation statements. Moreover, in practice, review of attestation statements by the Peer Review Organizations (PROs) as a part of DRG validation review has resulted in less than a 0.01 percent denial rate of sampled claims. Therefore, we believe it is now appropriate to eliminate the physician attestation requirement. Also, we note that the Administration has identified the elimination of physician attestation as one of its health care regulatory reforms.

This change would reduce significantly the paperwork and information collection burden on physicians and hospitals. We estimate that currently physicians spend about 192,000 hours per year completing attestations. This estimate is based on 11,500,000 hospital inpatient claims per year and 1 minute of physician time per claim. In addition, any time that hospitals spend following up on overdue and unsigned attestations would also be saved.

The only remaining requirement under § 412.46 is that a hospital have on file a signed statement from each attending physician acknowledging that he or she has received a notice from the hospital explaining the penalties applicable for misrepresenting, falsifying, or concealing essential information required for payment. We estimate that this requirement imposes on physicians and hospitals a shared one-time burden of 5 minutes for acknowledgement for each physician that gains admitting privileges. We further estimate that no more than 1–2 percent of the nation's roughly 700,000 active physicians gain admitting privileges at a hospital each year, resulting in an estimated annual burden of approximately 1,200 hours.

Under § 412.106(b)(3), for purposes of the DSH adjustment, a hospital's Medicare Part A/SSI percentage may be calculated based on its cost reporting period rather than the Federal fiscal year. (See section IV.E of the preamble.) Under current policy, a hospital must submit, in machine-readable format, data on its Medicare Part A patients for its cost reporting period. As discussed in detail in the preamble, this process has not resulted in accurate recalculations of the disproportionate

patient percentages, and thus requiring hospitals to submit data has not proven useful or necessary. Therefore, we are revising this requirement to provide that hospitals need only make a written request for the recalculation and need not submit the data. We estimate that the current burden associated with submitting the data is approximately 24 hours per request. Under the revision, we estimate a burden of 1 hour per request. Based on an estimate of 12 requests per year, the total burden will be 12 hours, in comparison to the current total burden of approximately 288 hours.

These information collection and recordkeeping requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained. Organizations and individuals desiring to submit comments on these information collection and recordkeeping requirements should direct them to the Office of Management and Budget, Human Resources and Housing Branch, Room 10235, New Executive Office Building, Washington, D.C., 20503, Attention: Allison Eydt, HCFA Desk Officer.

B. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format or cartridges; however, some files are available on diskette. In our June 2, 1995 proposed rule, we published a list of data sets that are available for purchase (60 FR 29249). We received no comments concerning this process.

C. Waiver of Notice of Proposed Rulemaking and 30-Day Delay in the Effective Date for the Elimination of the Physician Attestation Requirement

We ordinarily publish a notice of proposed rulemaking for a rule to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest. We find good cause to implement this rule as a final rule because the delay involved in prior notice and comment procedures for the new provisions of this rule would be contrary to the public interest.

One provision of this rule that was not part of our June 2, 1995 proposed rule is the elimination of the requirement in 42 CFR § 412.46(a) that a physician sign an attestation statement for each Medicare patient discharged from a hospital. Although this change was not part of the proposed rule, we received close to 1,000 letters from physicians and hospitals requesting that we eliminate the physician attestation requirement. As discussed above, this change will reduce significantly the paperwork and information collection burden on physicians and hospitals. We believe that it is appropriate to implement this revision as part of this final rule as the most expeditious means of removing this burden on physicians and hospitals. Thus, particularly in view of the many unsolicited letters we have already received on this subject, we find that the delay involved in prior notice and comment would be contrary to the public interest. Therefore, we have concluded that it is appropriate to implement the revisions to § 412.46 as final in this instance.

We also normally provide a delay of 30 days in the effective date of a regulation. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date. We may also waive the delay in the case of a rule that grants an exemption or relieves a restriction. We find good cause to waive the usual 30-day delay in this instance. As explained above, it is in the public interest for the elimination of the physician attestation requirement to take effect as soon as possible. A 30-day delay in the effective date would only extend unnecessarily an onerous requirement on physicians and hospitals. Therefore, we believe that a 30-day delay in the effective date for this provision would be contrary to the public interest, and we find good cause to waive the usual 30-day delay in the effective date.

D. Waiver of Notice of Proposed Rulemaking for Allowing the Provision of Skilled Nursing Facility (SNF) Services by Rural Primary Care Hospitals (RPCHs)

In addition to the elimination of the physician attestation requirement under § 412.46, this final rule contains one other provision that was not included in the June 2, 1995 proposed rule. Specifically, the proposed rule did not include the changes contained in this final rule to § 485.645, Special requirements for RPCH providers of long-term care services (''swing beds''). As noted above, we ordinarily publish a notice of proposed rulemaking for a substantive rule to provide a period of public comment. Again, however, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest.

As explained in detail in section IV.G of this preamble, effective October 31, 1994, section 102(c) of the Social Security Act Amendments of 1994 (SSAA '94) allows a hospital with a swing-bed agreement in effect when it applies for RPCH designation to maintain as many beds for the furnishing of SNF-level services as it had on its hospital license when it applied to the State for designation as a RPCH, minus the number of inpatient beds (not to exceed six) used for the provision of RPCH inpatient care. The new legislation further states that the number of beds the facility uses for SNF-level care is not to include any beds of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a RPCH. To implement this provision, we are amending § 485.645 to reflect the new statutory language. We also are providing that swing-bed RPCHs that applied for RPCH designation before October 31, 1994, may either continue to provide care in accordance with the prior provisions of the regulations or request redesignation under the new provisions.

The regulations published in final in this rule implement the provisions of section 102(c) of SSAA '94 as the statute intends. The statutory effective date of the provisions of section 102(c) is October 31, 1994, and several facilities have indicated an interest in being designated as RPCHs under the new provisions. Moreover, we believe these changes may be necessary to assure access to SNF-level care in rural areas. Thus, we believe that it is both unnecessary and contrary to the public interest to delay implementation of these provisions until the process of publishing both a proposed and a final rule can be completed. Therefore, we find good cause to waive proposed rulemaking for the revised requirements set forth under § 485.645 and to issue these regulations as final. However, we are providing a 60-day period for public comment, as indicated at the beginning of this rule, on the changes to § 485.645.

E. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and we will respond to these comments in subsequent rulemaking document. Comments on

changes to the revised requirements under § 485.645 will be considered if we receive them by the date specified in the **DATES** section of this preamble. We will not consider comments concerning provisions that remain unchanged from the June 2, 1995 proposed rule or that were changed based on public comments.

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 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 485

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

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as set forth below:

A. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102, 1815(e), 1820, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395i–4, 1395hh, and 1395ww).

Subpart A—General Provisions

2. Section 412.4 is amended as follows:

a. In the first sentence of paragraph (d)(1), the phrase ''is paid a per diem rate'' is removed and the phrase ''is paid a graduated per diem rate'' is added in its place.

b. In paragraph (d)(1), a new sentence is added at the end of the paragraph.

The addition reads as follows:

§ 412.4 Discharges and transfers.

* * * * *

(d) *Payment to a hospital transferring an inpatient to another hospital.* (1) * * * Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the limit as described in paragraph (d)(1) of this section.

* * * * *

Subpart B—Hospital Services Subject to and Excluded from the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.23 is amended as follows:

a. Paragraphs (e)(2) and (e)(3) are revised.

b. In paragraph (e)(4), the phrase ''in paragraphs (e)(3) of this section'' is removed and the phrase ''in paragraph (e)(3) of this section'' is added in its place.

The revisions read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) *Long-term care hospitals.* * * *

(2) The hospital must have an average length of inpatient stay greater than 25 days—

(i) As computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period;

(ii) If a change in the hospital's average length of stay is indicated, as computed by the same method for the immediately preceding 6-month period; or

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the preceding 6 months, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

(3) Except as provided in paragraph (e)(4) of this section, for cost reporting periods beginning on or after October 1, 1994, a hospital that occupies space 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, must meet the following criteria:

(i) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(ii) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(iii) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces bylaws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) *Chief executive officer.* The hospital has a single chief executive officer through whom all administrative authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive office is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(v) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(A) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, and 482.42 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(B) For the same period of at least 6 months used to determine compliance with the length-of-stay criterion in paragraph (e)(2) of this section, the cost of the services that the hospital obtained under contracts or other agreements

with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph, however, the costs of preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(b)(5).

(C) For the same period of at least 6 months used to determine compliance with the length-of-stay criterion in paragraph (e)(2) of this section, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

* * * * *

4. In § 412.29, the introductory text is republished, and paragraph (a) is revised to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

In order to be excluded from the prospective payment systems, a rehabilitation unit must meet the following requirements:

(a) Have met either the requirements for—

(1) New units under § 412.30(a); or

(2) Converted units under § 412.30(b).

* * * * *

5. Section 412.30 is amended as follows:

a. Paragraph (a) is revised.

b. Paragraphs (b) and (c) are redesignated as paragraphs (c) and (d).

c. A new paragraph (b) is added.

d. Redesignated paragraph (c) is revised.

e. In redesignated paragraph (d), the phrase ''under paragraph (b) of this section,'' is removed and the phrase ''under paragraph (c) of this section,'' is added in its place.

The revisions and addition read as follows:

§ 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.

(a) *New units.* (1) A hospital unit is considered a new unit if the hospital—

(i) Has not previously sought exclusion for any rehabilitation unit; and

(ii) Has obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds in the unit.

(2) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2) instead of showing that the unit has treated such a population during the hospital's most recent cost reporting period.

(3) The written certification described in paragraph (a)(2) of this section is effective for the first full cost reporting period during which the unit is used to provide hospital inpatient care. If the hospital has not previously participated in the Medicare program as a hospital, the written certification also is effective for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(4) A hospital that has undergone a change of ownership or leasing as defined in § 489.18 of this chapter is not considered to have participated previously in the Medicare program.

(b) *Converted units.* A hospital unit is considered a converted unit if it does not qualify as a new unit under paragraph (a) of this section. A converted unit must have treated, for the hospital's most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitation services for the treatment of one or more conditions listed under § 412.23(b)(2).

(c) *Expansion of excluded rehabilitation units.*

(1) *New bed capacity.* The beds that a hospital seeks to add to its excluded rehabilitation unit are considered new beds only if—

(i) The hospital's State-licensed and Medicare-certified bed capacity increases at the start of the cost reporting period for which the hospital seeks to increase the size of its excluded rehabilitation unit, or at any time after the start of the preceding cost reporting period; and

(ii) The number of beds the hospital seeks to add to its excluded rehabilitation unit is greater than 50 percent of the number of beds by which the hospital's State licensed and Medicare certified bed capacity increased under paragraph (c)(1)(i) of this section.

(2) *Conversion of existing bed capacity.*

(i) Bed capacity is considered to be existing bed capacity if it does not meet the definition of new bed capacity under paragraph (c)(1) of this section.

(ii) A hospital may increase the size of its excluded rehabilitation unit through conversion of existing bed capacity only if it shows that, for all of the hospital's most recent cost reporting period of at least 12 months, the beds have been used to treat an inpatient population meeting the requirements of § 412.23(b)(2).

* * * * *

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

6. Section 412.46 is revised to read as follows:

§ 412.46 Medical review requirements: Physician acknowledgement.

(a) *Basis.* Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must complete an acknowledgement statement to this effect.

(b) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

> Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(c) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

7. In § 412.63, a new paragraph (s)(5) is added to read as follows:

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

* * * * *

(s) * * *

(5) If a judicial decision reverses a HCFA denial of a hospital's wage data revision request, HCFA pays the

hospital by applying a revised wage index that reflects the revised wage data as if HCFA's decision had been favorable rather than unfavorable.

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

§ 412.92 [Amended]

8. In paragraph (b)(5) of § 412.92, remove the phrase ''under § 413.30(e)(1) of this chapter'', wherever it appears.

9. In § 412.96, the first sentence of paragraph (c)(2)(ii) is revised to read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(c) * * *

(2) * * *

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its most recently completed cost reporting period to meet the number of discharges criterion. * * *

* * * * *

10. In § 412.105, paragraph (b) is revised to read as follows:

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

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

* * * * *

11. In § 412.106, paragraph (b)(3) is revised to read as follows:

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

* * * * *

(b) * * *

(3) *First computation: Cost reporting period.* If a hospital prefers that HCFA use its cost reporting period instead of the Federal fiscal year, it must furnish to HCFA, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

* * * * *

12. Section 412.109 is amended as follows:

a. Paragraph (a) is revised.

b. Paragraphs (b) through (e) are redesignated as paragraphs (c) through (f).

c. A new paragraph (b) is added.

d. Redesignated paragraphs (c)(1), (c)(2)(ii), (d) introductory text, and (d)(1) are revised.

e. The paragraph heading of redesignated paragraph (e) and redesignated paragraph (e)(1) are revised.

The revisions and addition read as follows:

§ 412.109 Special treatment: Essential access community hospitals (EACHs).

(a) *General rule.* For payment purposes, HCFA treats as a sole community hospital any hospital that is located in a rural area as described in paragraph (b) of this section and that HCFA designates as an EACH under the criteria in paragraph (c) of this section. The payment methodology for sole community hospitals is set forth at § 412.92(d).

(b) *Location in a rural area.* For purposes of this section, a hospital is located in a rural area if it—

(1) Is located outside any area that is a Metropolitan Statistical Area as defined by the Office of Management and Budget or that has been recognized as urban under § 412.62;

(2) Is not deemed to be located in an urban area under § 412.63;

(3) Is not classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board; or

(4) Is not located in a rural county that has been redesignated to an adjacent urban area under § 412.232.

(c) *Criteria for HCFA designation.* (1) HCFA designates a hospital as an EACH if the hospital is located in a State that has received a grant under section 1820(a)(1) of the Act or in an adjacent State and is designated as an EACH by the State that has received the grant.

* * * * *

(2) * * *

(ii) Is not eligible for State designation solely because the hospital is located in a rural area, has fewer than 75 beds and is located 35 miles or less from any other hospital; and

* * * * *

(d) *Criteria for State designation.* A State that has received a grant under section 1820(a)(1) of the Act may designate as an EACH any hospital in the State or in an adjoining State that meets the criteria of this paragraph (d).

(1) *Geographic location.* The hospital meets one of the following requirements:

(i) If it is located in a rural area as described in paragraph (b) of this section, the hospital is located more than 35 miles from any hospital that either has been designated as an EACH, or has been classified as a rural referral center under § 412.96.

(ii) The hospital meets other criteria relating to geographic location, imposed by the State with HCFA's approval.

* * * * *

(e) *Adjustment to the hospital-specific rate for rural EACH's experiencing increased costs*—(1) *General rule.* HCFA increases the applicable hospital-specific rate of an EACH that it treats as a sole community hospital if, during a cost reporting period, the hospital experiences an increase in its Medicare inpatient operating costs per discharge that is directly attributable to activities related to its membership in a rural health network.

* * * * *

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

§ 412.130 [Amended]

13. In paragraph (a)(3) of § 412.130, remove the reference ''§ 412.30(b)'' wherever it appears and add, in its place, the reference ''§ 412.30(c)''.

Subpart L—The Medicare Geographic Classification Review Board

14. In § 412.230, paragraph (a)(1) is revised and a new paragraph (a)(5) is added to read as follows:

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

(a) *General*—(1) *Purpose.* Except as provided in paragraph (a)(5) of this section, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, wage index value, or both.

* * * * *

(5) *Limitations on redesignation.* The following limitations apply to redesignation:

(i) An individual hospital may not be redesignated to another area for purposes of the wage index if the pre-

reclassified average hourly wage for that area is lower than the pre-reclassified average hourly wage for the area in which the hospital is located.

(ii) A hospital may not be redesignated for purposes of the standardized amount if the area to which the hospital seeks redesignation does not have a higher standardized amount than the standardized amount the hospital currently receives.

(iii) A hospital may not be redesignated to more than one area.

* * * * *

15. In § 412.232, a new paragraph (a)(4) is added to read as follows:

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

(a) * * *

(4) The hospitals may be redesignated only if one of the following conditions is met:

(i) The pre-reclassified average hourly wage for the area to which they seek redesignation is higher than the pre-reclassified average hourly wage for the area in which they are currently located.

(ii) The standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

* * * * *

16. In § 412.234, a new paragraph (a)(4) is added to read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) * * *

(4) The hospitals may be redesignated only if one of the following conditions is met.

(i) The pre-reclassified average hourly wage for the area to which they seek redesignation is higher than the pre-reclassified average hourly wage for the area in which they are currently located.

(ii) The standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are currently located.

* * * * *

17. Section 412.266 is revised to read as follows:

§ 412.266 Availability of wage data.

A hospital may obtain the average hourly wage data necessary to prepare its application to the MGCRB from **Federal Register** documents published in accordance with the provisions of § 412.8(b).

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

18. In § 412.308, a new paragraph (b)(3) is added and paragraph (c)(1)(ii) is revised to read as follows:

§ 412.308 Determining and updating the Federal rate.

* * * * *

(b) * * *

(3) Effective FY 1996, the standard Federal rate used to determine the Federal rate each year under paragraph (c) of this section is reduced by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

(c) * * *

(1) * * *

(ii) *Effective FY 1996.* Effective FY 1996, the standard Federal rate is updated based on an analytical framework. The framework includes a capital input price index, which measures the annual change in the prices associated with capital-related costs during the year. HCFA adjusts the capital input price index rate of change to take into account forecast errors, changes in the case mix index, the effect of changes to DRG classification and relative weights, and allowable changes in the intensity of hospital services.

* * * * *

19. In § 412.328, a new paragraph (e)(4) is added to read as follows:

§ 412.328 Determining and updating the hospital-specific rate.

* * * * *

(e) * * *

(4) Effective FY 1996, the intermediary reduces the updated amount determined in paragraph (d) of this section by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

* * * * *

B. Part 413 is amended as follows:

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

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

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l (a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart C—Limits on Cost Reimbursement

2. Section 413.30 is amended as follows:

a. Paragraph (e) is revised.

b. In paragraph (f) introductory text, the first sentence is revised.

c. Paragraphs (f)(5), (f)(6), (f)(7), and (f)(9) are removed and paragraph (f)(8) is redesignated as paragraph (f)(5).

The revisions read as follows:

§ 413.30 Limitations on reimbursable costs.

* * * * *

(e) *Exemptions.* Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

(f) *Exceptions.* Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. * * *

* * * * *

§ 413.35 [Amended]

3. In paragraph (b)(2) of § 413.35, remove the reference ''§ 413.30(e)(2)'' wherever it appears in the paragraph and add, in its place, the reference ''§ 413.30(e)''.

4. Section 413.40 is amended as follows:

a. In § 413.40(c)(2), remove the phrase ''during the 3 days'' wherever it appears in the paragraph and add, in its place, the phrase ''on the calendar day''.

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

c. A new sentence is added at the end of paragraph (g)(1).

The revision and addition read as follows:

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

* * * * *

(e) *Hospital requests regarding adjustments to the payment allowed under the rate-of-increase ceiling*—(1) *Timing of application.* A hospital may request an adjustment to the rate-of-increase ceiling imposed under this section. The hospital's request must be received by the hospital's fiscal intermediary no later than 180 days after the date on the intermediary's initial notice of amount of program reimbursement (NPR) for the cost

reporting period for which the hospital requests an adjustment.

* * * * *

(g) * * *

(1) * * * The amount of payment made to a hospital after an adjustment under paragraph (e) of this section may not exceed the difference between the hospital's operating costs and the payment previously allowed.

* * * * *

Subpart E—Payments to Providers

5. In § 413.70, the first sentence of paragraph (b)(2)(i) is revised to read as follows:

§ 413.70 Payment for services of an RPCH.

* * * * *

(b) * * *

(2) * * * (i) *RPCH services.* Payment under this method for outpatient RPCH services is equal to the amounts described in section 1833(a)(2)(B) of the Act (which describes amounts paid for hospital outpatient services) and subject to the applicable principles of cost reimbursement in this part and in part 405, subpart D of this chapter, except for the principle of the lesser of costs or charges in § 413.13. * * *

* * * * *

C. Part 424 is amended as follows:

PART 424—CONDITIONS FOR MEDICARE PAYMENT

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 216(j), 1102, 1814, 1815(c), 1835, 1842(b), 1861, 1866(d), 1870(e) and (f), 1871, 1872 and 1883(d) of the Social Security Act (42 U.S.C. 416(j), 1302, 1395f, 1395g(c), 1395n, 1395u(b), 1395x, 1395cc(d), 1395gg(e) and (f), 1395hh, 1395ii and 1395tt(d)).

Subpart B—Physician Certification Requirements

2. In § 424.15, paragraph (a) is revised to read as follows:

§ 424.15 Requirements for inpatient RPCH services.

(a) *Content of certification.* Medicare Part A pays for inpatient RPCH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the RPCH.

* * * * *

D. Part 485 is amended as follows:

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

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).

Subpart F—Conditions of Participation: Rural Primary Care Hospitals (RPCHs)

§ 485.603 [Amended]

2. In paragraph (a)(2)(i) of § 485.603, remove the reference ''§ 412.109(c)'' wherever it appears in the paragraph and add, in its place, the reference ''§ 412.109(d)''.

3. In § 485.606, paragraphs (a)(1), (b)(1), (b)(3), the paragraph heading of paragraph (c), (c)(1) introductory text, (c)(1)(i), (c)(2) introductory text, and (c)(2)(ii) are revised to read as follows:

§ 485.606 Designation of RPCHs.

(a) *Criteria for State designation*—(1) A State that has received a grant under section 1820(a)(1) of the Act may designate as an RPCH any hospital that—

(i) Is located in the State that has received the grant, or is located in an adjoining State and is a member of a rural health network that also includes one or more facilities located in the State that has received the grant;

(ii) Meets the RPCH conditions of participation in this subpart F; and

(iii) Applies to the State that has received the grant for designation as an RPCH.

* * * * *

(b) *Criteria for HCFA designation*—(1) HCFA designates a hospital as an RPCH if the hospital is designated as an RPCH by the State in which it is located or by an adjoining State that has received a grant.

* * * * *

(3) HCFA may also designate not more than 15 hospitals as RPCHs if the hospitals are not located in States that have received grants under section 1820(a)(1) of the Act and meet the requirements of paragraph (c)(1) of this section.

(c) *Special rule: Hospitals not designated by a State as RPCHs*—(1) HCFA may designate not more than 15 hospitals as RPCHs under this paragraph (c)(1). These hospitals must be located in a State that has not received a grant under section 1820(a)(1) of the Act, must not have been designated as RPCHs by a State that has received a grant under paragraph (a)(1) of this section, and must meet the requirements with regard to location, participation in the Medicare program, and emergency services as defined in §§ 485.610, 485.612, and 485.618, respectively. In designating a hospital as an RPCH under this paragraph (c)(1), HCFA—

(i) Gives preference to a hospital that has entered into an agreement with a rural health network as defined in § 485.603 that is located in a State that has received a grant under section 1820(a)(1) of the Act; and

* * * * *

(2) HCFA may designate a hospital as an RPCH if the hospital is located in a State that has received a grant under section 1820(a)(1) of the Act and is not eligible for State designation under paragraph (a) of this section solely because the hospital—

* * * * *

(ii) Has more than six inpatient beds or does not maintain an average length of stay for inpatients not greater than 72 hours for each 12-month cost reporting period, excluding periods of stays that exceeded 72 hours because transfer was precluded because of inclement weather or other emergency conditions, as described in § 485.620; or

* * * * *

4. Section 485.614 is revised to read as follows:

§ 485.614 Condition of participation: Termination of inpatient care services.

(a) *General rule.* The hospital has ceased providing inpatient hospital care or has agreed to cease providing inpatient hospital care upon approval of its application for designation as an RPCH except to the extent permitted under paragraph (b) of this section.

(b) *Limitations on inpatient care*—(1) If the RPCH does not have a swing-bed agreement under § 485.645, it provides not more than six inpatient beds for providing inpatient RPCH care to patients, but only if—

(i) The patient requires stabilization before discharge or transfer to a hospital;

(ii) The patient's attending physician certifies that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; and

(iii) The RPCH complies with the limitation on inpatient surgery set forth in paragraph (b)(3) of this section.

(2) If the RPCH has a swing-bed agreement under § 485.645, it provides inpatient RPCH care as described under paragraph (b)(1) of this section and, under the swing-bed agreement, provides posthospital SNF care.

(3) The RPCH does not provide any inpatient hospital services consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by HCFA under § 416.65 of this chapter), unless the attending physician certifies that the risk associated with transferring the

patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.

(c) *Exception for RPCHs designated by HCFA.* If an RPCH is designated by HCFA under the specific criteria in § 485.606(c), the RPCH is not subject to the requirements in this section.

5. In § 485.620, paragraph (b) is revised to read as follows:

§ 485.620 Condition of participation: Number of beds and length of stay.

* * * * *

(b) *Standard: Length of stay.* The RPCH maintains an average length of stay for inpatients that is not greater than 72 hours for each 12-month cost reporting period. In determining the average length of stay, periods of stay of inpatients in excess of 72 hours are not taken into account to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.

6. A new § 485.639 is added to read as follows:

§ 485.639 Condition of participation: Surgical services.

Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the RPCH in accordance with the designation requirements under paragraph (a) of this section.

(a) *Designation of qualified practitioners.* The RPCH designates the practitioners who are allowed to perform surgery for RPCH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by—

(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(2) A doctor of dental surgery or dental medicine; or

(3) A doctor of podiatric medicine.

(b) *Anesthetic risk and evaluation.* A qualified practitioner, as described in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Before discharge from the RPCH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner as described in paragraph (a) of this section.

(c) *Administration of anesthesia.* The RPCH designates the person who is allowed to administer anesthesia to RPCH patients in accordance with its approved policies and procedures and with State scope of practice laws.

(1) Anesthetics must be administered only by—

(i) A qualified anesthesiologist;

(ii) A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;

(iii) A doctor of dental surgery or dental medicine;

(iv) A doctor of podiatric medicine;

(v) A certified registered nurse anesthetist, as defined in § 410.69(b) of this chapter;

(vi) An anesthesiologist's assistant, as defined in § 410.69(b) of this chapter; or

(vii) A supervised trainee in an approved educational program, as described in §§ 413.85 or 413.86 of this chapter.

(2) In those cases in which a certified registered nurse anesthetist administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.

(d) *Discharge.* All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.

7. In § 485.645, the introductory text and paragraph (a) are revised, paragraph (b) is redesignated as paragraph (c), and a new paragraph (b) is added to read as follows:

§ 485.645 Special requirements for RPCH providers of long-term care services.

An RPCH that has a Medicare provider agreement to participate in Medicare as an RPCH must meet the following requirements in order to be granted an approval from HCFA to provide post-hospital SNF care, as specified in § 409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (b) of this section.

(a) *Eligibility.* An RPCH must meet the following eligibility requirements:

(1) Effective October 31, 1994, if an RPCH meets all other requirements of this section, and applies for approval as a provider of post-hospital SNF care, the RPCH uses no more beds for providing post-hospital SNF care than the total number of licensed hospital inpatient beds at the time it applied to the State for RPCH designation, minus the number of beds, not to exceed six, used for providing inpatient RPCH care in accordance with § 485.620(a).

(2) (i) Notwithstanding paragraph (a)(1) of this section, a hospital that applied for RPCH status before October 31, 1994, and was designated by the State (or HCFA), and that applied for swing-bed approval before October 31, 1994, and received approval from HCFA, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

(ii) An RPCH that was granted swing-bed approval under paragraph (a)(2)(i) of this section may request that its application to be an RPCH and a swing-bed provider be re-evaluated under paragraph (a)(1) of this section. If this request is approved, the approval is effective not earlier than October 1994. As of the date of approval, the RPCH no longer has any status under paragraph (a)(2)(i) of this section, and may not request re-instatement under paragraph (a)(2)(i) of this section.

(3) Beds used for post-hospital SNF care in a separately participating ''distinct part'' unit may not be included in any determination under this section.

(b) *Payment.* Payment for inpatient RPCH services to an RPCH that has qualified as an RPCH under the provisions in paragraph (a) of this section is made in accordance with § 413.70(a) of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in § 413.114 of this chapter.

* * * * *

E. Part 489 is amended as follows:

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, and 1395hh).

Subpart E—Termination of Agreement and Reinstatement After Termination

2. In § 489.53, a new paragraph (a)(14) is added to read as follows:

§ 489.53 Termination by HCFA.

(a) * * *

(14) In the case of a rural primary care hospital as defined in part 485, subpart F of this chapter, the rural primary care hospital maintains an average length of stay for inpatients in its most recent 12-month cost reporting period that is in excess of 72 hours. In determining the length of stay of a rural primary care hospital for purposes of this paragraph, HCFA does not take into account periods of stay in excess of 72 hours that occurred because transfer to a hospital

was precluded because of inclement weather or other emergency conditions.

* * * * *

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

Dated: August 23, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 23, 1995.

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 On or After October 1, 1995 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1995

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 new 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, 1995, except for sole community 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. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act).

As discussed below in section II, we are making changes to the prospective payment rates for Medicare inpatient operating costs. The changes, to be applied prospectively, will affect the calculation of the Federal rates. In section III, we discuss changes we are making in determining the prospective payment rates for Medicare inpatient capital-related costs. Section IV sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the final rule are presented at the end of this addendum in section V.

II. Changes to Prospective Payment Rates For Inpatient Operating Costs for FY 1996

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 manner in which we are changing some of the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes are effective for discharges occurring on or after October 1, 1995. 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 1996.

In summary, the standardized amounts set forth in Tables 1a, 1b, and 1c of section V of this addendum reflect—

- Updates of 1.5 percent for all areas (that is, the market basket percentage increase of 3.5 percent minus 2.0 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 1995 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 1995 outlier offsets and applying a new offset; and
- An adjustment to apply a budget neutrality factor for the change in the payment methodology for transfer cases.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

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

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

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(C) and (d)(9)(B)(ii) of the Act required that the updated base-year per discharge costs and, for Puerto Rico, the updated target amounts, respectively, be standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Since the standardized amounts have 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, no additional adjustments for these factors for FY 1996 were made. That is, the standardization adjustments reflected in the FY 1996 standardized amounts are the same as those reflected in the FY 1995 standardized amounts.

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act require that, in making payments under the prospective payment system, the Secretary adjust the proportion (as estimated by the Secretary from time to time) of costs that are wages and wage-related costs. Beginning October 1, 1990, when the market basket was rebased, we have considered 71.40 percent of costs to be labor-related for purposes of the prospective payment system.

2. Computing Large Urban and Other Averages Within Geographic Areas

Section 1886(d)(3) of the Act requires 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 large urban and other areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 75 percent of the applicable Puerto Rico standardized amount and 25 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban areas'' 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). 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 1994 population estimates published by the Bureau of the Census, 57 areas meet the criteria to be defined as large urban areas for FY 1996. These areas are identified by an asterisk in Table 4a.

Table 1a contains the two national standardized amounts that are applicable to most hospitals. Table 1b sets forth the 18 regional standardized amounts that will continue to be applicable for hospitals located in census areas subject to the regional floor. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is set forth in Table 1c. Table 1c also includes the standardized amounts that will be applicable to most hospitals in Puerto Rico.

We note that on June 30, 1995, the Office of Management and Budget announced the designation of the Flagstaff, Arizona-Utah MSA and the Grand Junction, Colorado MSA.

3. Updating the Average 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 1996 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XI) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 1996 is the market basket percentage increase minus 2.0 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 1996 is 3.5 percent. For FY 1996, this yields an update to the average standardized amounts of 1.5 percent (3.5 percent minus 2.0 percent).

As in the past, we are adjusting the FY 1995 standardized amounts to remove the effects of the FY 1995 geographic reclassifications and outlier payments before applying the FY 1996 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. After including the FY 1996 offsets to the standardized amounts for outliers and geographic reclassification, we estimate that there will be an actual increase of 1.2 percent to the large urban and other area standardized amounts.

Beginning in FY 1995, we revised the national average standardized amounts based on national average labor/nonlabor shares. In FY 1996, we will continue to adjust the labor and nonlabor proportions of the standardized amount to reflect the national average. As a result, the national average labor share (as reflected in the hospital market basket) will equal 71.4 percent of the standardized payment amounts. (We are revising the Puerto Rico standardized amounts by the average labor share in Puerto Rico of 82.8 percent.)

Although the update factor for FY 1996 is set by law, we were required by section 1886(e)(3)(B) of the Act to report to Congress on our initial recommendation of update factors for FY 1996 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we published the report to Congress as Appendix C to the proposed rule, as revised in the correction notice published on August 2, 1995 (60 FR 39305). That recommendation was based on an earlier forecast of the market basket increase. Our final recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix C to this final rule.

Comment: One commenter urged that an add-on adjustment of not less than 7 percent be made to the Puerto Rico standardized amounts to account for the penalty resulting from the use of temporary cost allocation methods by government hospitals in Puerto Rico with a noncharge structure.

Response: At this time, we do not believe it is appropriate to adjust the standardized amounts of Puerto Rico for those government hospitals with a noncharge structure. However, as noted in section III.B.4, we will continue to study the issue of payments to Puerto Rico.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment.

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

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

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we compared aggregate payments using the FY 1995 relative weights and the wage index effective October 1, 1994, to aggregate payments using the FY 1996 relative weights and wage index. The same methodology was used for the FYs

1993, 1994, and 1995 budget neutrality adjustment. Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.999174. Based on the final FY 1996 relative weights and wage index, the final budget neutrality adjustment factor is equal to 0.999306. This budget neutrality adjustment factor is applied to the standardized amounts without removing the effects of the FY 1995 budget neutrality adjustment. 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 apply the same FY 1996 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1995, in order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the FY 1996 DRG weights and updated wage index. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

Section 1886(d)(5)(I) of the Act, as amended by section 109 of the Social Security Act Amendments of 1994 (Public Law 103–432), authorizes the Secretary to make adjustments to the prospective payment system standardized amounts so that adjustments to the payment policy for transfer cases do not affect aggregate payments. As discussed in section IV.A of the preamble of this final rule, we are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. To implement this change in a budget neutral manner, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule. The final budget neutrality adjustment factor for this transfer change is equal to 0.997575. This adjustment will be applied on a one-time basis to the FY 1996 standardized amounts. After FY 1996, there will be no need for a further budget neutrality adjustment unless or until we make further changes to the transfer payment methodology.

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), 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 estimated 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 estimated aggregate prospective payments that would have been made absent these provisions. In the proposed rule, we applied an adjustment of 0.994125 to ensure that the effects of reclassification are budget neutral. The final budget neutrality adjustment factor is 0.994011.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1995 budget neutrality adjustment factor. We note that the proposed FY 1996 adjustment reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 14, 1995. The final budget neutrality adjustment factor reflects the effects of all reclassification decisions and changes in these decisions resulting from appeals and reviews of the MGCRB decisions for FY 1996 or from requests for withdrawal of a reclassification.

c. Outliers.

Section 1886(d)(5)(A) of the Act provides that, in addition to the basic prospective payment rates, for discharges occurring before October 1, 1997, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act requires the Secretary to adjust both the large urban and other areas national standardized amounts by the same factor to account for the estimated proportion of total DRG payments made to outlier cases. Section 1886(d)(9)(B)(iv) of the Act requires that the large urban and other standardized amounts applicable to hospitals in Puerto Rico be reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments. Furthermore, under section 1886(d)(5)(A)(iv) of the Act, estimated outlier payments in any year may not be less than 5 percent nor more than 6 percent of total payments projected or estimated to be made based on DRG prospective payment rates.

Beginning with FY 1995, section 1886(d)(5)(A) of the Act requires the Secretary to reduce the proportion of total outlier payments paid under the day outlier methodology. Under the requirements of section 1886(d)(5)(A)(v) of the Act, the proportion of outlier payments made under the day outlier methodology, relative to the proportion of outlier payments made under the day outlier methodology in FY 1994 (which we estimated at 31.3 percent in our September 1, 1993 final rule (58 FR 46348)), will be 75 percent in FY 1995, 50 percent in FY 1996, and 25 percent in FY 1997. For discharges occurring after September 30, 1997, the Secretary will no longer pay for day outliers under the provisions of section 1886(d)(5)(A)(i) of the Act.

i. FY 1996 Outlier Thresholds.

For FY 1995, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 22 days or 3.0 standard deviations. The marginal cost factor for day outliers (or the percent of Medicare's average per diem payment paid for each outlier day) is equal to 47 percent in FY 1995. The fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $20,500 ($18,800 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (or the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1995 standardized amounts of 0.948940 for the large urban and other areas rates and 0.9414 for the capital Federal rate.

For FY 1996, we proposed to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 23 days or 3.0 standard deviations. We also proposed to reduce the marginal cost factor for each outlier day from 47 percent to 45 percent in FY 1996. The thresholds that we are establishing in this final rule continue to be the geometric mean length of stay for each DRG plus the lesser of 23 days or 3.0 standard deviations. However, based on updated simulations, we are establishing in this final rule a marginal cost factor of 44 percent for each outlier day in FY 1996. We estimate that these policies will reduce the proportion of outlier payments paid to day outliers to approximately 16 percent in accordance with section 1886(d)(5)(A) of the Act.

We proposed a fixed loss cost outlier threshold in FY 1996 equal to the prospective payment rate for the DRG plus $16,700 ($15,200 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 this final rule, based on updated simulations, we are establishing a fixed loss cost outlier threshold in FY 1996 equal to the prospective payment rate for the DRG plus $15,150 ($13,800 for hospitals that have not yet entered the prospective payment system for capital-related costs). We are also establishing a marginal cost factor for cost outliers of 80 percent for FY 1996, as proposed.

As provided in section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that estimated outlier payments equal 5.1 percent of estimated total payments based on DRGs. The model that we use to determine the outlier thresholds necessary to meet the estimated outlier payment percentage for FY 1996 uses the June 1995 update of the FY 1994 MedPAR file and the July 1995 update of the provider-specific file used in the PRICER program, which contains information on hospital-specific payment parameters (such as the cost-to-charge ratios).

In simulating payments, we convert billed charges to costs for purposes of estimating cost outlier payments. As we explained in the September 1, 1993 final rule (58 FR 46347), prior to FY 1994, we used a charge inflation factor to adjust charges to costs; beginning with FY 1994, we are using a cost inflation factor to estimate costs. In other words, instead of inflating the FY 1994 charge data by a charge inflation factor for 2 years in order to estimate FY 1996 charge data and then applying the cost-to-charge ratio, we adjust the charges by the cost-to-charge ratio and then inflate the estimated costs for 2 years of cost inflation. In this manner, we automatically adjust for any changes in the cost-to-charge ratios that may occur, since the relevant variable is the costs estimated for a given case.

In setting the proposed FY 1996 outlier thresholds, we used a cost inflation factor of 1.02009. In setting the final FY 1996 outlier thresholds, we used a cost inflation factor of 1.00871. The difference is attributable to the use of the cost per case increase in cost reporting periods beginning in FY 1993 (referred to as PPS–X data) in setting the final FY 1996 outlier thresholds instead of the average increase in cost per case for cost reporting periods beginning in FY 1991 (PPS–VIII) through PPS–X. This modification was introduced after a review of the cost per case increase for 2700 hospitals in cost reporting periods beginning in FY 1994 (PPS–XI). The cost per case increase from PPS–X to PPS–XI was much closer to the increase from PPS–IX to PPS–X than the average increase between PPS–VIII through PPS–X. We believe it is more appropriate to use the increase from PPS–IX to PPS–X as our cost inflation factor in setting the final FY 1996 outlier thresholds. In the future, we still plan to use 2-year averages in computing the cost inflation factors, unless preliminary data from more recent years indicate that the 2-year average may be inaccurate.

When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We estimate the final thresholds for FY 1996 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.6 percent of capital payments based on the Federal rate.

As stated in the September 1, 1993 final rule (58 FR 46348), we have established outlier thresholds that will be applicable to both inpatient operating costs and inpatient capital-related costs. As explained earlier, we are applying a reduction of approximately 5.1 percent to the FY 1996 standardized amounts to account for the estimated proportion of outliers payments. The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1996 were as follows:

Operating standardized amounts	Capital Federal rate
0.949054	0.9526

The final outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1996 are as follows:

Operating standardized amounts	Capital Federal rate
0.948950	0.9536

As in the proposed rule, we apply the final outlier adjustment factors after removing the effects of the FY 1995 outlier adjustment factors on the standardized amounts and the capital Federal rate.

ii. Other Changes Concerning Outliers.

Table 5 of section V of this addendum contains the DRG relative weights, geometric and arithmetic mean lengths of stay, as well as the day outlier threshold for each DRG. When we recalibrate DRG weights, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight and geometric mean length of stay. DRGs that do not have at least 10 cases are considered to be low volume DRGs. For the low volume DRGs, we use the original geometric mean lengths of stay, because no arithmetic mean length of stay was calculated based on the original data.

Table 8a in section V of this addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 1995, these Statewide average ratios will replace the ratios published in the September 1, 1994 final rule (59 FR 45480). Table 8b contains comparable Statewide average capital cost-to-charge ratios. These average ratios will be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.25218 or greater than 1.32569 and capital cost-to-charge ratios lower than 0.012998 or greater than 0.21483. 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. The cost-to-charge ratios in Tables 8a and 8b will be applied to all hospital-specific cost-to-charge ratios based on cost report settlements occurring during FY 1996.

iii. FY 1994 and FY 1995 Outlier Payments.

In the proposed rule, we estimated that actual FY 1994 outlier payments were approximately 3.5 percent of total DRG payments (60 FR 29260). Our estimates of actual outlier payments and actual total DRG payments were computed by simulating payments using actual FY 1994 bill data available at the time of the proposed rule. Our current estimate remains the same; that is, we estimate that actual FY 1994 outlier payments were approximately 3.5 percent of actual total DRG payments. These estimates are based on simulations using the July 1995 update of the provider-specific file and the June 1995 update of the MedPAR file.

In setting outlier policies for FY 1994, we began using a cost inflation factor rather than a charge inflation factor to update billed charges for purposes of estimating outlier payments. This refinement was made in order to improve our estimation methodology. We believe that actual FY 1994 outlier payments as a percentage of actual total

DRG payments may be lower than estimated because actual hospital costs may be lower than reflected in the estimation methodology. Our most recent data on hospital costs show a significant trend in declining rates of increase. Thus, the cost inflation factor of 8.3 percent used to estimate FY 1994 outlier payments (based on the best available data) appears to have been overstated. For FY 1995, we used a cost inflation factor of 2.5 percent. Based on more recent data, we are using a cost inflation factor of 0.871 percent to calculate outlier payments for FY 1996. Also, although we estimate that FY 1994 outlier payments will approximate 3.5 percent of total DRG payments, we note that the estimate of the market basket rate of increase used to set the FY 1994 rates was 4.3 percentage points, while the latest FY 1994 market basket rate of increase forecast is 2.5 percent. Thus, the net effect is that total FY 1994 payments are higher than they would have been if the market basket rate of increase and the outlier percentage were estimated with precise accuracy.

In the proposed rule (60 FR 29260), we estimated that actual FY 1995 outlier payments would be approximately 4.2 percent of actual FY 1995 total DRG payments. We currently estimate that FY 1995 outlier payments will approximate 4.0 percent of total DRG payment. This current estimate is based on simulations using the July 1995 update of the provider-specific file and the June 1995 update of the FY 1994 MedPAR file.

We believe that there are two main reasons why our current estimate of FY 1995 outlier payments is below 5.1 percent. First, in setting the outlier thresholds for FY 1995, we used 2.5 percent as our cost inflation factor to inflate FY 1993 bills to FY 1995 levels. Our current estimate of cost inflation is 0.871 percent. Thus, the rate of increase in costs continues to slow. We note that this factor is reflected in the estimation methodology used to set thresholds. Thus, the final FY 1996 cost outlier threshold is lower than the proposed cost outlier threshold.

Second, in setting the outlier thresholds for FY 1995, we used cost-to-charge ratios that had a mean value of 0.618. Our current estimate of cost-to-charge ratios for FY 1995 is down to 0.600. Thus, not only are costs not rising as fast as we estimated, but they also make up a lower percentage of charges than we estimated in setting FY 1995 thresholds. We are continuing to explore better ways to forecast the changes in cost inflation.

Comment: We received a number of comments expressing concern that the projected percentages of outlier payments for FYs 1994 and 1995 are lower than estimated when we set the thresholds. Some of the commenters requested that any difference between outlier payments and the amount set aside be used to offset the amount required in the next year. Other commenters requested that we monitor outlier payments during a fiscal year, so that we can change the thresholds in the middle of the year in the event that projected outlier payments are not between 5 and 6 percent of total DRG payments.

Response: We responded to similar comments in the final rules for FY 1993 (57 FR 39784), FY 1994 (58 FR 46347), and FY 1995 (59 FR 45404). In accordance with section 1886(d)(5)(A)(iv) of the Act, we set the FY 1994 and FY 1995 outlier thresholds so that the estimated proportion of outlier payments relative to total DRG payments is 5.1 percent. We used the most recent Medicare discharge and hospital-specific data available to estimate payments. This is necessarily a prospective process and the resulting estimate may prove to be inaccurate.

We believe that it would be inappropriate to revise in midyear any of the payment policies based on estimates. These policies include not only the outlier thresholds, but also factors such as the market basket rate of increase used to establish the update factors, the recalibration of the DRG weights, and the various required budget neutrality provisions. We also believe it would be inappropriate to reduce the standardized amounts to account for outlier cases in a fiscal year by an amount that differs from the estimated proportion of outlier payments in that fiscal year. Section 1886(d)(3)(B) of the Act requires the Secretary to ''reduce each of the standardized amounts * * * by the factor *equal to* the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).'' (Emphasis added.) Thus, if we estimate that outlier payments will be 5.1 percent of total DRG payments in an upcoming fiscal year, we must reduce the standardized amounts by an ''equal'' percentage, not by some lower or higher percentage.

We believe the more appropriate action is to continue to examine the outlier policy and try to refine the methodology for setting outlier thresholds. To that end, as we did in FY 1995, we have attempted to improve our outlier projections in FY 1996. Normally, we would use the average increase in cost per case between PPS–VIII and PPS–X as the cost inflation factor in setting the FY 1996 outlier thresholds. However, as noted above, after reviewing the preliminary data for 2700 hospitals from PPS–XI, we found the cost per case increase of PPS–XI data to be much closer to the PPS–X data than the PPS–VIII data, indicating a continued downward trend in the rate of increase in hospital costs. Thus, for FY 1996, we have decided to use solely the PPS–X cost per case increase of 0.871 percent.

B. Adjustments for Area Wage Levels and Cost of Living

The adjusted standardized amounts are divided into labor and nonlabor portions. Tables 1a, 1b, 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 require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble to this final rule, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 4e 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 1996, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

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

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.225
County of Hawaii	1.15
County of Kauai	1.20
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 to this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have calculated relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs.

Table 5 of section V of this addendum contains the relative weights that we will use for discharges occurring in FY 1996. These factors have been recalibrated as explained in section II.C of the preamble to this final rule.

D. Calculation of Prospective Payment Rates for FY 1996

General Formula for Calculation of Prospective Payment Rates for FY 1996

Prospective payment rate for all hospitals located outside Puerto Rico except sole community 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 Puerto Rico = 75 percent of the Puerto Rico rate + 25 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, 1995 and before October 1, 1996, except for sole community hospitals and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal rate. Section 1866(d)(1)(A)(iii) of the Act provides that the Federal rate is comprised of 100 percent of the Federal national rate except for those hospitals in census regions that have a regional rate that is higher than the national rate. The Federal rate for hospitals located in census regions that have a regional rate that is higher than the national rate equals 85 percent of the Federal national rate plus 15 percent of the Federal regional rate. Based on the final rates, for discharges occurring on or after October 1, 1995, hospitals in regions I, IV, and VI are affected by the regional floor.

The Federal rates are determined as follows:

Step 1—Select the appropriate national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Tables 1a and 1b, section V of this addendum).

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

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

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

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

2. Hospital-Specific Rate (Applicable Only to Sole Community 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.

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 1996.

We are increasing the hospital-specific rates by 1.5 percent (the hospital market basket percentage increase minus 2.0 percentage points) for sole community hospitals located in all areas in FY 1996. Section 1886(b)(3)(C)(ii) 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)(ii) of the Act, which, for FY 1996, is the market basket rate of increase minus 2.0 percentage points.

b. Calculation of Hospital-Specific Rate.

For sole community hospitals, the applicable FY 1996 hospital-specific rate will be calculated by multiplying a hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (1.5 percent), which is the same as the update for all prospective payment hospitals. In addition, the hospital-specific rate will be adjusted by the budget neutrality adjustment factor (that is, 0.999306) as discussed in section II.A.4.a of this addendum. This resulting rate will be used in determining under which rate a sole community hospital is paid for its discharges beginning on or after October 1, 1995, 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, 1995 and Before October 1, 1996

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, section V of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index (see Tables 4a and 4b, section V of the addendum).

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

Step 4—Multiply the result in Step 3 by 75 percent.

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

b. National Rate.

The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section V of the addendum) by the appropriate wage index.

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 25 percent.

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

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

III. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1996

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 the 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 1996. The rates will be effective for discharges occurring on or after October 1, 1995.

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 additional payments under the Federal rate for outlier cases, determined as a proportion of total capital payments under the Federal rate. Section 412.308(c)(3) further requires that the Federal rate be reduced by an adjustment factor equal to the estimated additional payments made for exceptions under § 412.348, and § 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 FY 1992 through FY 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that estimated aggregate payments for inpatient hospital capital costs will equal 90 percent of the estimated payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. As discussed below, that provision has now expired.

The hospital-specific rate for each hospital 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. The hospital-specific rate is updated each year after FY 1992 for inflation and for changes in the exceptions payment adjustment factor. For FY 1992 through FY 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor.

To determine the appropriate budget neutrality adjustment factors 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 more fully in Appendix B.

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 under a special payment formula. These hospitals are paid a blended rate that is comprised of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. 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. Hospitals in Puerto Rico are paid based on 75 percent of the Puerto Rico rate and 25 percent of the Federal rate.

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

For FY 1995, the Federal rate was $376.83. In the proposed rule, we stated that the proposed FY 1996 Federal rate was $457.11. In this final rule, we are establishing an FY 1996 Federal rate of $461.96.

In the discussion that follows, we explain the factors that were used to determine the FY 1996 Federal rate. In particular, we explain why the FY 1996 Federal rate has increased 22.59 percent compared to the FY 1995 Federal rate. We also explain that aggregate payments for capital in FY 1996 are estimated to increase by 20.56 percent.

The major factor contributing to the increase in the FY 1996 rate in comparison to FY 1995 is the expiration of the budget neutrality requirement. Section 412.352 required that estimated payments each year from FY 1992 through FY 1995 for capital costs equal 90 percent of the amount that would have been payable that year on a reasonable cost basis. Accordingly, each year from FY 1992 through FY 1995, we applied an adjustment to the Federal rate and the hospital-specific rate so that estimated capital prospective payments would equal 90 percent of estimated Medicare hospital inpatient capital-related costs.

Based on the most recent data, we now estimate that capital payments equalled 95.77 percent of reasonable costs in FY 1992, 90.99 percent of reasonable costs in FY 1993, 90.43 percent of reasonable costs in FY 1994, and 90.58 percent of reasonable costs in FY 1995. Thus, the data indicate that the budget neutrality adjustment for FY 1992 was not sufficient to meet the 90-percent target and, consequently, the Federal rate for FY 1992 was higher than it should have been. For FY 1993, FY 1994 and FY 1995, however, our estimates are that payments exceeded the budget neutrality target by less than one percentage point. We do not retroactively adjust the budget neutrality factor and the Federal rate for previous years to account for revised estimates. For FY 1996, we estimate that payments will exceed costs by 3.97 percent as a result of the expiration of the budget neutrality provision.

As we explain in section III.A.8 below, the predominant factor in the 22.59 percent increase in the Federal rate, as well as the 20.56 percent increase in payments, is the expiration

of the budget neutrality provision. For FY 1995, the budget neutrality adjustment was 0.8432, a 15.68 percent reduction to the rates. The expiration of that provision alone accounts for an 18.6 percent increase (1.00/.8432 = 1.186, or 18.6 percent) in the rate. The FY 1996 update factor and changes in the outlier and exceptions factors also contribute to the increase in the rate. The factors contributing to the increase in the rate were partially offset by a special adjustment to the rate to account for the effects of the new transfer policy, and by the effect of the DRG/GAF reduction factor.

Total payments to hospitals under the prospective payment system are relatively insensitive even to changes of such magnitude in the capital Federal rate. 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. Therefore, the large increase in the FY 1996 Federal rate can be expected to increase total payments to hospitals under the prospective payment system by only about 2.06 percent.

1. Special Federal Rate Adjustment for the Effects of the New Transfer Payment Policy

Section 412.312(d) provides that payment under the capital prospective payment system for transfer cases is made under the same rules governing transfer payments under the operating prospective payment system. Transfer cases under the prospective payment system for capital-related costs have been paid on a per diem basis, using the full prospective payment amount for the DRG (both Federal rate and hospital-specific rate, if appropriate) divided by the geometric mean length of stay for the DRG, but not to exceed the full prospective payment. Section IV.A of the preamble describes the implementation of a graduated per diem payment methodology for transfer cases. Beginning in FY 1996, we will pay double the per diem amount for the first day and the per diem amount for subsequent days, up to the full prospective payment amount. Section 109 of the Social Security Amendments of 1994 (Public Law 103–432) authorizes the Secretary to make adjustments to the operating prospective payment system rates so that adjustments to the payment policy for transfer cases do not affect aggregate payments. Section II of the addendum describes the methodology for making the adjustment to the operating rates.

In order to maintain consistency with the prospective payment system for operating costs, we believe that a parallel adjustment to the Federal capital rate and the hospital-specific capital rates is warranted. In this way, revision of the payment policy for transfer cases will not affect aggregate payments under the prospective payment system for capital-related costs. We describe the methodology for making this adjustment in Appendix B of this final rule. Following that methodology, we have determined that a special adjustment of .9972 (−0.28 percent) to the standard Federal rate and the hospital-specific rates is required.

2. Standard Federal Rate Update

Section 412.308(c)(1)(ii) provides that, effective FY 1996, 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. We discuss the analytical framework and the derivation of the final FY 1996 update factor under that framework in section V.A of the preamble to this final rule. The final update factor for FY 1996 is 1.2 percent.

3. 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, 50 percent for cost reporting periods beginning in FY 1996 for hospitals paid under the fully prospective methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that estimated outlier payments are 5.1 percent of estimated total DRG payments. The inpatient capital-related outlier reduction factor is then set according to the estimated inpatient capital-related outlier payments that would be made if all hospitals were paid according to 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model all hospitals as if 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 September 1, 1994 final rule, we estimated that outlier payments for capital in FY 1995 would equal 5.86 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9414 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d of the addendum, we estimate that outlier payments will equal 4.64 percent of inpatient capital-related payments based on the Federal rate in FY 1996. We are, therefore, applying an outlier adjustment factor of 0.9536 to the Federal rate. Thus, estimated capital outlier payments for FY 1996 represent a lower percentage of total capital payments than in FY 1995.

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 1996 is 1.0129 (.9536/.9414). Thus, the outlier adjustment increases the FY 1996 Federal rate by 1.29 percent (1.0129–1) compared with the FY 1995 outlier adjustment.

4. 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 estimated aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor equal estimated 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 geographic adjustment factor. 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 geographic adjustment factor.

For FY 1995, we calculated a GAF/DRG budget neutrality factor of 0.9998. In the proposed rule for FY 1996, we proposed a GAF/DRG budget neutrality factor of 0.9993. In this final rule, based on calculations using updated data, we

are applying a factor of 0.9994 to meet this requirement. 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 geographic adjustment factor. The incremental change in the adjustment from FY 1995 to FY 1996 is 0.9994. The cumulative change in the rate due to this adjustment is 1.0025 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, and FY 1996: $.9980 \times 1.0053 \times .9998 \times .9994 = 1.0025$).

This factor accounts for DRG reclassifications and recalibration and for changes in the geographic adjustment factor. It also incorporates the effects on the geographic adjustment factor of FY 1996 geographic reclassification decisions made by the MGCRB compared to FY 1995 decisions. However, it does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors or in the large urban add-on.

5. 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 additional payments for exceptions under § 412.348 determined as a proportion of total payments under the hospital-specific rate and Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to estimate payments under the exceptions payment process and to determine the exceptions payment adjustment factor. We describe that model in Appendix B to this final rule.

For FY 1995, we estimated that exceptions payments would equal 2.66 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9734 (1–.0266) in determining the Federal rate. For FY 1996, we estimated in the June 2, 1995, proposed rule that exceptions payments would equal 1.60 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed to apply an exceptions reduction factor of 0.9840 (1–0.0160) to determine the FY 1996 Federal rate. For this final rule, we estimate that exceptions payments for FY 1996 will equal 1.51 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9849 to the Federal rate for FY 1996.

The final exceptions reduction factor for FY 1996 is thus 1.18 percent higher than the factor for FY 1995, and 0.09 percent higher than the factor in the FY 1996 proposed rule. The reduced level of estimated exceptions payments for FY 1996 compared to FY 1995 is a result of the significant increases in the capital rates and in aggregate capital payments.

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 1996 Federal rate is .9849/.9734, or 1.0118.

6. Expiration of Budget Neutrality Provision

For FY 1992 through FY 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that estimated aggregate payments for inpatient hospital capital costs would equal 90 percent of the estimated payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision has now expired. The expiration of the budget neutrality provision is the predominant factor in the 22.59 percent increase in the Federal rate, as well as the 20.56 percent increase in payments.

For FY 1995, the budget neutrality adjustment was 0.8432, a 15.68 percent reduction to the rates. The budget neutrality factors were not built permanently into the rates; that is, the factors were not applied cumulatively in determining the Federal rate. With the expiration of the budget neutrality provision, the net adjustment to the rate is thus 1.186 (1.00/.8432=1.186), or 18.6 percent. The expiration of the provision, therefore, accounts for an 18.6 percent increase in the rate.

7. Standard Capital Federal Rate for FY 1996

For FY 1995, the capital Federal rate was $376.83. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1996 Federal rate would be $457.11. In this final rule, we are establishing an FY 1996 Federal rate of $461.96. The final Federal rate for FY 1996 was calculated as follows:

- The FY 1996 special adjustment to the standard Federal rate to account for the change in transfer payment policy is 0.9972.
- The FY 1996 update factor is 1.0120.
- The FY 1996 outlier adjustment factor is 0.9536.
- The FY 1996 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the geographic adjustment factor is 0.9994.
- The FY 1996 exceptions payments adjustment factor is 0.9849.
- The expiration of the budget neutrality provision requires that the FY 1995 budget neutrality adjustment be removed from the rate without further incremental adjustment.

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 are making 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 geographic adjustment factor.

We are providing a chart that shows how each of the factors and adjustments for FY 1996 affected the computation of the final FY 1996 Federal rate in comparison to the FY 1995 Federal rate. The special adjustment to account for the effects of changes in transfer payment policy has the effect of reducing the rate by 0.28 percent. The final FY 1996 update factor has the effect of increasing the Federal rate 1.20 percent compared to the rate in FY 1995, while the final geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.06 percent. The final FY 1996 outlier adjustment factor has the effect of increasing the Federal rate by 1.29 percent compared to FY 1995. The final FY 1996 exceptions reduction factor has the effect of increasing the Federal rate by 1.18 percent compared to the exceptions reduction for FY 1995. Finally, the expiration of the budget neutrality provision has the effect of increasing the final FY 1996 rate by 18.60 percent compared to the effect of the budget neutrality reduction in FY 1995. The combined effect of all the changes is to increase the Federal rate by 22.59 percent compared to the Federal rate for FY 1995.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1995 FEDERAL RATE AND FY 1996 FEDERAL RATE

		Change	Percent change
Transfer adjustment:			
FY 1995	N/A	.....	
FY 1996	0.9972	0.9972	−0.28
Update factor [1]:			
FY 1995	1.0344	.....	.....
FY 1996	1.0120	1.0120	1.20
GAF/DRG adjustment factor: [1]			
FY 1995	0.9998	.....	.....
FY 1996	0.9994	0.9994	−0.06
Outlier adjustment factor: [2]			
FY 1995	0.9414	.....	.....
FY 1996	0.9536	1.0129	1.29
Exceptions adjustment factor: [2]			
FY 1995	0.9734	.....	.....
FY 1996	0.9849	1.0118	1.18
Budget neutrality adjustment factor: [2]			
FY 1995	0.8432	.....	.....
FY 1996	1.0000	1.1860	18.60
Federal Rate:			
FY 1995	$376.83	.....	.....
FY 1996	$461.96	1.2259	22.59

[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 1995 to FY 1996 resulting from the application of the 0.9994 GAF/DRG budget neutrality factor for FY 1996 is 0.9994.

[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 1996 exceptions reduction factor is 0.9849/0.9734, or 1.0118. The result of the expiration of budget neutrality is that the FY 1995 budget neutrality factor is removed from the rate without further incremental adjustment (i.e., the FY 1996 adjustment of .8432 is divided out of the rate without further adjustment, for a net adjustment of 1.0000/.8432, or 1.1860).

We are also providing a chart that shows how the final FY 1996 Federal rate differs from the proposed FY 1996 Federal rate.

This chart shows that the major factor in the 1.06 percent increase in the rate since the proposed rule is the 1.15 percent increase due to our decision not to implement the proposed tax adjustment factor at this time. We discuss our reasons for this decision in section V.B. of the preamble. As the chart shows, the effect of this change, when compared to the proposed FY 1996 Federal rate, is to increase the rate by 1.15 percent. In addition, there have been small changes in the outlier and exceptions factors that contribute to the small increase in the rate. As the chart also shows, the effect of these changes was partially offset by a decrease in the final update factor compared to the update factor in the proposed rule.

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 1996 FEDERAL RATE AND FINAL FY 1996 FEDERAL RATE

		Net adjustment	Percent change
Update factor:			
Proposed FY 1996	1.0150	.....	.....
Final FY 1996	1.0120	0.9970	−0.30
Transfer adjustment:			
Proposed FY 1996	0.9972	.....	.....
Final FY 1996	0.9972	1.0000	0.00
Tax adjustment:			
Proposed FY 1996	0.9886	.....	.....
Final FY 1996	1.0000	1.0115	1.15
Outlier reduction factor:			
Proposed FY 1996	0.9526	.....	.....
Final FY 1996	0.9536	1.0010	0.10
GAF/DRG reduction factor:			
Proposed FY 1996	0.9993	.....	.....
Final FY 1996	0.9994	1.0001	0.01
Exceptions reduction factor:			
Proposed FY 1996	0.9840	.....	.....
Final FY 1996	0.9849	1.0009	0.09
Budget neutrality adjustment factor:			
Proposed FY 1996	1.0000	.....	.....
Final FY 1996	1.0000	1.0000	0.00
Federal rate:			
Proposed FY 1996	$457.11	.....	.....
Final FY 1996	$461.96	1.0106	1.06

8. Special Rate for Puerto Rico Hospitals

For FY 1995, the special rate for Puerto Rico hospitals was $289.87. With the changes we proposed making to the factors used to determine the rate, the proposed FY 1996 special rate for Puerto Rico was $351.61. In this final rule, the FY 1996 capital rate for Puerto Rico is $355.35.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1996 be determined by adjusting the FY 1995 hospital-specific rate by the following factors:

1. Special Adjustment for the Effects of the New Transfer Policy

Section 412.312(d) of the regulations provides that payment under the capital prospective payment system for transfer cases is made under the same rules governing transfer payments under the operating prospective payment system. Transfer cases under the prospective payment system for capital-related costs have been paid on a per diem basis, using the full prospective payment amount for the DRG (both Federal rate and hospital-specific rate, if appropriate) divided by the geometric mean length of stay for the DRG, but not to exceed the full prospective payment. Section IV.A of the preamble to this final rule describes our adoption of a graduated per diem payment methodology for transfer cases. Under this policy, we will pay double the per diem amount for the first day and the per diem amount for subsequent days, up to the full prospective payment amount. Section 109 of the Social Security Amendments of 1994 (Public Law 103–432) authorizes the Secretary to make adjustments to the operating prospective payment system rates so that adjustments to the payment policy for transfer cases do not affect aggregate payments. Section II of this Addendum describes the methodology for making the adjustment to the operating rates.

In order to maintain consistency with the prospective payment system for operating costs, we believe that a parallel adjustment to the Federal capital rate and the hospital-specific capital rates is warranted. In this way, revision of the payment policy for transfer cases will not affect aggregate payments under the prospective payment system for capital-related costs. We describe the methodology for making this adjustment in Appendix B of this proposed rule. Following that methodology, we have determined that a special adjustment of 0.9972 (−0.28 percent) to the standard Federal rate and the hospital-specific rates is required. We have revised § 412.328(e) accordingly.

2. 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 1996, the hospital-specific rate will be updated by a factor of 1.012.

3. Exceptions Payment Adjustment Factor

For FY 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 1996, we estimated in the proposed rule that exceptions payments would be 1.60 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore proposed that the updated hospital-specific rate be reduced by a factor of 0.9840. In this final rule, we estimate that exceptions payments will be 1.51 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are therefore applying an exceptions reduction factor of 0.9849 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. Therefore, the proposed net adjustment to the FY 1996 hospital-specific rate is .9849/.9734, or 1.0118.

4. Expiration of the Budget Neutrality Provision

For FY 1992 through FY 1995, the updated hospital-specific rate was adjusted by a budget neutrality adjustment factor determined under § 412.352, so that estimated aggregate payments under the capital prospective payment system would equal 90 percent of estimated payments that would have been made on a reasonable cost basis. (The budget neutrality adjustment for changes in the DRG classifications and relative weights and in the geographic adjustment factor is not applied to the hospital-specific rate.) For FY 1995, the budget neutrality adjustment was 0.8432. The budget neutrality provision has now expired. Therefore, for FY 1996 there is no budget neutrality adjustment. The budget neutrality factor was not built permanently into the rates; that is, the factor was not applied cumulatively in determining the hospital-specific rate. Therefore, the net adjustment to the FY 1996 hospital-specific rate as a result of the expiration of the budget neutrality provision is 1.0000/.8432, or 1.1860.

5. 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 1995 and FY 1996 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1995 to FY 1996 is 1.2110, which represents an increase of 21.10 percent to the hospital-specific rate. The FY 1996 hospital-specific rate for each hospital is determined by multiplying the FY 1995 hospital-specific rate by the cumulative net adjustment of 1.2110.

FY 1996 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update factor:			
FY 1995	1.0344	.....	.....
FY 1996	1.0120	1.0120	1.20
Transfer adjustment:			
FY 1995	N/A		
FY 1996	0.9972	0.9972	−0.28
Exceptions payment adjustment factor:			
FY 1995	0.9734	.....	.....
FY 1996	0.9849	1.0118	1.18
Budget neutrality factor:			
FY 1995	0.8432	.....	.....

FY 1996 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES—Continued

		Net adjustment	Percent change
FY 1996	1.0000	1.1860	18.60
Cumulative adjustments:			
FY 1995	0.8457	.....	.....
FY 1996	1.0241	1.2110	21.10

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 1995 to FY 1996 is 1.0120. In contrast, the exceptions payment adjustment factor and the budget neutrality factor are not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1995 to FY 1996 is .9849/.9734, or 1.0118.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1996

During the capital prospective payment system transition period, a hospital is paid for inpatient capital-related costs under one of two alternative 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 adjusting:

- 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 geographic adjustment factor, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, when appropriate).

If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + Indirect Medical Education Adjustment Factor, if applicable).

The result is termed 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:

- 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 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 1996 are 50 percent of the adjusted Federal rate and 50 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 hospital's inpatient capital-related payments that is based on the Federal rate. For fully prospective hospitals, that portion is 50 percent Federal rate for discharges occurring in cost reporting periods beginning during FY 1996. Thus, a fully prospective hospital will receive 50 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1996. 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 based on 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 1996 are published in section II.A.4.c of this Addendum. For FY 1996, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $15,150. A case qualifies as a day outlier for FY 1996 if the length of stay is greater than the geometric mean length of stay for the DRG plus the lesser of three standard deviations of the length of stay or 23 days.

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 1996 are:

• Sole community hospitals (located in either an urban or rural area), 90 percent;

• Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent and urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and,

• All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

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

IV. Changes for Excluded Hospitals and Units

A. Rate-of-Increase Percentages for Excluded Hospitals and Units

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). 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.

Effective with cost reporting periods beginning on or after October 1, 1991, a hospital that has Medicare inpatient operating costs in excess of its ceiling is paid its ceiling plus 50 percent of its costs in excess of the ceiling. Total payment may not exceed 110 percent of the ceiling. A hospital that has inpatient operating costs less than its ceiling will continue to be paid its costs plus the lower of—

• Fifty percent of the difference between the allowable inpatient operating costs and the ceiling; or

• Five percent of the ceiling.

Each hospital's target amount is adjusted annually, at the beginning of its cost reporting period, by an applicable rate-of-increase percentage. Section 13502 of Public Law 103–66 amended section 1886(b)(3)(B) of the Act to provide that for cost reporting periods beginning on or after October 1, 1993 and before October 1, 1994, the applicable rate-of-increase percentage is the market basket percentage increase minus the lesser of one percentage point, or the percentage point difference between 10 percent and the hospital's ''update adjustment percentage'' except for hospitals with an ''update adjustment percentage'' of at least 10 percent. The rate-of-increase percentage for hospitals in the latter case will be the market basket percentage increase. The ''update adjustment percentage'' is the percentage by which a hospital's allowable inpatient operating costs exceeds the hospital's ceiling for the cost reporting period beginning in Federal fiscal year 1990. For cost reporting periods beginning on or after October 1, 1994 and before October 1, 1997, the update adjustment percentage is the update adjustment percentage from the previous year plus the previous year's applicable reduction. The applicable reduction and applicable rate-of-increase percentage are then determined in the same manner as for FY 1994. The most recent forecasted market basket increase for FY 1996 for hospitals and hospital units excluded from the prospective payment system is 3.4 percent.

B. Wage Index Exceptions for Excluded Hospitals and Units

In the August 30, 1991 final rule (56 FR 43232), we set forth our policy for target amount adjustments for significant wage increases. Effective with cost reporting periods beginning on or after April 1, 1990, significant increases in wages since the base period are recognized as a basis for an adjustment in the target amount under § 413.40(g).

To qualify for an adjustment, the excluded hospital or hospital unit must be located in a labor market area for which the average hourly wage increased significantly more than the national average hourly wage between the hospital's base period and the period subject to the ceiling. We use the hospital wage index for prospective payment hospitals to determine the rate of increase in the average hourly wage in the labor market area. For a hospital to qualify for an adjustment, the wage index value for the cost reporting period subject to the ceiling must be at least 8 percent higher than the wage index based on wage survey data collected for the base year cost reporting period. If survey data are not available for one (or both) of the cost reporting periods used in the comparison, the wage index based on the latest available survey data collected before that cost reporting period will be used. For example, to make the comparison between a 1983 base period and a hospital's cost reporting period beginning in FY 1993, we would use the rate of increase between the wage index based on 1982 wage data and the wage index based on the FY 1992 data, since the FY 1992 data are the most recent data that are currently available. Further, the comparison is made without regard to geographic reclassifications made by the MGCRB under sections 1886(d) (8) and (10) of the Act. Therefore, the comparison is made based on the wage index value of the labor market area in which the hospital is actually located.

We determine the amount of the adjustment for wage increases by considering three factors for the time between the base period and the period for which an adjustment is requested: the rate of increase in the hospital's average hourly wage; the rate of increase in the average hourly wage in the labor market area in which the hospital is located; and, the rate of increase in the national average hourly wage for hospital workers. The adjustment is limited to the amount by which the lower of the hospital's or the labor market area's rate of increase in average hourly wages significantly exceeds the national increase (that is, exceeds the national rate of increase by more than 8 percent). For purposes of computing the adjustment, the relative rate of increase in the average hourly wage for the labor market area is assumed to have been the

same over each of the intervening years between the wage surveys.

To determine the rate of increase in the national average hourly wage, we use the average hourly earnings (AHE) component of the wages and salaries portion of the market basket. This measure is derived from the 1982-based market basket since the 1987-based market basket uses the employment cost index (ECI) for hospital workers as the price proxy for this component. Unlike the AHE, the ECI for hospital workers can be measured historically only back to 1986. In addition, the ECI does not adjust for skill-mix shifts and, therefore, measures only the change in wage rates per hour.

The average hourly earnings for hospital workers as measured by the market basket show the following increases:

1992 = 4.8 percent
1993 = 3.7 percent
1994 = 2.8 percent
1995 = 3.4 percent
1996 = 4.3 percent

We note that this section merely provides updated information with respect to areas that would qualify for the wage index adjustment under § 413.30(g). This information was calculated in accordance with established policy and does not reflect any change in that policy. The geographic areas in which the percentage difference in wage indexes was sufficient to qualify for a wage index adjustment are listed in Table 10 of section V of the addendum to this final rule. The table is constructed with old MSAs instead of the revised MSAs effective October 1, 1993 because current adjustment requests are for years prior to FY 1995.

V. 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, 1b, 1c, 1d, 3C, 4a, 4b, 4c, 4d, 4e, 5, 6a, 6b, 6c, 6d, 6e, 6f, 6G, 6H, 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 1b—Regional 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 1994 and Hospital Average Hourly Wage for Federal Fiscal Year 1996 Wage Index
Table 4a—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4b—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4c—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4d—Average Hourly Wage for Urban Areas
Table 4e—Average Hourly Wage for Rural Areas
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Length of Stay Outlier Cutoff Points Used in the Prospective Payment System
Table 6a—New Diagnosis Codes
Table 6b—New Procedure Codes
Table 6c—Invalid Diagnosis Codes
Table 6d—Invalid Procedure Codes
Table 6e—Revised Diagnosis Code Titles
Table 6f—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 95 MEDPAR Update 06/95 GROUPER V12.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 94 MEDPAR Update 06/95 GROUPER V13.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) August 1995
Table 8B—Statewide Average Capital Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) August 1995
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
$2,741.39	$1,098.09	$2,697.99	$1,080.71

TABLE 1B.—REGIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
1. New England (CT, ME, MA, NH, RI, VT)	$2,874.14	$1,151.27	$2,828.62	$1,133.04
2. Middle Atlantic (PA, NJ, NY)	2,623.06	1,050.69	2,581.53	1,034.06
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,685.62	1,075.75	2,643.11	1,058.72
4. East North Central (IL, IN, MI, OH, WI)	2,926.45	1,172.22	2,880.12	1,153.66
5. East South Central (AL, KY, MS, TN)	2,537.85	1,016.56	2,497.67	1,000.47
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	2,743.19	1,098.81	2,699.76	1,081.41
7. West South Central (AR, LA, OK, TX)	2,669.98	1,069.49	2,627.71	1,052.55
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,652.82	1,062.62	2,610.82	1,045.79
9. Pacific (AK, CA, HI, OR, WA)	2,712.20	1,086.40	2,669.27	1,069.20

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

	Large urban areas		Other areas	
	Labor-related	Nonlabor—related	Labor-related	Nonlabor—related
National	$2,714.63	$1,087.37	$2,714.63	$1,087.37
Puerto Rico	2,444.77	509.50	2,406.07	501.43

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$461.96
Puerto Rico	355.35

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1994, HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 1996 WAGE INDEX

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
010001	01.3968	14.70	010095	01.0332	10.66	030004	01.0179	13.13	040003	01.0705	13.33	040105	01.0662	11.86
010004	01.0413	11.54	010097	00.9261	12.23	030006	01.5839	17.32	040004	01.4025	13.86	040106	01.2166	11.16
010005	01.1775	13.61	010098	01.0799	11.19	030007	01.2521	16.55	040005	00.9579	11.37	040107	01.1231	15.18
010006	01.3889	14.23	010099	01.0329	14.74	030008	01.9610	20.06	040007	01.7232	16.81	040109	01.0766	12.13
010007	01.0911	12.03	010100	01.1814	13.72	030009	01.2256	15.42	040008	01.1067	10.45	040114	01.8042	16.23
010008	01.0538	09.78	010101	01.1089	12.72	030010	01.4044	17.40	040010	01.1910	13.08	040116	01.3377	18.71
010009	01.0803	15.47	010102	00.9127	11.42	030011	01.4903	20.19	040011	00.9909	10.41	040118	01.1197	13.58
010010	01.0761	13.64	010103	01.7143	16.47	030012	01.2311	15.06	040013	00.8034	11.75	040119	01.1364	13.45
010011	01.5164	19.89	010104	01.6688	16.63	030013	01.2419	19.04	040014	01.2134	15.72	040124	01.1769	13.61
010012	01.2603	14.67	010108	01.2172	11.76	030014	01.4902	17.79	040015	01.2060	11.77	040126	00.9480	11.00
010015	01.0453	15.13	010109	01.0546	11.54	030016	01.3304	16.82	040016	01.7332	15.81	040132	00.3512	14.00
010016	01.1906	15.10	010110	00.9496	12.21	030017	01.3986	18.43	040017	01.2172	10.52	050002	01.5615	26.17
010018	00.9544	15.60	010112	01.0969	13.96	030018	01.7243	17.74	040018	01.2122	15.74	050006	01.4001	19.22
010019	01.2751	13.87	010113	01.6285	13.09	030019	01.2442	18.78	040019	01.1123	11.20	050007	01.5879	26.63
010021	01.2588	13.21	010114	01.3117	15.41	030022	01.4806	17.27	040020	01.5105	13.74	050008	01.4323	24.86
010022	01.0256	15.65	010115	00.8513	10.12	030023	01.2911	16.24	040021	01.2130	15.42	050009	01.6649	26.93
010023	01.3805	14.44	010117	00.9347	18.73	030024	01.7625	18.77	040022	01.8066	14.21	050013	01.8480	20.87
010024	01.3726	15.01	010118	01.2246	15.42	030025	01.1006	13.38	040024	01.0180	11.62	050014	01.1446	22.82
010025	01.3813	12.75	010119	01.2015	15.12	030027	01.1208	14.29	040025	00.9354	10.69	050015	01.4331	20.74
010027	00.8467	13.11	010120	00.9965	14.36	030030	01.6996	20.88	040026	01.5494	15.05	050016	01.1496	14.51
010029	01.4704	14.06	010121	01.1896	14.23	030033	01.2155	15.50	040027	01.2685	12.06	050017	02.0952	24.17
010031	01.2567	13.51	010123	01.2321	16.17	030034	01.1710	15.72	040028	01.0217	10.19	050018	01.2508	18.71
010032	00.9701	13.69	010124	01.2794	15.36	030035	01.3011	19.44	040029	01.2031	13.07	050021	01.3600	21.85
010033	01.8757	17.51	010125	01.0446	12.25	030036	01.1317	17.49	040030	00.8998	11.86	050022	01.5018	22.19
010034	01.0149	12.69	010126	01.1157	12.54	030037	01.9258	19.15	040032	01.0062	10.37	050024	01.3482	23.48
010035	01.2169	14.72	010127	01.4863	16.01	030038	01.5022	17.78	040035	00.9926	09.69	050025	01.7235	21.46
010036	01.1364	15.26	010128	01.0313	10.97	030040	00.9810	15.24	040036	01.4043	15.86	050026	01.4341	20.43
010038	01.2308	16.94	010129	01.0641	13.39	030041	00.9523	16.41	040037	01.1119	11.56	050028	01.4066	15.18
010039	01.6205	15.05	010130	01.0484	15.47	030043	01.1729	17.72	040039	01.2264	11.89	050029	01.2872	25.93
010040	01.4682	17.28	010131	01.2518	17.42	030044	00.9940	13.57	040040	01.1993	17.12	050030	01.2790	19.28
010043	01.0564	12.55	010134	00.8447	12.38	030046	01.0471	16.87	040041	01.3374	14.18	050032	01.2640	22.74
010044	00.9582	12.54	010137	01.2210	15.71	030047	00.9475	18.93	040042	01.2984	12.26	050033	01.3994	24.02
010045	01.1387	11.95	010138	00.9878	09.88	030049	00.9609	14.29	040044	00.8731	10.10	050036	01.7580	20.22
010046	01.4552	13.93	010139	01.6156	20.00	030054	00.9290	12.19	040045	01.0710	13.23	050038	01.3353	28.61
010047	01.0735	08.72	010143	01.1710	16.12	030055	01.2152	16.00	040047	01.0339	14.05	050039	01.5925	20.33
010049	01.1096	14.18	010144	01.3054	15.54	030059	01.3347	20.15	040048	01.1791	13.54	050040	01.2773	22.38
010050	01.0179	11.94	010145	01.2130	15.36	030060	01.1092	13.06	040050	01.1429	11.01	050041	01.3654	21.68
010051	00.8267	09.81	010146	01.1608	15.74	030061	01.5941	16.25	040051	01.1125	10.19	050042	01.2517	20.06
010052	00.9528	11.56	010148	00.9487	10.54	030062	01.2600	14.57	040053	01.1313	12.40	050043	01.5396	27.78
010053	01.0421	12.58	010149	01.3465	15.90	030064	01.6330	16.62	040054	01.0770	11.90	050045	01.3028	17.13
010054	01.1530	15.11	010150	01.0127	13.86	030065	01.6023	18.78	040055	01.4478	14.04	050046	01.1768	24.46
010055	01.4397	14.98	010152	01.3346	15.42	030067	01.0531	15.23	040058	01.2358	13.05	050047	01.6769	28.05
010056	01.4021	17.64	010155	00.9590	09.48	030068	00.9663	13.92	040060	00.9532	12.70	050051	01.0947	17.01
010058	01.0147	12.39	020001	01.5075	25.13	030069	01.3595	16.55	040062	01.5209	14.64	050052	01.1447	.....
010059	01.0348	13.89	020002	01.0097	24.19	030071	00.9416	.....	040063	01.4946	14.95	050054	01.1528	19.64
010061	00.9669	13.39	020004	01.1323	23.34	030072	00.8611	.....	040064	00.9489	09.57	050055	01.4117	29.68
010062	01.0039	11.97	020005	00.9083	23.80	030073	01.0810	.....	040066	01.0779	13.90	050056	01.3677	23.16
010064	01.7903	17.53	020006	01.1710	21.93	030074	00.8502	.....	040067	01.1361	11.31	050057	01.4622	19.73
010065	01.3665	14.14	020007	00.8393	17.74	030075	00.8573	.....	040069	01.0798	13.04	050058	01.4523	21.90
010066	00.9197	09.11	020008	00.9996	26.65	030076	00.8694	.....	040070	00.9387	13.28	050060	01.5727	19.17
010068	01.2297	18.14	020009	00.9280	19.88	030077	00.8113	.....	040071	01.4674	15.11	050061	01.3814	22.35
010069	01.0778	13.08	020010	01.0303	18.60	030078	01.1209	.....	040072	01.1259	14.24	050063	01.4300	21.08
010072	01.2032	12.45	020011	01.1331	21.26	030079	00.7942	.....	040074	01.3112	13.79	050065	01.6178	22.56
010073	00.9006	10.82	020012	01.2973	22.82	030080	01.6610	21.27	040075	01.0563	10.99	050066	01.2551	24.33
010078	01.1694	15.06	020013	00.8540	21.66	030083	01.3676	21.02	040076	01.0433	13.39	050067	01.4056	21.52
010079	01.1115	14.56	020014	01.2972	19.97	030084	00.9965	.....	040077	00.8759	10.34	050068	01.2515	18.27
010080	00.9621	13.13	020017	01.3934	25.88	030085	01.4980	17.85	040078	01.4179	15.29	050069	01.5984	23.54
010081	01.9629	16.46	020018	00.9100	.....	030086	01.2409	18.35	040080	01.0214	14.94	050070	01.3123	28.83
010083	01.0402	12.57	020019	00.8722	.....	030087	01.5981	17.23	040081	00.8802	09.81	050071	01.3070	28.37
010084	01.3687	15.98	020020	00.8894	.....	030088	01.3666	18.08	040082	01.2322	12.53	050072	01.3191	29.11
010085	01.2525	15.87	020021	00.8976	.....	030089	01.4360	18.51	040084	01.0970	14.26	050073	01.2552	29.08
010086	00.9830	13.22	020024	01.0720	22.25	030092	01.5477	18.71	040085	01.2523	14.29	050074	01.0875	31.87
010087	01.7658	16.49	020025	01.0426	21.61	030093	01.3513	17.76	040088	01.3551	13.14	050075	01.3402	28.71
010089	01.1268	15.32	020026	01.2538	.....	030094	01.3531	17.83	040090	00.9673	11.94	050076	01.6600	28.90
010090	01.5515	15.76	020027	00.9528	.....	030095	01.1298	14.39	040091	01.2662	17.58	050077	01.5894	22.97
010091	00.9581	12.37	030001	01.3021	19.25	030097	01.0287	.....	040093	00.9748	10.17	050078	01.3994	22.74
010092	01.3781	15.31	030002	01.8140	20.27	040001	01.1696	11.25	040095	00.8388	11.17	050079	01.5499	29.43
010094	01.1698	17.54	030003	01.7302	19.73	040002	01.1882	12.09	040100	01.1610	13.63	050080	01.2743	23.03

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050081	01.6679	21.10	050177	01.2282	18.24	050286	00.9265	26.63	050407	01.3626	26.56	050528	01.2336	16.76
050082	01.4770	21.26	050179	01.2418	18.28	050289	01.7527	25.91	050410	01.1100	16.16	050531	01.2049	19.81
050084	01.5885	21.52	050180	01.5435	30.93	050290	01.5196	24.38	050411	01.3968	27.93	050534	01.3893	23.99
050088	01.0729	21.32	050181	01.2989	.....	050291	01.2685	24.17	050414	01.2954	24.04	050535	01.4946	22.35
050089	01.3265	19.83	050183	01.2255	19.25	050292	01.1333	21.25	050417	01.2300	18.53	050537	01.2230	21.28
050090	01.3257	20.02	050186	01.3277	24.64	050293	00.8257	19.92	050418	01.3467	24.11	050539	01.1557	22.82
050091	01.1739	21.63	050188	01.4107	25.19	050295	01.4056	20.72	050419	01.2985	18.33	050541	01.5428	28.93
050092	00.9075	16.84	050189	00.9558	22.45	050296	01.2987	23.78	050420	01.4723	24.85	050542	01.1764	15.76
050093	01.5560	20.79	050191	01.5886	21.31	050298	01.2369	16.65	050421	01.4309	24.17	050543	00.9034	24.18
050095	00.9989	29.05	050192	01.2153	18.66	050299	01.2994	22.49	050423	01.0348	17.53	050545	00.8899	21.07
050096	01.1224	18.14	050193	01.4095	23.10	050300	01.2676	18.73	050424	01.7320	24.12	050546	00.8228	21.43
050097	01.4238	16.13	050194	01.1999	25.22	050301	01.4347	21.30	050425	01.2512	27.91	050547	00.9096	22.13
050099	01.4808	22.03	050195	01.5632	29.15	050302	01.3531	23.57	050426	01.3324	22.18	050549	01.7694	25.56
050100	01.8779	22.92	050196	01.4143	18.09	050305	01.6085	28.25	050427	00.9421	22.53	050550	02.3252	21.44
050101	01.4198	24.98	050197	01.8868	27.85	050307	01.3897	20.66	050430	00.9277	15.31	050551	01.3390	23.83
050102	01.5195	21.67	050199	01.0425	22.19	050308	01.5405	28.06	050431	01.1250	20.82	050552	01.3328	20.13
050103	01.6052	28.01	050204	01.3887	22.44	050309	01.3839	23.19	050432	01.5930	23.40	050557	01.5817	21.45
050104	01.3567	21.95	050205	01.4014	19.74	050310	01.2782	20.36	050433	01.0404	17.20	050559	01.3762	22.56
050107	01.4065	20.13	050207	01.3154	20.06	050312	01.8592	23.07	050434	01.1767	17.00	050560	01.5959	22.35
050108	01.5751	22.50	050208	01.2787	27.22	050313	01.2419	20.05	050435	01.2922	16.47	050561	01.2104	28.42
050109	02.2189	23.93	050211	01.3765	25.67	050315	01.3025	20.58	050436	00.9928	15.70	050564	01.2887	25.38
050110	01.2585	20.72	050213	01.4588	19.75	050317	01.2356	19.58	050438	01.6084	23.36	050565	01.2006	21.03
050111	01.3024	18.52	050214	01.5542	22.70	050320	01.3287	32.07	050440	01.3911	18.93	050566	00.9865	13.94
050112	01.5233	22.95	050215	01.5360	25.76	050324	01.8053	23.27	050441	01.8493	27.68	050567	01.6027	21.00
050113	01.3013	26.77	050217	01.3147	17.43	050325	01.2332	20.65	050443	00.9409	14.95	050568	01.3231	22.17
050114	01.4336	25.49	050219	01.2947	20.45	050327	01.5955	21.01	050444	01.3535	23.83	050569	01.4307	21.89
050115	01.5153	21.57	050222	01.5416	25.04	050328	01.5394	27.69	050446	00.9957	17.23	050570	01.5835	24.67
050116	01.4747	22.94	050224	01.5576	21.12	050329	01.2920	15.93	050447	01.0895	16.92	050571	01.3222	26.14
050117	01.3259	18.74	050225	01.3801	20.48	050331	01.4400	28.29	050448	01.0625	18.59	050573	01.6210	22.10
050118	01.2218	23.13	050226	01.3631	21.59	050333	00.9684	17.95	050449	01.3118	20.99	050575	01.2532	23.34
050121	01.5400	20.07	050228	01.4464	28.72	050334	01.5816	28.97	050454	01.8126	26.37	050577	01.3920	21.47
050122	01.6430	23.24	050230	01.3603	26.71	050335	01.2433	20.84	050455	01.8486	21.11	050578	01.2616	24.09
050124	01.2701	22.93	050231	01.6538	22.19	050336	01.2893	19.40	050456	01.2190	21.52	050579	01.5452	27.06
050125	01.3509	24.50	050232	01.8167	25.50	050337	01.2628	26.55	050457	01.9322	28.03	050580	01.4027	22.40
050126	01.4205	24.72	050233	01.2148	23.64	050342	01.3993	17.43	050458	00.7146	23.76	050581	01.4171	24.32
050127	01.2797	22.28	050234	01.3556	18.84	050343	01.1120	16.91	050459	01.1585	28.15	050583	01.6137	21.83
050128	01.5377	20.73	050235	01.4868	23.84	050348	01.6361	24.26	050464	01.8498	22.87	050584	01.2738	22.37
050129	01.5022	21.49	050236	01.5367	24.67	050349	00.9483	13.96	050468	01.3417	15.80	050585	01.3347	22.76
050131	01.2906	25.95	050238	01.5043	19.87	050350	01.3833	21.49	050469	01.1376	17.19	050586	01.3449	22.75
050132	01.3632	19.85	050239	01.5179	21.99	050351	01.4824	27.25	050470	01.1109	19.37	050587	01.2709	20.16
050133	01.3704	20.11	050240	01.4428	23.58	050352	01.2933	22.36	050471	01.6780	23.33	050588	01.2785	27.21
050135	01.2507	26.85	050241	01.3170	26.52	050353	01.5831	20.14	050476	01.2475	19.26	050589	01.3320	24.60
050136	01.4215	21.96	050242	01.3730	26.92	050355	00.9653	15.90	050477	01.4106	27.66	050590	01.4053	23.13
050137	01.3803	29.95	050243	01.5537	24.82	050357	01.7895	22.17	050478	00.9938	22.01	050591	01.1739	20.64
050138	01.7766	30.59	050245	01.3655	21.94	050359	01.0386	19.35	050481	01.4268	25.61	050592	01.3816	23.45
050139	01.3303	29.15	050248	01.1103	24.57	050360	01.5164	31.61	050482	00.9597	18.35	050593	01.5525	25.60
050140	01.4148	29.23	050251	01.1099	16.23	050366	01.2747	20.46	050483	01.1904	26.34	050594	02.0551	22.74
050144	01.6499	22.42	050253	00.8763	18.00	050367	01.2967	26.14	050485	01.6004	21.94	050597	01.2322	21.75
050145	01.3454	26.85	050254	01.1399	22.76	050369	01.3062	23.37	050486	01.4342	23.44	050598	01.4335	25.33
050146	01.3466	.....	050256	01.8935	19.43	050373	01.3703	23.22	050488	01.4138	27.49	050599	01.7122	22.85
050147	00.7123	20.96	050257	01.1982	17.90	050376	01.3429	25.07	050489	01.0669	23.36	050601	01.3033	30.28
050148	01.0691	17.09	050260	00.9782	21.22	050377	00.9475	16.99	050491	01.1810	26.44	050603	01.4452	22.96
050149	01.3651	22.42	050261	01.1624	17.18	050378	01.1675	22.91	050492	01.1874	20.52	050604	01.5474	27.40
050150	01.3121	21.41	050262	01.8406	25.72	050379	01.0648	18.39	050494	01.1616	23.56	050607	01.3481	19.27
050152	01.4075	25.02	050263	01.2553	26.81	050380	01.6428	26.54	050496	01.7182	29.82	050608	01.1805	15.26
050153	01.6199	29.55	050264	01.4300	26.35	050382	01.3947	23.92	050497	00.9065	11.78	050609	01.3393	30.07
050154	01.0949	21.63	050267	01.5691	24.29	050385	01.4407	24.00	050498	01.2744	21.87	050613	01.1025	22.87
050155	01.1562	19.97	050270	01.3246	22.68	050388	00.9432	14.21	050502	01.6692	21.87	050615	01.4503	21.15
050158	01.5592	26.71	050272	01.3615	19.69	050390	01.2350	21.04	050503	01.3323	22.11	050616	01.2735	20.76
050159	01.2369	21.78	050274	01.0960	18.11	050391	01.3409	19.68	050506	01.4708	24.09	050618	01.0205	16.48
050167	01.3568	22.09	050276	01.2591	28.37	050392	00.9821	16.53	050510	01.3648	28.70	050623	01.2040	23.19
050168	01.5962	23.78	050277	01.3622	21.80	050393	01.3945	22.22	050512	01.3749	29.35	050624	01.2514	26.72
050169	01.5252	23.32	050278	01.5011	21.16	050394	01.5281	22.04	050515	01.3295	28.65	050625	01.5858	23.29
050170	01.5054	21.35	050279	01.2210	20.42	050396	01.5525	21.13	050516	01.6481	23.36	050630	01.2448	21.58
050172	01.3087	20.41	050280	01.6345	22.36	050397	01.0703	17.88	050517	01.2673	19.52	050633	01.2660	21.41
050173	01.2190	22.01	050281	01.4865	.....	050401	01.2008	15.64	050522	01.3936	29.90	050635	01.3393	29.56
050174	01.7090	25.94	050282	01.3481	22.82	050404	01.1331	13.84	050523	01.2175	25.91	050636	01.3336	21.81
050175	01.3262	23.42	050283	01.3344	26.60	050406	01.1195	14.65	050526	01.3612	25.43	050637	01.0646	22.10

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050638	00.9513	24.17	060033	01.1476	11.24	070030	01.2535	23.06	100055	01.3743	17.82	100146	01.1447	14.10
050641	01.2117	15.92	060034	01.4987	19.01	070031	01.3049	19.23	100056	01.4899	20.15	100147	01.0930	13.00
050643	00.8711	.....	060036	01.1813	12.48	070033	01.3033	24.24	100057	01.3746	15.39	100150	01.2948	16.60
050644	00.9872	24.48	060037	01.0516	12.26	070034	01.3458	24.14	100059	00.9153	16.60	100151	01.7793	18.68
050660	01.2866	.....	060038	01.0530	11.85	070035	01.3917	22.12	100060	01.7354	16.88	100154	01.6427	18.00
050661	00.9135	20.77	060041	00.8964	15.38	070036	01.3278	25.69	100061	01.5117	20.28	100156	01.1459	17.50
050662	00.8619	21.30	060042	00.9425	17.68	070038	00.9919	.....	100062	01.7513	16.20	100157	01.6054	18.71
050663	01.1139	22.11	060043	00.9975	14.76	080001	01.6573	23.28	100063	01.2214	15.65	100159	01.0322	14.28
050666	00.7638	23.70	060044	01.1525	14.89	080002	01.2698	16.99	100067	01.3722	15.72	100160	01.0625	17.34
050667	01.1809	23.89	060046	01.1237	15.46	080003	01.3084	19.43	100068	01.4318	17.17	100161	01.5648	19.20
050668	01.2274	26.93	060047	01.1030	09.96	080004	01.3271	16.96	100069	01.5169	15.21	100162	01.4159	16.74
050671	01.6203	27.00	060049	01.2107	17.19	080005	01.3183	15.82	100070	01.4353	17.16	100165	01.2363	13.51
050672	00.6349	21.17	060050	01.2676	13.15	080006	01.3653	16.48	100071	01.2737	15.51	100166	01.4690	19.88
050674	01.2495	28.26	060052	01.1344	12.88	080007	01.2784	17.63	100072	01.2463	16.34	100167	01.4139	20.48
050675	01.7051	15.00	060053	00.9301	12.60	090001	01.4960	19.94	100073	01.7678	20.14	100168	01.3765	18.12
050676	00.9870	13.25	060054	01.3476	15.54	090002	01.1416	15.96	100074	01.2361	19.00	100169	01.8741	18.22
050677	01.3405	31.12	060056	00.8988	12.65	090003	01.3455	21.55	100075	01.6388	16.40	100170	01.4112	15.90
050678	01.1794	24.63	060057	01.0220	20.40	090004	01.6239	22.47	100076	01.4024	16.43	100172	01.3624	13.54
050680	01.2553	25.39	060058	00.8994	10.18	090005	01.2725	25.88	100077	01.3380	15.83	100173	01.5814	15.59
050682	00.9270	13.61	060060	00.9656	12.38	090006	01.3232	19.62	100078	01.1723	14.56	100174	01.4758	18.74
050684	01.1759	21.43	060062	00.9881	14.10	090007	01.4799	19.96	100079	01.4619	18.80	100175	01.1062	15.14
050685	01.2662	27.06	060063	01.0031	11.07	090008	01.5653	19.96	100080	01.5393	18.32	100176	01.9867	25.81
050686	01.3631	29.52	060064	01.3900	20.49	090010	00.9357	20.65	100081	01.1737	12.91	100177	01.3286	17.48
050688	01.2056	28.71	060065	01.3782	17.83	090011	01.9895	24.31	100082	01.5720	16.76	100179	01.6306	17.87
050689	01.4343	28.59	060066	00.9691	12.11	100001	01.5587	17.27	100083	01.3813	16.09	100180	01.4820	16.54
050690	01.3986	28.26	060068	01.1369	14.76	100002	01.4599	18.36	100084	01.5159	16.83	100181	01.4152	15.91
050693	01.5106	27.22	060070	01.1233	15.55	100004	01.0642	11.43	100085	01.3516	19.23	100183	01.3405	17.45
050694	01.4369	21.73	060071	01.2613	13.96	100005	01.0143	17.36	100086	01.3887	20.43	100186	01.3865	14.90
050695	01.1047	24.12	060072	00.9310	.....	100006	01.6473	18.18	100087	01.7370	19.99	100187	01.4505	19.93
050696	02.1885	26.95	060073	01.0637	14.30	100007	01.8060	18.70	100088	01.7194	16.94	100189	01.2663	21.83
050697	01.1355	16.30	060075	01.2280	18.89	100008	01.7161	19.32	100090	01.3598	15.22	100191	01.3230	18.97
050698	01.4891	21.28	060076	01.3825	16.07	100009	01.5540	19.83	100092	01.5115	16.62	100199	01.2982	18.97
050699	00.7489	25.39	060085	00.9265	10.79	100010	01.4427	19.21	100093	01.4388	14.09	100200	01.3820	21.22
050700	01.5233	30.13	060087	01.6314	20.20	100012	01.6373	17.94	100098	01.1755	16.49	100203	01.1492	18.76
050701	01.3466	27.27	060088	00.9716	13.54	100014	01.2434	17.55	100099	01.2245	15.33	100204	01.5986	17.77
050702	00.9229	16.26	060090	00.9339	14.20	100015	01.3079	16.81	100102	01.0695	15.80	100206	01.3467	20.26
050704	01.1765	.....	060096	00.9593	19.72	100017	01.5767	16.31	100103	01.1072	15.50	100207	01.4218	23.04
050705	00.6755	.....	060100	01.3764	20.85	100018	01.3236	18.69	100105	01.4167	17.66	100208	01.5597	21.28
050706	00.8631	.....	060103	01.2065	20.37	100019	01.5037	18.79	100106	01.0533	14.76	100209	01.6023	22.01
050707	00.8651	.....	060104	01.3098	19.86	100020	01.3154	19.55	100107	01.3184	17.58	100210	01.7086	15.89
050708	00.9092	.....	060106	01.3945	.....	100022	01.6583	22.47	100108	01.1084	15.65	100211	01.3203	17.57
050709	01.2686	.....	070001	01.7362	23.62	100023	01.3773	15.61	100109	01.3226	16.41	100212	01.6271	18.04
060001	01.5030	17.31	070002	01.8127	24.21	100024	01.4214	18.53	100110	01.4002	16.69	100213	01.5981	17.94
060003	01.3096	16.54	070003	01.1701	24.23	100025	01.6538	15.42	100112	01.0009	11.56	100217	01.2339	18.31
060004	01.1473	18.71	070004	01.1546	23.01	100026	01.6173	15.46	100113	02.1328	16.92	100220	01.8434	19.78
060006	01.1401	16.47	070005	01.3231	24.75	100027	00.9427	10.01	100114	01.4707	17.68	100221	01.4373	18.35
060007	01.2317	12.87	070006	01.3732	25.94	100028	01.3008	16.01	100117	01.3068	17.02	100222	01.3493	16.57
060008	00.9879	13.68	070007	01.3763	22.95	100029	01.3803	18.94	100118	01.3114	16.43	100223	01.4700	16.34
060009	01.4330	19.83	070008	01.2804	22.85	100030	01.3109	17.44	100121	01.2688	14.78	100224	01.4555	18.76
060010	01.5768	21.01	070009	01.2496	23.96	100032	01.9713	17.17	100122	01.3418	15.71	100225	01.3723	19.52
060011	01.2375	18.74	070010	01.4502	22.35	100034	01.7876	17.67	100124	01.4069	18.25	100226	01.3627	17.20
060012	01.4260	16.50	070011	01.2736	22.16	100035	01.6278	16.30	100125	01.0866	16.78	100227	01.0034	17.78
060013	01.2804	17.06	070012	01.1874	22.30	100038	01.6744	20.22	100126	01.4434	18.61	100228	01.2587	18.85
060014	01.7292	20.66	070013	01.3474	23.92	100039	01.7057	20.59	100127	01.5845	18.03	100229	01.3333	17.11
060015	01.6044	18.45	070015	01.3807	23.42	100040	01.6897	16.11	100128	02.1609	19.42	100230	01.3649	18.43
060016	01.1611	12.48	070016	01.3213	24.30	100042	01.6015	20.23	100129	01.3096	17.71	100231	01.6877	17.03
060018	01.2240	14.91	070017	01.4158	23.47	100043	01.4283	19.94	100130	01.1928	17.18	100232	01.2221	17.96
060020	01.4952	15.53	070018	01.4256	25.83	100044	01.4447	19.01	100131	01.3138	19.27	100234	01.6152	18.45
060022	01.7419	16.71	070019	01.2680	23.06	100045	01.4428	16.70	100132	01.4097	15.18	100235	01.4317	16.20
060023	01.5247	17.84	070020	01.4289	23.68	100046	01.5106	16.91	100134	01.2156	14.50	100236	01.4542	17.71
060024	01.7207	21.41	070021	01.2994	25.55	100047	01.7854	20.80	100135	01.4709	15.53	100237	02.1813	22.74
060026	01.4299	18.52	070022	01.6980	24.10	100048	00.9565	11.55	100137	01.2745	16.08	100238	01.4226	16.85
060027	01.5313	19.14	070024	01.3199	21.90	100049	01.3153	16.74	100138	00.9682	11.92	100239	01.4527	18.66
060028	01.4606	20.00	070025	01.6953	23.66	100050	01.2729	15.06	100139	01.0334	15.70	100240	00.8556	14.86
060029	01.0333	14.09	070026	01.1185	23.44	100051	01.2310	16.21	100140	01.1773	16.00	100241	00.9113	12.29
060030	01.3159	18.40	070027	01.2450	24.05	100052	01.4041	14.82	100142	01.1827	16.26	100242	01.4018	15.55
060031	01.5071	18.31	070028	01.4651	22.94	100053	01.3238	16.23	100144	01.2243	11.94	100243	01.4662	16.92
060032	01.4381	20.01	070029	01.2874	20.71	100054	01.2994	17.88	100145	01.4725	12.24	100244	01.3863	17.40

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
100246	01.3230	20.75	110042	01.1790	14.31	110134	00.8704	10.30	120015	00.8598	20.16	140026	01.1449	14.78
100248	01.6328	18.68	110043	01.6250	15.19	110135	01.1388	12.78	120016	00.8970	20.47	140027	01.2762	15.39
100249	01.3119	18.19	110044	01.1797	13.21	110136	01.1520	17.56	120018	00.9883	19.81	140029	01.2988	18.41
100252	01.1810	18.33	110045	01.2493	21.95	110140	00.8058	16.43	120019	01.1558	18.50	140030	01.5387	20.92
100253	01.3866	18.25	110046	01.1838	15.37	110141	00.8796	10.46	120021	00.9286	20.79	140031	01.1847	12.51
100254	01.5036	16.89	110048	01.2613	13.55	110142	01.0386	11.73	120022	01.6897	16.62	140032	01.2774	15.20
100255	01.2985	20.20	110049	01.0212	14.46	110143	01.3255	18.71	120025	00.9278	18.26	140033	01.2441	17.93
100256	01.8114	19.59	110050	01.0553	12.45	110144	01.1549	12.85	120026	01.2765	21.37	140034	01.1618	15.80
100258	01.6527	21.05	110051	00.9820	16.34	110146	00.9561	12.45	120027	01.4535	20.92	140035	01.0554	11.09
100259	01.4100	16.77	110052	00.8726	14.34	110149	01.0717	11.53	130001	00.9695	15.35	140036	01.1506	14.74
100260	01.4001	19.49	110054	01.2733	16.58	110150	01.3285	15.62	130002	01.3383	14.89	140037	00.9955	11.93
100262	01.4017	18.35	110056	01.0644	11.70	110152	01.1220	12.64	130003	01.2345	17.34	140038	01.1754	15.57
100263	01.4215	16.60	110059	01.2402	13.14	110153	00.9568	16.74	130005	01.4022	17.25	140039	00.9621	12.57
100264	01.3949	16.86	110061	01.0319	10.55	110154	00.9795	13.79	130006	01.8193	16.88	140040	01.2404	13.67
100265	01.2985	17.52	110062	00.9472	10.27	110155	01.1836	14.04	130007	01.5553	17.89	140041	01.1593	15.42
100266	01.2182	15.99	110063	01.0362	11.52	110156	00.9738	12.03	130008	00.9091	11.92	140042	01.0276	13.28
100267	01.2953	19.12	110064	01.2695	15.88	110157	01.0805	15.98	130009	00.9481	15.96	140043	01.2443	15.96
100268	01.2190	22.57	110065	01.0563	11.99	110161	01.2316	19.75	130010	01.0134	14.43	140045	00.9734	12.36
100269	01.3820	21.84	110066	01.3146	15.99	110162	00.8777	.....	130011	01.2663	15.29	140046	01.2920	15.06
100270	00.8854	08.60	110069	01.1375	16.05	110163	01.3592	18.05	130012	01.0033	17.91	140047	01.1556	12.83
100271	01.7876	16.19	110070	00.9918	10.92	110164	01.4399	18.67	130013	01.2907	16.78	140048	01.3210	21.62
100273	01.1555	16.72	110071	00.9799	09.13	110165	01.3380	16.78	130014	01.3583	16.02	140049	01.5612	18.55
100275	01.5128	21.10	110072	01.0385	11.97	110166	01.5044	16.62	130015	00.8456	11.94	140051	01.4159	19.71
100276	01.3266	21.04	110073	01.2536	12.73	110168	01.6390	19.01	130016	00.8863	16.82	140052	01.3254	15.64
100277	01.0704	13.45	110074	01.4550	17.30	110169	00.6684	19.82	130017	01.1662	14.08	140053	01.8281	17.25
100278	00.8470	17.64	110075	01.1944	14.67	110171	01.3974	21.21	130018	01.6857	18.13	140054	01.3179	22.79
100279	01.4017	19.25	110076	01.3738	18.20	110172	01.2170	.....	130019	01.1462	13.98	140055	00.9762	13.01
100280	01.4128	17.83	110078	01.6419	20.48	110174	00.9987	13.50	130021	00.9430	10.36	140058	01.1683	14.76
100281	01.2713	19.04	110079	01.3867	19.71	110176	01.0961	19.01	130022	01.2896	15.71	140059	01.1460	13.34
100282	01.1035	.....	110080	01.1510	15.47	110177	01.4732	18.73	130024	01.0074	15.03	140061	01.0905	13.15
100283	01.4423	.....	110082	02.0423	20.22	110178	01.0701	19.58	130025	01.1165	16.20	140062	01.2773	21.56
110001	01.2829	16.74	110083	01.6304	20.25	110179	01.2084	21.20	130026	01.1560	16.79	140063	01.3587	20.34
110002	01.2029	14.85	110086	01.1579	13.70	110181	00.9605	11.66	130027	00.8922	16.96	140064	01.2366	15.63
110003	01.3085	12.29	110087	01.2659	18.36	110183	01.4004	18.69	130028	01.2052	15.05	140065	01.4654	23.04
110004	01.2453	16.00	110088	01.0863	10.58	110184	01.1402	17.71	130029	01.0312	15.58	140066	01.2979	13.08
110005	01.2307	17.68	110089	01.1961	14.54	110185	01.1390	12.05	130030	01.0209	14.67	140067	01.8106	17.15
110006	01.3275	17.10	110091	01.3517	17.32	110186	01.2511	15.58	130031	01.0486	11.89	140068	01.3772	17.79
110007	01.4301	15.73	110092	01.0992	12.26	110187	01.1357	17.43	130034	01.0508	14.58	140069	01.0914	14.27
110008	01.1769	14.50	110093	00.9452	09.30	110188	01.4760	17.46	130035	00.9454	13.51	140070	01.3464	15.36
110009	01.0443	15.28	110094	01.0216	11.93	110189	01.2039	18.59	130036	01.2470	09.19	140074	01.0354	15.11
110010	02.0526	23.06	110095	01.2630	12.81	110190	01.1387	13.01	130037	01.1733	15.01	140075	01.4482	17.74
110011	01.2551	15.54	110096	01.0913	12.34	110191	01.3062	17.97	130043	01.0364	14.00	140077	01.1222	14.95
110013	01.1134	13.82	110097	01.0512	14.03	110192	01.3434	20.20	130044	01.0674	10.65	140079	01.2611	20.63
110014	01.0738	13.26	110098	01.0322	12.30	110193	01.1627	15.60	130045	01.0030	12.30	140080	01.6786	18.56
110015	01.2788	16.72	110100	01.0601	11.30	110194	00.9472	12.58	130048	01.0330	10.31	140081	01.1023	12.45
110016	01.2194	14.43	110101	01.0740	10.28	110195	01.1321	10.00	130049	01.2151	16.73	140082	01.5490	20.34
110017	00.9514	11.20	110103	00.9390	09.39	110198	01.3765	22.76	130054	00.9330	18.69	140083	01.2899	15.67
110018	01.1881	15.66	110104	01.1922	12.01	110200	01.9396	15.32	130056	00.9020	09.97	140084	01.2165	18.03
110020	01.2051	17.27	110105	01.0766	14.09	110201	01.3759	16.18	130058	01.0275	13.32	140086	01.1518	11.92
110023	01.2964	16.89	110107	01.7532	17.13	110203	00.9931	15.24	130060	01.2292	17.97	140087	01.2902	17.36
110024	01.4085	16.46	110108	01.0779	10.44	110204	00.7983	16.64	140001	01.2446	14.00	140088	01.5977	23.06
110025	01.4202	15.36	110109	01.1110	13.54	110205	01.0713	13.28	140002	01.3090	16.16	140089	01.2351	15.16
110026	01.1955	13.12	110111	01.1008	13.66	110207	01.0576	13.48	140003	01.0231	12.69	140090	01.4626	24.80
110027	01.0801	14.33	110112	00.9810	15.61	110208	00.9109	12.52	140004	01.0152	14.64	140091	01.7797	16.35
110028	01.6087	17.60	110113	01.0754	12.69	110209	00.9130	.....	140005	00.9445	09.86	140093	01.1615	15.98
110029	01.3243	17.70	110114	01.1082	13.17	110210	01.0869	.....	140007	01.4546	20.34	140094	01.2618	17.89
110030	01.2231	17.52	110115	01.6517	18.21	120001	01.7122	23.07	140008	01.4279	20.25	140095	01.5124	18.79
110031	01.3455	20.47	110118	01.0138	11.40	120002	01.2031	17.55	140010	01.3181	21.78	140097	00.9517	12.93
110032	01.2138	14.40	110120	01.1050	11.39	120003	01.1117	21.38	140011	01.0968	13.89	140098	01.6019	18.91
110033	01.4241	20.02	110121	01.1562	12.05	120004	01.2411	19.86	140012	01.2725	15.85	140100	01.3360	17.74
110034	01.5155	15.82	110122	01.2984	15.88	120005	01.2737	18.43	140013	01.6368	15.47	140101	01.1394	17.56
110035	01.3200	18.11	110124	01.0454	14.58	120006	01.1713	22.51	140014	01.1626	15.87	140102	01.0394	13.57
110036	01.6154	18.45	110125	01.2007	15.34	120007	01.6238	19.33	140015	01.2858	13.12	140103	01.3496	17.19
110037	01.0626	09.72	110127	00.9893	12.30	120009	01.0106	18.94	140016	00.9209	10.97	140105	01.2716	19.12
110038	01.4567	14.12	110128	01.1836	17.25	120010	01.8065	21.30	140018	01.3546	18.18	140107	01.0636	11.30
110039	01.3732	17.07	110129	01.6398	12.75	120011	01.2612	28.18	140019	00.9450	12.11	140108	01.3514	20.09
110040	01.0515	15.13	110130	01.0589	09.58	120012	00.9554	19.45	140024	01.0061	13.82	140109	01.0897	12.38
110041	01.2778	13.87	110132	01.1404	12.55	120014	01.2507	20.16	140025	01.0811	15.57	140110	01.2892	15.34

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
140112	01.0965	13.56	140202	01.3426	19.33	150022	01.0980	17.53	150101	01.1104	15.07	160048	01.1233	11.75
140113	01.4687	17.23	140203	01.1739	17.40	150023	01.4769	16.92	150102	01.0650	13.94	160049	00.9284	11.56
140114	01.3274	17.70	140205	00.9214	13.44	150024	01.3035	15.60	150103	01.0279	15.64	160050	01.0311	13.62
140115	01.2848	16.57	140206	00.9779	18.13	150025	01.4971	17.14	150104	01.1084	14.82	160051	01.1187	14.21
140116	01.2435	17.79	140207	01.3688	19.80	150026	01.1675	16.48	150105	01.3107	15.63	160052	01.0489	12.86
140117	01.4090	16.72	140208	01.5927	22.03	150027	01.0157	15.66	150106	01.0815	15.53	160054	00.9694	11.05
140118	01.6957	21.24	140209	01.7149	16.20	150029	01.2769	17.73	150109	01.4210	14.54	160055	01.0271	12.02
140119	01.6578	20.94	140210	01.0283	11.46	150030	01.0675	15.26	150110	00.9954	14.35	160056	01.0362	12.73
140120	01.4814	14.18	140211	01.1928	18.69	150031	01.0304	13.82	150111	01.2159	13.31	160057	01.3290	14.53
140121	01.4762	10.01	140212	01.1562	21.62	150032	01.8129	18.37	150112	01.2079	16.65	160058	01.6641	17.91
140122	01.5373	20.90	140213	01.2707	21.23	150033	01.5682	18.86	150113	01.1647	16.07	160060	01.0516	13.01
140124	01.1333	21.99	140215	01.1481	13.29	150034	01.3594	18.13	150114	01.0006	12.64	160061	01.0052	12.04
140125	01.3141	14.30	140217	01.2000	20.19	150035	01.4091	17.89	150115	01.3358	16.31	160062	01.0359	11.11
140127	01.3094	16.12	140218	00.9759	13.27	150036	01.0182	16.72	150122	01.1316	16.92	160063	01.1735	12.72
140128	01.0912	15.47	140220	01.1237	14.02	150037	01.2532	16.88	150123	01.2559	13.21	160064	01.5804	16.66
140129	01.0377	13.55	140223	01.5250	21.42	150038	01.3406	15.77	150124	01.1502	14.29	160065	01.0796	13.11
140130	01.1725	19.93	140224	01.3763	20.01	150039	00.9542	14.21	150125	01.3991	17.70	160066	01.1325	13.51
140132	01.4217	18.36	140228	01.5757	16.72	150042	01.2377	14.39	150126	01.5033	18.93	160067	01.4111	15.81
140133	01.3843	19.25	140230	00.9812	14.89	150043	01.0398	18.18	150127	01.1534	12.34	160068	00.9913	13.55
140135	01.2412	13.86	140231	01.5483	19.72	150044	01.2436	17.15	150128	01.2294	17.33	160069	01.3977	15.53
140137	01.0158	13.42	140233	01.7552	15.55	150045	01.1638	15.56	150129	01.1748	19.71	160070	00.9804	13.02
140138	00.9707	11.80	140234	01.1921	15.04	150046	01.4977	16.06	150130	01.0588	13.99	160072	01.0797	12.24
140139	01.0718	13.33	140236	00.9891	11.86	150047	01.6539	17.32	150132	01.3503	18.09	160073	00.9651	10.93
140140	01.1676	12.45	140239	01.5695	17.90	150048	01.1741	15.68	150133	01.1933	15.64	160074	00.9967	12.64
140141	00.9239	12.09	140240	01.4712	21.75	150049	01.1587	12.40	150134	01.2884	15.24	160075	01.0724	13.49
140143	01.1190	15.80	140242	01.5193	20.44	150050	01.1485	14.30	150136	00.9179	18.60	160076	01.0566	15.24
140144	01.0202	13.85	140245	01.1141	12.96	150051	01.2735	15.96	150137	03.1313	.....	160077	01.2005	10.22
140145	01.1235	15.06	140246	01.0607	11.58	150052	01.1241	11.23	150138	01.1910	.....	160079	01.4063	15.08
140146	00.9399	14.65	140250	01.2721	21.19	150053	01.0216	15.93	150140	02.4842	.....	160080	01.2127	15.51
140147	01.1689	13.02	140251	01.3111	17.14	150054	01.1266	13.30	150141	00.9198	.....	160081	01.0831	13.91
140148	01.7026	16.79	140252	01.4481	21.67	150056	01.6530	19.66	150897	05.1218	.....	160082	01.6924	16.88
140150	01.5334	22.42	140253	01.4610	14.43	150057	02.4338	14.55	160001	01.2439	16.04	160083	01.5064	16.82
140151	01.1688	16.06	140258	01.5165	20.74	150058	01.6757	17.54	160002	01.2061	12.61	160085	01.0754	11.90
140152	01.0932	21.14	140271	01.0467	13.77	150059	01.3249	18.15	160003	01.0308	12.40	160086	00.9602	12.15
140155	01.2094	16.91	140275	01.2155	15.26	150060	01.1564	15.01	160005	01.0538	12.42	160088	01.0433	13.89
140158	01.3335	20.44	140276	01.9959	19.03	150061	01.2447	14.90	160007	01.0184	12.24	160089	01.2073	13.54
140160	01.2063	14.61	140280	01.2762	16.62	150062	01.0233	14.82	160008	01.1335	14.26	160090	01.0580	14.34
140161	01.1250	16.18	140281	01.5943	19.85	150063	01.0873	19.83	160009	01.2106	13.13	160091	01.1695	10.55
140162	01.6805	17.28	140285	01.2309	14.65	150064	01.0346	16.55	160012	01.1292	13.88	160092	00.9649	12.70
140164	01.2497	15.27	140286	01.0922	16.58	150065	01.0989	16.08	160013	01.2580	14.28	160093	01.1424	12.92
140165	01.0894	12.83	140288	01.6787	21.28	150066	00.9891	13.07	160014	00.9703	12.72	160094	01.2097	14.65
140166	01.2670	15.81	140289	01.2885	14.43	150067	01.0729	13.96	160016	01.2622	15.22	160095	01.0123	15.81
140167	01.1570	13.88	140290	01.3203	19.56	150069	01.2194	16.18	160018	00.9108	12.92	160097	01.1814	13.10
140168	01.2012	14.64	140291	01.3419	22.01	150070	01.0530	14.00	160020	01.0625	11.57	160098	01.0188	12.41
140170	01.1306	11.77	140292	01.1778	18.63	150071	01.2019	11.71	160021	01.0819	14.23	160099	00.9949	11.94
140171	00.8944	10.42	140294	01.1511	15.03	150072	01.1576	15.53	160023	01.0941	13.47	160101	01.1236	17.13
140172	01.5026	17.11	140297	01.1950	21.49	150073	00.9918	17.12	160024	01.5923	16.25	160102	01.3050	15.06
140173	00.9836	12.88	140300	01.0367	.....	150074	01.5594	18.05	160025	01.7778	15.89	160103	00.9911	12.23
140174	01.4124	17.67	150001	01.0972	16.90	150075	01.1754	13.29	160026	01.1442	14.15	160104	01.1581	16.70
140176	01.2493	19.10	150002	01.4373	17.08	150076	01.0745	16.60	160027	01.1974	12.61	160106	01.0904	13.40
140177	01.2799	15.29	150003	01.7331	16.59	150077	01.3123	15.22	160028	01.3029	17.45	160107	01.1461	14.31
140179	01.3034	18.61	150004	01.4468	18.37	150078	01.0196	18.19	160029	01.4799	16.57	160108	01.1020	13.59
140180	01.4730	20.05	150005	01.2178	16.87	150079	01.2034	13.37	160030	01.2650	15.65	160109	00.9338	11.85
140181	01.3412	17.28	150006	01.1904	15.77	150082	01.4896	16.98	160031	01.1968	12.60	160110	01.5430	17.18
140182	01.3058	19.45	150007	01.2625	17.48	150084	01.8655	21.52	160032	01.1969	14.22	160111	00.9992	10.53
140184	01.1675	13.87	150008	01.3341	18.07	150086	01.2770	15.03	160033	01.5017	15.45	160112	01.4460	14.36
140185	01.4725	15.34	150009	01.2833	16.85	150088	01.1849	16.25	160034	01.0027	13.04	160113	01.0071	11.13
140186	01.2813	17.46	150010	01.1806	16.38	150089	01.3686	17.27	160035	00.9960	11.50	160114	01.0526	13.89
140187	01.4143	15.70	150011	01.2160	15.65	150090	01.2297	17.84	160036	01.0488	13.58	160115	00.9897	12.83
140188	00.9687	10.93	150012	01.6434	18.77	150091	01.0696	15.33	160037	01.1651	14.19	160116	01.1879	14.80
140189	01.1508	15.87	150013	01.1117	12.68	150092	01.0246	12.84	160039	01.0370	14.71	160117	01.2924	14.70
140190	01.1530	13.53	150014	01.4271	18.85	150094	01.0291	16.14	160040	01.3268	15.44	160118	01.0051	11.77
140191	01.4154	20.56	150015	01.2677	16.77	150095	01.0866	15.17	160041	01.0084	12.61	160120	00.9931	09.44
140192	01.1322	16.11	150017	01.7977	15.68	150096	01.0528	17.76	160043	01.0207	13.56	160122	01.1748	14.31
140193	01.0104	11.79	150018	01.2591	16.65	150097	01.0892	16.38	160044	01.1698	12.51	160123	01.1808	14.15
140197	01.3690	16.76	150019	01.0382	13.59	150098	01.1575	11.86	160045	01.6667	16.35	160124	01.2394	14.80
140199	01.0260	14.73	150020	01.1643	12.34	150099	01.2997	16.16	160046	01.0636	11.86	160126	01.0838	16.15
140200	01.4494	20.10	150021	01.6412	17.52	150100	01.6382	17.23	160047	01.3421	15.29	160129	01.0127	12.82

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
160130	01.0625	12.49	170067	00.9103	11.65	170160	01.0407	11.13	180067	01.9277	15.27	190034	01.1602	14.41
160131	01.1371	12.28	170068	01.3094	14.11	170164	00.9906	13.92	180069	01.0350	15.39	190035	01.4469	17.61
160133	01.1892	17.39	170069	01.1645	13.12	170166	01.1623	13.71	180070	01.0759	13.59	190036	01.6233	18.08
160134	01.0327	12.24	170070	01.0065	12.24	170168	00.8805	10.83	180072	00.9953	14.39	190037	01.0251	10.21
160135	00.9953	10.69	170072	00.9187	10.54	170171	01.0870	10.44	180075	00.9673	12.29	190039	01.4452	17.58
160138	01.1205	12.71	170073	01.0171	12.99	170172	00.9598	12.70	180078	01.0960	16.85	190040	01.3872	17.91
160140	01.0812	14.30	170074	01.1095	12.85	170174	01.0175	10.87	180079	01.2252	13.16	190041	01.4886	16.84
160142	01.0411	13.08	170075	00.8614	10.41	170175	01.2756	17.46	180080	01.0560	13.90	190043	01.0919	12.42
160143	01.0401	12.58	170076	01.0513	10.87	170176	01.5076	19.27	180085	01.2867	16.89	190044	01.1587	17.86
160145	01.1178	11.55	170077	00.9750	10.85	170181	01.1767	.....	180087	01.0977	13.07	190045	01.3452	18.67
160146	01.3788	14.96	170079	01.0894	10.45	180001	01.2221	15.86	180088	01.6293	18.09	190046	01.4675	16.26
160147	01.2215	14.07	170080	00.9829	11.16	180002	01.0469	16.25	180092	01.0862	13.78	190047	01.0592	16.48
160151	01.0912	13.10	170081	00.9978	10.32	180004	01.1119	13.38	180093	01.3382	14.08	190048	01.0642	13.69
160152	00.9447	12.41	170082	00.9942	10.30	180005	01.0618	17.26	180094	00.9419	11.42	190049	01.0172	13.95
160153	01.7242	16.90	170084	00.9622	10.65	180006	00.9274	08.63	180095	01.1899	12.50	190050	01.0694	13.14
170001	01.2131	14.88	170085	00.8999	11.95	180007	01.3845	14.33	180099	01.2077	10.89	190053	01.0354	12.25
170004	01.0693	12.69	170086	01.6679	17.55	180009	01.3240	16.50	180101	01.3186	18.68	190054	01.3615	13.23
170006	01.2010	15.19	170087	01.4303	18.81	180010	01.8396	16.23	180102	01.4368	14.54	190059	00.9426	13.39
170008	00.9801	12.92	170088	00.8977	09.76	180011	01.1454	15.42	180103	02.0493	17.52	190060	01.4785	15.16
170009	01.1155	17.18	170089	01.0612	12.95	180012	01.3085	16.85	180104	01.4735	15.55	190064	01.4974	16.92
170010	01.1763	14.08	170090	01.0082	09.95	180013	01.4626	15.12	180105	00.9012	12.43	190065	01.4931	17.04
170011	01.3537	14.19	170092	00.8129	11.15	180014	01.5910	17.73	180106	00.9012	11.83	190071	00.8498	11.85
170012	01.4645	15.64	170093	00.8838	11.10	180015	01.1845	14.35	180108	00.8747	12.16	190075	01.4543	18.92
170013	01.3540	13.97	170094	01.0632	13.44	180016	01.2633	14.75	180115	00.9720	14.02	190077	00.9541	11.73
170014	01.0794	14.53	170095	01.1095	13.17	180017	01.2913	13.27	180116	01.3169	15.01	190078	01.1817	11.43
170015	00.9806	13.60	170097	00.9789	10.48	180018	01.1740	13.63	180117	01.2367	15.41	190079	01.2300	14.73
170016	01.6091	19.51	170098	01.0225	15.18	180019	01.3293	16.80	180118	01.0391	11.92	190081	00.9047	08.99
170017	01.1922	15.10	170099	01.3189	10.77	180020	01.0556	15.49	180120	00.9822	12.26	190083	00.9672	11.08
170018	01.0161	11.92	170100	01.0247	13.48	180021	01.1618	12.98	180121	01.0719	12.71	190086	01.3024	14.53
170019	01.1399	14.63	170101	00.9913	13.45	180023	00.8798	10.99	180122	01.0623	12.63	190088	01.2370	16.36
170020	01.3110	14.68	170102	00.9680	12.36	180024	01.2590	15.48	180123	01.4446	17.30	190089	01.0711	09.26
170022	01.1413	13.47	170103	01.2817	14.83	180025	01.1179	15.19	180124	01.4142	15.91	190090	01.1668	14.43
170023	01.3799	15.56	170104	01.4279	19.34	180026	01.1606	11.76	180125	00.9599	15.97	190092	01.2573	12.24
170024	01.2165	11.95	170105	00.9750	13.23	180027	01.2141	14.17	180126	01.2179	11.31	190095	01.0284	13.52
170025	01.3789	14.29	170106	00.8751	12.19	180028	00.9833	16.46	180127	01.2600	16.63	190098	01.5166	17.10
170026	01.0526	13.40	170108	00.9812	10.51	180029	01.2220	15.43	180128	01.1607	13.00	190099	01.1300	17.03
170027	01.2573	14.72	170109	01.0068	13.96	180030	01.1336	09.54	180129	01.0456	15.03	190102	01.5245	15.33
170030	01.0235	13.67	170110	00.9179	15.29	180031	00.9296	12.11	180130	01.4167	17.27	190103	00.8384	09.39
170031	00.9325	11.65	170112	00.9238	12.74	180032	01.0559	15.53	180132	01.1821	14.40	190106	01.1220	15.42
170032	01.1074	13.49	170113	01.1925	13.04	180033	01.1073	12.13	180133	01.2386	17.31	190109	01.2162	14.04
170033	01.2882	14.68	170114	01.0133	12.48	180034	00.9890	14.93	180134	00.9786	12.39	190110	01.0315	11.76
170034	00.9131	13.26	170115	01.0216	10.73	180035	01.4971	16.92	180136	01.4161	16.84	190111	01.5568	17.17
170035	00.8750	12.11	170116	01.0387	13.57	180036	01.1477	16.65	180137	01.6839	17.08	190112	01.4902	17.35
170036	00.8821	11.44	170117	00.9050	12.83	180037	01.2434	19.20	180138	01.1826	16.52	190113	01.3396	17.08
170037	01.1169	15.23	170119	00.9649	10.20	180038	01.3562	14.14	180139	01.1051	15.33	190114	00.9851	12.28
170038	00.9551	11.29	170120	01.3299	14.75	180040	01.9301	19.09	190001	00.9644	16.01	190115	01.2542	17.60
170039	01.0968	12.22	170121	00.9411	11.71	180041	01.0478	13.28	190002	01.6374	18.16	190116	01.2858	13.30
170040	01.4401	16.25	170122	01.8098	18.62	180042	01.1672	12.00	190003	01.4074	18.23	190118	01.0092	12.00
170041	01.0143	11.04	170123	01.7901	18.27	180043	01.0935	15.39	190004	01.3544	14.02	190120	01.0309	13.37
170043	01.0640	12.94	170124	00.9830	12.46	180044	01.0544	13.83	190005	01.5020	15.78	190122	01.2919	13.38
170044	01.1084	14.61	170126	00.9847	10.58	180045	01.2217	16.28	190006	01.2258	13.74	190124	01.4639	18.66
170045	00.9976	12.44	170128	00.9854	13.53	180046	01.0915	16.36	190007	01.0434	12.27	190125	01.4620	15.18
170049	01.3162	17.80	170131	01.1350	09.38	180047	01.0650	13.71	190008	01.6475	16.82	190127	01.4558	19.90
170050	01.0199	10.54	170133	01.1703	14.32	180048	01.1869	15.40	190009	01.1425	13.81	190128	01.0642	16.60
170051	00.9951	12.83	170134	00.9502	12.07	180049	01.3278	14.26	190010	01.1244	13.57	190130	01.0520	11.86
170052	01.1045	12.81	170137	01.1506	16.18	180050	01.2987	15.06	190011	01.1585	13.25	190131	01.2964	14.32
170053	00.8956	11.99	170139	01.0518	11.91	180051	01.3456	13.60	190013	01.3692	15.51	190133	01.0540	10.90
170054	01.0671	12.27	170140	01.0645	11.61	180053	01.2163	13.52	190014	01.0595	13.49	190134	00.9924	11.85
170055	01.1158	14.16	170142	01.2551	15.60	180054	01.0523	12.43	190015	01.2040	16.70	190135	01.4554	20.08
170056	00.9899	10.07	170143	01.1521	13.23	180055	01.1054	13.29	190017	01.2604	14.98	190136	01.1399	12.08
170057	01.0076	14.13	170144	01.6074	14.82	180056	01.0784	15.70	190018	01.2232	15.07	190138	00.7376	18.82
170058	01.1368	16.33	170145	01.1826	13.74	180058	00.9120	12.01	190019	01.4599	15.79	190140	00.9870	11.41
170060	01.0095	12.67	170146	01.3553	17.87	180059	00.8790	11.19	190020	01.1434	16.43	190142	00.9693	13.12
170061	01.2333	11.89	170147	01.1927	17.94	180060	00.9768	11.01	190025	01.2407	12.09	190144	01.1976	14.30
170062	00.9532	11.22	170148	01.4374	17.40	180063	01.0505	09.44	190026	01.4204	14.85	190145	00.9489	13.28
170063	00.9660	09.03	170150	01.1431	14.56	180064	01.2302	12.70	190027	01.4175	15.44	190146	01.5725	17.87
170064	00.9331	11.28	170151	01.0535	11.47	180065	01.0596	09.61	190029	01.1868	15.59	190147	00.9619	12.68
170066	00.9185	11.39	170152	00.9490	13.46	180066	01.2304	17.26	190033	00.8818	09.88	190148	00.9425	11.65

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
190149	00.9929	10.60	200021	01.1487	17.17	210055	01.2113	26.02	220090	01.1993	20.51	230058	01.1252	15.97
190151	01.0876	11.14	200023	00.8912	15.25	210056	01.4275	15.73	220092	01.2503	20.92	230059	01.4661	18.12
190152	01.4102	19.90	200024	01.2557	18.55	210057	01.3256	22.58	220094	01.2099	18.76	230060	01.3317	16.27
190155	00.9849	14.75	200025	01.1783	18.48	210058	01.7447	17.53	220095	01.2315	17.94	230062	01.1130	14.71
190156	00.8862	11.37	200026	01.0457	15.56	210059	01.3134	21.97	220097	01.1025	19.24	230063	01.3458	17.81
190158	01.3048	20.92	200027	01.2207	15.52	210060	01.0967	21.07	220098	01.2361	17.34	230065	01.4526	18.13
190160	01.2539	14.82	200028	00.9634	15.57	210061	01.0430	.....	220099	01.1392	16.77	230066	01.3152	18.55
190161	01.0117	13.12	200031	01.2310	14.32	220001	01.1976	20.13	220100	01.2219	21.66	230068	01.4296	20.00
190162	01.2364	21.67	200032	01.2057	17.73	220002	01.5483	21.50	220101	01.4460	23.37	230069	01.1205	18.20
190164	01.0920	16.49	200033	01.6964	19.02	220003	01.0701	16.57	220104	01.2209	22.59	230070	01.4620	18.67
190166	01.0211	13.69	200034	01.2233	16.82	220004	01.1907	19.23	220105	01.1869	21.38	230071	00.8421	20.02
190167	01.2466	17.25	200037	01.1715	15.27	220006	01.3611	20.97	220106	01.2377	21.02	230072	01.2440	17.55
190170	00.9827	12.41	200038	01.0836	17.59	220008	01.2043	18.57	220107	01.1978	18.62	230075	01.5034	18.69
190173	01.4630	20.83	200039	01.2581	16.94	220010	01.2376	20.19	220108	01.1328	20.00	230076	01.3257	18.86
190175	01.4110	.....	200040	01.0808	15.62	220011	01.1200	28.03	220110	02.0106	29.37	230077	02.0001	18.35
190176	01.6417	17.06	200041	01.1404	16.98	220012	01.3024	26.53	220111	01.2194	19.33	230078	01.2068	14.77
190177	01.6197	20.78	200043	00.6087	16.71	220015	01.1897	19.96	220114	01.4568	18.43	230080	01.1882	18.22
190178	00.9582	10.79	200050	01.1492	15.77	220016	01.2459	19.14	220116	01.8553	23.87	230081	01.1626	16.37
190182	00.9566	20.15	200051	00.9912	17.33	220017	01.3072	23.11	220118	02.0244	25.34	230082	01.1171	14.65
190183	01.1614	12.24	200052	01.0230	13.59	220019	01.1584	18.25	220119	01.3055	23.40	230085	01.0995	16.38
190184	01.0158	11.69	200055	01.0929	15.03	220020	01.1232	17.89	220120	01.2446	18.85	230086	01.0390	14.27
190185	01.2193	19.21	200062	00.9693	14.32	220021	01.3770	22.08	220123	00.9948	22.88	230087	01.0361	13.82
190186	00.9482	12.11	200063	01.1759	16.86	220023	01.1947	18.44	220126	01.2639	17.78	230089	01.3695	21.88
190187	00.9318	12.65	200066	01.2341	14.87	220024	01.1843	18.45	220128	01.1216	22.23	230092	01.2787	17.42
190189	00.7764	16.06	210001	01.3646	17.18	220025	01.1360	17.91	220133	00.8589	28.96	230093	01.2534	18.00
190190	01.0161	18.85	210002	02.0515	16.27	220028	01.4387	20.23	220135	01.1607	22.89	230095	01.1863	15.62
190191	01.2715	20.41	210003	01.5173	26.44	220029	01.1282	21.86	220153	00.9800	17.41	230096	01.1620	18.32
190193	01.2707	19.19	210004	01.3041	24.62	220030	01.0843	15.28	220154	00.9489	19.60	230097	01.5679	17.19
190194	01.1518	18.53	210005	01.1988	18.75	220031	01.6928	25.43	220156	01.3161	19.38	230099	01.2435	18.35
190196	00.8489	16.88	210006	01.0805	16.17	220033	01.3632	19.43	220162	01.4775	.....	230100	01.2387	14.49
190197	01.2858	17.69	210007	01.5575	19.41	220035	01.2434	20.33	220163	01.9504	22.98	230101	01.0969	15.97
190199	01.3781	12.37	210008	01.3734	19.80	220036	01.6474	21.93	220171	01.7211	22.19	230102	00.7834	.....
190200	01.5574	18.93	210009	01.7273	18.18	220038	01.3326	20.40	220897	04.8013	.....	230103	01.0500	16.10
190201	01.2697	17.92	210010	01.2191	15.74	220041	01.1978	20.15	230001	01.2107	15.09	230104	01.6245	19.92
190202	01.5201	18.78	210011	01.2655	19.58	220042	01.2521	22.65	230002	01.2674	18.51	230105	01.5944	18.07
190203	01.5031	19.57	210012	01.5475	20.57	220046	01.4143	21.28	230003	01.1446	17.63	230106	01.1545	16.99
190204	01.4792	20.13	210013	01.2654	20.26	220049	01.2639	21.92	230004	01.6481	20.75	230107	00.8769	11.85
190205	01.8112	16.91	210015	01.1746	18.47	220050	01.0680	16.72	230005	01.2896	17.44	230108	01.2212	15.90
190206	01.4616	20.80	210016	01.7430	19.90	220051	01.2295	20.11	230006	01.1046	15.62	230110	01.2393	16.49
190207	01.1994	18.41	210017	01.1089	15.93	220052	01.2703	23.12	230007	01.0047	16.93	230111	01.0595	14.14
190208	00.8324	09.96	210018	01.2700	20.00	220053	01.2871	19.36	230012	00.6001	12.54	230113	00.9922	17.34
190211	00.6056	11.52	210019	01.3205	16.54	220055	01.3639	19.25	230013	01.3303	19.57	230114	00.6287	20.38
190212	00.7321	12.23	210022	01.4198	19.43	220057	01.3603	22.51	230015	01.1594	18.65	230115	00.9767	14.41
190216	00.6297	18.37	210023	01.3483	19.46	220058	01.0610	18.83	230017	01.5654	20.01	230116	00.9194	14.42
190217	00.9191	.....	210024	01.3754	17.35	220060	01.1489	23.11	230019	01.4946	20.56	230117	01.8754	22.68
190218	01.0516	.....	210025	01.3202	17.00	220062	00.6790	18.68	230020	01.6382	19.60	230118	01.2164	15.76
190223	00.5207	.....	210026	01.3603	22.97	220063	01.2217	18.81	230021	01.5867	16.12	230119	01.3453	22.01
190226	00.8135	.....	210027	01.2333	15.59	220064	01.1869	20.35	230022	01.3133	16.98	230120	01.1522	23.67
190227	00.8873	.....	210028	01.2118	16.10	220065	01.1891	19.93	230024	01.4936	23.87	230121	01.3023	18.60
190229	02.4642	.....	210029	01.3271	17.21	220066	01.3085	18.74	230027	01.1037	14.80	230122	01.3015	17.81
190230	00.8400	.....	210030	01.0685	18.36	220067	01.2643	22.39	230029	01.5937	20.50	230124	01.1111	16.69
190231	01.1981	.....	210031	01.6197	17.91	220068	00.5785	15.96	230030	01.2668	16.14	230125	01.3058	13.25
190232	01.7205	.....	210032	01.1992	18.14	220070	01.2733	17.86	230031	01.4708	18.10	230128	01.4402	19.92
200001	01.2566	14.52	210033	01.1728	17.70	220071	01.8242	24.13	230032	01.7439	18.41	230129	01.9293	19.58
200002	01.0559	16.63	210034	01.3497	19.13	220073	01.3852	23.80	230034	01.1872	15.14	230130	01.6340	21.89
200003	01.1171	15.66	210035	01.2142	20.18	220074	01.2794	20.97	230035	01.1903	16.81	230132	01.4283	21.06
200006	01.1701	15.38	210037	01.2548	15.17	220075	01.2079	18.15	230036	01.2920	18.69	230133	01.2463	14.88
200007	00.9811	14.93	210038	01.4342	19.79	220076	01.1689	21.63	230037	01.1725	16.35	230134	01.1369	16.43
200008	01.2424	18.02	210039	01.1532	15.16	220077	01.6349	21.71	230038	01.6738	20.24	230135	01.2139	19.52
200009	01.7323	19.47	210040	01.3767	19.85	220079	01.0974	20.24	230040	01.2196	17.05	230137	01.1843	17.53
200012	01.1162	15.58	210043	01.2576	20.43	220080	01.2793	17.64	230041	01.1727	17.55	230141	01.6069	20.25
200013	01.1207	14.58	210044	01.2302	20.56	220081	01.0455	21.45	230042	01.1831	18.66	230142	01.1826	19.33
200015	01.2633	16.46	210045	00.9736	11.99	220082	01.2554	17.24	230046	01.7722	25.27	230143	01.2154	15.80
200016	01.0159	16.05	210046	01.1333	12.11	220083	01.1952	19.46	230047	01.2937	19.18	230144	01.1448	20.99
200017	01.2461	17.38	210048	01.2058	21.96	220084	01.2206	23.28	230053	01.5048	23.90	230145	01.1262	14.78
200018	01.1752	14.04	210049	01.1165	16.76	220086	01.5367	24.89	230054	01.7859	18.80	230146	01.2901	19.28
200019	01.2513	17.59	210051	01.3824	13.41	220088	01.5488	21.94	230055	01.1569	16.59	230147	01.5230	19.33
200020	01.1539	19.52	210054	01.2555	19.16	220089	01.2981	23.19	230056	00.9682	13.06	230149	01.2085	14.21

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
230151	01.3233	19.88	240002	01.6725	19.53	240090	01.0732	13.12	240193	01.0606	14.44	250081	01.2292	14.24
230153	01.0349	14.92	240003	01.1479	23.37	240091	01.0937	10.92	240196	00.6031	18.69	250082	01.2324	12.01
230154	00.9714	12.93	240004	01.4625	19.26	240093	01.3102	15.75	240200	00.8656	12.36	250083	01.0859	11.71
230155	01.0761	13.24	240005	00.8750	13.13	240094	00.9900	16.21	240205	00.9024	.....	250084	01.1326	12.46
230156	01.6534	21.08	240006	01.0912	18.30	240096	01.0972	15.05	240206	00.8925	.....	250085	01.0384	11.38
230157	01.2631	18.67	240007	01.1001	14.77	240097	01.0203	16.73	240207	01.2148	20.96	250088	00.9623	14.19
230159	01.3273	18.09	240008	01.1026	13.42	240098	00.9520	14.88	240210	01.2573	21.49	250089	01.1194	11.05
230161	00.9933	12.75	240009	01.0008	15.30	240099	01.0626	11.12	240211	00.9051	11.55	250093	01.1480	12.10
230162	00.9084	14.55	240010	01.9591	20.03	240100	01.2660	18.09	250001	01.6028	15.00	250094	01.2904	13.80
230165	01.8106	20.30	240011	01.1175	15.51	240101	01.2004	16.22	250002	00.7930	12.37	250095	00.9758	12.64
230167	01.2554	18.08	240013	01.2838	15.46	240102	00.9699	13.30	250003	01.0075	12.86	250096	01.2819	15.13
230169	01.3305	20.76	240014	01.0662	16.73	240103	01.1370	14.12	250004	01.4407	14.26	250097	01.1086	13.52
230171	01.0332	14.03	240016	01.3937	14.72	240104	01.1893	19.56	250005	00.9885	09.59	250098	00.8759	11.22
230172	01.2727	22.25	240017	01.1536	14.77	240105	01.0763	13.71	250006	00.9874	13.07	250099	01.2391	11.86
230174	01.2418	17.96	240018	01.2886	15.31	240106	01.2773	22.45	250007	01.2429	16.54	250100	01.2131	12.66
230175	02.6753	14.23	240019	01.2248	19.80	240107	00.9785	13.40	250008	00.9665	10.63	250101	00.9434	09.57
230176	01.2043	19.69	240020	01.1723	17.23	240108	00.9827	11.10	250009	01.1540	12.76	250102	01.4660	13.97
230178	01.0119	14.97	240021	00.9716	12.83	240109	00.9555	13.75	250010	01.0241	11.13	250104	01.2793	14.47
230180	01.1001	14.82	240022	01.1386	16.66	240110	00.9468	14.99	250012	00.9571	14.17	250105	00.8550	11.42
230184	01.1705	16.11	240023	01.0863	15.38	240111	00.9794	12.94	250015	01.0999	12.36	250107	00.8983	13.99
230186	01.3015	15.69	240025	01.2377	13.94	240112	01.0860	13.13	250017	00.9522	12.98	250109	00.9693	12.07
230188	01.1288	15.61	240027	01.0029	12.39	240114	01.0045	10.23	250018	00.9424	10.22	250112	00.9521	12.65
230189	00.9168	14.34	240028	01.1422	15.53	240115	01.6327	21.28	250019	01.3283	16.89	250117	01.0319	12.65
230190	01.0148	20.60	240029	01.2204	15.39	240116	00.8833	12.64	250020	00.9812	09.79	250119	01.2539	11.54
230191	00.9038	14.34	240030	01.3116	16.01	240117	01.0892	16.56	250021	00.8899	07.83	250120	01.0502	11.96
230193	01.2146	16.81	240031	00.9538	12.78	240119	00.8532	16.27	250023	00.8958	09.70	250122	01.3088	14.29
230194	01.1621	13.35	240036	01.4871	18.61	240121	00.8919	17.30	250024	00.9704	08.93	250123	01.4131	18.33
230195	01.2654	21.05	240037	01.0790	15.12	240122	01.0333	16.04	250025	01.1605	14.21	250124	00.8930	11.34
230197	01.2729	20.03	240038	01.4674	21.40	240123	01.0160	12.31	250027	01.0442	10.04	250125	01.3329	15.75
230199	01.1844	16.77	240040	01.2418	18.94	240124	01.0500	15.19	250029	00.8985	11.10	250126	01.0024	12.25
230201	01.0422	13.64	240041	01.1943	14.12	240125	00.9073	10.62	250030	00.9668	11.80	250127	00.7908	.....
230204	01.3354	19.61	240043	01.2025	16.03	240127	00.9941	11.24	250031	01.3816	17.69	250128	00.9436	10.61
230205	01.1139	15.36	240044	01.1743	15.76	240128	01.0878	13.49	250032	01.2589	15.96	250131	01.0283	09.45
230207	01.2058	19.06	240045	01.0584	16.81	240129	00.9651	11.01	250033	00.9355	12.59	250134	00.9520	11.58
230208	01.1852	14.67	240047	01.4203	17.39	240130	00.9793	14.34	250034	01.4922	12.38	250136	00.8671	16.62
230211	00.9895	13.41	240048	01.2660	20.88	240132	01.2199	21.55	250035	00.8666	12.03	250138	01.3257	16.03
230212	01.0473	19.14	240049	01.6889	20.76	240133	01.1223	15.52	250036	00.9908	10.24	250140	00.8057	09.41
230213	01.0531	11.90	240050	01.1268	17.74	240135	00.9209	11.04	250037	00.8841	08.83	250141	01.2412	14.89
230216	01.4062	14.96	240051	00.9170	16.00	240137	01.1889	14.43	250038	00.9733	09.93	250144	00.9467	.....
230217	01.1401	17.17	240052	01.2359	16.24	240138	00.9656	11.55	250039	01.0067	10.13	250145	00.8829	.....
230219	00.9667	12.74	240053	01.5047	19.08	240139	00.9549	14.97	250040	01.3264	14.88	250146	01.0100	.....
230221	01.2982	18.57	240056	01.2934	19.39	240141	01.1105	19.61	250042	01.1532	13.22	250148	01.0637	.....
230222	01.3345	17.89	240057	01.7457	21.23	240142	01.1063	14.42	250043	00.8809	10.27	250149	00.9111	.....
230223	01.3148	19.52	240058	00.9587	09.56	240143	00.9185	11.41	250044	01.0076	12.85	260001	01.6498	15.91
230227	01.4498	20.47	240059	01.0818	17.97	240144	00.9655	13.73	250045	01.2115	15.80	260002	01.4327	19.48
230228	01.2890	17.02	240061	01.7137	19.93	240145	01.0049	11.38	250047	00.9196	08.87	260003	00.9751	12.78
230230	01.3845	20.01	240063	01.5305	20.52	240146	00.9799	14.99	250048	01.4047	12.62	260004	01.0432	12.06
230232	01.0545	16.94	240064	01.1601	17.31	240148	01.0008	10.45	250049	00.8974	10.42	260005	01.5844	19.17
230235	01.0046	14.62	240065	00.9338	10.64	240150	00.8780	10.86	250050	01.2596	11.28	260006	01.4804	16.01
230236	01.3262	20.31	240066	01.3795	19.06	240152	01.0006	17.14	250051	00.8750	08.96	260007	01.4060	16.14
230239	01.1482	14.99	240069	01.1330	17.24	240153	01.0192	14.24	250057	01.1491	12.74	260008	01.2376	13.90
230241	01.1550	16.43	240071	01.1292	17.46	240154	00.9905	14.61	250058	01.1665	12.27	260009	01.2653	15.01
230244	01.3835	18.88	240072	01.0019	15.57	240155	00.9286	16.12	250059	01.1891	11.77	260011	01.6051	16.63
230253	01.0636	16.84	240073	00.9783	14.01	240157	01.0225	12.12	250060	00.8058	11.28	260012	01.0636	11.88
230254	01.2272	21.93	240075	01.2057	18.33	240160	00.9496	14.46	250061	00.8775	09.15	260013	01.1493	13.50
230257	01.1250	17.12	240076	01.1450	19.11	240161	00.9605	14.31	250063	00.8500	12.49	260014	01.7535	17.79
230259	01.2698	18.67	240077	00.9211	12.69	240162	00.9630	14.88	250065	00.9011	10.82	260015	01.2443	12.97
230264	01.2471	16.92	240078	01.4412	19.92	240163	00.8630	13.46	250066	00.9326	12.03	260017	01.1937	12.42
230269	01.2450	21.14	240079	01.0116	13.47	240166	01.1232	14.50	250067	01.0946	12.22	260018	00.9428	08.66
230270	01.2233	18.95	240080	01.4123	19.62	240169	00.9513	13.93	250068	00.8683	12.14	260019	01.0687	13.01
230273	01.5933	19.35	240082	01.1392	14.18	240170	01.1212	14.12	250069	01.2544	12.65	260020	01.6841	19.79
230275	00.6409	15.75	240083	01.3350	17.68	240171	01.0074	13.83	250071	00.9869	11.25	260021	01.4693	16.68
230276	00.8837	15.48	240084	01.3215	16.20	240172	01.0814	14.56	250072	01.2924	15.11	260022	01.3476	14.85
230277	01.2088	18.95	240085	00.9135	15.23	240173	01.0091	14.49	250073	01.0574	09.16	260023	01.2169	14.03
230278	01.6978	17.19	240086	01.0879	14.33	240179	01.0502	14.05	250076	01.0126	11.04	260024	00.9975	11.71
230280	00.9203	.....	240087	01.1561	14.21	240180	00.9111	10.44	250077	00.9418	10.20	260025	01.3026	13.16
230281	01.4676	.....	240088	01.4415	17.29	240184	00.9037	11.75	250078	01.3897	13.77	260027	01.5904	18.65
240001	01.5227	20.18	240089	01.0048	14.73	240187	01.2634	15.97	250079	00.8444	12.64	260029	01.1107	17.08

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
260030	01.3033	09.37	260137	01.2883	14.24	270050	01.0455	16.53	280058	01.1987	13.63	290036	01.0268	.....
260031	01.4678	18.03	260138	01.8420	19.32	270051	01.2741	18.12	280060	01.5876	18.29	290037	01.7750	.....
260032	01.6073	13.18	260141	01.8940	17.33	270052	01.0618	13.84	280061	01.4422	14.63	290038	01.1870	.....
260034	01.0152	12.93	260142	01.1868	14.08	270053	00.9970	07.13	280062	01.1923	10.12	300001	01.4047	19.78
260035	01.0652	11.41	260143	00.9867	09.51	270057	01.1713	15.18	280064	00.9693	12.15	300003	01.7941	21.09
260036	01.0897	14.27	260146	01.4828	19.71	270058	00.9807	10.66	280065	01.2507	15.96	300005	01.2685	17.44
260037	01.3303	14.40	260147	01.0149	12.16	270059	00.8267	13.66	280066	01.0279	11.07	300006	01.1101	15.99
260039	01.2388	10.72	260148	01.0073	12.55	270060	00.9644	13.42	280068	00.9847	08.59	300007	01.1781	17.72
260040	01.6153	14.88	260158	01.1788	11.40	270063	00.9125	13.15	280070	01.0000	09.86	300008	01.2270	16.18
260042	01.3286	15.75	260159	01.3434	18.30	270068	00.9184	12.25	280073	01.0751	12.53	300009	01.1985	15.47
260044	01.0828	13.78	260160	01.0914	12.54	270072	00.9576	12.39	280074	01.0409	12.24	300010	01.2030	17.36
260047	01.4248	13.91	260162	01.5099	16.23	270073	01.1034	10.27	280075	01.3095	11.50	300011	01.3272	21.08
260048	01.2491	17.03	260163	01.1785	13.51	270074	00.9035	.....	280076	01.0748	12.42	300012	01.2920	21.68
260050	01.1065	13.74	260164	01.0462	11.93	270075	00.8783	.....	280077	01.3632	16.20	300013	01.1784	16.16
260052	01.2727	16.70	260166	01.1547	18.14	270076	00.7732	.....	280079	01.0096	08.85	300014	01.2554	17.01
260053	01.1634	09.81	260172	01.0140	11.31	270079	00.8806	13.15	280080	01.2501	10.50	300015	01.1415	16.94
260054	01.2584	15.10	260173	00.9894	10.67	270080	01.1206	14.02	280081	01.7016	18.52	300016	01.2632	19.06
260055	01.0724	12.81	260175	01.1485	13.86	270081	01.0037	10.21	280082	01.0906	11.81	300017	01.1739	19.63
260057	01.1608	13.77	260176	01.5967	15.21	270082	00.9086	16.06	280083	01.0470	12.63	300018	01.2143	18.68
260059	01.1236	12.90	260177	01.2822	18.47	270083	01.0332	11.82	280084	01.0205	10.55	300019	01.2254	18.15
260061	01.1071	11.10	260178	01.4986	19.19	270084	00.8579	13.29	280085	00.5745	13.22	300020	01.2443	18.81
260062	01.1874	15.30	260179	01.5429	20.22	270085	01.1363	.....	280088	01.6955	17.05	300021	01.1653	15.20
260063	01.0964	14.23	260180	01.7170	17.79	280001	01.1549	14.18	280089	01.0291	13.15	300022	01.1082	16.54
260064	01.3736	14.63	260183	01.6342	15.54	280003	01.9107	17.34	280090	01.0387	11.51	300023	01.2794	19.11
260065	01.7362	14.50	260186	01.1915	14.51	280005	01.4470	16.78	280091	01.1348	14.23	300024	01.2872	17.09
260066	01.1245	12.18	260188	01.2978	16.33	280009	01.5926	15.76	280092	00.8866	11.69	300028	01.3059	15.13
260067	00.9050	10.16	260189	00.9718	09.35	280010	00.9153	13.81	280094	01.1289	13.71	300029	01.2839	20.32
260068	01.7168	18.00	260190	01.1852	18.20	280011	00.9466	11.03	280097	00.9848	12.08	300033	01.0583	13.69
260070	01.2656	11.28	260191	01.1932	16.21	280012	01.1851	13.28	280098	00.9036	09.92	300034	01.9240	21.01
260073	01.0078	11.49	260193	01.2087	17.30	280013	01.9950	20.71	280101	01.0669	09.77	310001	01.6930	23.44
260074	01.3208	14.05	260195	01.1672	13.70	280014	00.9454	10.97	280102	01.1276	10.31	310002	01.6575	24.76
260077	01.5591	16.08	260197	01.2675	22.49	280015	01.1157	12.78	280104	01.0155	10.32	310003	01.2015	21.26
260078	01.1100	14.31	260198	01.2556	14.73	280017	01.1947	13.37	280105	01.2556	15.99	310005	01.1831	20.09
260079	01.0374	11.13	260200	01.2580	20.58	280018	01.0064	12.08	280106	00.9271	13.01	310006	01.2093	20.07
260080	00.9466	09.28	260202	01.1449	17.37	280020	01.5132	17.44	280107	01.0584	10.79	310008	01.2635	19.90
260081	01.3870	17.21	260204	00.6808	.....	280021	01.2597	14.03	280108	01.1035	12.56	310009	01.2280	20.09
260082	01.1706	13.16	270002	01.2061	14.67	280022	00.9537	10.41	280109	00.8849	10.22	310010	01.3079	17.46
260085	01.5221	18.65	270003	01.2427	17.35	280023	01.3719	14.33	280110	01.0153	10.55	310011	01.2881	19.99
260086	01.0078	12.28	270004	01.6741	16.44	280024	00.9370	10.93	280111	01.2565	15.55	310012	01.5330	22.98
260089	01.0433	12.88	270006	01.0315	11.79	280025	01.0059	10.58	280114	00.9330	10.07	310013	01.3256	19.19
260091	01.6144	18.97	270007	00.9035	12.34	280026	01.0774	12.62	280115	00.9760	13.60	310014	01.6329	22.95
260094	01.0888	14.92	270009	01.0522	18.56	280028	01.0505	12.46	280117	01.1662	14.07	310015	01.7741	23.86
260095	01.4311	16.21	270011	01.1422	14.69	280029	01.0102	12.23	280118	00.9862	13.25	310016	01.2302	21.83
260096	01.5493	19.82	270012	01.4573	17.25	280030	01.7873	22.60	280119	00.9944	.....	310017	01.3436	21.36
260097	01.1488	14.83	270013	01.3235	16.27	280031	01.0720	12.01	280123	00.9270	15.00	310018	01.2156	21.47
260100	01.1269	12.77	270014	01.6560	15.12	280032	01.2383	14.78	290001	01.7427	21.82	310019	01.6949	21.25
260102	01.0363	15.72	270016	00.8256	10.20	280033	01.0153	13.52	290002	00.9190	17.72	310020	01.1972	18.78
260103	01.3221	17.08	270017	01.2740	16.23	280034	01.1911	13.66	290003	01.6587	20.91	310021	01.2836	19.65
260104	01.6613	18.27	270019	00.9937	12.23	280035	00.8819	11.62	290005	01.2678	19.56	310022	01.2485	18.19
260105	01.8256	18.29	270021	01.1369	14.71	280037	00.9979	12.06	290006	01.0337	16.63	310024	01.2319	21.47
260107	01.3910	17.90	270023	01.3182	17.63	280038	01.0597	12.86	290007	01.7782	22.22	310025	01.1869	20.24
260108	01.7513	17.38	270024	00.9847	11.35	280039	01.2712	13.10	290008	01.2063	17.86	310026	01.2706	21.12
260109	01.0046	11.51	270026	00.9131	12.56	280040	01.6146	18.26	290009	01.5580	20.26	310027	01.3144	17.61
260110	01.5467	14.55	270027	01.0305	12.04	280041	01.0572	10.95	290010	01.1552	17.50	310028	01.1385	19.28
260111	00.8939	10.83	270028	01.0693	14.45	280042	01.1705	13.58	290011	00.9691	13.05	310029	01.7872	20.90
260112	01.4469	17.09	270029	01.0320	14.46	280043	01.0597	12.23	290012	01.4465	19.66	310031	02.6050	23.85
260113	01.1577	13.08	270031	00.9049	09.71	280045	01.1825	13.09	290013	01.1414	15.42	310032	01.2557	19.04
260115	01.1768	14.97	270032	01.1444	15.72	280046	01.0708	10.66	290014	01.0009	16.60	310034	01.2014	18.21
260116	01.1359	12.68	270033	00.8783	21.10	280047	01.1624	16.07	290015	00.9889	12.99	310036	01.2138	17.92
260119	01.1926	13.52	270035	00.9894	14.73	280048	01.0499	10.85	290016	01.3306	15.75	310037	01.2388	24.01
260120	01.2261	14.49	270036	01.0120	09.12	280049	01.1043	13.00	290018	00.9628	22.74	310038	01.7727	22.21
260122	01.1602	12.04	270039	00.9390	12.62	280050	01.0174	11.53	290019	01.2518	17.47	310039	01.2783	19.78
260123	01.0178	10.06	270040	01.0903	19.48	280051	01.0446	14.71	290020	01.2240	18.37	310040	01.2683	21.87
260127	00.9980	14.37	270041	01.0725	10.12	280052	01.1260	10.91	290021	01.5718	20.67	310041	01.2889	20.71
260128	01.0173	08.68	270044	01.2618	14.10	280054	01.2447	14.44	290022	01.6200	23.07	310042	01.1596	20.03
260129	01.1495	13.09	270046	00.9502	15.13	280055	00.9253	10.12	290027	01.0027	13.90	310043	01.1812	20.19
260131	01.3359	15.39	270048	01.0910	12.39	280056	01.0855	10.24	290029	00.8842	.....	310044	01.3145	19.51
260134	01.1840	13.51	270049	01.7658	16.51	280057	00.9872	14.21	290032	01.3433	19.50	310045	01.3120	24.22

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
310047	01.2978	21.60	320032	00.9776	20.28	330061	01.3120	22.35	330171	01.2992	21.23	330268	01.0090	14.96
310048	01.2227	20.26	320033	01.0818	19.40	330062	01.0664	15.08	330175	01.1063	13.41	330270	01.9642	27.18
310049	01.2908	20.19	320035	01.1660	13.24	330064	01.3911	27.78	330177	01.0514	12.91	330273	01.2855	21.42
310050	01.2017	20.51	320037	01.3899	12.74	330065	01.1624	16.59	330179	00.8581	12.51	330275	01.2081	18.08
310051	01.3227	22.94	320038	01.2002	14.49	330066	01.2995	17.69	330180	01.1690	15.30	330276	01.2082	16.38
310052	01.2366	19.79	320046	01.1906	18.36	330067	01.3225	20.03	330181	01.3008	27.47	330277	01.1319	16.03
310054	01.2848	22.08	320048	01.2872	14.65	330072	01.3563	26.92	330182	02.4742	26.72	330279	01.3510	16.78
310056	01.2278	18.60	320056	00.8819	.....	330073	01.1841	13.26	330183	01.3763	18.32	330281	00.5568	23.06
310057	01.2648	18.67	320057	00.9639	.....	330074	01.2524	16.33	330184	01.3472	23.65	330285	01.7116	20.80
310058	01.1165	22.53	320058	00.7808	.....	330075	01.0753	16.05	330185	01.1723	22.73	330286	01.3041	22.10
310060	01.1764	15.81	320059	01.0425	.....	330078	01.4389	16.68	330186	00.9130	19.17	330288	01.0139	17.60
310061	01.1722	18.96	320060	00.9410	.....	330079	01.2684	15.57	330188	01.2063	16.77	330290	01.6417	27.25
310062	01.2970	26.34	320061	01.1664	.....	330080	01.4665	23.97	330189	00.7331	12.31	330293	01.1276	13.51
310063	01.3226	20.46	320062	00.8931	.....	330082	01.1808	17.10	330191	01.2892	18.01	330304	01.2716	23.24
310064	01.2668	20.47	320063	01.3211	15.46	330084	00.9833	15.94	330193	01.3482	24.81	330306	01.3707	24.98
310067	01.2594	20.36	320065	01.2430	17.01	330085	01.3460	17.68	330194	01.8210	24.97	330307	01.1721	17.04
310069	01.1730	17.01	320067	00.8539	10.32	330086	01.2503	23.08	330195	01.5873	27.49	330308	01.2466	25.87
310070	01.3502	21.60	320068	00.9034	16.83	330088	01.0977	22.97	330196	01.3950	24.75	330309	01.1999	23.47
310072	01.2374	19.41	320069	01.0835	13.56	330090	01.5160	16.20	330197	01.0524	14.34	330314	01.4338	20.37
310073	01.4817	21.39	320070	00.9428	.....	330091	01.3705	17.15	330198	01.3620	25.91	330315	01.2292	23.02
310074	01.3262	20.59	320074	01.1259	17.57	330092	00.9957	14.04	330199	01.2860	23.44	330316	01.3096	24.11
310075	01.3128	20.53	320076	00.9991	16.21	330094	01.1855	14.91	330201	01.4531	24.83	330327	00.8781	15.44
310076	01.3226	26.50	320079	01.1685	18.53	330095	01.2824	16.28	330202	01.3373	24.50	330331	01.1813	25.65
310077	01.4994	22.03	320082	01.8075	.....	330096	01.0596	14.40	330203	01.3430	18.69	330332	01.2836	22.41
310078	01.2791	22.48	330001	01.2027	23.04	330097	01.1475	14.94	330204	01.2933	23.88	330333	01.2926	23.11
310081	01.2164	19.38	330002	01.4124	23.83	330100	00.6684	24.57	330205	01.1975	17.54	330336	01.3502	27.66
310083	01.2378	21.39	330003	01.3158	17.46	330101	01.7755	29.73	330208	01.2274	22.74	330338	01.2396	22.06
310084	01.2075	20.18	330004	01.2561	19.60	330102	01.3522	16.65	330209	01.1848	20.53	330339	00.8669	17.94
310086	01.2176	19.38	330005	01.7620	18.94	330103	01.2524	15.29	330211	01.2925	15.74	330340	01.1608	23.73
310087	01.2313	18.62	330006	01.3185	23.17	330104	01.4242	25.67	330212	01.1932	19.47	330350	01.8072	26.95
310088	01.1789	21.00	330007	01.3208	16.57	330106	01.5662	31.07	330213	01.0876	15.58	330353	01.2882	28.01
310090	01.1946	21.38	330008	01.1370	16.15	330107	01.2052	22.95	330214	01.7088	27.08	330354	01.3874	.....
310091	01.2415	18.79	330009	01.3261	27.98	330108	01.1972	15.71	330215	01.1519	16.55	330357	01.3452	29.51
310092	01.3962	19.24	330010	01.2191	14.38	330111	01.0845	14.47	330218	01.1659	15.36	330359	00.9345	19.17
310093	01.1435	19.43	330011	01.2428	16.56	330114	00.9193	15.00	330219	01.7195	18.75	330372	01.2575	21.28
310096	01.8860	21.72	330012	01.6258	25.68	330115	01.1851	14.41	330221	01.2718	25.64	330381	01.2114	26.55
310105	01.2351	20.43	330013	02.0631	17.16	330116	00.9613	13.66	330222	01.2469	15.21	330383	01.3259	.....
310108	01.3621	19.59	330014	01.3639	26.33	330118	01.5979	17.36	330223	01.1104	15.86	330385	01.2184	25.67
310110	01.2191	19.32	330016	00.9847	15.57	330119	01.7237	28.24	330224	01.2700	19.31	330386	01.2294	19.79
310111	01.2455	18.13	330019	01.2313	23.83	330121	01.0667	13.42	330225	01.1576	23.75	330387	00.7536	36.27
310112	01.2943	19.42	330020	01.0911	14.70	330122	01.2895	21.37	330226	01.2811	16.82	330389	01.8055	28.55
310113	01.2243	19.35	330023	01.1830	21.41	330125	01.7519	18.89	330229	01.3299	14.48	330390	01.2316	24.96
310115	01.2390	19.80	330024	01.8062	27.93	330126	01.1469	19.06	330230	01.5420	25.52	330393	01.6790	25.15
310116	01.2166	20.61	330025	01.1635	13.45	330127	01.3574	24.53	330231	01.1472	26.40	330394	01.4862	17.28
310118	01.2191	21.18	330027	01.4312	29.92	330128	01.3303	25.17	330232	01.2389	14.65	330395	01.3351	26.58
310119	01.5589	29.46	330028	01.3524	23.16	330132	01.0796	13.15	330233	01.5462	30.00	330396	01.2611	23.98
310120	01.0810	17.02	330029	01.0937	16.36	330133	01.3290	28.20	330234	02.1509	27.03	330397	01.4810	23.47
310121	01.0724	17.85	330030	01.2392	15.26	330135	01.2226	16.47	330235	01.1618	16.46	330398	01.2131	25.84
320001	01.4366	16.14	330033	01.2024	13.36	330136	01.2683	19.79	330236	01.3663	25.32	330399	01.3136	27.41
320002	01.3563	21.36	330034	00.8669	29.10	330140	01.6881	17.07	330238	01.1419	13.64	340001	01.4375	18.69
320003	01.2298	14.20	330036	01.2237	21.09	330141	01.3453	23.29	330239	01.2266	14.38	340002	01.8274	17.46
320004	01.1229	16.38	330037	01.1795	14.71	330144	01.0398	13.45	330240	01.3143	26.41	340003	01.1539	17.44
320005	01.3257	18.36	330038	01.1869	13.86	330148	01.0294	13.70	330241	01.9309	20.81	340004	01.4844	16.48
320006	01.4173	14.16	330039	00.8701	13.51	330151	01.0525	12.53	330242	01.3377	20.60	340005	01.2380	12.65
320009	01.5156	16.90	330041	01.3624	26.36	330152	01.3980	26.57	330245	01.2460	17.22	340006	01.1128	14.19
320011	01.0249	17.65	330043	01.2325	24.15	330153	01.6410	17.53	330246	01.2726	22.67	340007	01.1584	14.94
320012	01.0428	17.37	330044	01.2066	16.10	330154	01.5523	.....	330247	00.7884	25.42	340008	01.2193	15.82
320013	01.0889	17.38	330045	01.3974	23.27	330157	01.2584	18.01	330249	01.2357	15.87	340009	01.1741	19.21
320014	01.0454	09.02	330046	01.4962	26.80	330158	01.3006	22.12	330250	01.2316	15.80	340010	01.3038	15.46
320016	01.1562	14.52	330047	01.2200	16.37	330159	01.3142	17.37	330252	00.9099	15.14	340011	01.1066	13.94
320017	01.1504	17.38	330048	01.2674	15.50	330160	01.4544	27.75	330254	00.9916	15.51	340012	01.2143	15.39
320018	01.4185	16.77	330049	01.2673	17.22	330161	00.9392	15.60	330258	01.3589	23.96	340013	01.2166	14.57
320019	01.4846	18.67	330053	01.1259	14.20	330162	01.2563	24.16	330259	01.3537	21.55	340014	01.5912	18.83
320021	01.7030	20.73	330055	01.3713	27.96	330163	01.1593	16.79	330261	01.2206	23.08	340015	01.2407	15.33
320022	01.2443	17.51	330056	01.3550	27.22	330164	01.3538	18.48	330263	01.0437	15.85	340016	01.1503	14.55
320023	01.0444	14.13	330057	01.6043	17.28	330166	00.9855	13.97	330264	01.2549	19.42	340017	01.3015	14.65
320030	01.0646	18.67	330058	01.2642	15.35	330167	01.5896	26.67	330265	01.3454	14.34	340018	01.0825	14.66
320031	00.9696	11.41	330059	01.5861	27.24	330169	01.4497	29.07	330267	01.2471	21.54	340019	01.0463	10.97

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
340020	01.2214	19.33	340114	01.4370	18.91	350030	01.0782	15.42	360052	01.6706	17.01	360129	01.0212	13.31
340021	01.2429	15.10	340115	01.5516	17.01	350033	00.9414	13.28	360054	01.2364	14.87	360130	01.0803	13.93
340022	01.0861	14.07	340116	01.7556	19.43	350034	00.9862	14.00	360055	01.1887	17.02	360131	01.2766	16.41
340023	01.3551	16.96	340119	01.2827	14.92	350035	00.8461	10.06	360056	01.4023	14.80	360132	01.3067	18.64
340024	01.2088	14.35	340120	01.0627	12.83	350038	00.9999	13.01	360057	01.0616	12.70	360133	01.4340	17.01
340025	01.1085	14.27	340121	01.0948	13.86	350039	01.0331	13.63	360058	01.1741	15.10	360134	01.6313	17.77
340027	01.2066	14.87	340122	01.0074	12.44	350041	01.0451	11.63	360059	01.5386	19.71	360135	01.1456	15.15
340028	01.5189	16.47	340123	01.1032	14.48	350042	01.0138	13.85	360062	01.4513	18.00	360136	01.0358	14.10
340030	01.9236	18.03	340124	01.0598	13.16	350043	01.4085	15.08	360063	01.0436	17.30	360137	01.5633	17.61
340031	01.0073	11.38	340125	01.4126	16.38	350044	00.8723	10.01	360064	01.4685	18.71	360140	00.9977	15.13
340032	01.2722	16.65	340126	01.4006	16.98	350047	01.1514	15.96	360065	01.2562	16.05	360141	01.4459	19.09
340034	01.2862	17.26	340127	01.3145	15.68	350049	01.0973	09.92	360066	01.3256	16.87	360142	00.9941	14.51
340035	01.1055	14.26	340129	01.2766	18.25	350050	01.0007	10.35	360067	01.1115	11.73	360143	01.3138	17.32
340036	01.2272	16.44	340130	01.3380	15.99	350051	00.9666	11.29	360068	01.6362	20.80	360144	01.3278	19.94
340037	01.1607	14.58	340131	01.3791	16.02	350053	01.0840	09.16	360069	01.0676	15.90	360145	01.6473	15.96
340038	01.1622	14.65	340132	01.2661	12.80	350055	00.9493	11.52	360070	01.5784	16.33	360147	01.2733	14.83
340039	01.2728	17.98	340133	01.1294	14.24	350056	00.9567	12.07	360071	01.2933	15.64	360148	01.1734	15.29
340040	01.7442	17.23	340136	01.0903	16.92	350058	01.0054	11.46	360072	01.1550	14.77	360149	01.1353	16.99
340041	01.2497	15.28	340137	01.1904	13.07	350060	00.9061	07.20	360074	01.3468	18.13	360150	01.3102	16.70
340042	01.1070	13.11	340138	01.1282	14.31	350061	01.0508	14.13	360075	01.4104	18.42	360151	01.3471	16.20
340044	01.0368	12.58	340141	01.5336	18.20	350063	00.8168	.....	360076	01.3080	17.06	360152	01.5274	17.02
340045	01.0070	08.49	340142	01.1924	15.16	350064	00.8453	.....	360077	01.4463	18.22	360153	01.1435	13.32
340047	01.8771	17.46	340143	01.3424	18.36	350065	00.8966	09.89	360078	01.2808	18.19	360154	01.0543	12.01
340048	00.7695	08.62	340144	01.3526	16.96	350066	00.8594	.....	360079	01.6831	19.06	360155	01.3084	18.30
340049	00.6050	15.68	340145	01.3006	15.79	360001	01.2737	16.58	360080	01.0833	14.79	360156	01.3318	16.30
340050	01.1906	16.12	340146	01.0912	12.76	360002	01.1539	14.90	360081	01.3730	18.30	360159	01.1477	17.70
340051	01.2434	15.76	340147	01.2928	16.80	360003	01.7163	19.44	360082	01.2993	18.90	360161	01.3554	18.52
340052	01.0229	18.45	340148	01.4258	17.75	360006	01.7248	19.60	360083	01.2953	15.60	360162	01.1934	15.50
340053	01.6219	18.66	340151	01.1784	13.81	360007	01.0537	15.57	360084	01.6280	17.52	360163	01.8277	18.81
340054	01.0768	12.74	340153	01.9573	19.41	360008	01.2393	15.77	360085	01.7866	18.85	360164	00.8939	13.53
340055	01.2107	16.29	340154	01.0753	14.94	360009	01.3585	17.14	360086	01.4650	15.62	360165	01.1586	14.66
340060	01.1365	15.32	340155	01.4445	19.22	360010	01.1699	15.09	360087	01.3579	17.19	360166	01.1803	16.68
340061	01.7024	18.17	340156	00.7886	.....	360011	01.2316	17.13	360088	01.2297	15.09	360169	01.0152	16.77
340063	01.0854	14.50	340158	01.1620	16.37	360012	01.2575	18.10	360089	01.1095	16.46	360170	01.2081	17.19
340064	01.2236	15.48	340159	01.1374	15.06	360013	01.1234	15.10	360090	01.2171	18.32	360172	01.4144	16.01
340065	01.2563	11.40	340160	01.1423	12.04	360014	01.1305	16.24	360091	01.2693	18.20	360174	01.2615	16.86
340067	01.2050	13.69	340162	01.3232	16.41	360016	01.5690	17.58	360092	01.3081	17.29	360175	01.2606	17.31
340068	01.2906	12.83	340164	01.4023	17.72	360017	01.6623	19.27	360093	01.2115	15.93	360176	01.1864	13.50
340069	01.6454	17.99	340166	01.3806	18.12	360018	01.5828	18.43	360094	01.2319	19.09	360177	01.2503	15.44
340070	01.2856	16.22	340168	00.4892	16.61	360019	01.2602	18.17	360095	01.3224	15.76	360178	01.2477	15.16
340071	01.0192	13.98	340170	01.2903	.....	360020	01.4408	17.58	360096	01.0972	15.60	360179	01.3059	18.53
340072	01.1001	13.96	340171	01.1886	.....	360021	01.2308	17.68	360098	01.3847	17.38	360180	02.0926	22.00
340073	01.4140	19.33	350001	01.1048	11.68	360024	01.4150	17.78	360099	00.9965	15.45	360184	00.5635	15.74
340075	01.2118	15.40	350002	01.7422	16.34	360025	01.1647	16.65	360100	01.3185	15.79	360185	01.2250	16.35
340080	01.1487	10.79	350003	01.1706	15.20	360026	01.1441	15.74	360101	01.7121	19.44	360186	01.2001	15.60
340084	01.0637	13.21	350004	01.9130	17.61	360027	01.5510	18.78	360102	01.2239	18.95	360187	01.2755	15.63
340085	01.2350	14.60	350005	01.1536	11.38	360028	01.3557	15.35	360103	01.3601	19.18	360188	01.0228	14.47
340087	01.2050	16.57	350006	01.3190	15.87	360029	01.1328	15.69	360104	01.2382	18.94	360189	01.0674	14.86
340088	01.1530	16.20	350007	00.9819	11.64	360030	01.1077	14.24	360106	01.0728	14.17	360192	01.3026	18.10
340089	00.9587	11.53	350008	01.0282	17.11	360031	01.2692	14.01	360107	01.2622	15.52	360193	01.2990	14.39
340090	01.1072	15.15	350009	01.1700	15.04	360032	01.1041	15.63	360108	01.0507	14.22	360194	01.1138	15.67
340091	01.6938	18.09	350010	01.0948	11.48	360034	01.2332	12.05	360109	01.1010	16.95	360195	01.1665	16.12
340093	01.0960	12.41	350011	01.8078	16.90	360035	01.5032	19.25	360112	01.7037	21.03	360197	01.1624	16.55
340094	01.2541	16.46	350012	01.0559	11.94	360036	01.1697	17.01	360113	01.3399	17.68	360200	01.0671	12.61
340096	01.2466	15.59	350013	01.1172	14.23	360037	02.0688	19.75	360114	01.1335	15.45	360203	01.1252	15.23
340097	01.1638	14.13	350014	01.0793	10.84	360038	01.5302	16.88	360115	01.2330	18.39	360204	01.2108	15.84
340098	01.6534	17.84	350015	01.5962	15.49	360039	01.2972	15.46	360116	01.0463	15.21	360210	01.1859	18.60
340099	01.1570	13.04	350016	01.0047	10.29	360040	01.2865	17.57	360118	01.3302	16.33	360211	01.1862	17.02
340100	00.9781	.....	350017	01.3945	14.02	360041	01.3229	17.13	360119	01.2505	16.21	360212	01.4129	18.54
340101	00.9994	11.37	350018	01.1037	10.15	360042	01.1307	15.94	360120	00.6082	.....	360213	01.1319	15.72
340104	00.9394	10.52	350019	01.6020	17.70	360044	01.0998	15.06	360121	01.2473	16.95	360218	01.2494	15.77
340105	01.3234	17.43	350020	01.3474	15.80	360045	01.5166	19.48	360122	01.3128	17.15	360230	01.2932	19.39
340106	01.0977	16.14	350021	01.0671	10.47	360046	01.0676	17.35	360123	01.2101	17.96	360231	01.0985	12.30
340107	01.2666	15.88	350023	00.8750	14.45	360047	01.1655	13.68	360124	01.2525	16.62	360232	01.2411	20.25
340109	01.3020	15.08	350024	01.0840	12.46	360048	01.7585	20.91	360125	01.0866	15.71	360234	01.3135	17.37
340111	01.2307	13.16	350025	01.0046	13.17	360049	01.3468	17.28	360126	01.2385	18.24	360236	01.1914	16.82
340112	01.0315	12.98	350027	00.9939	13.76	360050	01.0922	11.62	360127	01.0931	15.24	360238	01.0788	12.57
340113	01.9539	19.22	350029	00.9491	10.79	360051	01.4681	19.97	360128	01.1129	13.39	360239	01.1676	18.44

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
360240	00.4529	09.64	370085	00.7965	12.79	380013	01.1950	19.76	390016	01.1958	15.75	390098	01.7221	19.80
360241	00.5971	16.19	370086	01.1603	09.31	380014	01.3873	18.00	390017	01.1833	13.74	390100	01.6581	18.56
360242	01.6504	.....	370089	01.2840	11.32	380017	01.7679	21.74	390018	01.1902	18.44	390101	01.2352	15.40
360243	00.8333	15.66	370091	01.6606	15.44	380018	01.7785	18.54	390019	01.1196	15.02	390102	01.3553	19.54
360244	00.8182	14.72	370092	01.0516	11.97	380019	01.1920	17.57	390022	01.3562	20.09	390103	01.0890	16.83
360245	00.8606	14.97	370093	01.8102	18.31	380020	01.4631	19.42	390023	01.2620	20.25	390104	01.1238	13.92
360246	00.8831	.....	370094	01.3503	16.33	380021	01.2003	19.11	390024	00.7630	21.76	390106	00.9494	16.62
370001	01.7432	18.38	370095	00.9025	10.78	380022	01.1792	17.88	390025	00.7561	15.82	390107	01.2140	17.78
370002	01.2128	13.52	370097	01.3556	18.32	380023	01.2933	16.49	390026	01.2627	20.06	390108	01.3539	17.21
370004	01.3050	13.98	370099	01.1988	13.57	380025	01.2496	21.04	390027	01.9362	22.10	390109	01.1417	13.32
370005	01.0163	11.81	370100	00.9930	10.79	380026	01.3246	16.19	390028	01.7661	18.59	390110	01.5526	18.76
370006	01.1880	14.35	370103	00.9353	11.13	380027	01.2259	18.77	390029	01.7547	17.52	390111	01.7889	26.50
370007	01.1282	13.12	370105	01.9314	16.18	380029	01.1923	15.70	390030	01.2137	15.42	390112	01.2051	12.38
370008	01.4032	14.97	370106	01.4815	16.09	380031	01.0018	14.64	390031	01.1392	17.02	390113	01.2139	14.98
370011	01.0534	13.17	370108	01.0799	10.32	380033	01.6739	21.91	390032	01.2170	17.70	390114	01.0997	20.24
370012	00.9141	11.46	370112	01.0585	11.98	380035	01.3441	18.88	390035	01.2980	17.23	390115	01.3237	20.80
370013	01.7263	17.86	370113	01.1333	13.21	380036	01.0279	16.34	390036	01.2563	16.92	390116	01.1823	19.21
370014	01.2868	17.05	370114	01.6294	14.92	380037	01.2562	19.57	390037	01.2991	17.90	390117	01.1278	15.07
370015	01.2342	13.90	370121	01.2113	13.37	380038	01.3261	20.34	390039	01.0821	15.36	390118	01.2364	15.74
370016	01.3725	15.42	370122	01.1492	09.31	380039	01.2600	20.17	390040	00.9405	12.87	390119	01.3644	17.02
370017	01.1287	10.87	370123	01.2248	13.70	380040	01.3376	18.06	390041	01.2776	17.41	390121	01.3191	17.22
370018	01.2937	16.87	370125	00.9676	11.42	380042	01.1747	21.92	390042	01.3876	20.08	390122	01.0374	15.47
370019	01.3530	11.35	370126	01.1557	09.48	380047	01.6487	19.29	390043	01.1087	14.27	390123	01.2533	19.42
370020	01.3032	11.92	370131	00.9570	12.42	380048	01.0224	13.14	390044	01.5701	18.24	390125	01.2123	15.75
370021	00.9264	10.11	370133	01.0789	09.65	380050	01.3167	16.38	390045	01.5158	16.69	390126	01.2807	20.35
370022	01.3140	15.01	370138	01.0804	15.13	380051	01.5315	18.38	390046	01.4888	17.71	390127	01.1718	19.86
370023	01.3457	14.52	370139	00.9646	09.78	380052	01.1595	15.90	390047	01.6328	22.95	390128	01.1729	17.17
370025	01.3493	14.57	370140	00.9612	11.36	380055	01.1802	23.98	390048	01.1701	15.25	390130	01.1049	17.23
370026	01.4655	15.54	370141	01.3618	19.76	380056	01.0308	15.19	390049	01.5133	19.09	390131	01.2505	15.35
370028	01.8025	17.10	370146	01.1923	10.18	380060	01.4607	21.21	390050	02.0254	20.30	390132	01.2306	18.08
370029	01.2379	11.52	370148	01.4229	17.76	380061	01.5092	21.74	390051	02.1917	23.77	390133	01.7637	20.23
370030	01.2303	11.25	370149	01.1566	14.18	380062	01.1219	13.68	390052	01.1552	15.52	390135	01.2401	19.41
370032	01.4686	14.67	370153	01.0837	14.50	380063	01.2709	22.15	390054	01.1515	13.42	390136	01.2190	15.59
370033	01.1587	10.89	370154	01.0306	12.64	380064	01.3409	18.16	390055	01.7095	20.40	390137	01.1696	17.43
370034	01.2251	12.87	370156	01.1282	12.99	380065	00.9805	17.74	390056	01.1719	15.60	390138	01.2397	16.41
370035	01.5390	14.70	370158	01.0248	12.52	380066	01.3503	17.09	390057	01.2912	18.37	390139	01.4632	21.08
370036	01.0287	09.08	370159	01.3498	13.48	380068	01.0131	18.61	390058	01.2889	16.75	390142	01.6767	21.77
370037	01.5897	16.07	370163	00.9111	10.33	380069	01.1321	17.14	390060	01.1142	15.65	390145	01.3345	18.30
370038	00.9678	10.86	370165	01.1694	11.10	380070	01.3005	19.47	390061	01.5073	20.59	390146	01.2340	15.37
370039	01.2989	15.91	370166	01.1522	16.13	380071	01.2980	19.74	390062	01.1205	14.75	390147	01.2315	18.19
370040	01.0664	11.17	370169	01.0487	10.14	380072	00.9304	14.25	390063	01.7188	18.14	390148	01.1846	17.53
370041	00.9314	13.21	370170	00.9331	.....	380075	01.4127	19.35	390064	01.5206	15.84	390149	01.2472	19.33
370042	00.8323	11.93	370171	01.0282	.....	380078	01.0299	16.80	390065	01.2194	17.97	390150	01.1446	17.62
370043	01.0171	11.72	370172	00.8595	.....	380081	01.1232	16.57	390066	01.3031	16.55	390151	01.2996	17.35
370045	01.0563	10.29	370173	01.2978	.....	380082	01.3175	20.54	390067	01.7360	18.65	390152	01.0265	15.13
370046	00.9411	11.89	370174	00.6125	.....	380083	01.3362	17.08	390068	01.3209	17.00	390153	01.1973	21.16
370047	01.3164	13.84	370176	01.1825	16.22	380084	01.2653	18.54	390069	01.2822	18.31	390154	01.1643	13.88
370048	01.1517	12.59	370177	00.9262	10.16	380087	01.0074	13.59	390070	01.3131	19.08	390155	01.3050	17.65
370049	01.3213	15.14	370178	00.9819	10.53	380088	00.9674	15.05	390071	01.0983	13.09	390156	01.3758	21.65
370051	00.9489	13.39	370179	00.8489	13.14	380089	01.2979	20.02	390072	01.0753	15.84	390157	01.2559	16.75
370054	01.2306	14.66	370180	00.9753	.....	380090	01.3074	21.62	390073	01.5189	17.44	390158	01.4547	18.63
370056	01.5068	15.57	370183	01.2609	12.03	380091	01.1984	23.39	390074	01.2306	16.29	390159	01.2909	19.66
370057	01.1350	14.30	370186	00.9700	10.36	380897	04.7366	.....	390075	01.3391	15.51	390160	01.2003	17.44
370059	01.1386	12.80	370189	01.0967	11.81	390001	01.2957	17.00	390076	01.2601	20.04	390161	01.0387	13.71
370060	01.0833	14.13	370190	01.5659	16.45	390002	01.3114	17.45	390078	01.0443	14.92	390162	01.3081	19.03
370063	01.1256	10.89	370192	01.0518	.....	390003	01.2089	16.14	390079	01.6752	15.99	390163	01.1829	16.45
370064	00.9724	09.12	370193	01.5813	.....	390004	01.3574	16.37	390080	01.2217	17.76	390164	01.8500	18.93
370065	01.0831	14.46	380001	01.2941	18.46	390005	01.0234	13.53	390081	01.3066	20.10	390166	01.1614	16.81
370071	01.0248	10.53	380002	01.2496	17.64	390006	01.7687	17.25	390083	01.1851	20.41	390167	01.2638	20.38
370072	00.9459	11.97	380003	01.1800	17.46	390007	01.1626	20.95	390084	01.2284	14.79	390168	01.1943	17.18
370076	01.2870	11.71	380004	01.6210	22.25	390008	01.0940	15.45	390086	01.0903	15.51	390169	01.2157	17.22
370077	01.3610	15.34	380005	01.1604	19.10	390009	01.6057	17.97	390088	01.3463	19.25	390170	01.8561	23.09
370078	01.6915	14.53	380006	01.3742	16.46	390010	01.2048	16.98	390090	01.7218	19.42	390173	01.2147	17.58
370079	00.9190	11.99	380007	01.6261	20.55	390011	01.1973	16.82	390091	01.1478	18.41	390174	01.7096	23.29
370080	00.9794	11.31	380008	01.0644	16.93	390012	01.2118	18.59	390093	01.1830	14.61	390176	01.1355	16.28
370082	00.9188	10.54	380009	01.8099	21.55	390013	01.2043	15.89	390095	01.1731	14.43	390178	01.2800	17.36
370083	01.0320	10.95	380010	01.1001	19.18	390014	01.5661	15.29	390096	01.2822	16.50	390179	01.2574	20.80
370084	01.0538	08.49	380011	01.1580	14.12	390015	01.1363	12.32	390097	01.3255	20.69	390180	01.5909	22.45

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
390181	01.0567	16.51	400009	00.9585	07.08	420018	01.6744	17.26	430015	01.1953	13.84	440029	01.3354	15.62
390183	01.1579	17.62	400010	00.9770	10.23	420019	01.2114	14.47	430016	01.7002	17.29	440030	01.1477	12.68
390184	01.1162	17.14	400011	01.0729	06.77	420020	01.2550	16.07	430018	00.9508	13.20	440031	00.9745	11.83
390185	01.1728	15.64	400012	01.1136	07.24	420022	00.9393	15.80	430022	00.9341	10.22	440032	01.0065	12.50
390186	01.1975	12.18	400013	01.1634	09.09	420023	01.3918	18.61	430023	00.9430	09.74	440033	01.1147	14.66
390189	01.0744	16.34	400014	01.4222	07.31	420026	01.8511	17.80	430024	00.8545	11.51	440034	01.4727	17.16
390191	01.0451	14.03	400015	01.3962	10.35	420027	01.3601	14.55	430025	00.9418	10.29	440035	01.2814	14.81
390192	01.1105	16.42	400016	01.3551	09.54	420028	01.0490	14.33	430026	01.0159	10.38	440039	01.5604	16.47
390193	01.1499	15.76	400017	01.1630	06.80	420029	01.7205	14.74	430027	01.7393	16.35	440040	00.9573	11.47
390194	01.0783	18.49	400018	01.2999	08.93	420030	01.2787	17.01	430028	01.0746	12.21	440041	01.0356	12.55
390195	01.8149	21.40	400019	01.6166	09.45	420031	01.0044	10.97	430029	01.0015	12.56	440046	01.3480	14.06
390196	01.3571	.....	400021	01.3458	07.96	420033	01.2457	19.01	430031	00.9411	10.95	440047	00.9832	12.05
390197	01.2759	18.62	400022	01.3107	09.75	420035	00.8101	11.93	430033	01.0803	11.10	440048	01.7516	15.85
390198	01.2288	14.41	400024	00.9882	07.75	420036	01.2244	15.01	430034	01.0196	10.93	440049	01.6359	15.45
390199	01.2242	14.46	400026	00.9404	07.20	420037	01.3233	19.81	430036	01.0422	09.44	440050	01.2307	13.86
390200	01.0074	12.74	400027	01.1225	06.87	420038	01.2403	14.65	430037	00.9525	12.46	440051	00.8902	13.44
390201	01.2922	18.28	400028	01.1413	07.08	420039	01.2260	13.96	430038	01.0411	10.31	440052	01.2700	17.91
390203	01.3020	18.63	400029	01.1113	07.59	420040	01.2120	14.36	430039	00.9738	10.63	440053	01.2982	16.09
390204	01.2596	18.31	400031	01.0365	07.37	420042	01.1943	13.01	430040	00.9048	11.88	440054	01.2513	13.93
390205	01.2210	22.42	400032	01.1747	07.75	420043	01.1777	16.87	430041	00.9680	11.58	440056	01.0740	10.33
390206	01.3668	19.80	400044	01.1248	09.07	420044	01.1942	15.94	430042	01.0001	10.28	440057	01.0255	10.50
390209	01.0381	14.45	400048	01.0912	08.01	420048	01.1167	13.96	430043	01.1190	12.47	440058	01.3908	18.36
390211	01.2078	16.56	400061	01.4735	12.57	420049	01.1468	14.52	430044	00.9331	12.62	440059	01.1604	13.84
390213	01.0973	14.10	400079	01.2413	09.48	420051	01.5754	16.86	430047	01.1161	11.03	440060	01.1519	13.95
390215	01.1567	20.50	400087	01.3227	08.37	420053	01.0676	14.06	430048	01.2139	15.58	440061	01.1571	14.49
390217	01.2291	17.56	400094	01.0188	07.41	420054	01.3914	16.63	430049	00.9343	11.35	440063	01.5537	17.05
390219	01.2478	15.84	400098	01.2470	07.68	420055	01.1239	12.86	430051	00.9707	11.88	440064	01.1859	15.87
390220	01.1967	18.50	400102	01.2005	07.47	420056	01.0941	13.40	430054	00.9389	14.12	440065	01.2217	14.09
390222	01.2922	19.29	400103	01.4900	10.21	420057	01.2682	12.58	430056	00.8709	08.95	440067	01.1662	15.85
390223	01.6287	22.05	400104	01.2323	09.13	420059	00.9558	13.16	430057	00.9123	10.35	440068	01.1840	16.22
390224	00.9142	13.29	400105	01.2642	07.81	420061	01.2214	15.80	430060	00.9948	08.97	440069	01.0893	13.34
390225	01.2212	15.41	400106	01.2411	07.28	420062	01.4737	15.07	430062	00.8308	10.10	440070	01.1199	13.07
390226	01.7113	22.03	400109	01.5822	08.85	420064	01.1420	12.36	430064	01.1525	11.35	440071	01.4836	15.35
390228	01.1936	17.98	400110	01.0953	08.90	420065	01.3499	16.17	430065	01.0287	09.01	440072	01.4293	13.45
390231	01.3451	20.59	400111	01.1494	07.90	420066	00.9394	13.87	430066	00.9826	10.61	440073	01.2767	16.09
390233	01.2767	17.67	400112	01.2510	07.00	420067	01.1965	15.84	430073	01.1944	13.35	440078	00.9790	12.17
390235	01.7664	23.05	400113	01.1838	07.07	420068	01.2582	15.36	430076	00.9618	08.60	440081	01.1398	14.51
390236	01.1535	16.00	400114	01.0673	07.53	420069	01.0854	13.87	430077	01.5420	15.65	440082	01.8991	19.65
390237	01.5568	18.82	400115	01.0127	08.28	420070	01.2534	15.79	430079	00.9545	10.60	440083	01.1648	10.26
390238	01.0894	16.51	400117	01.2052	08.75	420071	01.3360	15.95	430080	00.8917	08.87	440084	01.1705	11.11
390242	01.3227	18.78	400118	01.1427	07.88	420072	01.0021	09.92	430081	00.9763	.....	440087	00.9796	11.67
390244	00.9153	12.37	400120	01.2844	08.63	420073	01.2975	17.80	430082	00.7899	.....	440090	00.9808	13.53
390245	01.3582	20.14	400121	00.8973	07.05	420074	00.9444	09.76	430083	00.8400	.....	440091	01.5310	16.83
390246	01.1577	15.60	400122	00.9790	06.35	420075	01.0336	13.97	430084	00.8592	.....	440095	01.2178	19.62
390247	01.0044	16.83	400123	01.1528	08.39	420076	01.1230	20.04	430085	00.8528	.....	440100	01.0220	12.92
390249	00.9992	11.06	400124	02.7935	.....	420078	01.7109	18.68	430087	00.9462	09.28	440102	01.0894	12.32
390256	01.6957	20.51	410001	01.3181	21.94	420079	01.5207	17.23	440001	01.1438	11.96	440103	01.2356	16.26
390258	01.3229	19.30	410004	01.3535	20.28	420080	01.2176	17.43	440002	01.5819	16.12	440104	01.5496	17.72
390260	01.2454	17.74	410005	01.3614	20.46	420081	00.7967	18.94	440003	01.0982	14.90	440105	01.4359	16.93
390262	01.9001	17.06	410006	01.2126	21.65	420082	01.3460	18.34	440006	01.4833	16.87	440109	01.0518	12.33
390263	01.4742	18.55	410007	01.6863	19.83	420083	01.2177	17.28	440007	01.0100	11.40	440110	00.9963	14.21
390265	01.3075	17.62	410008	01.1749	20.30	420084	00.9239	12.71	440008	01.0294	14.41	440111	01.3776	18.41
390266	01.1996	15.69	410009	01.3416	20.77	420085	01.2801	17.16	440009	01.1191	12.87	440114	01.0168	11.73
390267	01.2662	19.03	410010	01.0352	24.28	420086	01.4018	16.97	440010	00.9290	10.52	440115	01.0917	13.98
390268	01.3883	19.24	410011	01.2176	21.48	420087	01.6123	15.64	440011	01.2479	15.18	440120	01.4814	15.84
390270	01.3047	16.33	410012	01.7204	18.98	420088	01.1687	16.05	440012	01.4314	16.29	440121	01.9731	.....
390272	00.5347	20.70	410013	01.2564	24.87	420089	01.2401	19.72	440014	00.9936	10.17	440125	01.4135	16.36
390277	00.5685	19.80	420002	01.3076	20.09	420091	01.1896	15.91	440015	01.5414	15.38	440130	01.1216	13.51
390278	00.8123	16.44	420004	01.8572	17.72	430004	01.0162	14.56	440016	00.9709	10.91	440131	01.0820	13.17
390279	01.1355	.....	420005	01.1291	14.18	430005	01.2522	13.79	440017	01.5885	17.33	440132	01.1216	13.29
390280	00.8687	.....	420006	01.3106	15.86	430007	01.1290	11.45	440018	01.4879	15.33	440133	01.5290	17.70
400001	01.2171	08.19	420007	01.5047	15.99	430008	01.1381	13.47	440019	01.5921	18.39	440135	01.3506	19.68
400002	01.4419	10.77	420009	01.2531	15.89	430009	01.0883	10.81	440020	01.2181	16.73	440137	00.9636	11.88
400003	01.2195	08.34	420010	01.0854	13.22	430010	01.1134	08.78	440022	01.2003	12.79	440141	01.1777	12.78
400004	01.2103	08.02	420011	01.0971	14.00	430011	01.3615	14.10	440023	01.0157	11.52	440142	01.0517	10.83
400005	01.0871	06.34	420014	01.0714	13.05	430012	01.3050	14.13	440024	01.3814	16.35	440143	01.1010	16.30
400006	01.2516	06.86	420015	01.3661	16.20	430013	01.1996	15.09	440025	01.0818	12.19	440144	01.2163	17.90
400007	01.1884	07.19	420016	01.1283	13.46	430014	01.2671	16.05	440026	00.9153	15.63	440145	01.0539	13.40

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
440146	01.2978	12.03	450051	01.5096	18.04	450153	01.5438	17.33	450292	01.2600	17.64	450465	01.1813	11.39
440148	01.1549	15.81	450052	01.0230	13.39	450154	01.1285	10.93	450293	01.0277	12.90	450467	00.9691	13.77
440149	01.2150	15.70	450053	01.0703	15.65	450155	01.0107	10.09	450296	01.3571	16.97	450469	01.3473	15.87
440150	01.2583	18.75	450054	01.7336	21.09	450157	01.0311	14.31	450297	00.8956	13.66	450473	01.0491	15.90
440151	01.4156	15.89	450055	01.1093	11.71	450160	00.9356	17.51	450299	01.4096	17.66	450475	01.1874	14.99
440152	01.6578	17.32	450056	01.6499	17.62	450162	01.1964	17.13	450303	00.9720	10.74	450484	01.5173	17.72
440153	01.2633	14.46	450058	01.5208	14.43	450163	01.1423	16.18	450306	01.0838	11.84	450488	01.2219	19.43
440156	01.5231	18.76	450059	01.2787	12.62	450164	01.1333	12.97	450307	00.9772	13.59	450489	00.9989	14.86
440157	01.0053	13.12	450060	01.3766	19.96	450165	01.0054	14.05	450309	01.0505	11.15	450497	01.1598	12.54
440159	01.2421	.....	450063	01.0234	11.54	450166	00.9211	11.39	450315	01.2119	19.84	450498	01.1296	13.21
440161	01.5951	20.02	450064	01.5106	15.53	450169	00.8607	14.45	450320	01.3603	17.73	450508	01.5551	15.68
440166	01.4014	17.40	450065	01.1189	13.86	450170	00.9895	12.30	450321	00.9793	10.98	450514	01.1878	16.22
440168	01.0191	13.32	450068	01.7833	17.27	450176	01.2578	14.33	450322	00.8870	15.26	450517	01.0115	11.00
440173	01.4900	16.51	450070	01.1662	13.40	450177	01.1371	12.72	450324	01.5522	15.53	450518	01.5165	15.17
440174	00.9730	14.29	450072	01.2259	17.28	450178	01.0836	15.65	450325	01.1881	09.56	450523	01.5622	20.04
440175	01.2420	17.24	450073	01.1191	10.92	450181	00.9133	15.39	450327	00.9869	10.00	450530	01.2882	19.74
440176	01.3017	17.31	450074	00.8492	16.51	450184	01.5011	19.61	450330	01.1758	14.47	450534	00.9344	17.01
440178	01.2129	18.01	450076	01.5227	.....	450185	01.1232	09.25	450334	01.0079	11.79	450535	01.1966	16.74
440180	01.1306	16.13	450078	00.9592	10.69	450187	01.3348	15.83	450337	01.2726	14.42	450537	01.3800	18.07
440181	01.0368	12.30	450079	01.4470	19.51	450188	00.9808	12.13	450340	01.3364	14.79	450538	01.2233	18.62
440182	00.9087	14.69	450080	01.2576	14.43	450190	01.1818	17.82	450341	00.9763	16.17	450539	01.2718	14.11
440183	01.4914	15.92	450081	01.0910	12.40	450191	01.1079	15.11	450346	01.3821	15.86	450544	01.4394	19.57
440184	01.4104	18.05	450082	00.9799	14.21	450192	01.0655	15.77	450347	01.1385	14.95	450545	01.1893	16.75
440185	00.9987	17.19	450083	01.6927	16.91	450193	01.8455	20.78	450348	00.9936	10.99	450546	01.3009	15.56
440186	01.2154	16.59	450085	01.1191	13.44	450194	01.2628	16.17	450349	01.0976	25.54	450547	01.1799	13.04
440187	01.2318	16.58	450087	01.4765	20.99	450195	01.1649	17.01	450351	01.2378	20.82	450550	00.9777	17.28
440189	01.4607	16.08	450090	01.0814	11.92	450196	01.4781	13.63	450352	01.1492	15.51	450551	01.1352	12.64
440192	01.1078	14.00	450092	01.3766	12.51	450197	01.1513	18.21	450353	01.2989	17.12	450558	01.7485	18.18
440193	01.3105	17.42	450094	01.2950	17.42	450200	01.4362	15.19	450355	01.1550	11.43	450559	00.8703	10.67
440194	01.3026	17.11	450096	01.5012	18.60	450201	00.9844	14.55	450358	02.0824	19.02	450561	01.5458	16.77
440196	00.9296	14.68	450097	01.4119	17.99	450203	01.2264	15.81	450362	01.0825	11.91	450563	01.2669	21.61
440197	01.3620	19.48	450098	01.2552	13.96	450209	01.5849	16.60	450366	01.6443	18.85	450565	01.2714	14.73
440200	01.2074	16.77	450099	01.3037	16.51	450210	01.1197	12.40	450369	01.1403	10.97	450570	01.0643	12.15
440203	00.9627	11.16	450101	01.4061	14.92	450211	01.3930	14.50	450370	01.2110	11.99	450571	01.4160	14.67
440205	01.3025	14.19	450102	01.6381	17.29	450213	01.5335	15.73	450371	01.1823	10.92	450573	00.9645	13.22
440206	01.0764	13.22	450104	01.2372	13.07	450214	01.3888	17.29	450372	01.3285	22.86	450574	00.9827	13.75
450002	01.4686	18.34	450107	01.5476	18.16	450217	01.1331	11.65	450373	01.2235	13.96	450575	00.9515	14.24
450004	01.1281	12.11	450108	01.0272	12.16	450219	01.1040	13.42	450374	00.9039	11.71	450578	01.0238	14.27
450005	01.0892	14.37	450109	01.0396	16.18	450221	00.9863	13.35	450376	01.4734	14.76	450580	01.1179	12.70
450007	01.3197	13.04	450110	01.2341	14.61	450222	01.7067	17.58	450378	01.0687	18.25	450583	00.9814	12.02
450008	01.4103	14.15	450111	01.1514	18.57	450224	01.3981	15.77	450379	01.5572	20.78	450584	01.2182	12.25
450010	01.3556	14.39	450112	01.3449	12.60	450229	01.5394	15.30	450381	00.9491	12.16	450586	01.0168	12.00
450011	01.5223	16.73	450113	01.2319	14.59	450231	01.5327	17.95	450388	01.7306	17.23	450587	01.2802	15.54
450014	01.1081	13.51	450118	01.5353	15.96	450234	01.0317	11.57	450389	01.2099	17.39	450591	01.1080	15.20
450015	01.6382	14.59	450119	01.2988	15.78	450235	00.9859	12.40	450393	01.2470	21.55	450596	01.2924	16.49
450016	01.5859	18.64	450121	01.5746	18.89	450236	01.0705	13.45	450395	01.0148	14.21	450597	01.0598	15.32
450018	01.4858	19.82	450123	01.1617	16.60	450237	01.5886	15.96	450399	01.0278	12.52	450603	00.8258	11.74
450020	01.0466	14.94	450124	01.4856	18.15	450239	01.2557	12.21	450400	01.1214	13.83	450604	01.3711	12.85
450021	01.8443	19.58	450126	01.3582	16.49	450241	00.9480	13.71	450403	01.3371	19.91	450605	01.2926	18.17
450023	01.4041	15.21	450128	01.2520	13.45	450243	00.8275	11.52	450410	00.9614	16.52	450609	00.8993	11.00
450024	01.3873	14.47	450130	01.4833	16.85	450246	01.0125	10.82	450411	00.9623	11.26	450610	01.4896	17.33
450025	01.4725	15.12	450131	01.3207	17.06	450249	01.0282	10.84	450417	01.0110	13.74	450614	01.0715	12.13
450028	01.5375	17.21	450132	01.5960	15.46	450250	01.0189	12.12	450418	01.3733	16.29	450615	00.9254	11.97
450029	01.4012	11.81	450133	01.6059	17.50	450253	01.2030	12.54	450419	01.2552	20.88	450617	01.3368	18.17
450031	01.6419	18.78	450135	01.7237	19.83	450258	01.0849	10.82	450422	00.8158	23.68	450620	01.0358	13.85
450032	01.2840	13.14	450137	01.4452	21.51	450259	01.2156	17.92	450423	01.4053	22.35	450623	01.2321	17.54
450033	01.5984	16.13	450140	01.0268	12.94	450264	00.8617	09.77	450424	01.2098	16.01	450626	01.0232	13.74
450034	01.5650	16.34	450142	01.4624	19.12	450269	01.0790	13.32	450429	01.0802	12.22	450628	00.8951	11.43
450035	01.4950	19.26	450143	01.1229	11.76	450270	01.1067	10.66	450431	01.5647	17.87	450630	01.5789	22.91
450037	01.5437	16.93	450144	01.1095	15.44	450271	01.1987	14.76	450438	01.1417	13.61	450631	01.7397	18.06
450039	01.3673	17.94	450145	00.8879	12.61	450272	01.2222	15.51	450446	00.8057	13.57	450632	00.9909	10.90
450040	01.6012	16.80	450146	00.9990	16.15	450276	01.1137	11.27	450447	01.3466	17.04	450633	01.5675	17.65
450042	01.6252	15.24	450147	01.3675	17.10	450278	00.8682	11.11	450450	01.1208	13.64	450634	01.5775	20.13
450043	01.4123	17.52	450148	01.2850	18.70	450280	01.3411	19.11	450451	01.0779	16.31	450637	01.3732	17.24
450044	01.5738	19.16	450149	01.4000	18.97	450283	01.0279	13.57	450457	01.7418	16.53	450638	01.5845	21.91
450046	01.3278	16.83	450150	00.9221	12.55	450286	01.0489	13.54	450460	00.9999	11.81	450639	01.4385	23.61
450047	01.1284	14.89	450151	01.1844	12.12	450288	01.2387	13.72	450462	01.8365	18.04	450641	00.9502	11.53
450050	00.9784	13.70	450152	01.2996	14.41	450289	01.4874	16.97	450464	01.0067	13.17	450643	01.2894	16.86

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
450644	01.6088	21.23	450750	01.0246	11.13	460041	01.2248	18.67	490057	01.4890	16.35	500024	01.6083	21.17
450646	01.5906	18.64	450751	01.3272	21.86	460042	01.4963	15.69	490059	01.5998	17.16	500025	01.8684	22.05
450647	01.9884	22.49	450754	00.9098	11.72	460043	01.3741	19.57	490060	01.0575	17.44	500026	01.4016	21.54
450648	01.1125	12.96	450755	01.2089	13.35	460044	01.1648	18.10	490063	01.6367	22.05	500027	01.5390	21.51
450649	01.0969	12.57	450757	00.9885	12.42	460046	00.8607	12.57	490066	01.2549	17.26	500028	01.1284	14.22
450651	01.7432	22.45	450758	01.8822	20.89	460047	01.7937	18.94	490067	01.2556	14.34	500029	00.9587	12.95
450652	00.9632	12.52	450760	01.1644	18.92	460049	01.9333	15.66	490069	01.4348	14.22	500030	01.3685	24.00
450653	01.1757	16.49	450761	01.0223	09.89	460050	01.2337	.....	490071	01.4542	17.65	500031	01.2640	19.54
450654	00.9469	11.33	450763	01.0199	15.67	460051	01.0445	.....	490073	01.3843	21.85	500033	01.2449	17.29
450656	01.3727	15.58	450766	02.1856	19.39	470001	01.1934	17.49	490074	01.2589	16.61	500036	01.2776	18.39
450658	00.9981	10.98	450769	00.9727	12.82	470003	01.9247	17.39	490075	01.2964	16.02	500037	01.1897	17.16
450659	01.4943	19.28	450770	01.0467	12.94	470004	01.0722	14.19	490077	01.2149	17.00	500039	01.3377	19.49
450660	01.5981	20.17	450771	02.0587	18.83	470005	01.2108	18.33	490079	01.2757	14.03	500041	01.2747	21.21
450661	01.3065	18.06	450774	00.7538	21.30	470006	01.2015	18.12	490083	00.7547	13.47	500042	01.3098	20.40
450662	01.5933	16.63	450775	01.2005	17.45	470008	01.2928	16.29	490084	01.2941	16.33	500043	01.1372	16.16
450665	00.9971	11.26	450776	00.9537	10.12	470010	01.1493	17.20	490085	01.1576	12.49	500044	01.8736	19.89
450666	01.2396	17.31	450777	01.0057	14.24	470011	01.1925	18.92	490088	01.1847	14.26	500045	01.1212	18.22
450668	01.5522	18.60	450778	01.0640	15.29	470012	01.2697	15.64	490089	01.1042	14.82	500048	00.9117	15.45
450669	01.2481	19.18	450779	01.3064	21.26	470013	01.1390	18.59	490090	01.2200	13.95	500049	01.4899	16.56
450670	01.2784	16.66	450780	00.9836	22.14	470015	01.1457	16.60	490091	01.2392	21.12	500050	01.4060	19.25
450672	01.6395	19.60	450781	01.3563	17.80	470018	01.1609	17.36	490092	01.1705	14.20	500051	01.5384	21.26
450673	01.0761	11.01	450785	00.9009	.....	470020	00.9563	13.25	490093	01.2825	13.84	500052	01.2712	.....
450674	00.8953	21.14	450787	01.6643	.....	470023	01.2131	16.94	490094	01.1699	14.92	500053	01.2515	18.75
450675	01.4186	18.92	450788	01.3734	.....	470024	01.1176	17.30	490095	01.3280	15.08	500054	01.8258	19.36
450677	01.4547	17.98	450789	01.5166	.....	490001	01.0841	18.15	490097	01.1514	13.16	500055	01.0515	19.51
450678	01.6001	20.58	450790	01.4639	.....	490002	01.1122	13.81	490098	01.3214	11.28	500057	01.3245	15.53
450681	01.6741	16.31	450791	01.3605	.....	490003	00.6435	17.00	490099	00.9238	14.45	500058	01.4327	18.94
450683	01.2986	18.99	450792	02.0245	.....	490004	01.1979	16.16	490100	01.3493	15.30	500059	01.1171	19.10
450684	01.2701	19.08	450793	01.7205	.....	490005	01.5122	15.84	490101	01.1264	22.88	500060	01.4666	20.13
450686	01.4767	14.11	450794	01.5005	.....	490006	01.1536	11.33	490104	00.8991	13.15	500061	01.0210	18.41
450688	01.3862	18.04	450795	00.7983	.....	490007	02.0030	16.84	490105	00.7117	14.49	500062	01.1748	16.66
450690	01.4546	20.68	450797	00.8211	.....	490009	01.7149	17.43	490106	00.8530	14.71	500064	01.4821	20.82
450691	01.1341	17.17	450798	00.6737	.....	490010	01.1081	16.48	490107	01.2127	21.41	500065	01.3304	16.86
450694	01.3398	18.17	450799	01.7205	.....	490011	01.3387	16.63	490108	00.8585	.....	500068	00.9814	17.47
450696	01.4552	25.42	450897	04.9398	.....	490012	01.1697	15.28	490109	00.9591	15.20	500069	01.1385	17.48
450697	01.4442	16.21	460001	01.7298	18.59	490013	01.1924	14.26	490110	01.2966	17.10	500071	01.2496	18.61
450698	00.9526	11.08	460003	01.5949	18.81	490014	01.4385	20.38	490111	01.2268	15.12	500072	01.2221	20.50
450700	00.9540	12.44	460004	01.7192	19.08	490015	01.4857	15.02	490112	01.6762	18.77	500073	01.0568	15.12
450702	01.5786	18.31	460005	01.5937	17.62	490017	01.3020	16.09	490113	01.3532	20.37	500074	01.0883	14.41
450703	01.5413	19.25	460006	01.3874	17.64	490018	01.2041	16.62	490114	01.1088	14.33	500075	01.2828	19.27
450704	01.2670	17.67	460007	01.3090	17.38	490019	01.2498	14.91	490115	01.2261	13.65	500077	01.3492	20.78
450705	01.0180	17.17	460008	01.4032	17.62	490020	01.1735	14.05	490116	01.2469	15.71	500079	01.3578	19.43
450706	01.2046	20.86	460009	01.6060	18.12	490021	01.3480	16.28	490117	01.1112	12.95	500080	00.8344	11.39
450709	01.1943	20.28	460010	02.0221	18.98	490022	01.2783	17.26	490118	01.7075	20.83	500084	01.2294	20.02
450711	01.6186	17.54	460011	01.4052	15.54	490023	01.2035	16.32	490119	01.2866	15.88	500085	01.0260	16.17
450712	00.8013	13.61	460013	01.4857	17.85	490024	01.6911	16.18	490120	01.3466	15.75	500086	01.3689	17.97
450713	01.4662	18.26	460014	01.0888	13.89	490027	01.1650	12.79	490122	01.2872	20.90	500088	01.3266	22.26
450715	01.4731	18.76	460015	01.2749	18.76	490028	01.3394	18.38	490123	01.1430	14.54	500089	01.0004	13.34
450716	01.2218	19.00	460016	00.9499	11.00	490030	01.2407	11.35	490124	01.1661	15.26	500090	00.7866	11.74
450717	01.2784	21.01	460017	01.4383	17.16	490031	01.1795	12.64	490126	01.2848	14.21	500092	01.0572	15.00
450718	01.2203	18.08	460018	00.9576	12.68	490032	01.7158	17.92	490127	01.0520	14.36	500094	00.9085	14.32
450723	01.3063	18.47	460019	01.0413	12.47	490033	01.1833	14.44	490130	01.2888	15.51	500096	00.9781	17.15
450724	01.2219	15.86	460020	01.0260	13.72	490035	01.0368	.....	490131	00.9910	14.07	500097	01.2091	15.19
450725	01.1353	17.82	460021	01.3642	18.22	490037	01.1718	12.63	500001	01.3060	20.75	500098	00.9354	13.14
450726	00.8698	13.38	460022	00.9921	18.32	490038	01.1871	12.51	500002	01.4361	17.37	500101	00.9677	15.87
450727	00.9143	11.28	460023	01.1554	19.51	490040	01.3958	20.53	500003	01.3129	19.31	500102	00.9781	17.18
450728	00.9353	11.43	460024	01.0223	13.10	490041	01.2628	17.07	500005	01.7732	21.79	500104	01.2642	19.06
450730	01.3395	20.38	460025	00.7899	13.76	490042	01.3552	14.57	500007	01.3550	19.61	500106	00.9461	14.69
450732	01.3497	18.21	460026	01.0403	16.26	490043	01.2576	19.59	500008	01.8774	22.18	500107	01.1150	14.46
450733	01.3875	18.33	460027	00.9741	17.65	490044	01.3074	16.12	500009	01.3107	20.51	500108	01.6565	21.71
450734	01.3020	16.26	460029	01.1357	14.92	490045	01.1758	18.21	500011	01.3536	22.04	500110	01.2379	17.96
450735	00.9322	11.77	460030	01.2052	15.88	490046	01.4569	16.95	500012	01.5160	19.95	500118	01.1807	19.87
450742	01.2757	19.64	460032	00.9608	14.10	490047	01.0538	17.13	500014	01.8057	22.08	500119	01.3366	19.61
450743	01.3731	20.69	460033	00.9525	16.93	490048	01.4629	16.87	500015	01.3083	19.91	500122	01.2713	18.49
450745	00.7868	20.44	460035	00.8922	12.40	490050	01.3959	20.10	500016	01.3773	21.55	500123	01.0450	15.07
450746	01.0246	12.27	460036	00.9189	18.64	490052	01.5704	14.59	500019	01.2746	19.53	500124	01.3300	21.30
450747	01.4159	14.21	460037	01.0249	13.35	490053	01.2549	13.56	500021	01.5192	19.18	500125	01.0634	10.72
450749	01.0392	12.03	460039	00.9759	19.55	490054	01.0939	13.83	500023	01.2135	19.80	500127	00.7012	14.81

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
500129	01.6435	20.99	520003	01.1019	14.95	520092	01.1009	15.89	530012	01.5259	15.96			
500132	00.9823	18.61	520004	01.1977	15.96	520094	01.0671	15.88	530014	01.2904	14.52			
500134	00.8256	15.48	520006	01.0303	17.00	520095	01.3481	17.75	530015	01.1431	18.14			
500137	00.6497	17.85	520007	01.0705	13.40	520096	01.5431	16.65	530016	01.1199	11.30			
500138	05.5857	.....	520008	01.5038	20.21	520097	01.3461	16.82	530017	01.0566	15.09			
500139	01.4518	21.47	520009	01.6685	16.69	520098	01.8261	19.03	530018	01.0261	13.70			
500140	00.9789	13.96	520010	01.1333	18.74	520100	01.2401	15.22	530019	00.9964	12.98			
500141	01.3370	20.95	520011	01.1787	15.82	520101	01.1171	15.24	530022	01.0572	15.34			
500143	00.8363	14.99	520013	01.3440	17.39	520102	01.2258	18.37	530023	00.8340	16.19			
500145	01.8903	.....	520014	01.1833	14.92	520103	01.3072	16.55	530025	01.3592	17.07			
500898	01.1447	.....	520015	01.1939	16.10	520107	01.2720	15.90	530026	01.0587	13.67			
510001	01.6943	16.64	520016	01.0266	12.10	520109	01.0103	16.79	530027	00.8666	08.89			
510002	01.2607	17.53	520017	01.2182	16.17	520110	01.1029	16.26	530029	00.8700	13.80			
510004	00.9418	11.47	520018	00.9654	15.12	520111	01.0740	13.12	530031	00.8812	12.07			
510005	00.9081	12.40	520019	01.3228	15.81	520112	01.1233	17.91	530032	01.1554	16.45			
510006	01.2424	17.07	520021	01.3295	17.87	520113	01.1931	17.45						
510007	01.4216	16.92	520024	01.0301	12.06	520114	01.0922	12.56						
510008	01.0998	14.78	520025	01.0787	14.84	520115	01.2924	15.40						
510009	01.0048	12.02	520026	01.0610	16.62	520116	01.2584	16.86						
510012	01.0531	14.30	520027	01.1488	18.20	520117	01.0564	14.29						
510013	01.1930	14.68	520028	01.3486	16.60	520118	00.9485	09.62						
510015	00.9510	13.86	520029	00.9455	15.32	520120	00.9830	11.97						
510016	01.0213	11.19	520030	01.6743	18.99	520121	00.9330	13.81						
510018	01.0890	12.75	520031	01.1703	16.00	520122	01.0095	13.21						
510020	01.0922	09.36	520032	01.1521	14.19	520123	01.0554	15.20						
510022	01.7054	18.97	520033	01.1822	15.92	520124	01.1511	14.50						
510023	01.1019	15.21	520034	01.1919	16.24	520130	01.0949	12.36						
510024	01.3533	16.56	520035	01.2474	14.95	520131	01.0242	15.72						
510025	00.9456	10.06	520037	01.5852	17.92	520132	01.1825	13.60						
510026	00.9312	11.40	520038	01.3793	16.35	520134	01.0935	14.40						
510027	00.9817	13.01	520039	01.0054	15.55	520135	01.0064	12.70						
510028	01.0630	18.75	520040	01.4619	19.00	520136	01.5225	18.05						
510029	01.2924	15.75	520041	01.1965	14.44	520138	01.8502	17.66						
510030	01.0608	14.71	520042	01.0497	15.99	520139	01.2028	17.83						
510031	01.3136	15.41	520044	01.3539	15.83	520140	01.5559	18.24						
510033	01.2401	13.81	520045	01.6488	16.87	520141	01.1553	15.56						
510035	01.1549	17.54	520047	01.0317	14.12	520142	00.8153	11.71						
510036	00.9330	11.78	520048	01.4308	16.96	520144	01.0173	15.72						
510038	01.0459	13.86	520049	01.8222	17.11	520145	00.9640	16.59						
510039	01.3509	14.77	520051	01.9233	18.64	520146	01.0787	12.88						
510043	00.9749	10.23	520053	01.0459	14.95	520148	01.1487	14.99						
510046	01.2071	15.27	520054	01.0481	15.66	520149	00.9606	12.29						
510047	01.1461	16.64	520056	01.2856	17.61	520151	01.0828	13.81						
510048	01.1064	17.03	520057	01.1572	15.81	520152	01.1492	15.57						
510050	01.3072	14.07	520058	01.0289	17.40	520153	00.9151	12.42						
510053	00.9862	13.43	520059	01.2817	17.27	520154	01.1233	15.66						
510055	01.2700	18.38	520060	01.3379	14.70	520156	01.0988	17.35						
510058	01.2284	15.23	520062	01.2446	15.60	520157	01.0073	13.06						
510059	01.0508	13.61	520063	01.1934	16.74	520159	00.8912	15.84						
510060	01.1108	13.44	520064	01.6924	17.58	520160	01.7825	16.98						
510061	01.0267	13.23	520066	01.3684	17.75	520161	01.0499	14.34						
510062	01.2044	15.84	520068	00.9064	14.65	520170	01.3136	17.27						
510063	01.0554	13.39	520069	01.2244	15.89	520171	00.9780	13.38						
510065	00.9964	18.80	520070	01.4628	16.29	520173	01.2002	17.49						
510066	01.1021	11.29	520071	01.1162	16.28	520174	01.4623	19.90						
510067	01.2260	16.60	520074	01.1022	14.80	520177	01.5389	19.26						
510068	01.1324	14.26	520075	01.4723	16.74	520178	01.0619	13.83						
510070	01.1945	15.60	520076	01.0948	14.67	520186	02.1412	.....						
510071	01.2602	14.58	520077	01.0475	13.87	530002	01.1018	16.35						
510072	01.0953	12.86	520078	01.4727	16.04	530003	00.8823	12.54						
510077	01.1439	13.21	520082	01.4075	15.87	530004	01.0189	12.81						
510080	01.1711	10.11	520083	01.6393	20.44	530005	01.0032	11.90						
510081	00.9772	12.88	520084	01.1026	14.57	530006	01.1623	16.90						
510082	01.1301	11.32	520087	01.6097	16.33	530007	01.0744	11.30						
510084	00.9945	12.23	520088	01.2813	16.17	530008	01.2067	16.29						
510085	01.2462	17.51	520089	01.5211	18.22	530009	01.0242	15.00						
510086	01.1086	14.08	520090	01.2264	15.59	530010	01.2322	16.82						
520002	01.2769	16.70	520091	01.2702	16.49	530011	01.0511	15.86						

Note: Case mix indexes do not include discharges from PPS-Exempt Units. Case mix indexes include cases received in HCFA Central Office through June 1995.

BILLING CODE 4120–01–P

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index	GAF
0040 Abilene, TX	0.8546	0.8980
Taylor, TX		
0060 Aguadilla, PR	0.4744	0.6001
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9578	0.9709
Portage, OH		
Summit, OH		
0120 Albany, GA	0.8608	0.9024
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8818	0.9175
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9542	0.9684
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8010	0.8590
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0198	1.0135
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9007	0.9309
Blair, PA		
0320 Amarillo, TX	0.8759	0.9133
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3373	1.2202
Anchorage, AK		
0440 Ann Arbor, MI	1.2116	1.1405
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8158	0.8699
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8844	0.9193
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4498	0.5786
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9218	0.9458
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9097	0.9372
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 *Atlanta, GA	1.0069	1.0047
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
De Kalb, 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 City-Cape May, NJ	1.0935	1.0631
Atlantic City, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA-SC	0.8955	0.9272
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 Austin-San Marcos, TX	0.9255	0.9484
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA	1.0502	1.0341
Kern, CA		
0720 *Baltimore, MD	0.9866	0.9908
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Annes, MD		
0733 Bangor, ME	0.9360	0.9557
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3457	1.2255
Barnstable, MA		
0760 Baton Rouge, LA	0.8670	0.9069
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8603	0.9021
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.2681	1.1766
Whatcom, WA		
0870 Benton Harbor, MI	0.8304	0.8805
Berrien, MI		
0875 *Bergen-Passaic, NJ	1.1474	1.0987
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.8705	0.9094
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8448	0.8909
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.9005	0.9307
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9144	0.9406
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8299	0.8801
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8429	0.8896
Monroe, IN		
1040 Bloomington-Normal, IL	0.8740	0.9119
McLean, IL		
1080 Boise City, ID	0.9150	0.9410
Ada, ID		
Canyon, ID		
1123 *Boston-Brockton-Nashua, MA-NH	1.1685	1.1125
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	0.9780	0.9849
Boulder, CO		
1145 Brazoria, TX	0.8584	0.9007
Brazoria, TX		
1150 Bremerton, WA	1.0295	1.0201
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8650	0.9055
Cameron, TX		
1260 Bryan-College Station, TX	0.8987	0.9295
Brazos, TX		
1280 *Buffalo-Niagara Falls, NY	0.9186	0.9435
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9252	0.9482
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4706	0.5968
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
1320 Canton-Massillon, OH	0.8749	0.9125
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.8662	0.9063
Natrona, WY		
1360 Cedar Rapids, IA	0.8359	0.8845
Linn, IA		
1400 Champaign-Urbana, IL	0.8867	0.9210
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8930	0.9254
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9498	0.9653
Kanawha, WV		
Putnam, WV		
1520 *Charlotte-Gastonia-Rock Hill, NC-SC	0.9668	0.9771
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	0.9179	0.9430
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.9129	0.9395
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 Cheyenne, WY	0.7935	0.8535
Laramie, WY		
1600 *Chicago, IL	1.0632	1.0429
Cook, IL		
De Kalb, IL		
Du Page, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0531	1.0361
Butte, CA		
1640 *Cincinnati, OH-KY-IN	0.9418	0.9598
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	0.7542	0.8243
Christian, KY		
Montgomery, TN		
1680 *Cleveland-Lorain-Elyria, OH	0.9835	0.9887
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9294	0.9511
El Paso, CO		
1740 Columbia, MO	0.9461	0.9628
Boone, MO		
1760 Columbia, SC	0.9033	0.9327
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.7756	0.8403
Russell, AL		
Chattanoochee, GA		
Harris, GA		
Muscogee, GA		
1840 *Columbus, OH	0.9734	0.9817
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8941	0.9262
Nueces, TX		
San Patricio, TX		
1900 Cumberland, MD-WV	0.8372	0.8854
Allegany, MD		
Mineral, WV		
1920 *Dallas, TX	0.9804	0.9865
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8465	0.8922
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Rock Island-Moline, IA-IL	0.8347	0.8836
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9428	0.9605
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.8902	0.9234
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8180	0.8715
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.7790	0.8428
Macon, IL		
2080 *Denver, CO	1.0447	1.0304
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8792	0.9156
Dallas, IA		
Polk, IA		
Warren, IA		
2160 *Detroit, MI	1.0834	1.0564
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7751	0.8399
Dale, AL		
Houston, AL		
2190 Dover, DE	0.8960	0.9276
Kent, DE		
2200 Dubuque, IA	0.8054	0.8623
Dubuque, IA		
2240 Duluth-Superior, MN-WI	0.9660	0.9766
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0697	1.0472
Dutchess, NY		
2290 Eau Claire, WI	0.8660	0.9062
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9266	0.9491
El Paso, TX		
2330 Elkhart-Goshen, IN	0.8806	0.9166
Elkhart, IN		
2335 Elmira, NY	0.8460	0.8918
Chemung, NY		
2340 Enid, OK	0.8170	0.8707
Garfield, OK		
2360 Erie, PA	0.9196	0.9442
Erie, PA		
2400 Eugene-Springfield, OR	1.1184	1.0796
Lane, OR		
2440 Evansville-Henderson, IN-KY	0.8899	0.9232
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND-MN	0.8912	0.9242
Clay, MN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Cass, ND		
2560 Fayetteville, NC	0.8843	0.9192
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7090	0.7902
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ-UT	0.8619	0.9032
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.0738	1.0500
Genesee, MI		
2650 Florence, AL	0.7970	0.8561
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8537	0.8973
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0595	1.0404
Larimer, CO		
2680 *Ft. Lauderdale, FL	1.0952	1.0643
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9666	0.9770
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0401	1.0273
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR-OK	0.7608	0.8293
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.8705	0.9094
Okaloosa, FL		
2760 Fort Wayne, IN	0.8691	0.9084
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 *Forth Worth-Arlington, TX	1.0052	1.0036
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0522	1.0355
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8568	0.8996
Etowah, AL		
2900 Gainesville, FL	0.9007	0.9309
Alachua, FL		
2920 Galveston-Texas City, TX	1.0304	1.0207
Galveston, TX		
2960 Gary, IN	0.9452	0.9621
Lake, IN		
Porter, IN		
2975 Glens Falls, NY	0.9276	0.9498
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8165	0.8704
Wayne, NC		
2985 Grand Forks, ND-MN	0.8983	0.9292
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.7988	0.8574
Mesa, CO		
3000 Grand Rapids-Muskegon-Holland, MI	1.0055	1.0038
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9039	0.9331
Cascade, MT		
3060 Greeley, CO	0.9146	0.9407
Weld, CO		
3080 Green Bay, WI	0.9190	0.9438
Brown, WI		
3120 *Greensboro-Winston-Salem-High. Point, NC	0.9160	0.9417
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9102	0.9376
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9047	0.9337
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9074	0.9356
Washington, MD		
3200 Hamilton-Middletown, OH	0.8782	0.9149
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9972	0.9981
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 *Hartford, CT	1.2391	1.1581
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS	0.7245	0.8020
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.7983	0.8570
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1212	1.0815
Honolulu, HI		
3350 Houma, LA	0.7596	0.8284
Lafourche, LA		
Terrebonne, LA		
3360 *Houston, TX	0.9874	0.9914
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.8997	0.9302
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8113	0.8666
Limestone, AL		
Madison, AL		
3480 *Indianapolis, IN	0.9757	0.9833
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9371	0.9565
Johnson, IA		
3520 Jackson, MI	0.9132	0.9397
Jackson, MI		
3560 Jackson, MS	0.7642	0.8318
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8511	0.8955
Madison, TN		
3600 Jacksonville, FL	0.8953	0.9271
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC	0.6926	0.7776
Onslow, NC		
3610 Jamestown, NY	0.7535	0.8238
Chautaqua, NY		
3620 Janesville-Beloit, WI	0.8786	0.9152
Rock, WI		
3640 Jersey City, NJ	1.1039	1.0700
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8769	0.9140
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA ..	0.8521	0.8962
Cambria, PA		
Somerset, PA		
3710 Joplin, MO	0.7923	0.8526
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0657	1.0445
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9114	0.9384
Kankakee, IL		
3760 *Kansas City, KS-MO	0.9351	0.9551
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	0.8872	0.9213
Kenosha, WI		
3810 Killeen-Temple, TX	1.0526	1.0357
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8518	0.8960
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8834	0.9186
Howard, IN		
Tipton, IN		
3870 La Crosse, WI-MN	0.8519	0.8960
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8498	0.8945
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8328	0.8822
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.8094	0.8652
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8668	0.9067
Polk, FL		
4000 Lancaster, PA	0.9569	0.9703
Lancaster, PA		
4040 Lansing-East Lansing, MI	1.0105	1.0072
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.6750	0.7640
Webb, TX		
4100 Las Cruces, NM	0.8861	0.9205
Dona Ana, NM		
4120 *Las Vegas, NV-AZ	1.0934	1.0631
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8549	0.8982
Douglas, KS		
4200 Lawton, OK	0.8594	0.9014
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9433	0.9608
Androscoggin, ME		
4280 Lexington, KY	0.8348	0.8837
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.8863	0.9207
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9093	0.9370
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8527	0.8966
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8653	0.9057
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 *Los Angeles-Long Beach, CA	1.2461	1.1626
Los Angeles, CA		
4520 Louisville, KY-IN	0.9327	0.9534
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8443	0.8906
Lubbock, TX		
4640 Lynchburg, VA ...	0.8205	0.8733
Amherst, VA		
Bedford City, VA		
Bedford, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8991	0.9298
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0055	1.0038
Dane, WI		
4800 Mansfield, OH ...	0.8373	0.8855
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR ...	0.4644	0.5914
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8669	0.9068
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0162	1.0111
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9323	0.9531
Brevard, Fl		
4920 *Memphis, TN-AR-MS	0.8399	0.8874
Crittenden, AR		
De Soto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0877	1.0593
Merced, CA		
5000 *Miami, FL	0.9552	0.9691
Dade, FL		
5015 *Middlesex-Somerset-Hunterdon, NJ ..	1.0583	1.0396
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 *Milwaukee-Waukesha, WI	0.9498	0.9653
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 *Minneapolis-St Paul, MN-WI	1.0744	1.0504
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		
5160 Mobile, AL	0.7706	0.8366
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0658	1.0446
Stanislaus, CA		
5190 *Monmouth-Ocean, NJ	1.0562	1.0382
Monmouth, NJ		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Ocean, NJ		
5200 Monroe, LA	0.7948	0.8545
Ouachita, LA		
5240 Montgomery, AL	0.7901	0.8510
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9125	0.9392
Delaware, IN		
5330 Myrtle Beach, SC	0.7961	0.8554
Horry, SC		
5345 Naples, FL	0.9871	0.9911
Collier, FL		
5360 *Nashville, TN	0.9266	0.9491
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 *Nassau-Suffolk, NY	1.3128	1.2049
Nassau, NY		
Suffolk, NY		
5483 *New Haven-Bridgeport-StamfordDanbury-Waterbury, CT	1.2534	1.1673
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2088	1.1387
New London, CT		
5560 *New Orleans, LA	0.9454	0.9623
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	1.3852	1.2500
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 *Newark, NJ	1.1241	1.0834
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.0619	1.0420
Orange, NY		
Pike, PA		
5720 *Norfolk-Virginia Beach-Newport News, VA-NC	0.8411	0.8883
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	1.5203	1.3322
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.8942	0.9263
Marion, FL		
5800 Odessa-Midland, TX	0.8753	0.9128
Ector, TX		
Midland, TX		
5880 *Oklahoma City, OK	0.8358	0.8844
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.1109	1.0747
Thurston, WA		
5920 Omaha, NE-IA	0.9794	0.9858
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 *Orange County, CA	1.2299	1.1522
Orange, CA		
5960 *Orlando, FL	0.9515	0.9665
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.7498	0.8210
Daviess, KY		
6015 Panama City, FL	0.8182	0.8716
Bay, FL		
6020 Parkersburg-Marietta, WV-OH	0.7751	0.8399
Washington, OH		
Wood, WV		
6080 Pensacola, FL	0.8183	0.8717
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8619	0.9032
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 *Philadelphia, PA-NJ	1.1098	1.0739
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 *Phoenix-Mesa, AZ	0.9808	0.9868
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7985	0.8572
Jefferson, AR		
6280 *Pittsburgh, PA	0.9743	0.9823
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA	1.0838	1.0567
Berkshire, MA		
6360 Ponce, PR	0.4780	0.6032
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9744	0.9824
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 *Portland-Vancouver, OR-WA	1.1248	1.0839
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 *Providence-Warwick, RI	1.1027	1.0692
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9843	0.9892
Utah, UT		
6560 Pueblo, CO	0.8508	0.8953
Pueblo, CO		
6580 Punta Gorda, FL	0.8806	0.9166
Charlotte, FL		
6600 Racine, WI	0.8704	0.9093
Racine, WI		
6640 Raleigh-Durham-Chapel Hill, NC	0.9539	0.9682
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Wake, NC		
6660 Rapid City, SD ..	0.8267	0.8778
Pennington, SD		
6680 Reading, PA	0.9570	0.9704
Berks, PA		
6690 Redding, CA	1.1796	1.1198
Shasta, CA		
6720 Reno, NV	1.1087	1.0732
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.0011	1.0008
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9055	0.9343
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	1.1489	1.0997
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8570	0.8997
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN ..	1.0545	1.0370
Olmsted, MN		
6840 *Rochester, NY .	0.9585	0.9714
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8872	0.9213
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8836	0.9187
Edgecombe, NC		
Nash, NC		
6920 *Sacramento, CA	1.2539	1.1676
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9489	0.9647
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9549	0.9689
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO .	0.8457	0.8916
Andrews, MO		
Buchanan, MO		
7040 *St. Louis, MO-IL	0.8880	0.9219
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	0.9575	0.9707
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4263	1.2753
Monterey, CA		
7160 *Salt Lake City-Ogden, UT	0.9681	0.9780
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX .	0.7777	0.8418
Tom Green, TX		
7240 *San Antonio, TX	0.8414	0.8885
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 *San Diego, CA .	1.1856	1.1237
San Diego, CA		
7360 *San Francisco, CA	1.4288	1.2768
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 *San Jose, CA ...	1.4455	1.2870
Santa Clara, CA		
7440 *San Juan-Bayamon, PR	0.4514	0.5800
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		
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	1.1405	1.0942
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.1136	1.0765
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3944	1.2557
Santa Cruz, CA		
7490 Santa Fe, NM	1.1108	1.0746
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2693	1.1774
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9824	0.9879
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA ...	0.8968	0.9281
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8724	0.9108
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 *Seattle-Bellevue-Everett, WA	1.1307	1.0878
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA	0.9093	0.9370
Mercer, PA		
7620 Sheboygan, WI ..	0.7981	0.8569
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8780	0.9148
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9007	0.9309
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.8436	0.8901
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD .	0.8761	0.9134
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN ..	0.9475	0.9637
St. Joseph, IN		
7840 Spokane, WA	1.0377	1.0257
Spokane, WA		
7880 Springfield, IL	0.8940	0.9261

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.7896	0.8506
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA	1.0517	1.0351
Hampden, MA		
Hampshire, MA		
8050 State College, PA	1.0162	1.0111
Centre, PA		
8080 Steubenville-Weirton, OH-WV	0.8455	0.8914
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.1672	1.1117
San Joaquin, CA		
8140 Sumter, SC	0.8344	0.8834
Sumter, SC		
8160 Syracuse, NY	0.9531	0.9676
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.0828	1.0560
Pierce, WA		
8240 Tallahassee, FL	0.8321	0.8817
Gadsden, FL		
Leon, FL		
8280 *Tampa-St. Petersburg-Clearwater, FL	0.9311	0.9523
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8672	0.9070
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8257	0.8771
Miller, AR		
Bowie, TX		
8400 Toledo, OH	1.0330	1.0225
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9735	0.9818
Shawnee, KS		
8480 Trenton, NJ	1.0033	1.0023
Mercer, NJ		
8520 Tucson, AZ	0.9291	0.9509
Pima, AZ		
8560 Tulsa, OK	0.8245	0.8762
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8090	0.8649
Tuscaloosa, AL		
8640 Tyler, TX	0.9430	0.9606
Smith, TX		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
8680 Utica-Rome, NY	0.8514	0.8957
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3040	1.1993
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.2330	1.1542
Ventura, CA		
8750 Victoria, TX	0.8435	0.8900
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	0.9966	0.9977
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0446	1.0303
Tulare, CA		
8800 Waco, TX	0.7898	0.8508
McLennan, TX		
8840 *Washington, DC-MD-VA-WV	1.1075	1.0724
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpepper, 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	0.8638	0.9046
Black Hawk, IA		
8940 Wausau, WI	1.0034	1.0023
Marathon, WI		
8960 West Palm Beach-Boca Raton, FL	1.0096	1.0066
Palm Beach, FL		
9000 Wheeling, OH-WV	0.7518	0.8225
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9562	0.9698
Butler, KS		
Harvey, KS		
Sedgwick, KS		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
9080 Wichita Falls, TX	0.7763	0.8408
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8508	0.8953
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.1539	1.1030
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9299	0.9514
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	0.9951	0.9966
Yakima, WA		
9270 Yolo, CA	1.1615	1.1080
Yolo, CA		
9280 York, PA	0.9165	0.9420
York, PA		
9320 Youngstown-Warren, OH	0.9555	0.9693
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0611	1.0414
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9769	0.9841
Yuma, AZ		

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7183	0.7973
Alaska	1.2034	1.1352
Arizona	0.7995	0.8579
Arkansas	0.6901	0.7757
California	1.0096	1.0066
Colorado	0.7988	0.8574
Connecticut	1.3117	1.2042
Delaware	0.9019	0.9317
Florida	0.8668	0.9067
Georgia	0.7721	0.8377
Hawaii	0.9847	0.9895
Idaho	0.8378	0.8859
Illinois	0.7497	0.8210
Indiana	0.8067	0.8632
Iowa	0.7352	0.8101
Kansas	0.7229	0.8007
Kentucky	0.7660	0.8331
Louisiana	0.7275	0.8042
Maine	0.8425	0.8893
Maryland	0.8463	0.8920
Massachusetts	1.0577	1.0392
Michigan	0.8744	0.9122
Minnesota	0.8129	0.8677
Mississippi	0.6697	0.7599
Missouri	0.7187	0.7976
Montana	0.8091	0.8650
Nebraska	0.7219	0.8000
Nevada	0.8788	0.9153
New Hampshire	1.0013	1.0009

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
New Jersey [1]	.....	.....
New Mexico	0.8329	0.8823
New York	0.8647	0.9052
North Carolina	0.7983	0.8570
North Dakota	0.7265	0.8035
Ohio	0.8286	0.8792
Oklahoma	0.6985	0.7821
Oregon	0.9486	0.9645
Pennsylvania	0.8521	0.8962
Puerto Rico	0.4326	0.5634
Rhode Island [1]	.....	.....
South Carolina	0.7738	0.8389
South Dakota	0.6987	0.7823
Tennessee	0.7409	0.8144
Texas	0.7302	0.8063
Utah	0.8652	0.9056
Vermont	0.9043	0.9334
Virginia	0.7801	0.8436
Washington	0.9775	0.9845
West Virginia	0.8069	0.8634
Wisconsin	0.8391	0.8868
Wyoming	0.8013	0.8592

[1] All counties within the State are classified urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to	Wage index	GAF
Abilene, TX	0.8546	0.8980
Albuquerque, NM	0.9542	0.9684
Alexandria, LA	0.8010	0.8590
Allentown-Bethlehem-Easton, PA	1.0198	1.0135
Amarillo, TX	0.8759	0.9133
Anchorage, AK	1.3373	1.2202
Asheville, NC	0.9218	0.9458
Atlanta, GA	1.0069	1.0047
Augusta-Aiken, GA-SC	0.8955	0.9272
Baton Rouge, LA	0.8670	0.9069
Benton Harbor, MI	0.8304	0.8805
Benton Harbor, MI (Rural Michigan Hosp.)	0.8744	0.9122
Bergen-Passaic, NJ	1.1329	1.0892
Biloxi-Gulfport-Pascagoula, MS	0.8448	0.8909
Birmingham, AL	0.9144	0.9406
Bismarck, ND	0.8172	0.8709
Boise City, ID	0.9150	0.9410
Boston-Brockton-Nashua, MA-NH	1.1685	1.1125
Brazoria, TX	0.7724	0.8379
Casper, WY	0.8662	0.9063
Champaign-Urbana, IL	0.8664	0.9065
Charleston-North Charleston, SC	0.8930	0.9254
Charleston, WV	0.9317	0.9527
Charlotte-Gastonia-Rock Hill, NC-SC	0.9668	0.9771
Charlottesville, VA	0.9030	0.9325
Chattanooga, TN-GA	0.9015	0.9315

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Chicago, IL	1.0511	1.0347
Cincinnati, OH-KY-IN	0.9418	0.9598
Cleveland-Lorain-Elyria, OH	0.9835	0.9887
Columbia, MO	0.9151	0.9411
Columbus, GA-AL	0.7756	0.8403
Columbus, OH	0.9734	0.9817
Dallas, TX	0.9804	0.9865
Davenport-Rock Island-Moline, IA-IL	0.8347	0.8836
Dayton-Springfield, OH	0.9428	0.9605
Denver, CO	1.0447	1.0304
Des Moines, IA	0.8684	0.9079
Detroit, MI	1.0834	1.0564
Duluth-Superior, MN-WI	0.9660	0.9766
Dutchess County, NY	1.0546	1.0371
Eau Claire, WI	0.8660	0.9062
Elkhart-Goshen, IN	0.8806	0.9166
Eugene-Springfield, OR	1.1184	1.0796
Fargo-Moorhead, ND-MN	0.8912	0.9242
Fayetteville, NC	0.8504	0.8950
Flint, MI	1.0738	1.0500
Florence, AL	0.7970	0.8561
Florence, SC	0.8537	0.8973
Fort Lauderdale, FL	1.0952	1.0643
Fort Pierce-Port St Lucie, FL	1.0069	1.0047
Fort Smith, AR-OK	0.7608	0.8293
Fort Walton Beach, FL	0.8705	0.9094
Fort Worth-Arlington, TX	1.0052	1.0036
Gadsden, AL	0.8568	0.8996
Grand Forks, ND-MN	0.8983	0.9292
Great Falls, MT	0.9039	0.9331
Greeley, CO	0.8993	0.9299
Green Bay, WI	0.9190	0.9438
Greenville-Spartanburg-Anderson, SC	0.9047	0.9337
Harrisburg-Lebanon-Carlisle, PA	0.9972	0.9981
Hartford, CT	1.2228	1.1477
Honolulu, HI	1.1212	1.0815
Houston, TX	0.9874	0.9914
Huntington-Ashland, WV-KY-OH	0.8997	0.9302
Huntsville, AL	0.7948	0.8545
Indianapolis, IN	0.9647	0.9757
Jackson, MS	0.7642	0.8318
Jacksonville, FL	0.8953	0.9271
Johnson City-Kingsport-Bristol, TN-VA	0.8769	0.9140
Joplin, MO	0.7923	0.8526
Kalamazoo-Battlecreek, MI	1.0449	1.0305
Kansas City, KS-MO	0.9351	0.9551
Knoxville, TN	0.8518	0.8960
Lafayette, LA	0.8498	0.8945
Lansing-East Lansing, MI	1.0105	1.0072
Las Vegas, NV-AZ	1.0934	1.0631
Lexington, KY	0.8348	0.8837
Lima, OH	0.8863	0.9207
Lincoln, NE	0.8885	0.9222
Little Rock-North Little Rock, AR	0.8527	0.8966
Longview-Marshall, TX	0.8479	0.8932
Los Angeles-Long Beach, CA	1.2461	1.1626

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Louisville, KY-IN	0.9327	0.9534
Lubbock, TX	0.8443	0.8906
Madison, WI	1.0055	1.0038
Mansfield, OH	0.8373	0.8855
Medford-Ashland, OR	1.0162	1.0111
Memphis, TN-AR-MS	0.8292	0.8796
Middlesex-Somerset-Hunterdon, NJ	1.0355	1.0242
Milwaukee-Waukesha, WI	0.9498	0.9653
Minneapolis-St. Paul, MN-WI	1.0744	1.0504
Modesto, CA	1.0658	1.0446
Monroe, LA	0.7948	0.8545
Montgomery, AL	0.7901	0.8510
Nashville, TN	0.9266	0.9491
New London-Norwich, CT	1.2088	1.1387
New Orleans, LA	0.9454	0.9623
New York, NY	1.3852	1.2500
Newark, NJ	1.1241	1.0834
Newburgh, NY-PA	1.0619	1.0420
Oakland, CA	1.5203	1.3322
Odessa-Midland, TX	0.8753	0.9128
Oklahoma City, OK	0.8358	0.8844
Omaha, NE-IA	0.9794	0.9858
Orange County, CA	1.5593	1.3556
Peoria-Pekin, IL	0.8619	0.9032
Philadelphia, PA-NJ	1.1098	1.0739
Pittsburgh, PA	0.9743	0.9823
Portland, ME	0.9744	0.9824
Portland-Vancouver, OR-WA	1.1248	1.0839
Provo-Orem, UT	0.9646	0.9756
Raleigh-Durham-Chapel Hill, NC	0.9539	0.9682
Rapid City, SD	0.8267	0.8778
Richland-Kennewick-Pasco, WA	0.9768	0.9841
Roanoke, VA	0.8570	0.8997
Rochester, MN	1.0545	1.0370
Rockford, IL	0.8872	0.9213
Rocky Mount, NC	0.8836	0.9187
Sacremento, CA	1.2539	1.1676
Saginaw-Bay City-Midland, MI,	0.9489	0.9647
St. Cloud, MN	0.9549	0.9689
St. Louis, MO-IL	0.8880	0.9219
Salem, OR	0.9575	0.9707
Salinas, CA	1.4141	1.2678
Salt Lake City-Ogden, UT	0.9681	0.9780
San Diego, CA	1.1856	1.1237
San Francisco, CA	1.4288	1.2768
San Jose, CA	1.4455	1.2870
Santa Rosa, CA	1.2574	1.1698
Sarasota-Bradenton, FL	0.9824	0.9879
Savannah, GA	0.8968	0.9281
Seattle-Bellevue-Everett, WA	1.1307	1.0878
Sharon, PA	0.9093	0.9370
Sherman-Denison, TX	0.8436	0.8901
Sioux Falls, SD	0.8761	0.9134
South Bend, IN	0.9475	0.9637
Springfield, IL	0.8836	0.9187
Springfield, MO	0.7896	0.8506
Stockton, CA	1.1672	1.1117

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Syracuse, NY	0.9531	0.9676
Tampa-St. Petersburg-Clearwater, FL	0.9311	0.9523
Texarkana, TX-Texarkana, AR	0.8257	0.8771
Topeka, KS	0.9401	0.9586
Trenton, NJ	1.2599	1.1714
Tucson, AZ	0.9291	0.9509
Tulsa, OK	0.8245	0.8762
Tyler, TX	0.9164	0.9420
Ventura, CA	1.2330	1.1542
Victoria, TX	0.8435	0.8900
Waco, TX	0.7898	0.8508
Washington, DC-MD-VA-WV	1.1075	1.0724
Waterloo-Cedar Falls, IA	0.8638	0.9046
Wausau, WI	0.9679	0.9779
Wichita, KS	0.9309	0.9521
Rural Alabama	0.7183	0.7973
Rural Arkansas	0.6901	0.7757
Rural Florida	0.8668	0.9067
Rural Kentucky	0.7660	0.8331
Rural Louisiana	0.7275	0.8042
Rural Michigan	0.8744	0.9122
Rural Minnesota	0.8129	0.8677
Rural Missouri	0.7187	0.7976
Rural New Hampshire	1.0013	1.0009
Rural North Carolina	0.7983	0.8570
Rural Virginia	0.7801	0.8436
Rural West Virginia	0.8069	0.8634
Rural Wyoming	0.8013	0.8592

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	16.1778
Aguadilla, PR	8.9796
Akron, OH	18.0935
Albany, GA	16.2942
Albany-Schenectady-Troy, NY	16.6927
Albuquerque, NM	18.0635
Alexandria, LA	14.9860
Allentown-Bethlehem-Easton, PA-NJ	19.3050
Altoona, PA	17.0490
Amarillo, TX	16.5798
Anchorage, AK	25.3141
Ann Arbor, MI	22.9356
Anniston, AL	15.4427
Appleton-Oshkosh-Neenah, WI	16.7413
Arecibo, PR	8.5149
Asheville, NC	17.4501
Athens, GA	17.2208
Atlanta, GA	19.0600
Atlantic City-Cape May, NJ	20.7004
Augusta-Aiken, GA-SC	16.9519
Austin-San Marcos, TX	17.5193
Bakersfield, CA	19.8792
Baltimore, MD	18.6758
Bangor, ME	17.7185
Barnstable-Yarmouth, MA	25.4728
Baton Rouge, LA	16.4123

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Beaumont-Port Arthur, TX	16.2858
Bellingham, WA	24.0042
Benton Harbor, MI	15.6323
Bergen-Passaic, NJ	22.1050
Billings, MT	16.4779
Biloxi-Gulfport-Pascagoula, MS	15.9912
Binghamton, NY	17.0452
Birmingham, AL	17.3090
Bismarck, ND	15.7090
Bloomington, IN	15.9556
Bloomington-Normal, IL	16.5439
Boise City, ID	17.1324
Boston-Brockton-Nashua, MA-NH	22.1167
Boulder-Longmont, CO	18.5131
Brazoria, TX	16.6847
Bremerton, WA	19.4876
Brownsville-Harlingen-San Benito, TX	16.3732
Bryan-College Station, TX	17.0117
Buffalo-Niagara Falls, NY	17.3886
Burlington, VT	17.5139
Caguas, PR	8.9087
Canton-Massillon, OH	16.5610
Casper, WY	15.9558
Cedar Rapids, IA	15.8233
Champaign-Urbana, IL	16.7843
Charleston-North Charleston, SC	16.9003
Charleston, WV	17.9801
Charlotte-Gastonia-Rock Hill, NC-SC	18.3004
Charlottesville, VA	17.3750
Chattanooga, TN-GA	17.2815
Cheyenne, WY	15.0213
Chicago, IL	20.1255
Chico-Paradise, CA	19.9349
Cincinnati, OH-KY-IN	17.8270
Clarksville-Hopkinsville, TN-KY	14.2763
Cleveland-Lorain-Elyria, OH	18.6165
Colorado Springs, CO	17.5930
Columbia, MO	17.9090
Columbia, SC	17.0995
Columbus, GA-AL	14.6815
Columbus, OH	18.4253
Corpus Christi, TX	16.9241
Cumberland, MD-WV	15.8483
Dallas, TX	18.5580
Danville, VA	16.0243
Davenport-Moline-Rock Island, IA-IL	15.8012
Dayton-Springfield, OH	17.8462
Daytona Beach, FL	16.8507
Decatur, AL	15.4835
Decatur, IL	14.7466
Denver, CO	19.7749
Des Moines, IA	16.6435
Detroit, MI	20.4975
Dothan, AL	14.6729
Dover, DE	16.9613
Dubuque, IA	15.2452
Duluth-Superior, MN-WI	18.2853
Dutchess County, NY	20.2495
Eau Claire, WI	16.3926
El Paso, TX	17.5401
Elkhart-Goshen, IN	16.5895
Elmira, NY	16.0141
Enid, OK	15.4658
Erie, PA	17.4069
Eugene-Springfield, OR	21.0833
Evansville, Henderson, IN-KY	16.8454

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Fargo-Moorhead, ND-MN	16.8702
Fayetteville, NC	16.7399
Fayetteville-Springdale-Rogers, AR	13.4214
Flagstaff, AZ-UT	16.3150
Flint, MI	20.3263
Florence, AL	14.5759
Florence, SC	16.1316
Fort Collins-Loveland, CO	20.0554
Fort Lauderdale, FL	19.8737
Fort Myers-Cape Coral, FL	18.2967
Fort Pierce-Fort St Lucie, FL	19.6884
Fort Smith, AR-OK	14.3640
Fort Walton Beach, FL	16.4775
Fort Wayne, IN	16.4522
Fort Worth-Arlington, TX	19.0148
Fresno, CA	19.9179
Gadsden, AL	16.2189
Gainesville, FL	17.0500
Galveston-Texas City, TX	19.5055
Gary, IN	18.0150
Glens Falls, NY	17.5596
Goldsboro, NC	15.4556
Grand Forks, ND-MN	16.9349
Grand Junction, CO	16.9556
Grand Rapids-Muskegon-Holland, MI	19.0334
Great Falls, MT	16.8712
Greeley, CO	17.3139
Green Bay, WI	16.8657
Greensboro-Winston-Salem-High Point, NC	17.3386
Greenville, NC	17.2294
Greenville-Spartanburg-Anderson, SC	17.1252
Hagerstown, MD	17.1762
Hamilton-Middletown, OH	16.6240
Harrisburg-Lebanon-Carlisle, PA	18.8766
Hartford, CT	23.4548
Hattiesburg, MS	13.7150
Hickory-Morganton-Lenoir, NC	16.4247
Honolulu, HI	21.2237
Houma, LA	14.3783
Houston, TX	18.6920
Huntington-Ashland, WV-KY-OH	17.0304
Huntsville, AL	15.3580
Indianapolis, IN	18.4690
Iowa City, IA	17.7396
Jackson, MI	17.2871
Jackson, MS	14.2875
Jackson, TN	16.1114
Jacksonville, FL	16.9472
Jacksonville, NC	13.1113
Jamestown, NY	14.2640
Janesville-Beloit, WI	16.6310
Jersey City, NJ	20.9167
Johnson City-Kingsport-Bristol, TN-VA	16.5566
Johnstown, PA	16.9376
Joplin, MO	14.9986
Kalamazoo-Battle Creek, MI	20.1733
Kankakee, IL	17.2516
Kansas City, KS-MO	17.7010
Kenosha, WI	16.7936
Killeen-Temple, TX	19.9249
Knoxville, TN	16.1236
Kokomo, IN	16.7227
LaCrosse, WI-MN	16.1256
Lafayette, LA	15.9831

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Lafayette, IN	15.7641
Lake Charles, LA	15.3213
Lakeland-Winter Haven, FL	16.8079
Lancaster, PA	18.1140
Lansing-East Lansing, MI	19.1281
Laredo, TX	12.7772
Las Cruces, NM	16.7732
Las Vegas, NV-AZ	20.6967
Lawrence, KS	16.1829
Lawton, OK	16.2688
Lewiston-Auburn, ME	17.8565
Lexington, KY	15.8030
Lima, OH	16.7765
Lincoln, NE	17.2129
Little Rock-North Little Rock, AR	16.1414
Longview-Marshall, TX	16.5201
Los Angeles-Long Beach, CA	23.6449
Louisville, KY-IN	17.6559
Lubbock, TX	15.9821
Lynchburg, VA	15.5313
Macon, GA	17.0204
Madison, WI	19.0333
Mansfield, OH	15.8496
Mayaguez, PR	8.7914
McAllen-Edinburg-Mission, TX	16.4091
Medford-Ashland, OR	18.8231
Melbourne-Titusville-Palm Bay, FL	17.6476
Memphis, TN-AR-MS	15.8992
Merced, CA	20.5898
Miami, FL	19.2390
Middlesex-Somerset-Hunterdon, NJ	20.4619
Milwaukee-Waukesha, WI	17.9801
Minneapolis-St Paul, MN-WI	20.3375
Mobile, AL	14.7679
Modesto, CA	21.1266
Monmouth-Ocean, NJ	19.9942
Monroe, LA	14.9551
Montgomery, AL	14.9130
Muncie, IN	17.2733
Myrtle Beach, SC	15.0700
Naples, FL	18.6860
Nashville, TN	17.5408
Nassau-Suffolk, NY	25.7257
New Haven-Bridgeport-Stamford-. Danbury-Waterbury, CT	23.7262
New London-Norwich, CT	22.5252
New Orleans, LA	17.8955
New York, NY	26.1508
Newark, NJ	22.5401
Newburgh, NY-PA	20.1006
Norfolk-Virginia Beach-Newport News, VA-NC	15.9211
Oakland, CA	28.7763
Ocala, FL	16.9266
Odessa-Midland, TX	16.5687
Oklahoma City, OK	15.8211
Olympia, WA	21.0283
Omaha, NE-IA	18.5393
Orange County, CA	23.2815
Orlando, FL	18.0111
Owensboro, KY	14.1939
Panama City, FL	15.4882
Parkersburg-Marietta, WV-OH	14.6723
Pensacola, FL	15.4904
Peoria-Pekin, IL	16.3153
Philadelphia, PA-NJ	21.0452
Phoenix-Mesa, AZ	18.5670
Pine Bluff, AR	15.1147

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Pittsburgh, PA	18.4432
Pittsfield, MA	20.5161
Ponce, PR	9.0479
Portland, ME	18.4457
Portland-Vancouver, OR-WA	21.2923
Providence-Warwick, RI	20.8739
Provo-Orem, UT	18.6323
Pueblo, CO	16.1052
Punta Gorda, FL	17.7975
Racine, WI	16.4769
Raleigh-Durham-Chapel Hill, NC	18.0562
Rapid City, SD	15.6494
Reading, PA	18.1153
Redding, CA	22.3298
Reno, NV	20.9876
Richland-Kennewick-Pasco, WA	18.9500
Richmond-Petersburg, VA	17.1415
Riverside-San Bernardino, CA	21.9893
Roanoke, VA	16.0589
Rochester, MN	19.9607
Rochester, NY	18.1442
Rockford, IL	16.7939
Rocky Mount, NC	16.5823
Sacramento, CA	23.7352
Saginaw-Bay City-Midland, MI	17.9615
St Cloud, MN	18.0754
St Joseph, MO	16.0095
St Louis, MO-IL	16.8087
Salem, OR	18.1534
Salinas, CA	26.9989
Salt Lake City-Ogden, UT	18.3253
San Angelo, TX	14.7224
San Antonio, TX	15.9267
San Diego, CA	22.4200
San Francisco, CA	27.2835
San Jose, CA	27.3139
San Juan-Bayamon, PR	8.5450
San Luis Obispo-Atascadero-Paso Robles, CA	21.5899
Santa Barbara-Santa Maria-Lompoc, CA	21.0804
Santa Cruz-Watsonville, CA	26.3954
Santa Fe, NM	21.0277
Santa Rosa, CA	24.0268
Sarasota-Bradenton, FL	18.4321
Savannah, GA	16.9751
Scranton-Wilkes Barre-Hazleton, PA	16.5137
Seattle-Bellevue-Everett, WA	21.3995
Sharon, PA	16.8537
Sheboygan, WI	15.1072
Sherman-Denison, TX	16.6210
Shreveport-Bossier City, LA	17.0508
Sioux City, IA-NE	15.9684
Sioux Falls, SD	16.5847
South Bend,IN	17.9364
Spokane, WA	19.6432
Springfield, IL	16.9223
Springfield, MO	14.9476
Springfield, MA	19.9089
State College, PA	19.2360
Steubenville-Weirton, OH-WV	16.0044
Stockton-Lodi, CA	21.8377
Sumter, SC	15.7945
Syracuse, NY	18.0411
Tacoma, WA	20.4969
Tallahassee, FL	15.7519
Tampa-St Petersburg-Clearwater, FL	17.5324

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Terre Haute, IN	16.4157
Texarkana, TX-Texarkana, AR	15.5180
Toledo, OH	19.7316
Topeka, KS	18.4279
Trenton, NJ	18.9912
Tucson, AZ	17.5838
Tulsa, OK	15.6073
Tuscaloosa, AL	15.3144
Tyler, TX	17.8508
Utica-Rome, NY	16.1173
Vallejo-Fairfield-Napa, CA	25.5228
Ventura, CA	22.5710
Victoria, TX	15.9679
Vineland-Millville-Bridgeton, NJ	18.8648
Visalia-Tulare-Porterville, CA	19.7741
Waco, TX	14.9500
Washington, DC-MD-VA-WV	20.9642
Waterloo-Cedar Falls, IA	16.2799
Wausau, WI	18.9938
West Palm Beach-Boca Raton, FL	19.3398
Wheeling, WV-OH	14.2319
Wichita, KS	18.0997
Wichita Falls, TX	14.6944
Williamsport, PA	16.1054
Wilmington-Newark, DE-MD	21.8419
Wilmington, NC	17.6028
Yakima, WA	18.8374
Yolo, CA	21.9861
York, PA	17.3484
Youngstown-Warren, OH	18.0869
Yuba City, CA	20.0865
Yuma, AZ	18.4923

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	13.5615
Alaska	22.7793
Arizona	15.1344
Arkansas	13.0557
California	19.1114
Colorado	15.1209
Connecticut	24.8299
Delaware	17.0720
Florida	16.4079
Georgia	14.6148
Hawaii	18.6401
Idaho	15.8589
Illinois	14.1915
Indiana	15.2704
Iowa	13.9176
Kansas	13.6838
Kentucky	14.4809
Louisiana	13.7719
Maine	15.9481
Maryland	16.0195
Massachusetts	20.0223
Michigan	16.5516
Minnesota	15.3842
Mississippi	12.6771
Missouri	13.6029
Montana	15.3151
Nebraska	13.6661

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Nevada	16.6350
New Hampshire	18.9536
New Jersey [1]	.....
New Mexico	15.7665
New York	16.3687
North Carolina	15.1058
North Dakota	13.7514
Ohio	15.6847
Oklahoma	13.2228

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Oregon	17.9571
Pennsylvania	16.1301
Puerto Rico	8.1889
Rhode Island [1]	.....
South Carolina	14.6476
South Dakota	13.2255
Tennessee	14.0250
Texas	13.8226
Utah	16.3774

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Vermont	17.1172
Virginia	14.7420
Washington	18.5043
West Virginia	15.2110
Wisconsin	15.8839
Wyoming	15.1685

[1] All counties within the State are classified urban.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0932	8.7	12.4	32
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0095	9.0	12.6	32
3	01	SURG	*CRANIOTOMY AGE 0–17	1.8848	12.7	12.7	36
4	01	SURG	SPINAL PROCEDURES	2.3296	6.5	10.0	29
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5798	4.0	5.2	27
6	01	SURG	CARPAL TUNNEL RELEASE	.8124	2.4	4.0	25
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC.	2.6017	9.3	14.7	32
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.1794	3.1	4.6	26
9	01	MED	SPINAL DISORDERS & INJURIES	1.3047	5.7	8.5	29
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2299	6.2	8.9	29
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8000	3.8	5.3	27
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9891	6.0	8.7	29
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7858	5.4	6.9	28
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA.	1.2065	6.0	8.2	29
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS.	.7227	3.8	4.9	27
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC.	1.0639	5.4	7.4	28
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.	.6026	3.2	4.3	26
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9242	5.1	6.9	28
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.5990	3.6	4.7	27
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS.	2.1157	8.3	11.5	31
21	01	MED	VIRAL MENINGITIS	1.5350	6.5	8.7	30
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.8127	4.0	5.1	27
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8090	3.9	5.5	27
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9908	4.6	6.5	28
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5681	3.1	4.1	26
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.8993	3.1	4.5	26
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3476	3.9	7.2	27
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC.	1.2001	5.2	7.9	28
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	.6217	3.1	4.4	26
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17.	.3187	2.0	2.0	17
31	01	MED	CONCUSSION AGE >17 W CC	.7934	3.8	5.7	27
32	01	MED	CONCUSSION AGE >17 W/O CC	.4819	2.4	3.3	22
33	01	MED	*CONCUSSION AGE 0–17	.2003	1.6	1.6	9
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0569	4.9	6.9	28
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5914	3.4	4.8	26
36	02	SURG	RETINAL PROCEDURES	.5930	1.4	1.7	7
37	02	SURG	ORBITAL PROCEDURES	.8821	2.6	4.1	26
38	02	SURG	PRIMARY IRIS PROCEDURES	.4243	2.0	2.7	17
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5036	1.5	1.9	9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	.7000	2.3	3.6	25
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17.	.3244	1.6	1.6	7

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	.5615	1.6	2.2	12
43	02	MED	HYPHEMA	.3665	3.0	3.8	25
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6150	4.8	5.9	28
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6460	3.4	4.3	25
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7593	4.2	5.9	27
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4539	3.0	4.0	26
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2859	2.9	2.9	26
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7701	4.7	7.0	28
50	03	SURG	SIALOADENECTOMY	.7522	1.8	2.4	12
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	.7325	2.0	3.0	23
52	03	SURG	CLEFT LIP & PALATE REPAIR	.8492	2.4	3.4	25
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.9392	2.3	3.7	25
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4634	3.2	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.7238	1.9	3.0	22
56	03	SURG	RHINOPLASTY	.8195	2.1	3.0	21
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0450	3.2	4.9	26
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2631	1.5	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.5963	2.1	2.9	19
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2004	1.5	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2221	3.1	5.9	26
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2837	1.3	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.1462	3.3	4.9	26
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1887	5.1	8.2	28
65	03	MED	DYSEQUILIBRIUM	.5162	2.9	3.7	22
66	03	MED	EPISTAXIS	.5306	3.0	3.9	24
67	03	MED	EPIGLOTTITIS	.8060	3.4	4.3	25
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.7094	4.2	5.2	27
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5270	3.4	4.1	21
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3129	2.4	3.0	17
71	03	MED	LARYNGOTRACHEITIS	.7206	3.6	4.4	25
72	03	MED	NASAL TRAUMA & DEFORMITY	.6419	3.0	4.7	26
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	.7730	4.0	5.4	27
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3223	2.1	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES	3.1034	9.3	11.9	32
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5601	9.6	13.4	33
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1219	3.9	5.9	27
78	04	MED	PULMONARY EMBOLISM	1.4136	7.4	8.8	30
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.6625	7.8	10.1	31
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9508	5.7	7.2	29
81	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17.	.9558	4.7	6.7	28
82	04	MED	RESPIRATORY NEOPLASMS	1.3166	6.0	8.4	29
83	04	MED	MAJOR CHEST TRAUMA W CC	.9557	5.2	6.9	28
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5002	3.0	4.2	25
85	04	MED	PLEURAL EFFUSION W CC	1.1917	5.9	7.9	29
86	04	MED	PLEURAL EFFUSION W/O CC	.6848	3.6	4.6	27
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3589	5.3	7.3	28
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0018	5.3	6.6	28
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.1211	6.2	7.6	29
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6996	4.7	5.5	26
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.8366	4.4	6.0	27
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2000	6.0	7.7	29
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7550	4.2	5.3	27
94	04	MED	PNEUMOTHORAX W CC	1.2378	6.2	8.1	29
95	04	MED	PNEUMOTHORAX W/O CC	.6242	3.8	4.7	26
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.8390	4.9	5.9	28
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.6089	3.8	4.6	23
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.6696	4.2	5.1	27

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6959	2.9	3.9	26
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5034	2.1	2.6	14
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.9120	4.5	6.0	27
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5595	2.9	4.0	26
103	05	SURG	HEART TRANSPLANT	13.8273	27.4	39.1	50
104	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.3143	13.3	16.0	36
105	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.6310	10.0	12.0	33
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.6187	11.2	12.7	34
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.1803	8.6	9.8	32
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.9455	10.5	13.5	33
109			NO LONGER VALID	.0000	.0	.0	0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1308	8.7	11.6	32
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2584	6.3	7.2	29
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9922	3.6	5.0	27
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7536	11.6	16.0	35
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5383	7.4	10.5	30
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK.	3.5513	9.5	11.8	33
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GENERATOR PROC.	2.3949	4.2	5.9	27
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.1454	3.0	4.5	26
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5260	2.2	3.4	25
119	05	SURG	VEIN LIGATION & STRIPPING	1.1247	3.4	5.9	26
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9531	5.8	10.1	29
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE.	1.6459	7.0	8.4	30
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE.	1.1614	4.9	5.8	28
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4370	2.8	4.9	26
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.2933	4.0	5.3	27
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	.8767	2.4	3.2	22
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.6049	12.3	16.3	35
127	05	MED	HEART FAILURE & SHOCK	1.0302	5.2	6.7	28
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7929	6.3	7.2	29
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1376	2.1	3.7	25
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9384	5.6	7.2	29
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6002	4.5	5.5	27
132	05	MED	ATHEROSCLEROSIS W CC	.6861	3.1	4.0	23
133	05	MED	ATHEROSCLEROSIS W/O CC	.5347	2.5	3.1	18
134	05	MED	HYPERTENSION	.5800	3.3	4.2	25
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.8988	4.1	5.7	27
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5789	2.8	3.6	22
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	.7866	3.3	3.3	26
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC.	.8049	3.7	5.0	27
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	.4945	2.5	3.2	18
140	05	MED	ANGINA PECTORIS	.6312	3.1	3.8	22
141	05	MED	SYNCOPE & COLLAPSE W CC	.7149	3.7	5.0	27
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5216	2.7	3.5	20
143	05	MED	CHEST PAIN	.5159	2.3	2.8	15
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0689	4.3	6.1	27
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6204	2.7	3.5	22
146	06	SURG	RECTAL RESECTION W CC	2.5898	10.2	11.8	33
147	06	SURG	RECTAL RESECTION W/O CC	1.5368	7.2	7.9	29
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3264	11.7	14.2	35
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.5654	7.4	8.1	26
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.6561	10.1	12.4	33
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2606	5.5	6.8	29
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8860	8.0	9.7	31

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.1257	5.7	6.4	26
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.2102	12.6	16.1	36
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3885	5.4	6.7	28
156	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8101	6.0	6.0	29
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.1048	4.3	6.1	27
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5789	2.3	3.0	18
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.1707	4.1	5.6	27
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.6746	2.5	3.1	17
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	.9554	3.1	4.5	26
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.5365	1.8	2.2	11
163	06	SURG	HERNIA PROCEDURES AGE 0–17	.7578	3.5	5.0	27
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	2.2374	8.5	9.9	31
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.2365	5.3	6.1	25
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	1.3695	4.9	6.1	28
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	.7892	3.0	3.6	16
168	03	SURG	MOUTH PROCEDURES W CC	1.1761	3.6	5.6	27
169	03	SURG	MOUTH PROCEDURES W/O CC	.6434	2.0	2.7	17
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7116	9.1	13.3	32
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.1628	4.4	6.2	27
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.2898	6.1	8.8	29
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6569	3.2	4.6	26
174	06	MED	G.I. HEMORRHAGE W CC	.9880	4.7	6.0	28
175	06	MED	G.I. HEMORRHAGE W/O CC	.5457	3.1	3.8	19
176	06	MED	COMPLICATED PEPTIC ULCER	1.0563	5.0	6.5	28
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8270	4.4	5.4	27
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.5990	3.2	3.9	21
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0993	6.0	7.8	29
180	06	MED	G.I. OBSTRUCTION W CC	.9240	5.0	6.5	28
181	06	MED	G.I. OBSTRUCTION W/O CC	.5231	3.4	4.2	23
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7794	4.1	5.4	27
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5480	3.0	3.7	22
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.3910	2.5	3.1	18
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8892	4.1	5.8	27
186	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3088	2.9	2.9	23
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.6473	2.8	3.8	26
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC.	1.0458	4.7	6.6	28
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	.5438	2.8	3.8	26
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	1.2379	4.6	6.5	28
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.4495	12.9	17.5	36
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC ...	1.7103	6.4	8.3	29
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.2131	12.3	14.9	35
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6937	6.9	8.6	30
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.6147	9.4	11.2	32
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.5695	6.2	7.2	29
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.2034	7.9	9.7	31
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1355	4.6	5.4	24

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.3309	9.2	12.4	32
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.0158	7.9	12.7	31
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.2951	11.7	16.1	35
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3177	6.1	8.3	29
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.2187	5.9	8.3	29
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2020	5.5	7.2	28
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC.	1.2276	5.8	8.0	29
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.6801	3.6	5.0	27
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0287	4.7	6.2	28
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.5943	2.8	3.6	23
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.2707	6.8	7.6	27
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8616	8.2	9.8	31
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2893	6.3	7.2	28
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	1.1296	4.3	5.2	27
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7196	7.6	10.6	31
214	08	SURG	BACK & NECK PROCEDURES W CC	1.9184	5.7	7.4	29
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.0924	3.5	4.2	22
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1075	8.6	12.2	32
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.8975	11.1	17.1	34
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4231	5.3	6.9	28
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	.9179	3.4	4.1	22
220	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5611	5.3	5.3	28
221	08	SURG	KNEE PROCEDURES W CC	1.8463	6.3	8.8	29
222	08	SURG	KNEE PROCEDURES W/O CC	.9747	3.3	4.2	26
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.8364	2.3	3.0	17
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.6983	2.0	2.4	11
225	08	SURG	FOOT PROCEDURES	.9504	3.3	5.1	26
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.3656	4.7	7.3	28
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.7273	2.4	3.2	20
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	.9315	2.4	3.8	25
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	.5965	1.8	2.4	14
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.0399	3.5	5.6	27
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.2131	3.5	5.5	26
232	08	SURG	ARTHROSCOPY	1.0578	2.6	4.5	26
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	1.9275	6.8	9.8	30
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.0039	3.3	4.5	26
235	08	MED	FRACTURES OF FEMUR	.8501	5.2	7.8	28
236	08	MED	FRACTURES OF HIP & PELVIS	.7818	5.2	7.1	28
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	.5711	3.7	4.9	27
238	08	MED	OSTEOMYELITIS	1.4356	8.4	11.5	31
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0219	6.3	8.4	29
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.1900	5.9	8.1	29
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5986	3.8	4.9	27
242	08	MED	SEPTIC ARTHRITIS	1.1295	6.7	9.0	30

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
243	08	MED	MEDICAL BACK PROBLEMS	.7248	4.7	6.1	28
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7446	4.6	6.4	28
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	.5050	3.4	4.6	26
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5646	3.7	4.7	27
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5534	3.1	4.3	26
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7275	4.1	5.7	27
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6558	3.1	4.7	26
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.7193	3.9	5.7	27
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4423	2.4	3.2	21
252	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	.2438	1.8	1.8	15
253	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7637	4.7	6.6	28
254	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4365	3.0	4.1	26
255	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2838	2.9	2.9	26
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.6419	3.2	4.4	26
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.8997	3.1	3.9	20
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6965	2.4	2.8	11
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8765	2.6	4.1	26
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.5749	1.7	2.0	8
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.8080	1.9	2.6	13
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	.7115	2.6	4.0	26
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.2344	11.2	15.8	34
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1633	6.7	9.2	30
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.4131	4.9	7.9	28
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.7451	2.8	3.9	26
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.8022	2.8	4.4	26
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	.9068	2.7	4.4	26
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6495	6.7	10.0	30
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.6796	2.4	3.6	25
271	09	MED	SKIN ULCERS	1.1157	7.2	9.5	30
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0208	6.1	8.1	29
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.6403	4.5	6.1	27
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0741	5.5	8.1	28
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.4845	2.4	3.5	25
276	09	MED	NON-MALIGNANT BREAST DISORDERS	.6418	4.2	5.4	27
277	09	MED	CELLULITIS AGE >17 W CC	.8703	5.9	7.3	29
278	09	MED	CELLULITIS AGE >17 W/O CC	.5822	4.6	5.5	27
279	09	MED	CELLULITIS AGE 0–17	.7070	4.2	5.9	27
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	.6847	4.0	5.6	27
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4523	2.8	3.9	26
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17.	.2467	2.2	2.2	19
283	09	MED	MINOR SKIN DISORDERS W CC	.7171	4.4	6.0	27
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4307	3.1	4.1	26
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.3880	11.0	15.4	34
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.3163	6.9	9.0	30
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	2.1126	10.7	15.5	34
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0397	5.9	8.0	29
289	10	SURG	PARATHYROID PROCEDURES	1.0385	3.0	4.5	26
290	10	SURG	THYROID PROCEDURES	.8537	2.3	3.0	16

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
291	10	SURG	THYROGLOSSAL PROCEDURES	.4657	1.4	1.6	6
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.	2.6301	9.2	13.5	32
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.1866	4.6	6.4	28
294	10	MED	DIABETES AGE >35	.7579	4.7	6.2	28
295	10	MED	DIABETES AGE 0–35	.7634	3.7	5.1	27
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	.9166	5.1	7.0	28
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5353	3.5	4.6	27
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17.	.4756	2.8	3.8	26
299	10	MED	INBORN ERRORS OF METABOLISM	.9790	4.2	6.2	27
300	10	MED	ENDOCRINE DISORDERS W CC	1.0919	5.8	7.9	29
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6181	3.6	4.8	27
302	11	SURG	KIDNEY TRANSPLANT	4.1370	11.9	14.0	35
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.6171	9.1	11.0	32
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3715	8.1	11.1	31
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1600	4.2	5.4	27
306	11	SURG	PROSTATECTOMY W CC	1.2441	4.9	7.1	28
307	11	SURG	PROSTATECTOMY W/O CC	.6639	2.7	3.3	17
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.4848	5.0	7.5	28
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8061	2.5	3.2	21
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	.9694	3.3	4.9	26
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5486	1.9	2.4	12
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	.8891	3.3	5.1	26
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.5008	1.9	2.6	15
314	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4756	2.3	2.3	25
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES.	2.0612	5.7	10.3	29
316	11	MED	RENAL FAILURE	1.2996	5.7	8.1	29
317	11	MED	ADMIT FOR RENAL DIALYSIS	.6556	2.7	4.1	26
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1007	5.2	7.6	28
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5432	2.2	3.4	25
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC.	.9320	5.6	7.1	29
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC.	.6104	4.2	5.1	25
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.6651	3.9	5.4	27
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7281	2.8	3.8	26
324	11	MED	URINARY STONES W/O CC	.3992	1.8	2.3	11
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6436	3.7	4.9	27
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4233	2.6	3.4	21
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	.2302	3.1	3.1	26
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.6672	3.2	4.4	26
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4233	1.9	2.3	13
330	11	MED	*URETHRAL STRICTURE AGE 0–17	.3063	1.6	1.6	9
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	1.0122	4.9	6.8	28
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6176	3.1	4.2	26
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17.	.8701	4.2	6.0	27
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.6948	6.1	6.9	25
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.3044	4.8	5.3	20
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8802	3.6	4.6	25
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6128	2.6	3.0	12
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.0260	3.7	5.7	27
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.9330	3.1	4.7	26
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2723	2.4	2.4	13
341	12	SURG	PENIS PROCEDURES	1.0699	2.6	3.7	25
342	12	SURG	CIRCUMCISION AGE >17	.7360	2.8	4.2	26
343	12	SURG	*CIRCUMCISION AGE 0–17	.1479	1.7	1.7	6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.0209	2.4	3.5	25
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8435	3.0	4.6	26
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC .	.9626	5.1	7.5	28
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	.4853	2.5	3.6	25
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7106	3.8	5.3	27
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4241	2.3	3.1	22
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	.6810	4.3	5.3	27
351	12	MED	*STERILIZATION, MALE	.2271	1.3	1.3	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES ..	.5932	3.1	4.2	26
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9483	7.5	9.4	30
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.4609	5.6	6.8	29
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.8881	3.8	4.1	12
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7323	2.9	3.3	13
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3679	8.5	10.6	31
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC.	1.1458	4.3	5.1	20
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC.	.8072	3.2	3.5	10
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8739	3.3	4.2	23
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION .	1.1984	3.2	5.0	26
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.2902	1.4	1.4	5
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	.6881	2.7	3.7	22
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.6667	2.6	3.8	26
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	1.7739	6.0	8.7	29
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC.	1.1405	5.5	8.2	29
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.	.5179	2.5	3.7	25
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.9841	5.5	7.1	29
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5130	2.7	3.9	26
370	14	SURG	CESAREAN SECTION W CC	.9573	4.5	5.7	26
371	14	SURG	CESAREAN SECTION W/O CC	.6531	3.4	3.8	11
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5558	2.6	3.5	20
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3446	1.8	2.1	8
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6721	2.3	2.8	13
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C.	.6587	4.4	4.4	27
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.4418	2.5	3.7	26
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.8181	2.8	4.3	26
378	14	MED	ECTOPIC PREGNANCY	.7409	2.4	2.8	14
379	14	MED	THREATENED ABORTION	.3962	2.2	3.4	25
380	14	MED	ABORTION W/O D&C	.3742	1.6	2.0	9
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.4673	1.5	2.1	11
382	14	MED	FALSE LABOR	.1922	1.2	1.9	7
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.4587	3.1	4.4	26
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.2818	1.6	2.1	10
385	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3219	1.8	1.8	25
386	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.3591	17.9	17.9	41
387	15		*PREMATURITY W MAJOR PROBLEMS	2.9772	13.3	13.3	36
388	15		*PREMATURITY W/O MAJOR PROBLEMS	1.7964	8.6	8.6	32
389	15		FULL TERM NEONATE W MAJOR PROBLEMS	2.3785	7.8	10.3	31

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				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
390	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	.6218	2.7	4.4	26
391	15		*NORMAL NEWBORN	.1465	3.1	3.1	11
392	16	SURG	SPLENECTOMY AGE >17	3.1908	9.3	12.0	32
393	16	SURG	*SPLENECTOMY AGE 0–17	1.2949	9.1	9.1	32
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.6252	4.9	8.5	28
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8359	4.1	5.8	27
396	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	.5980	2.8	4.2	26
397	16	MED	COAGULATION DISORDERS	1.2825	4.8	6.6	28
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC.	1.2360	5.6	7.2	29
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	.6934	3.8	4.7	27
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6034	7.2	11.2	30
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.4533	9.0	13.1	32
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	.9428	3.1	4.6	26
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6823	6.9	10.0	30
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8140	3.8	5.4	27
405	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	1.8358	4.9	4.9	28
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC.	2.6558	8.6	12.0	32
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC.	1.1626	4.0	5.1	27
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC.	1.6840	5.2	8.8	28
409	17	MED	RADIOTHERAPY	.9475	4.9	7.0	28
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.7172	2.6	3.3	20
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.5015	2.5	3.4	25
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4530	2.1	2.9	24
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3422	6.4	9.2	29
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7285	3.9	5.9	27
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	3.4769	12.4	17.3	35
416	18	MED	SEPTICEMIA AGE >17	1.4770	6.5	8.9	30
417	18	MED	SEPTICEMIA AGE 0–17	.8764	4.8	6.1	28
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9777	5.7	7.3	29
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.9223	4.8	6.2	28
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6258	3.8	4.6	25
421	18	MED	VIRAL ILLNESS AGE >17	.6982	3.8	4.9	27
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17.	.5446	3.3	4.3	26
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.5828	6.8	9.4	30
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.4543	12.1	20.0	35
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION.	.7129	3.9	5.5	27
426	19	MED	DEPRESSIVE NEUROSES	.5949	4.5	6.3	27
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5794	4.1	5.9	27
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.6847	5.2	8.1	28
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.9537	6.6	10.4	30
430	19	MED	PSYCHOSES	.8670	7.5	10.7	30
431	19	MED	CHILDHOOD MENTAL DISORDERS	.6362	5.3	7.6	28
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7018	4.2	6.6	27
433	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3080	2.6	3.7	26
434	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7373	4.7	6.4	28
435	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4249	3.9	5.1	27
436	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY.	.8384	12.6	15.7	36
437	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.7972	9.9	11.8	33
438			NO LONGER VALID	.0000	.0	.0	0

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				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.6599	5.6	9.3	29
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.7792	7.0	11.0	30
441	21	SURG	HAND PROCEDURES FOR INJURIES	.8785	2.3	4.3	25
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.0836	5.7	9.1	29
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.8130	2.4	3.4	25
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7290	4.4	5.8	27
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4664	2.9	3.9	26
446	21	MED	*TRAUMATIC INJURY AGE 0–17	.2846	2.4	2.4	22
447	21	MED	ALLERGIC REACTIONS AGE >17	.4976	2.3	3.1	20
448	21	MED	ALLERGIC REACTIONS AGE 0–17	.0896	1.0	1.0	1
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.	.7886	3.3	4.8	26
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	.4329	1.9	2.6	15
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2527	2.1	2.1	17
452	21	MED	COMPLICATIONS OF TREATMENT W CC	.9127	3.9	5.6	27
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4752	2.6	3.5	24
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.	.8906	3.8	6.1	27
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	.4689	2.3	3.5	25
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.9410	4.2	8.2	27
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	1.5849	2.5	5.1	26
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.4645	12.8	18.4	36
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC.	1.9398	8.2	13.2	31
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	.9369	5.1	7.3	28
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.0104	2.6	5.4	26
462	23	MED	REHABILITATION	1.4731	11.8	14.7	35
463	23	MED	SIGNS & SYMPTOMS W CC	.7416	4.2	5.9	27
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4972	3.0	4.0	26
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.4362	1.9	2.9	20
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5601	2.5	4.6	26
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4291	2.6	5.0	26
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.5391	11.4	16.5	34
469			**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.	.0000	.0	.0	0
470			**UNGROUPABLE	.0000	.0	.0	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.6458	8.0	9.6	31
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	10.6993	14.3	31.4	37
473	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.4797	8.9	15.3	32
474			NO LONGER VALID	.0000	.0	.0	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.7015	9.1	13.1	32
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2703	11.5	15.1	35
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.5682	5.8	9.4	29
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2709	6.0	9.0	29
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.3864	3.7	5.0	27
480		SURG	LIVER TRANSPLANT	16.3066	24.4	33.8	47
481		SURG	BONE MARROW TRANSPLANT	11.6796	27.2	31.2	50
482		SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES.	3.6620	12.4	16.3	35
483		SURG	TRACHEOSTOMY EXCEPT FOR FACE,MOUTH & NECK DIAGNOSES.	16.1090	38.2	49.7	61
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.4488	10.9	17.1	34
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	3.2610	10.5	13.4	33
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.8763	9.6	15.1	33
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9932	6.8	10.1	30
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.2177	13.9	19.0	37

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
489	25	MED	HIV W MAJOR RELATED CONDITION	1.7856	7.8	11.7	31
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0476	4.7	7.3	28
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6088	4.0	4.8	22
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.1529	11.8	18.4	35
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.	1.6501	4.3	6.2	27
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	.8769	1.8	2.4	15
495	.....	SURG	LUNG TRANSPLANT	9.5678	18.2	23.2	41

* 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 used only to determine payment for outlier cases.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

Table 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
005.81	Food poisoning due to Vibrio vulnificus	N	6	182, 183, 184
005.89	Other bacterial food poisoning	N	6	182, 183, 184
041.86	Helicobacter pylori (H. pylori) infection	N	18	423
079.81	Hantavirus infection	N	18	421, 422
278.00	Obesity, unspecified	N	10	296, 297, 298
278.01	Morbid obesity	N	10	296, 297, 298
415.11	Iatrogenic pulmonary embolism and infarction	Y	4	78
			5	121, 124
			15	387, 389 [1]
415.19	Other pulmonary embolism and infraction	Y	4	78
			5	121, 124
			15	387, 389 [1]
435.3	Vertebrobasilar artery syndrome	N	1	15
458.2	Iatrogenic hypotension	N	5	141, 142
569.60	Colostomy and enterostomy complication, not otherwise specified	Y	6	188, 189, 190
569.61	Infection of colostomy or enterostomy	Y	6	188, 189, 190
569.69	Other colostomy and enterostomy complication	Y	6	188, 189, 190
690.10	Seborrheic dermatitis, unspecified	N	9	283, 284
690.11	Seborrhea capitis	N	9	283, 284
690.12	Seborrheic infantile dermatitis	N	9	283, 284
690.18	Other seborrheic dermatitis	N	9	283, 284
690.8	Other erythematosquamous dermatosis	N	9	283, 284
728.86	Necrotizing fasciitis	Y	8	248
787.91	Diarrhea	N	6	182, 183, 184
787.99	Other symptoms involving digestive system	N	6	182, 183, 184
989.81	Toxic effect of asbestos	N	21	449, 450, 451
989.82	Toxic effect of latex	N	21	449, 450, 451
989.83	Toxic effect of silicone	N	21	449, 450, 451
989.84	Toxic effect of tobacco	N	21	449, 450, 451
989.89	Toxic effect of other substance, chiefly nonmedicinal as to source, not elsewhere classified.	N	21	449, 450, 451
997.00	Nervous system complication, unspecified	Y	1	34, 35
			15	387, 389 [1]
997.01	Central nervous system complication	Y	1	34, 35
			15	387, 389 [1]
997.02	Iatrogenic cerebrovascular infarction or hemorrhage	Y	1	34, 35
			15	387, 389 [1]
997.09	Other nervous system complications	Y	1	34, 35
			15	387, 389 [1]
997.91	Complications affecting other specified body systems, hypertension	N	21	452, 453
997.99	Complications affecting other specified body systems, not elsewhere classified.	Y	21	452, 453
V12.50	Personal history of unspecified circulatory disease	N	23	467
V12.51	Personal history of venous thrombosis and embolism	N	23	467
V12.52	Personal history of thrombophlebitis	N	23	467
V12.59	Personal history of other diseases, of circulatory system, not elsewhere classified.	N	23	467
V15.84	Personal history of exposure to asbestos	N	23	467

Table 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V15.85	Personal history of exposure to potentially hazardous body fluids	N	23	467
V15.86	Personal history of exposure to lead	N	23	467
V43.81	Larynx replacement status	N	23	467
V43.82	Breast replacement status	N	23	467
V43.89	Other organ or tissue replacement status, not elsewhere classified	N	23	467
V45.83	Breast implant removal status	N	23	467
V56.1	Fitting and adjustment of dialysis (extracorporeal) (peritoneal) catheter	N	11	317
V58.61	Long-term (current) use of anticoagulants	N	23	465, 466
V58.69	Long-term (current) use of other medications	N	23	465, 466
V58.82	Fitting and adjustment of non-vascular catheter, not elsewhere classified	N	23	465, 466
V59.01	Blood donor, whole blood	N	23	467
V59.02	Blood donor, stem cells	N	23	467
V59.09	Other blood donor	N	23	467
V59.6	Liver donor	N	7	205, 206

[1] Diagnosis code is classified as a ''major problem'' in these DRGs.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
05.25	Periarterial sympathectomy	Y	1	7, 8
			5	120
32.22	Lung volume reduction surgery	Y	4	75
33.50	Lung transplantation, not otherwise specified	Y	Pre	495
33.51	Unilateral lung transplantation	Y	Pre	495
33.52	Bilateral lung transplantation	Y	Pre	495
36.06	Insertion of coronary artery stent(s)	N	.....	
37.65	Implant of an external, pulsatile heart assist system	Y	5	110, 111
37.66	Implant of an implantable, pulsatile heart assist system	Y	5	110, 111
39.50	Angioplasty or atherectomy of non-coronary vessel	Y	1	5
			5	478, 479
			9	269, 270
			10	292, 293
			11	315
			21	442, 443
			24	486
48.36	[Endoscopic] polypectomy of rectum	N [1]	17	412
59.72	Injection of implant into urethra and/or bladder neck	N [1]	11	308, 309
			13	356
60.21	Transurethral (ultrasound) guided laser induced prostatectomy (TULIP)	Y	11	306, 307
			12	336, 337
			.....	476
60.29	Other transurethral prostatectomy	Y	11	306, 307
			12	336, 337
			.....	476
92.3	Stereotactic radiosurgery	N [1]	1	1, 2, 3
			10	286
			17	400, 406, 407
99.00	Perioperative autologous transfusion of whole blood or blood components	N	.....	

[1] Non-OR procedure that affects DRG assignment.

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
005.8	Other bacterial food poisoning	N	6	182, 183, 184
278.0	Obesity	N	10	296, 297, 298
415.1	Pulmonary embolism and infarction	Y	4	78
			15	387, 389
569.6	Colostomy and enterostomy malfunction	Y	6	188, 189, 190
690	Erythematosquamous dermatosis	N	9	283, 284
787.9	Other symptoms involving digestive system	N	6	182, 183, 184
989.8	Toxic effect of other substances, chiefly nonmedicinal as to source	N	21	449, 450, 451
997.0	Central nervous system complications	Y	1	34, 35
			15	387, 389
997.9	Complications affecting other specified body systems, not elsewhere classified.	Y	21	452, 453
V12.5	Personal history of diseases of circulatory system	N	23	467
V43.8	Organ or tissue replaced by other means, not elsewhere classified	N	23	467
V59.0	Blood donor	N	23	467

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
33.5	Lung transplant	Y	Pre	495
39.7	Periarterial sympathectomy	Y	5	478, 479
60.2	Transurethral prostatectomy	Y	11	306, 307
			12	336, 337, 476

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
441.00	Dissection of aorta, unspecified site	Y	5	121, 130, 131
441.01	Dissection of aorta, thoracic	Y	5	121, 130, 131
441.02	Dissection of aorta, abdominal	Y	5	121, 130, 131
441.03	Dissection of aorta, thoracoabdominal	Y	5	121, 130, 131
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection).	Y	6	180, 181
568.0	Peritoneal adhesions (postoperative) (postinfection)	N	6	188, 189, 190
614.6	Pelvic peritoneal adhesions, female (postoperative) (postinfection)	N	13	358, 359, 369
650	Normal delivery	N	14	370, 371, 372, 373, 374, 375
780.6	Fever	N	18	419, 420, 422
997.4	Digestive system complication	Y	6	188, 189, 190
V52.4	Fitting and adjustment of breast prosthesis and implant	N	23	467
V53.5	Fitting and adjustment of other intestinal appliance	N	6	188, 189, 190
V58.81	Fitting and adjustment of vascular catheter	N	23	465, 466
V67.51	Follow-up examination following completed treatment with high-risk medications, not elsewhere classified.	N	23	467

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
99.02	Transfusion of previously collected autologous blood	N	.....	

TABLE 6G--ADDITIONS TO THE CC EXCLUSIONS LIST

*0011	*00843	01110	01191	01351	01622	01732	01882
00849	00849	01111	01192	01352	01623	01733	01883
*0020	*00844	01112	01193	01353	01624	01734	01884
00849	00849	01113	01194	01354	01625	01735	01885
*0029	*00845	01114	01195	01355	01626	01736	01886
00849	00849	01115	01196	01356	01630	01740	01890
*0030	*00846	01116	01200	01360	01631	01741	01891
00849	00849	01120	01201	01361	01632	01742	01892
*0049	*00847	01121	01202	01362	01633	01743	01893
00849	00849	01122	01203	01363	01634	01744	01894
*0050	*00849	01123	01204	01364	01635	01745	01895
00849	00849	01124	01205	01365	01636	01746	01896
*0051	*0085	01125	01206	01366	01640	01750	0310
00849	00849	01126	01210	01380	01641	01751	0360
*0052	*00861	01130	01211	01381	01642	01752	0361
00849	00849	01131	01212	01382	01643	01753	0362
*0060	*00862	01132	01213	01383	01644	01754	0363
00849	00849	01133	01214	01384	01645	01755	03640
*0061	*00863	01134	01215	01385	01646	01756	03641
00849	00849	01135	01216	01386	01650	01760	03642
*0062	*00864	01136	01300	01390	01651	01761	03643
00849	00849	01140	01301	01391	01652	01762	03681
*0069	*00865	01141	01302	01392	01653	01763	03682
00849	00849	01142	01303	01393	01654	01764	03689
*0071	*00866	01143	01304	01394	01655	01765	0369
00849	00849	01144	01305	01395	01656	01766	0380
*0072	*00867	01145	01306	01396	01660	01770	0381
00849	00849	01146	01310	01400	01661	01771	0382
*0073	*00869	01150	01311	01401	01662	01772	0383
00849	00849	01151	01312	01402	01663	01773	03840
*0078	*0088	01152	01313	01403	01664	01774	03841
00849	00849	01153	01314	01404	01665	01775	03842
*0079	*0090	01154	01315	01405	01666	01776	03843
00849	00849	01155	01316	01406	01670	01780	03844
*00800	*01480	01156	01320	01480	01671	01781	03849
00849	00849	01160	01321	01482	01672	01782	0388
*00801	*01481	01161	01322	01483	01673	01783	0389
00849	00849	01162	01323	01484	01674	01784	3570
*00802	*01482	01163	01324	01485	01675	01785	6800
00849	00849	01164	01325	01486	01676	01786	6801
*00803	*01483	01165	01326	01600	01690	01790	6802
00849	00849	01170	01330	01601	01691	01791	6803
*00804	*01484	01171	01331	01602	01692	01792	6804
00849	00849	01172	01332	01603	01693	01793	6805
*00809	*01485	01173	01333	01604	01694	01794	6806
00849	00849	01174	01334	01605	01695	01795	6807
*0081	*01486	01175	01335	01606	01696	01796	6808
00849	00849	01176	01336	01610	01720	01800	6809
*0082	*04186	01180	01340	01611	01721	01801	6820
00849	01100	01181	01341	01612	01722	01802	6821
*0083	01101	01182	01342	01613	01723	01803	6822
00849	01102	01183	01343	01614	01724	01804	6823
*00841	01103	01184	01344	01615	01725	01805	6825
00849	01104	01185	01345	01616	01726	01806	6826
*00842	01105	01186	01346	01620	01730	01880	6827
00849	01106	01190	01350	01621	01731	01881	6828

TABLE 6G--ADDITIONS TO THE CC EXCLUSIONS LIST

6829	0706	00849	*7283	*99709	99678	9587	99691
*07981	0709	*5564	72886	99700	99679	9954	99692
0520	0720	00849	*72881	99701	99680	99600	99693
0521	0721	*5565	7280	99702	99681	99601	99694
0527	0722	00849	72886	99709	99682	99602	99695
0528	0723	*5566	*72886	*99791	99683	99603	99696
0529	07271	00849	7280	9580	99684	99604	99699
0530	07272	*5568	72886	9581	99685	99609	99700
05310	07279	00849	*7750	9582	99686	9961	99701
05311	0728	*5569	00849	9583	99689	9962	99702
05312	*11285	00849	*7751	9584	99690	99630	99709
05313	00849	*5570	00849	9585	99691	99639	9971
05319	*129	00849	*7752	9587	99692	9964	9972
05379	00849	*5571	00849	9954	99693	99651	9973
0538	*41511	00849	*7753	99600	99694	99652	9974
05479	41511	*5579	00849	99601	99695	99653	9975
0548	41519	00849	*7754	99602	99696	99654	99762
0550	*41519	*5582	00849	99603	99699	99659	99799
0551	41511	00849	*7755	99604	99700	99660	9980
0552	41519	*5589	00849	99609	99701	99661	9981
05571	*45989	00849	*7756	9961	99702	99662	9982
05579	41511	*5641	00849	9962	99709	99663	9983
0558	41519	00849	*7757	99630	9971	99664	9984
05600	*4599	*56960	00849	99639	9972	99665	9985
05601	41511	56960	*7758	9964	9973	99666	9986
05609	41519	56961	00849	99651	9974	99667	9987
05671	*4878	56969	*7759	99652	9975	99669	99889
05679	00849	*56961	00849	99653	99762	99670	9989
0568	*5363	56960	*7775	99654	99799	99671	*99881
07020	00849	56961	00849	99659	9980	99672	99700
07021	*5368	56969	*7778	99660	9981	99673	99701
07022	00849	*56969	00849	99661	9982	99674	99702
07023	*5550	56960	*99700	99662	9983	99675	99709
07030	00849	56961	99700	99663	9984	99676	99799
07031	*5551	56969	99701	99664	9985	99677	*99889
07032	00849	*7280	99702	99665	9986	99678	99700
07033	*5552	72886	99709	99666	9987	99679	99701
07041	00849	*72811	*99701	99667	99889	99680	99702
07042	*5559	72886	99700	99669	9969	99681	99709
07043	00849	*72812	99701	99670	*99799	99682	99799
07044	*5560	72886	99702	99671	9580	99683	*9989
07049	00849	*72813	99709	99672	9581	99684	99700
07051	*5561	72886	*99702	99673	9582	99685	99701
07052	00849	*72819	99700	99674	9583	99686	99702
07053	*5562	72886	99701	99675	9584	99689	99709
07054	00849	*7282	99702	99676	9585	99690	99799
07059	*5563	72886	99709	99677			

TABLE 6H--DELETIONS TO THE CC EXCLUSIONS LIST

*2760	2768	*9970	99604	99663	99679	99696	9985
2768	*2768	9970	99609	99664	99680	99699	9986
*2761	2768	*9979	9961	99665	99681	9970	9987
2768	*2769	9580	9962	99666	99682	9971	99889
*2762	2768	9581	99630	99667	99683	9972	9989
2768	*4151	9582	99639	99669	99684	9973	*99881
*2763	4151	9583	9964	99670	99685	9974	9970
2768	*45989	9584	99651	99671	99686	9975	9979
*2764	4151	9585	99652	99672	99689	99762	*99889
2768	*4599	9587	99653	99673	99690	9979	9970
*2765	4151	9954	99654	99674	99691	9980	9979
2768	*5696	99600	99659	99675	99692	9981	*9989
*2766	5696	99601	99660	99676	99693	9982	9970
2768	*72810	99602	99661	99677	99694	9983	9979
*2767	7280	99603	99662	99678	99695	9984	

BILLING CODE 4120–01–C

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
001	32563	12.4181	3	5	9	15	25
002	6318	12.5554	3	6	9	15	25
003	1	7.0000	7	7	7	7	7
004	5716	9.9696	2	3	7	13	21
005	69427	5.2597	2	3	4	6	10
006	501	4.0279	1	1	2	4	9
007	10150	14.6042	3	5	9	16	29
008	2567	4.4437	1	1	3	6	10
009	1736	8.2160	2	3	6	10	16
010	20459	8.7558	2	3	6	11	18
011	2983	5.0851	1	2	4	7	10
012	23793	8.6530	2	4	6	10	16
013	6352	6.9216	3	4	5	8	12
014	355976	8.1794	2	4	6	10	15
015	148758	4.9390	2	2	4	6	9
016	12186	7.4179	2	3	5	8	14
017	3269	4.1318	1	2	3	5	8
018	22386	6.8428	2	3	5	8	13
019	7310	4.5988	1	2	4	6	9
020	8255	11.2443	3	5	9	14	22
021	1176	8.6548	2	4	7	11	17
022	3015	5.1035	2	2	4	6	10
023	6002	5.4725	1	2	4	7	11
024	58588	6.4046	2	3	4	7	12
025	22077	4.0534	1	2	3	5	8
026	48	4.4792	1	2	3	5	11
027	3438	7.1175	1	1	4	9	16
028	10488	7.7212	1	3	5	9	16
029	3382	4.1824	1	2	3	5	8
030	1	20.0000	20	20	20	20	20
031	3665	5.5831	1	2	4	6	10
032	2081	3.2912	1	1	2	4	6
034	16015	6.8307	2	3	5	8	14
035	3372	4.6987	1	2	3	6	9
036	13095	1.7163	1	1	1	2	3
037	2216	4.1119	1	1	2	5	8
038	365	2.7342	1	1	2	3	6
039	4054	1.9171	1	1	1	2	4
040	2929	3.8631	1	1	2	5	8
041	1	2.0000	2	2	2	2	2
042	9820	2.1876	1	1	1	2	4
043	132	3.8409	1	2	3	5	7
044	1727	5.8871	2	3	5	7	10
045	2559	4.3118	1	2	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
046	3321	5.9377	1	3	4	7	11
047	1455	3.9072	1	2	3	5	7
049	2308	7.0156	2	3	5	8	14
050	3738	2.3767	1	1	2	3	4
051	376	3.0213	1	1	2	3	7
052	89	3.3596	1	1	2	4	7
053	3955	3.7067	1	1	2	4	8
054	2	4.0000	1	1	7	7	7
055	2311	2.9619	1	1	1	3	7
056	788	3.0089	1	1	2	4	6
057	663	4.8763	1	2	3	6	12
059	109	2.9174	1	1	2	3	6
060	2	1.5000	1	1	2	2	2
061	269	5.8513	1	1	3	8	14
063	4451	4.9155	1	2	3	6	10
064	3708	8.1238	1	2	5	10	18
065	35151	3.6832	1	2	3	4	7
066	7326	3.8463	1	2	3	5	7
067	482	4.3320	1	2	3	5	8
068	15474	5.1430	2	3	4	6	9
069	4123	4.0196	2	2	3	5	7
070	20	2.9500	1	1	2	3	4
071	131	4.3282	1	2	4	6	8
072	672	4.6652	1	2	3	5	8
073	6398	5.3993	1	2	4	7	10
074	1	5.0000	5	5	5	5	5
075	39140	11.8686	4	6	9	14	23
076	39566	13.3501	3	6	10	16	25
077	2515	5.6342	1	2	4	8	12
078	27898	8.7011	4	6	8	10	14
079	202654	10.0625	3	5	8	12	19
080	8161	6.9295	2	4	6	8	12
081	15	6.7333	1	2	7	9	14
082	71979	8.4061	2	4	6	11	17
083	7621	6.8267	2	3	5	8	13
084	1580	4.1968	1	2	3	5	7
085	18459	7.8104	2	4	6	10	15
086	1382	4.5224	1	2	4	6	9
087	56282	7.2175	1	3	6	9	14
088	362753	6.5711	2	4	5	8	12
089	452431	7.5640	3	4	6	9	13
090	40399	5.4006	2	3	5	7	9
091	84	6.0238	1	3	4	8	12
092	11561	7.6630	2	4	6	9	14
093	1306	5.2167	2	3	4	7	10
094	10591	8.0006	2	4	6	10	15
095	1141	4.6599	2	3	4	6	8
096	76006	5.8803	2	3	5	7	10
097	26848	4.5073	2	3	4	6	8
098	30	5.1000	2	3	4	8	9
099	27557	3.8826	1	2	3	5	7
100	10548	2.6031	1	1	2	3	5
101	19218	5.9849	2	3	5	7	12
102	3041	3.9596	1	2	3	5	7
103	404	39.0495	10	15	26	51	82
104	22320	16.0147	7	9	14	20	28
105	19215	11.9858	6	7	9	14	21
106	92000	12.7277	7	8	11	15	21
107	59494	9.7554	5	7	8	11	15
108	6459	13.4696	5	7	11	16	25
110	59003	11.4622	3	6	9	14	22
111	5083	6.9695	3	5	7	8	11
112	184483	4.9679	1	2	4	7	10
113	45403	15.9297	4	7	11	19	32
114	8940	10.4375	2	4	8	13	20
115	10550	11.7955	4	7	10	14	21
116	80447	5.8978	1	2	4	7	12
117	4411	4.4493	1	2	3	5	9
118	7528	3.4186	1	1	2	4	7
119	1966	5.9135	1	1	3	7	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
120	42953	10.1101	1	3	6	13	22
121	166750	8.0265	3	5	7	10	14
122	94088	5.5209	1	3	5	7	9
123	51365	4.8941	1	1	3	6	12
124	140645	5.2202	1	2	4	7	10
125	64294	3.1754	1	1	2	4	6
126	4717	15.9275	4	7	12	20	32
127	703314	6.7118	2	3	5	8	13
128	21635	7.2159	4	5	6	8	11
129	5134	3.7156	1	1	1	4	9
130	89825	7.1214	2	4	6	9	12
131	24718	5.3976	1	3	5	7	9
132	57611	3.9362	1	2	3	5	7
133	4868	3.0657	1	1	2	4	6
134	30488	4.2292	1	2	3	5	8
135	6938	5.6345	1	2	4	7	11
136	1136	3.5810	1	2	3	4	6
137	1	19.0000	19	19	19	19	19
138	208494	4.8987	1	2	4	6	9
139	66382	3.1027	1	2	2	4	6
140	274276	3.8055	1	2	3	5	7
141	78924	4.9675	1	2	4	6	9
142	34007	3.3981	1	2	3	4	6
143	139417	2.8478	1	1	2	3	5
144	66373	6.0168	1	2	4	7	12
145	6471	3.3973	1	2	3	4	7
146	8486	11.6614	6	8	10	13	19
147	1434	7.6974	4	6	8	9	11
148	150277	14.0788	6	8	11	16	25
149	14026	7.8700	5	6	7	9	11
150	23835	12.2790	5	7	10	15	22
151	4168	6.4614	2	3	6	9	11
152	4836	9.5604	4	6	8	11	16
153	1712	6.2693	3	4	6	8	9
154	38124	15.9926	6	8	12	19	30
155	3900	6.3703	2	3	6	8	11
156	7	14.2857	3	7	17	18	22
157	12182	6.0488	1	2	4	7	12
158	5934	2.8586	1	1	2	4	6
159	18175	5.5457	1	3	4	7	10
160	10370	2.9751	1	2	2	4	6
161	17004	4.5169	1	2	3	6	9
162	9529	2.1407	1	1	2	3	4
163	14	5.0000	1	2	3	7	11
164	5431	9.8404	4	6	8	12	17
165	1586	5.9010	3	4	5	7	9
166	3464	6.0141	2	3	5	7	11
167	2230	3.5422	1	2	3	4	6
168	2006	5.6306	1	2	3	7	13
169	1133	2.6946	1	1	2	3	6
170	13222	13.2743	3	6	10	17	27
171	1092	5.7830	1	2	5	7	11
172	32353	8.7210	2	3	6	11	18
173	2164	4.3170	1	2	3	6	9
174	243846	5.9482	2	3	5	7	11
175	23696	3.6676	1	2	3	4	6
176	16136	6.4648	2	3	5	8	12
177	13362	5.4526	2	3	4	7	10
178	4508	3.8434	1	2	3	5	7
179	10795	7.7602	2	4	6	9	14
180	83783	6.4540	2	3	5	8	12
181	19982	3.9407	1	2	3	5	7
182	245809	5.3597	2	3	4	6	10
183	69783	3.6047	1	2	3	5	7
184	81	3.0494	1	1	2	4	6
185	4072	5.7876	1	2	4	7	12
186	4	5.7500	3	3	5	6	9
187	947	3.8353	1	2	3	5	7
188	60746	6.5210	2	3	5	8	13
189	7663	3.5758	1	1	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
190	90	6.4556	2	3	4	8	14
191	10832	17.3060	5	8	13	21	34
192	787	7.9352	2	4	7	10	14
193	9766	14.8273	6	8	12	18	26
194	853	8.1184	3	5	7	10	14
195	11362	11.1542	5	7	9	13	19
196	877	6.9259	3	4	6	9	11
197	32416	9.5929	4	5	8	11	17
198	8653	5.1453	2	3	4	6	8
199	2540	12.4102	3	6	10	16	24
200	1620	12.6056	2	4	9	16	27
201	1615	16.0904	4	7	12	20	30
202	24533	8.2755	2	4	6	10	16
203	29689	8.2140	2	3	6	10	16
204	48970	7.1515	2	3	5	9	14
205	22352	7.9561	2	3	6	10	16
206	1749	4.6798	1	2	4	6	9
207	38216	6.0794	2	3	5	8	11
208	10442	3.4061	1	2	3	4	7
209	327144	7.6473	4	5	7	9	12
210	139525	9.7688	4	6	8	11	16
211	25044	7.0987	3	5	6	8	11
212	22	5.2273	2	3	4	9	10
213	6859	10.6336	3	4	8	13	21
214	53636	7.3683	2	4	6	8	14
215	41531	4.1269	2	2	3	5	7
216	6776	12.2010	3	5	9	15	25
217	19370	17.0114	3	6	11	20	36
218	24059	6.8165	2	3	5	8	13
219	19021	4.0634	2	2	3	5	7
220	5	4.8000	1	1	3	9	9
221	5129	8.7853	2	4	6	10	17
222	3855	4.1642	1	2	3	5	8
223	20648	3.0600	1	1	2	3	6
224	8807	2.3823	1	1	2	3	4
225	7067	5.0662	1	2	3	6	11
226	5949	7.2674	1	2	5	9	15
227	5229	3.1427	1	1	2	4	6
228	3268	3.7840	1	1	2	4	8
229	1575	2.4000	1	1	2	3	5
230	2717	5.5778	1	2	3	6	12
231	11115	5.5294	1	2	3	7	12
232	658	4.4848	1	1	2	5	10
233	4844	9.7967	2	4	7	12	19
234	2286	4.4383	1	2	3	5	9
235	6118	7.6857	2	3	5	8	15
236	40137	6.9930	2	3	5	8	13
237	1595	4.9292	1	2	4	6	9
238	7380	11.3585	3	5	8	13	22
239	62864	8.3598	3	4	6	10	16
240	12072	8.0041	2	4	6	10	16
241	3044	4.8288	1	2	4	6	9
242	2565	8.8881	3	4	7	11	17
243	88802	6.1276	2	3	5	8	11
244	11849	6.3984	2	3	5	8	12
245	4413	4.4829	1	2	3	6	8
246	1417	4.6789	2	2	4	6	8
247	10573	4.2631	1	2	3	5	8
248	6790	5.7025	2	3	4	7	10
249	9934	4.6467	1	2	3	6	9
250	3565	5.6230	1	2	4	6	11
251	2351	3.2157	1	1	2	4	6
252	1	1.0000	1	1	1	1	1
253	18681	6.5628	2	3	5	7	12
254	10004	4.0136	1	2	3	5	7
255	5	9.0000	3	3	8	10	20
256	9799	4.3950	1	2	3	5	9
257	26742	3.8993	2	2	3	4	7
258	20636	2.7720	1	2	2	3	5
259	4509	4.0734	1	1	2	4	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
260	5286	1.9799	1	1	2	2	3
261	2601	2.5698	1	1	2	3	5
262	810	4.0099	1	1	2	5	9
263	31179	15.7680	4	7	11	19	31
264	3564	9.0659	3	4	7	11	18
265	4760	7.9055	1	2	5	9	17
266	2987	3.8373	1	1	3	5	8
267	250	4.4360	1	1	2	5	9
268	1194	4.4422	1	1	2	5	9
269	11049	9.9436	2	4	7	13	20
270	3978	3.4947	1	1	2	4	7
271	21708	9.4615	3	5	7	11	17
272	6574	8.0613	2	4	6	10	15
273	1539	6.0754	2	3	4	7	12
274	2646	8.0567	1	3	6	10	16
275	246	3.3211	1	1	2	4	7
276	942	5.4055	2	3	4	7	10
277	82558	7.2729	3	4	6	9	13
278	25634	5.4291	2	3	5	7	9
279	14	5.8571	1	2	4	7	14
280	13922	5.5335	1	2	4	7	10
281	6217	3.8679	1	2	3	5	7
282	1	18.0000	18	18	18	18	18
283	5700	5.9395	2	3	4	7	11
284	1779	4.0596	1	2	3	5	8
285	4921	15.3534	4	7	11	19	29
286	1918	8.9724	3	5	6	10	17
287	6703	15.4899	4	6	10	18	31
288	844	7.9656	3	4	6	8	14
289	5118	4.5346	1	2	3	4	9
290	9053	2.9759	1	2	2	3	5
291	85	1.6235	1	1	1	2	3
292	5313	13.7899	3	5	10	17	27
293	291	6.2509	1	2	5	8	12
294	95175	6.1560	2	3	5	7	11
295	3733	5.1117	1	2	4	6	9
296	226917	7.0173	2	3	5	8	13
297	34165	4.5850	1	2	3	5	8
298	110	3.8636	1	2	3	5	7
299	934	6.1392	1	2	4	7	12
300	14035	7.8248	2	4	6	9	15
301	1905	4.5701	1	2	4	6	8
302	7927	14.0269	6	8	11	16	25
303	18561	11.0121	5	6	9	13	20
304	13534	11.0159	3	5	8	13	22
305	2574	5.2284	1	3	4	6	9
306	12148	7.0957	2	3	5	9	15
307	2922	3.2396	1	2	3	4	5
308	10029	7.5203	1	3	5	9	16
309	3547	3.1844	1	1	2	4	6
310	31805	4.8918	1	2	3	6	10
311	11801	2.3329	1	1	2	3	4
312	2346	5.1206	1	2	3	6	11
313	983	2.5239	1	1	2	3	5
314	1	5.0000	5	5	5	5	5
315	30593	10.2945	1	2	6	13	23
316	65609	7.9880	2	3	6	10	16
317	877	4.0718	1	1	2	4	8
318	6481	7.5303	2	3	5	9	16
319	519	3.4085	1	1	2	4	7
320	179201	7.0307	3	4	5	8	13
321	24147	4.9488	2	3	4	6	8
322	89	5.4270	1	2	4	6	12
323	19263	3.7542	1	2	3	5	7
324	9715	2.2297	1	1	2	3	4
325	8579	4.8887	1	2	4	6	9
326	2581	3.3266	1	2	3	4	6
327	6	1.8333	1	1	1	2	2
328	903	4.3810	1	2	3	5	8
329	147	2.2857	1	1	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
331	38189	6.7612	2	3	5	8	13
332	4970	4.0767	1	2	3	5	8
333	346	5.9711	1	2	4	7	14
334	23415	6.8661	4	5	6	8	10
335	10652	5.2443	3	4	5	6	8
336	71694	4.5883	2	2	3	5	8
337	45574	2.9658	1	2	3	4	4
338	6388	5.6464	1	2	4	7	12
339	2672	4.7178	1	2	3	6	10
340	1	2.0000	2	2	2	2	2
341	7825	3.7127	1	2	3	4	7
342	230	4.1783	1	1	2	5	9
344	5318	3.4810	1	1	2	4	7
345	1679	4.6176	1	2	3	5	10
346	5933	7.5142	2	3	5	9	15
347	562	3.4982	1	1	2	4	7
348	3299	5.2716	1	2	4	6	10
349	812	3.1022	1	1	2	4	6
350	7474	5.2455	2	3	4	6	9
352	718	4.2382	1	2	3	5	9
353	2662	9.3963	4	5	7	11	17
354	10561	6.7353	3	4	5	7	12
355	5601	3.9991	3	3	4	5	6
356	36835	3.3217	2	2	3	4	5
357	6765	10.6010	4	5	8	12	19
358	27871	5.0576	3	3	4	6	8
359	26945	3.4724	2	3	3	4	5
360	9750	4.2228	2	2	3	5	7
361	556	4.9730	1	2	3	6	10
363	4977	3.7261	1	2	2	4	7
364	1926	3.8089	1	1	2	5	8
365	2585	8.7060	2	3	6	11	19
366	4794	8.1264	2	3	6	10	17
367	582	3.5481	1	1	2	4	8
368	2177	7.1075	2	3	6	9	13
369	2475	3.8869	1	1	3	5	8
370	1055	5.7261	3	3	4	6	10
371	1020	3.7598	2	3	3	4	5
372	771	3.5175	1	2	2	3	6
373	3627	2.1012	1	1	2	2	3
374	149	2.8389	1	2	2	3	4
375	6	2.6667	1	2	3	3	3
376	198	3.7121	1	1	2	4	8
377	37	4.2973	1	1	2	5	10
378	195	2.8410	1	2	3	4	4
379	358	3.3715	1	1	2	4	7
380	79	1.9747	1	1	1	2	4
381	234	2.0556	1	1	1	2	3
382	62	1.8548	1	1	1	1	2
383	1290	4.3473	1	2	3	5	8
384	129	2.0543	1	1	1	2	4
385	4	9.2500	1	1	7	9	20
389	29	10.3448	1	5	9	14	18
390	20	4.4000	1	2	2	3	7
392	2618	12.0038	4	6	9	15	24
393	4	10.5000	4	4	7	12	19
394	1826	8.4869	1	2	5	10	20
395	69620	5.7869	1	2	4	7	11
396	25	4.1600	1	1	2	5	11
397	14099	6.6178	2	3	5	8	13
398	17210	7.1325	2	4	6	8	13
399	1330	4.5850	1	2	4	6	8
400	8054	11.1912	2	4	8	14	24
401	6917	13.0344	3	5	10	16	27
402	1773	4.3971	1	1	3	6	10
403	34463	9.9275	2	4	7	13	21
404	3962	5.1562	1	2	4	7	10
405	1	1.0000	1	1	1	1	1
406	3686	11.9745	3	5	9	15	24
407	801	4.9189	1	2	4	6	9

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
408	3384	8.8230	1	2	5	11	21
409	7060	6.9874	2	3	4	7	15
410	106214	3.3485	1	2	3	4	6
411	53	3.3585	1	1	3	5	7
412	66	2.9394	1	1	2	4	7
413	8956	9.1131	2	4	7	11	19
414	913	5.6396	1	2	4	7	11
415	38353	17.2555	4	8	13	21	34
416	183781	8.8472	2	4	7	11	17
417	43	6.1395	2	3	5	7	13
418	17185	7.2542	2	4	6	9	13
419	16932	6.1817	2	3	5	7	11
420	2916	4.5710	2	2	4	6	8
421	13445	4.8837	2	2	4	6	9
422	88	4.3295	1	2	3	5	9
423	8948	9.3368	3	4	7	11	19
424	2299	19.9696	3	7	13	24	41
425	17710	5.4580	1	2	4	7	11
426	5265	6.2494	1	3	4	8	13
427	2024	5.8384	1	2	4	7	12
428	1016	8.0807	1	3	5	10	17
429	36024	10.3797	2	4	6	11	20
430	59399	10.5850	2	4	8	14	21
431	223	7.5471	2	3	6	9	14
432	499	6.6092	1	2	4	7	13
433	7779	3.7063	1	1	2	4	8
434	21294	6.3439	2	3	5	7	12
435	14719	5.0931	1	3	4	6	9
436	2865	15.4918	4	9	14	21	28
437	14576	11.7871	4	7	10	15	21
439	944	9.2606	1	3	6	11	19
440	4613	10.9638	2	4	7	13	24
441	631	4.2504	1	1	2	4	7
442	13846	9.0475	1	3	6	11	19
443	3731	3.3251	1	1	2	4	7
444	3562	5.7381	2	3	4	7	11
445	1441	3.8709	1	2	3	5	7
447	3613	3.0576	1	1	2	4	6
448	58	1.0000	1	1	1	1	1
449	30844	4.7908	1	2	3	6	10
450	6631	2.5091	1	1	2	3	5
451	8	3.6250	1	1	2	5	7
452	19393	5.6265	1	2	4	7	12
453	3899	3.4047	1	1	2	4	7
454	4486	6.0105	1	2	4	7	12
455	1011	3.4649	1	1	2	4	7
456	199	8.2412	1	1	4	9	20
457	148	5.0811	1	1	1	6	13
458	1702	18.4036	4	8	14	24	37
459	605	13.1818	3	5	8	14	25
460	2470	7.3405	2	3	5	9	15
461	3604	5.4456	1	1	2	5	14
462	10537	14.5672	5	7	13	19	27
463	11242	5.8466	2	3	4	7	11
464	2675	3.9267	1	2	3	5	7
465	257	2.9144	1	1	2	3	5
466	2364	4.5998	1	1	2	4	10
467	2726	4.9409	1	1	2	5	9
468	61159	16.4808	3	7	13	21	32
471	8878	9.6683	4	6	8	11	16
472	187	31.3850	1	5	23	44	72
473	8347	14.9680	2	4	8	23	37
475	89293	12.9142	2	6	10	17	25
476	7977	15.0950	4	8	12	18	27
477	33933	9.3951	1	3	6	12	19
478	118706	9.0006	2	3	7	11	19
479	16953	4.8781	1	2	4	6	9
480	305	33.7836	11	14	22	41	73
481	136	31.1544	18	22	28	37	46
482	7250	16.2116	5	8	12	19	30

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V12.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
483	36919	49.3175	16	25	39	60	91
484	359	17.1142	2	6	13	22	33
485	3100	13.3335	5	7	10	15	25
486	2297	14.9495	1	6	11	19	30
487	3787	9.8590	2	4	7	12	19
488	1217	18.9836	5	8	14	23	36
489	13239	11.6630	3	4	8	14	24
490	3969	7.3263	1	3	5	8	15
491	9282	4.7884	2	3	4	6	8
492	2077	18.3524	4	5	12	28	38
493	53242	6.1192	1	2	5	8	12
494	28904	2.3069	1	1	1	3	5
495	145	23.2897	9	13	18	26	36
	11003466						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
001	32563	12.4181	3	5	9	15	25
002	6317	12.5552	3	6	9	15	25
003	1	7.0000	7	7	7	7	7
004	5716	9.9696	2	3	7	13	21
005	69427	5.2597	2	3	4	6	10
006	501	4.0279	1	1	2	4	9
007	10054	14.6588	3	5	9	16	30
008	2662	4.5995	1	1	3	6	10
009	1736	8.2160	2	3	6	10	16
010	20281	8.7667	2	3	6	11	18
011	3161	5.2221	1	2	4	7	11
012	23793	8.6530	2	4	6	10	16
013	6352	6.9216	3	4	5	8	12
014	355976	8.1794	2	4	6	10	15
015	148758	4.9390	2	2	4	6	9
016	11897	7.4574	2	3	5	8	14
017	3558	4.2664	1	2	3	5	8
018	21928	6.8581	2	3	5	8	13
019	7768	4.6881	1	2	4	6	9
020	8255	11.2443	3	5	9	14	22
021	1176	8.6548	2	4	7	11	17
022	3015	5.1035	2	2	4	6	10
023	6002	5.4725	1	2	4	7	11
024	56785	6.4601	2	3	4	7	12
025	23880	4.0990	1	2	3	5	8
026	48	4.4792	1	2	3	5	11
027	3431	7.0982	1	1	4	8	16
028	10184	7.7692	1	3	5	9	16
029	3686	4.3416	1	2	3	5	9
030	1	20.0000	20	20	20	20	20
031	3525	5.6423	1	2	4	6	10
032	2221	3.3417	1	1	2	4	6
034	15768	6.8472	2	3	5	8	14
035	3619	4.7720	1	2	3	6	9
036	12400	1.6868	1	1	1	2	3
037	2216	4.1119	1	1	2	5	8
038	365	2.7342	1	1	2	3	6
039	4054	1.9171	1	1	1	2	4
040	3624	3.5524	1	1	2	4	8
041	1	2.0000	2	2	2	2	2
042	9820	2.1876	1	1	1	2	4
043	132	3.8409	1	2	3	5	7
044	1727	5.8871	2	3	5	7	10
045	2559	4.3118	1	2	3	5	8
046	3246	5.9640	1	3	4	7	11
047	1530	3.9510	1	2	3	5	8
049	2308	7.0156	2	3	5	8	14

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
050	3738	2.3767	1	1	2	3	4
051	376	3.0213	1	1	2	3	7
052	89	3.3596	1	1	2	4	7
053	3955	3.7067	1	1	2	4	8
054	2	4.0000	1	1	7	7	7
055	2311	2.9619	1	1	1	3	7
056	788	3.0089	1	1	2	4	6
057	663	4.8763	1	2	3	6	12
059	109	2.9174	1	1	2	3	6
060	2	1.5000	1	1	2	2	2
061	269	5.8513	1	1	3	8	14
063	4451	4.9155	1	2	3	6	10
064	3708	8.1238	1	2	5	10	18
065	35151	3.6832	1	2	3	4	7
066	7326	3.8463	1	2	3	5	7
067	482	4.3320	1	2	3	5	8
068	15027	5.1614	2	3	4	6	9
069	4570	4.0689	2	2	3	5	7
070	20	2.9500	1	1	2	3	4
071	131	4.3282	1	2	4	6	8
072	672	4.6652	1	2	3	5	8
073	6398	5.3993	1	2	4	7	10
074	1	5.0000	5	5	5	5	5
075	39140	11.8686	4	6	9	14	23
076	39373	13.3698	3	6	10	16	25
077	2708	5.8988	1	2	4	8	12
078	27898	8.7011	4	6	8	10	14
079	201195	10.0750	3	5	8	12	19
080	9620	7.1426	3	4	6	9	13
081	15	6.7333	1	2	7	9	14
082	71979	8.4061	2	4	6	11	17
083	7543	6.8481	2	3	5	8	13
084	1658	4.2232	1	2	3	5	7
085	18380	7.8162	2	4	6	10	15
086	1461	4.6283	1	2	4	6	9
087	56282	7.2175	1	3	6	9	14
088	362753	6.5711	2	4	5	8	12
089	446949	7.5767	3	4	6	9	13
090	45881	5.5353	2	3	5	7	9
091	84	6.0238	1	3	4	8	12
092	11454	7.6810	2	4	6	9	14
093	1413	5.2562	2	3	4	7	10
094	10540	8.0123	2	4	6	10	15
095	1192	4.6988	2	3	4	6	8
096	73149	5.9075	2	3	5	7	10
097	29705	4.5723	2	3	4	6	8
098	30	5.1000	2	3	4	8	9
099	26903	3.9009	1	2	3	5	7
100	11202	2.6338	1	1	2	3	5
101	19018	5.9986	2	3	5	7	12
102	3241	4.0040	1	2	3	5	7
103	404	39.0495	10	15	26	51	82
104	22320	16.0147	7	9	14	20	28
105	19215	11.9858	6	7	9	14	21
106	92000	12.7277	7	8	11	15	21
107	59494	9.7554	5	7	8	11	15
108	6459	13.4696	5	7	11	16	25
110	58130	11.5090	3	6	9	14	22
111	5956	7.1711	3	5	7	9	11
112	184483	4.9679	1	2	4	7	10
113	45403	15.9297	4	7	11	19	32
114	8942	10.4369	2	4	8	13	20
115	10550	11.7955	4	7	10	14	21
116	80447	5.8978	1	2	4	7	12
117	4411	4.4493	1	2	3	5	9
118	7528	3.4186	1	1	2	4	7
119	1966	5.9135	1	1	3	7	13
120	42958	10.1097	1	3	6	13	22
121	166593	8.0247	3	5	7	10	14
122	94245	5.5284	1	3	5	7	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
123	51365	4.8941	1	1	3	6	12
124	140582	5.2192	1	2	4	7	10
125	64357	3.1794	1	1	2	4	6
126	4717	15.9275	4	7	12	20	32
127	703314	6.7118	2	3	5	8	13
128	21635	7.2159	4	5	6	8	11
129	5134	3.7156	1	1	1	4	9
130	88588	7.1348	2	4	6	9	13
131	25955	5.4340	1	3	5	7	9
132	57370	3.9386	1	2	3	5	7
133	5109	3.0803	1	1	2	4	6
134	30488	4.2292	1	2	3	5	8
135	6876	5.6498	1	2	4	7	11
136	1198	3.5993	1	2	3	4	6
137	1	19.0000	19	19	19	19	19
138	203018	4.9328	1	2	4	6	9
139	71858	3.1432	1	2	2	4	6
140	274276	3.8055	1	2	3	5	7
141	76039	5.0041	2	2	4	6	9
142	36892	3.4454	1	2	3	4	6
143	139417	2.8478	1	1	2	3	5
144	65937	6.0300	1	2	4	7	12
145	6907	3.4368	1	2	3	4	7
146	8234	11.7471	6	8	10	13	19
147	1686	7.8713	4	6	8	9	11
148	147371	14.1723	6	8	11	17	25
149	16932	8.1214	5	6	8	9	12
150	23228	12.3597	5	7	10	15	22
151	4775	6.8084	2	4	6	9	12
152	4652	9.6466	4	6	8	11	16
153	1896	6.3771	3	5	6	8	10
154	37655	16.0775	6	8	12	20	30
155	4369	6.6709	2	4	6	8	12
156	7	14.2857	3	7	17	18	22
157	11925	6.0642	1	2	4	7	12
158	6191	2.9616	1	1	2	4	6
159	17740	5.5558	1	3	4	7	11
160	10805	3.0621	1	2	3	4	6
161	16711	4.5214	1	2	3	6	9
162	9822	2.2040	1	1	2	3	4
163	14	5.0000	1	2	3	7	11
164	5233	9.9318	4	6	8	12	17
165	1784	6.0701	3	4	6	7	9
166	3351	6.0624	2	3	5	8	11
167	2343	3.5924	2	2	3	4	6
168	1989	5.6310	1	2	3	7	13
169	1150	2.7374	1	1	2	3	6
170	13122	13.2964	3	6	10	17	27
171	1192	6.1678	1	3	5	8	12
172	32126	8.7343	2	3	6	11	18
173	2391	4.5575	1	2	3	6	9
174	241449	5.9594	2	3	5	7	11
175	26093	3.7730	1	2	3	5	7
176	16136	6.4648	2	3	5	8	12
177	13035	5.4607	2	3	4	7	10
178	4835	3.9305	1	2	3	5	7
179	10795	7.7602	2	4	6	9	14
180	80115	6.5037	2	3	5	8	12
181	23650	4.1622	1	2	4	5	7
182	237691	5.3815	2	3	4	7	10
183	77901	3.7210	1	2	3	5	7
184	81	3.0494	1	1	2	4	6
185	4072	5.7876	1	2	4	7	12
186	4	5.7500	3	3	5	6	9
187	947	3.8353	1	2	3	5	7
188	59776	6.5322	2	3	5	8	13
189	8633	3.8291	1	1	3	5	8
190	90	6.4556	2	3	4	8	14
191	10712	17.3836	5	8	13	22	35
192	907	8.2591	2	5	7	10	15

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
193	9602	14.8980	6	8	12	18	27
194	1017	8.5320	3	5	8	11	15
195	11225	11.1842	5	7	9	13	19
196	1014	7.1647	3	5	7	9	11
197	31505	9.6595	4	5	8	11	17
198	9564	5.3496	2	3	5	7	9
199	2540	12.4102	3	6	10	16	24
200	1620	12.6056	2	4	9	16	27
201	1615	16.0904	4	7	12	20	30
202	24533	8.2755	2	4	6	10	16
203	29689	8.2140	2	3	6	10	16
204	48970	7.1515	2	3	5	9	14
205	22181	7.9563	2	3	6	10	16
206	1920	4.9693	1	2	4	6	10
207	37149	6.1056	2	3	5	8	12
208	11509	3.5696	1	2	3	5	7
209	327144	7.6473	4	5	7	9	12
210	136786	9.8010	4	6	8	11	16
211	27783	7.2033	4	5	6	8	11
212	22	5.2273	2	3	4	9	10
213	6859	10.6336	3	4	8	13	21
214	52362	7.3958	2	4	6	9	14
215	42805	4.1898	2	2	3	5	7
216	6776	12.2010	3	5	9	15	25
217	19370	17.0114	3	6	11	20	36
218	23321	6.8681	2	3	5	8	13
219	19759	4.1052	2	2	3	5	7
220	5	4.8000	1	1	3	9	9
221	5000	8.8390	2	4	6	10	17
222	3984	4.2465	1	2	3	5	8
223	20206	3.0441	1	1	2	3	6
224	8998	2.4032	1	1	2	3	4
225	7067	5.0662	1	2	3	6	11
226	5814	7.3156	1	2	5	9	15
227	5364	3.1943	1	1	2	4	6
228	3483	3.8088	1	1	2	4	8
229	1608	2.4254	1	1	2	3	5
230	2717	5.5778	1	2	3	6	12
231	11115	5.5294	1	2	3	7	12
232	661	4.4781	1	1	2	5	10
233	4776	9.8306	2	4	7	12	20
234	2354	4.5242	1	2	3	6	9
235	6118	7.6857	2	3	5	8	15
236	40137	6.9930	2	3	5	8	13
237	1595	4.9292	1	2	4	6	9
238	7380	11.3585	3	5	8	13	22
239	62864	8.3598	3	4	6	10	16
240	11832	8.0401	2	4	6	10	16
241	3284	4.9315	1	2	4	6	9
242	2565	8.8881	3	4	7	11	17
243	88802	6.1276	2	3	5	8	11
244	11514	6.4164	2	3	5	8	12
245	4748	4.5746	1	2	3	6	8
246	1417	4.6789	2	2	4	6	8
247	10573	4.2631	1	2	3	5	8
248	6790	5.7025	2	3	4	7	10
249	9934	4.6467	1	2	3	6	9
250	3475	5.6636	1	2	4	6	11
251	2441	3.2466	1	1	2	4	6
252	1	1.0000	1	1	1	1	1
253	18273	6.5851	2	3	5	8	12
254	10412	4.0742	1	2	3	5	8
255	5	9.0000	3	3	8	10	20
256	9799	4.3950	1	2	3	5	9
257	26246	3.9084	2	2	3	4	7
258	21132	2.7872	1	2	2	3	5
259	4424	4.0995	1	1	2	4	8
260	5371	1.9916	1	1	2	2	3
261	2601	2.5698	1	1	2	3	5
262	810	4.0099	1	1	2	5	9

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
263	30957	15.8007	4	7	11	19	31
264	3786	9.1918	3	4	7	11	19
265	4698	7.9208	1	2	5	9	17
266	3049	3.8964	1	1	3	5	8
267	250	4.4360	1	1	2	5	9
268	1194	4.4422	1	1	2	5	9
269	10904	9.9901	2	4	7	13	21
270	4123	3.5986	1	1	2	4	8
271	21708	9.4615	3	5	7	11	17
272	6462	8.0888	2	4	6	10	15
273	1651	6.1024	2	3	4	7	13
274	2629	8.0738	1	3	6	10	16
275	263	3.4563	1	1	2	4	8
276	942	5.4055	2	3	4	7	10
277	80460	7.2966	3	4	6	9	13
278	27732	5.4998	2	3	5	7	9
279	14	5.8571	1	2	4	7	14
280	13633	5.5404	1	2	4	7	10
281	6506	3.9276	1	2	3	5	7
282	1	18.0000	18	18	18	18	18
283	5608	5.9627	2	3	4	7	11
284	1871	4.0823	1	2	3	5	8
285	4921	15.3534	4	7	11	19	29
286	1918	8.9724	3	5	6	10	17
287	6703	15.4899	4	6	10	18	31
288	844	7.9656	3	4	6	8	14
289	5118	4.5346	1	2	3	4	9
290	9053	2.9759	1	2	2	3	5
291	85	1.6235	1	1	1	2	3
292	5300	13.8000	3	5	10	17	27
293	304	6.3980	1	2	5	8	12
294	95175	6.1560	2	3	5	7	11
295	3733	5.1117	1	2	4	6	9
296	226402	7.0218	2	3	5	8	13
297	34680	4.5918	1	2	3	6	8
298	110	3.8636	1	2	3	5	7
299	934	6.1392	1	2	4	7	12
300	13699	7.8699	2	4	6	9	15
301	2241	4.7822	1	2	4	6	9
302	7927	14.0269	6	8	11	16	25
303	18561	11.0121	5	6	9	13	20
304	13350	11.0605	3	5	8	14	22
305	2758	5.3985	1	3	5	7	9
306	12058	7.0994	2	3	5	9	15
307	3012	3.3396	1	2	3	4	6
308	9940	7.5354	1	3	5	9	16
309	3636	3.2492	1	1	2	4	7
310	31553	4.8978	1	2	3	6	10
311	12053	2.3708	1	1	2	3	4
312	2334	5.1127	1	2	3	6	11
313	995	2.5739	1	1	2	3	5
314	1	5.0000	5	5	5	5	5
315	30593	10.2945	1	2	6	13	23
316	65609	7.9880	2	3	6	10	16
317	877	4.0718	1	1	2	4	8
318	6466	7.5396	2	3	5	9	16
319	534	3.4120	1	1	2	4	7
320	175172	7.0612	3	4	6	8	13
321	28176	5.0569	2	3	4	6	8
322	89	5.4270	1	2	4	6	12
323	18929	3.7670	1	2	3	5	7
324	10049	2.2562	1	1	2	3	4
325	8473	4.8960	1	2	4	6	9
326	2687	3.3651	1	2	3	4	6
327	6	1.8333	1	1	1	2	2
328	900	4.3789	1	2	3	5	8
329	150	2.3400	1	1	2	3	5
331	37821	6.7707	2	3	5	8	13
332	5338	4.1948	1	2	3	5	8
333	346	5.9711	1	2	4	7	14

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
334	22781	6.8779	4	5	6	8	10
335	11286	5.3115	3	4	5	6	8
336	70900	4.5949	2	2	3	5	8
337	46368	2.9836	1	2	3	4	5
338	6388	5.6464	1	2	4	7	12
339	2672	4.7178	1	2	3	6	10
340	1	2.0000	2	2	2	2	2
341	7825	3.7127	1	2	3	4	7
342	230	4.1783	1	1	2	5	9
344	5318	3.4810	1	1	2	4	7
345	1679	4.6176	1	2	3	5	10
346	5920	7.5142	2	3	5	9	15
347	575	3.5896	1	1	2	4	7
348	3277	5.2820	1	2	4	6	10
349	834	3.1187	1	1	2	4	6
350	7474	5.2455	2	3	4	6	9
352	718	4.2382	1	2	3	5	9
353	2662	9.3963	4	5	7	11	17
354	10205	6.7863	3	4	5	8	12
355	5957	4.0754	3	3	4	5	6
356	36835	3.3217	2	2	3	4	5
357	6765	10.6010	4	5	8	12	19
358	26783	5.0861	3	3	4	6	8
359	28033	3.5067	2	3	3	4	5
360	9750	4.2228	2	2	3	5	7
361	556	4.9730	1	2	3	6	10
363	4977	3.7261	1	2	2	4	7
364	1926	3.8089	1	1	2	5	8
365	2585	8.7060	2	3	6	11	19
366	4743	8.1564	2	3	6	10	17
367	633	3.6919	1	1	2	4	8
368	2177	7.1075	2	3	6	9	13
369	2475	3.8869	1	1	3	5	8
370	1052	5.7253	3	3	4	6	10
371	1023	3.7664	2	3	3	4	5
372	771	3.5175	1	2	2	3	6
373	3627	2.1012	1	1	2	2	3
374	149	2.8389	1	2	2	3	4
375	6	2.6667	1	2	3	3	3
376	198	3.7121	1	1	2	4	8
377	37	4.2973	1	1	2	5	10
378	195	2.8410	1	2	3	4	4
379	358	3.3715	1	1	2	4	7
380	79	1.9747	1	1	1	2	4
381	234	2.0556	1	1	1	2	3
382	62	1.8548	1	1	1	1	2
383	1290	4.3473	1	2	3	5	8
384	129	2.0543	1	1	1	2	4
385	4	9.2500	1	1	7	9	20
389	29	10.3448	1	5	9	14	18
390	20	4.4000	1	2	2	3	7
392	2618	12.0038	4	6	9	15	24
393	4	10.5000	4	4	7	12	19
394	1826	8.4869	1	2	5	10	20
395	69620	5.7869	1	2	4	7	11
396	25	4.1600	1	1	2	5	11
397	14099	6.6178	2	3	5	8	13
398	17056	7.1449	2	4	6	8	13
399	1484	4.7069	1	2	4	6	8
400	8054	11.1912	2	4	8	14	24
401	6822	13.0981	3	5	10	17	27
402	1868	4.6039	1	1	3	6	10
403	34099	9.9506	2	4	7	13	21
404	4326	5.3754	1	2	4	7	11
405	1	1.0000	1	1	1	1	1
406	3631	12.0353	3	5	9	15	24
407	856	5.1145	1	3	4	7	9
408	3384	8.8230	1	2	5	11	21
409	7060	6.9874	2	3	4	7	15
410	106214	3.3485	1	2	3	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
411	53	3.3585	1	1	3	5	7
412	66	2.9394	1	1	2	4	7
413	8869	9.1250	2	4	7	11	19
414	1000	5.8360	1	2	4	7	12
415	38353	17.2555	4	8	13	21	34
416	183781	8.8472	2	4	7	11	17
417	43	6.1395	2	3	5	7	13
418	17185	7.2542	2	4	6	9	13
419	16596	6.2037	2	3	5	7	12
420	3252	4.6248	2	3	4	6	8
421	13445	4.8837	2	2	4	6	9
422	88	4.3295	1	2	3	5	9
423	8948	9.3368	3	4	7	11	19
424	2299	19.9696	3	7	13	24	41
425	17710	5.4580	1	2	4	7	11
426	5265	6.2494	1	3	4	8	13
427	2024	5.8384	1	2	4	7	12
428	1016	8.0807	1	3	5	10	17
429	36024	10.3797	2	4	6	11	20
430	59399	10.5850	2	4	8	14	21
431	223	7.5471	2	3	6	9	14
432	499	6.6092	1	2	4	7	13
433	7779	3.7063	1	1	2	4	8
434	20506	6.3770	2	3	5	7	12
435	15507	5.1130	1	3	4	6	9
436	2865	15.4918	4	9	14	21	28
437	14576	11.7871	4	7	10	15	21
439	944	9.2606	1	3	6	11	19
440	4613	10.9638	2	4	7	13	24
441	631	4.2504	1	1	2	4	7
442	13715	9.0734	1	3	6	11	19
443	3862	3.4270	1	1	2	4	7
444	3496	5.7695	2	3	4	7	11
445	1507	3.8799	1	2	3	5	7
447	3613	3.0576	1	1	2	4	6
448	58	1.0000	1	1	1	1	1
449	30186	4.8263	1	2	3	6	10
450	7289	2.5681	1	1	2	3	5
451	8	3.6250	1	1	2	5	7
452	19238	5.6305	1	2	4	7	12
453	4054	3.4706	1	1	2	4	7
454	4384	6.0557	1	2	4	7	12
455	1113	3.5202	1	1	2	4	7
456	199	8.2412	1	1	4	9	20
457	148	5.0811	1	1	1	6	13
458	1702	18.4036	4	8	14	24	37
459	605	13.1818	3	5	8	14	25
460	2470	7.3405	2	3	5	9	15
461	3604	5.4456	1	1	2	5	14
462	10537	14.5672	5	7	13	19	27
463	10985	5.8645	2	3	4	7	11
464	2932	4.0280	1	2	3	5	7
465	257	2.9144	1	1	2	3	5
466	2364	4.5998	1	1	2	4	10
467	2726	4.9409	1	1	2	5	9
468	61093	16.4858	3	7	13	21	32
471	8878	9.6683	4	6	8	11	16
472	187	31.3850	1	5	23	44	72
473	8347	14.9680	2	4	8	23	37
475	89293	12.9142	2	6	10	17	25
476	7978	15.0978	4	8	12	18	27
477	33998	9.3991	1	3	6	12	19
478	117647	9.0174	2	3	7	11	19
479	18005	5.0104	1	2	4	6	9
480	305	33.7836	11	14	22	41	73
481	136	31.1544	18	22	28	37	46
482	7250	16.2116	5	8	12	19	30
483	36919	49.3175	16	25	39	60	91
484	360	17.1056	2	6	13	22	33
485	3100	13.3335	5	7	10	15	25

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY94 MEDPAR Update 06/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
486	2298	14.9500	1	6	11	19	30
487	3794	9.8714	2	4	7	12	19
488	1217	18.9836	5	8	14	23	36
489	13239	11.6630	3	4	8	14	24
490	3969	7.3263	1	3	5	8	15
491	9282	4.7884	2	3	4	6	8
492	2077	18.3524	4	5	12	28	38
493	51794	6.1615	1	2	5	8	12
494	30352	2.4166	1	1	1	3	5
495	145	23.2897	9	13	18	26	36
	11003466						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1995

State	Urban	Rural
ALABAMA	0.436	0.484
ALASKA	0.535	0.721
ARIZONA	0.459	0.643
ARKANSAS	0.552	0.516
CALIFORNIA	0.438	0.537
COLORADO	0.518	0.582
CONNECTICUT	0.557	0.576
DELAWARE	0.533	0.516
DISTRICT OF COLUMBIA	0.532	.....
FLORIDA	0.435	0.432
GEORGIA	0.541	0.540
HAWAII	0.519	0.553
IDAHO	0.580	0.673
ILLINOIS	0.523	0.605
INDIANA	0.580	0.633
IOWA	0.554	0.716
KANSAS	0.506	0.688
KENTUCKY	0.522	0.562
LOUISIANA	0.497	0.559
MAINE	0.613	0.560
MARYLAND	0.764	0.806
MASSACHUSETTS	0.612	0.622
MICHIGAN	0.549	0.657
MINNESOTA	0.583	0.648
MISSISSIPPI	0.544	0.532
MISSOURI	0.474	0.531
MONTANA	0.544	0.661
NEBRASKA	0.529	0.694
NEVADA	0.343	0.628
NEW HAMPSHIRE	0.592	0.625
NEW JERSEY	0.543	.....
NEW MEXICO	0.485	0.549
NEW YORK	0.633	0.721
NORTH CAROLINA	0.567	0.520
NORTH DAKOTA	0.652	0.695
OHIO	0.594	0.633
OKLAHOMA	0.506	0.572
OREGON	0.604	0.637

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1995—Continued

State	Urban	Rural
PENNSYLVANIA	0.455	0.579
PUERTO RICO	0.554	0.855
RHODE ISLAND	0.615	.....
SOUTH CAROLINA	0.510	0.524
SOUTH DAKOTA	0.563	0.656
TENNESSEE	0.530	0.569
TEXAS	0.491	0.593
UTAH	0.591	0.648
VERMONT	0.627	0.611
VIRGINIA	0.513	0.549
WASHINGTON	0.657	0.676
WEST VIRGINIA	0.577	0.529
WISCONSIN	0.640	0.706
WYOMING	0.611	0.765

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1995

State	Ratio
ALABAMA	0.053
ALASKA	0.075
ARIZONA	0.062
ARKANSAS	0.050
CALIFORNIA	0.041
COLORADO	0.051
CONNECTICUT	0.037
DELAWARE	0.055
DISTRICT OF COLUMBIA	0.043
FLORIDA	0.053
GEORGIA	0.050
HAWAII	0.063
IDAHO	0.075
ILLINOIS	0.049

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1995—Continued

State	Ratio
INDIANA	0.059
IOWA	0.058
KANSAS	0.062
KENTUCKY	0.059
LOUISIANA	0.074
MAINE	0.042
MASSACHUSETTS	0.061
MICHIGAN	0.059
MINNESOTA	0.055
MISSISSIPPI	0.055
MISSOURI	0.054
MONTANA	0.067
NEBRASKA	0.061
NEVADA	0.036
NEW HAMPSHIRE	0.064
NEW JERSEY	0.051
NEW MEXICO	0.056
NEW YORK	0.061
NORTH CAROLINA	0.048
NORTH DAKOTA	0.075
OHIO	0.061
OKLAHOMA	0.059
OREGON	0.068
PENNSYLVANIA	0.047
PUERTO RICO	0.090
RHODE ISLAND	0.027
SOUTH CAROLINA	0.064
SOUTH DAKOTA	0.065
TENNESSEE	0.057
TEXAS	0.059
UTAH	0.050
VERMONT	0.050
VIRGINIA	0.058
WASHINGTON	0.068
WEST VIRGINIA	0.058
WISCONSIN	0.048
WYOMING	0.072

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS

Area	1982–1992 difference	1984–1992 difference	1988–1992 difference	1990–1992 difference	1991–1992 difference
Rural Connecticut	26.405	28.914	10.079	.....	.....
Rural Hawaii	.....	11.391	.....	.....	.....
Rural Massachusetts	18.481	22.338	.....	.....	'

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1992 difference	1984–1992 difference	1988–1992 difference	1990–1992 difference	1991–1992 difference
Rural New Hampshire	9.086	12.861			
Rural New Mexico				10.819	
Rural South Carolina		8.253			
Albany, GA		10.486			
Anchorage, AK				9.498	
Anderson, SC				14.207	
Ann Arbor, MI			8.583		
Arecibo, PR			13.672	21.305	18.431
Athens, GA	11.226	16.932	9.859	9.779	
Atlanta, GA		8.942			
Atlantic City, NJ		11.027			
Bellingham, WA	11.423	16.929	20.702	13.649	12.901
Bergen-Passaic, NJ	9.510	11.379	13.314		
Biloxi-Gulfport, MS		10.148	9.629	11.397	
Boston-Lowell-Brockton-Lawrence-Salem, MA		10.756			
Bridgeport-Stamford-Norwalk-Danbury, CT		11.180			
Burlington, NC	12.654	16.034	10.822		
Caguas, PR		18.450			
Charlotte-Gastonia-Rock Hill, NC–SC	8.386	15.466			
Clarksville-Hopkinsville, TN–KY				10.392	
Danville, VA		10.958	12.671		
Decatur, AL		10.600	9.169		
Eugene-Springfield, OR		9.207	9.486	17.366	
Fayetteville, NC		8.397			
Florence, AL		8.604			
Florence, SC	11.764	10.618			
Gadsden, AL				10.612	
Galveston-Texas City, TX			9.164		
Hartford-Middletown-New Britain, CT	8.970	12.697			
Jackson, TN	8.379	12.579			
Killeen-Temple, TX	19.900				
Lakeland-Winter Haven, FL		8.426	8.572		
Las Cruces, NM			11.938		
Lima, OH			9.827		
Longview-Marshall, TX		8.646			
Macon-Warner Robins, GA		15.225			
Manchester-Nashua, NH	11.703	13.083			
McAllen-Edinburg-Mission, TX		12.892	12.264		8.052
Merced, CA		8.186		8.434	10.359
Middlesex-Somerset-Hunterdon, NJ		8.863			
Midland, TX					9.018
Monmouth-Ocean, NJ		12.517			
Muncie, IN			13.003		
Nassau-Suffolk, NY		12.249			
New Bedford-Fall River-Attleboro, MA	11.576	14.390	8.311		
New Haven-West Haven-Waterbury, CT	11.773	16.122			
New London-Norwich, CT	8.025	11.529			
Newark, NJ		10.378			
Oakland, CA		8.361			
Ocala, FL		9.812			
Omaha, NE–IA			8.859		
Orange County, NY	15.111	19.315	9.916		
Panama City, FL					8.543
Portsmouth-Dover-Rochester, NH	8.033				
Poughkeepsie, NY		9.961			
Providence-Pawtucket-Woonsocket, RI		13.272			
Reading, PA			8.479		
Redding, CA		19.139	11.715		
Richland-Kennewick, WA				8.544	
Salinas-Seaside-Monterey, CA	14.360	13.360	9.278	8.053	
Santa Cruz, CA	13.053	13.136	8.972	9.313	
Santa Fe, NM	14.139	17.074	21.439	11.136	
Sarasota, FL		9.833			
Vallejo-Fairfield-Napa, CA		9.859		8.054	
Wilmington, DE–NJ–MD		9.972			
Worcester-Fitchburg-Leomister, MA	10.995	18.031			
Yuma, AZ			9.850		12.611

Appendix A—Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final rule would 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 the Secretary to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSAs) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the prospective payment system, we classified these hospitals as urban hospitals.

It is clear that the changes discussed in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

II. Changes in the Final Rule

With respect to the prospective payment system for capital-related costs, the major change in this final rule compared to the proposed rule is our decision not to proceed with the adjustment for capital-related taxes. We discuss the reasons for that decision in section V.B of the preamble to this final rule. With respect to the prospective payment system for operating costs, there are no significant policy changes in this final rule compared to the proposed rule.

Otherwise, the differences in the impact analysis of this final rule compared to that in the proposed rule are the result of using more recent or more complete hospital data. For example, a more complete FY 1994 MedPAR file (June 1995 update) is now available compared to the one available at the time of the proposed rule. In addition, more recent hospital-specific data, including cost reports, are used in this analysis. Finally, the final geographic reclassifications are included.

Our most recent hospital market basket forecast for prospective payment system hospitals, 3.5 percent, is unchanged from that reported in the proposed rule. However, the latest forecast for the excluded hospital market basket has decreased from 3.6 percent to 3.4 percent. Therefore, the applicable update factor for prospective payment hospital operating payments is unchanged from the proposed rule while the update factor for excluded hospitals and units has decreased by 0.2 percentage points from the proposed.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 1996, on various hospital groups. We estimate the effects of each policy change by estimating payments while holding all other payment variables 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 46 Indian Health Service Hospitals in our database, which we excluded from the analysis due to the special characteristics of the payment method for these hospitals. We also excluded the 49 short-term, acute care hospitals in Maryland from our analysis. These hospitals remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. (As of January 1, 1995, the hospitals participating in the New York Finger Lakes demonstration project began to be paid under the prospective payment system.) Thus, as of August 1995, just over 5,200 hospitals were receiving prospectively based payments for furnishing inpatient services. 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 impact on these hospitals of the changes implemented in this final rule is discussed below.

V. Impact on Excluded Hospitals and Units

As of August 1995, just over 1,100 specialty hospitals are excluded from the prospective payment system and are instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. In addition, approximately 2,250 psychiatric and rehabilitation units in hospitals that are subject to the prospective payment system are excluded from the prospective payment system and paid in accordance with § 413.40.

In accordance with section 1886(b)(3)(B)(ii)(V) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 1996 is the hospital market basket minus 1.0 percentage point, adjusted to account for the relationship between the hospital's allowable operating cost per case and its target amounts. We are currently projecting an increase in the excluded hospital market basket of 3.4 percent.

The impact on excluded hospitals and units of the proposed update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital and excluded 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 limit, the major effect will be the amount of excess costs that the hospitals would have to absorb.

In this context, we note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed the rate-of-increase limit may receive the lower of its rate-of-increase ceiling plus 50 percent of reasonable costs in excess of

the ceiling, or 110 percent of its ceiling. In addition, under the various provisions set forth in § 413.40, excluded hospitals and units may obtain payment adjustments for significant, yet 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. Impact of Changes In the Operating Prospective Payment System

A. Basis and Methodology of Estimates

In this final rule, we are implementing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate analyses of the changes to each system, beginning with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1994 MedPAR file (updated through June 1995) 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 any actual cost data, the most recently available hospital cost report data were used to create some of the variables by which hospitals are categorized. 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 a given 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 1994 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 the FY 1996 changes to the capital prospective payment system are discussed below in section VII of Appendix A.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the diagnosis-related group (DRG) relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospital wage index values reflecting the wage index update.
- The effects of changing the transfer payment policy to a graduated per diem payment methodology.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that are effective in FY 1996.
- The effects of phasing out payments for extraordinarily lengthy cases (day outlier cases) (with a corresponding increase in payments for extraordinarily costly cases (cost outliers)), in accordance with section 1886(d)(5)(A)(v) of the Act.
- The total change in payments based on FY 1996 policies relative to payments based on FY 1995 policies.

To illustrate the impacts of the FY 1996 changes, our FY 1996 baseline simulation model uses: the FY 1995 GROUPER (version 12.0); the FY 1995 wage indexes; the current uniform per diem transfer payment policy; no effects of FY 1996 reclassifications; and current outlier policy (25 percent phase-out of day outlier payments). Outliers are estimated to be 5.1 percent of total DRG payments.

Each policy change is then added incrementally to this baseline model, finally arriving at an FY 1996 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 1995 to FY 1996. Three factors not displayed in the previous five columns have significant impacts here. First is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban and the other areas average standardized amounts for FY 1996 using the most recent forecasted hospital market basket increase for FY 1996 of 3.5 percent, minus 2.0 percentage points. Thus, the update to the large urban and other areas' standardized amounts is 1.5 percent. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs) and essential access community hospitals (EACHs) (which are treated as SCHs for payment purposes) is also the market basket increase minus 2.0 percent, or 1.5 percent.

A second significant factor impacting upon changes in payments per case from FY 1995 to FY 1996 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1995 that are no longer reclassified in FY 1996 may have a negative payment impact going from FY 1995 to FY 1996; conversely, hospitals not reclassified in FY 1995 and reclassified in FY 1996 may have a positive payment impact from FY 1995 to FY 1996. In some cases these impacts can be quite substantial, so that a relatively few number of hospitals in a particular category that lost their reclassification status can hold the average percentage change for the category below the mean.

Third, when comparing our estimated FY 1995 payments to FY 1996 payments, another significant consideration is that we currently estimate that actual outlier payments during FY 1995 will be 4.0 percent of actual total DRG payments. When the FY 1995 final rule was published September 1, 1994 (59 FR 45330), we estimated that FY 1995 outlier payments would be 5.1 percent of total DRG payments, and the standardized amounts were reduced correspondingly. The effects of the lower than expected outlier payments during FY 1995 are reflected in the analyses below comparing our current estimates of FY 1995 total payments to estimated FY 1996 payments.

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 5,207 hospitals included in the analysis. This is 47 fewer hospitals than were included in the impact analysis in the FY 1995 final rule (59 FR 45496). Data for 106 hospitals that were included in last year's analysis were not available for analysis this year; however, data were available this year for 54 hospitals for which data were not available last year. In addition, 5 hospitals previously excluded from our analysis because they were participating in the Finger Lakes demonstration project are included in our analysis this year because the demonstration authority has expired and these

hospitals are now being paid under the prospective payment system.

The next four rows of Table I contain hospitals categorized according to their geographic location (all urbans as well as large urban and other urban or rural). There are 2,942 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,647 hospitals located in large urban areas (populations over 1 million), and 1,295 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,265 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 changes in payments based on hospitals' FY 1996 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show the numbers of hospitals being paid based on these categorizations, after consideration of geographic reclassifications, are 3,152; 1,835; 1,317; and 2,055, respectively.

The next three groupings examine the impacts of the changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive disproportionate share (DSH) payments, or both. There are 4,135 nonteaching hospitals in our analysis, 841 with fewer than 100 residents, and 231 with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status. In the past, we have included as urban hospitals those that are located in a rural area but were reclassified as urban by the MGCRB for purposes of the standardized amount, since they have been considered urban in determining the amount of their DSH adjustment. This year, however, we have isolated these hospitals in separate rows to identify the payment impacts of reclassification solely for DSH. In these rows, labeled ''Large Urban and DSH'' and ''DSH Only,'' under the heading ''Reclassified Rural DSH,'' we group reclassified rural hospitals that receive DSH after reclassification based on whether they also receive the higher large urban amount, or are only benefitting from reclassification to an other urban area by receiving higher DSH payments. Hospitals in the rural DSH categories, therefore, including those in the rural referral center (RRC) and SCH categories, represent hospitals that were not reclassified for purposes of the standardized amount. They may, however, have been reclassified for purposes of assigning the wage index. The next category groups hospitals paid on the basis of the urban standardized amount in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next four rows examine the impacts of the changes on rural hospitals by special payment groups (SCHs, RRCs, and EACHs). Rural hospitals reclassified for FY 1996 for purposes of the standardized amount are not included here.

The RRCs (91), SCH/EACHs (623), and SCH/EACHs and RRCs (39) shown here were not reclassified for purposes of the standardized amount. There are 5 SCH/EACHs included in our analysis and 4 EACH/RRCs.

There are 7 RRCs and 12 SCHs that will be reclassified for the standardized amount in FY 1996 and are therefore not included in these rows. In addition, two hospitals that are SCH/RRCs will be reclassified for the standardized amount (one of these hospitals will also be reclassified for the wage index).

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 from the FY 1993 Medicare cost report files, the latest available. Data needed to calculate Medicare utilization percentages were unavailable for 122 hospitals. For the most part, these are either new hospitals or hospitals filing manual cost reports that are not yet entered into the data base.

The next series of groupings concern the geographic reclassication status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for either FY 1995 or FY 1996, or for both years, by urban/rural status. The next rows illustrate the overall number of 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 1996 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Num. of hosps.[1] (0)	DRG recalibration[2] (1)	New wage data[3] (2)	New transfer policy[4] (3)	MGCRB reclassification[5] (4)	Day outlier policy changes[6] (5)	All FY 1996 changes[7] (6)
(BY GEOGRAPHIC LOCATION)							
ALL HOSPITALS	5,207	0.0	0.0	0.0	0.0	0.0	2.6
URBAN HOSPITALS	2,942	0.0	−0.1	0.0	−0.4	0.0	2.5
LARGE URBAN	1,647	0.1	−0.3	0.0	−0.5	−0.1	2.2
OTHER URBAN	1,295	−0.1	0.4	0.0	−0.1	0.1	3.0
RURAL HOSPITALS	2,265	0.2	0.3	0.3	2.3	0.0	3.1
BED SIZE (URBAN):							
0–99 BEDS	755	0.1	0.0	0.3	−0.5	0.2	2.8
100–199 BEDS	925	0.1	0.2	0.1	−0.4	0.1	3.0
200–299 BEDS	595	0.0	0.0	0.0	−0.3	0.0	2.7
300–499 BEDS	489	0.0	−0.1	−0.1	−0.4	0.0	2.4
500 OR MORE BEDS	178	0.0	−0.3	−0.2	−0.3	−0.3	2.0
BED SIZE (RURAL):							
0–49 BEDS	1,179	0.3	0.1	0.6	0.0	0.0	3.1
50–99 BEDS	665	0.2	0.2	0.4	0.9	0.1	3.4
100–149 BEDS	227	0.1	0.4	0.3	3.1	0.1	2.6
150–199 BEDS	109	0.2	0.2	0.1	2.8	0.0	3.3
200 OR MORE BEDS	85	0.0	0.4	0.0	5.4	0.0	3.2

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1996 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Num. of hosps.[1]	DRG recalibration[2]	New wage data[3]	New transfer policy[4]	MGCRB reclassification[5]	Day outlier policy changes[6]	All FY 1996 changes[7]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)
URBAN BY CENSUS DIVISION:							
NEW ENGLAND	164	0.2	−0.3	0.0	−0.2	−0.2	2.1
MIDDLE ATLANTIC	441	0.4	−0.6	−0.1	−0.4	−0.8	1.8
SOUTH ATLANTIC	435	0.0	0.1	0.0	−0.5	0.1	2.6
EAST NORTH CENTRAL	490	−0.1	−0.1	0.0	−0.1	0.2	2.6
EAST SOUTH CENTRAL	164	−0.2	0.1	−0.1	−0.4	0.2	2.7
WEST NORTH CENTRAL	196	−0.1	−0.7	−0.1	−0.5	0.3	1.9
WEST SOUTH CENTRAL	387	−0.3	0.7	−0.1	−0.5	0.3	3.7
MOUNTAIN	132	−0.1	−0.5	−0.1	−0.4	0.3	2.2
PACIFIC	485	−0.1	0.4	0.0	−0.5	0.2	2.8
PUERTO RICO	48	0.0	2.7	−0.2	−0.5	0.0	5.5
RURAL BY CENSUS DIVISION:							
NEW ENGLAND	53	0.3	0.5	0.1	1.3	0.1	3.8
MIDDLE ATLANTIC	84	0.5	−0.5	0.1	1.5	−0.3	3.0
SOUTH ATLANTIC	300	0.1	0.6	0.3	3.2	0.0	3.0
EAST NORTH CENTRAL	305	0.2	0.5	0.4	1.9	0.1	3.6
EAST SOUTH CENTRAL	278	0.0	0.8	0.4	3.7	0.0	3.5
WEST NORTH CENTRAL	529	0.2	−0.2	0.3	2.0	0.1	2.9
WEST SOUTH CENTRAL	354	0.1	−0.4	0.3	3.1	0.1	2.6
MOUNTAIN	214	0.3	−0.1	0.1	−0.1	0.1	2.2
PACIFIC	143	0.3	0.6	0.2	1.4	0.1	3.4
PUERTO RICO	5	0.4	−0.6	−0.1	−0.5	0.1	2.3
(BY PAYMENT CATEGORIES)							
URBAN HOSPITALS	3,152	0.0	0.0	0.0	−0.2	0.0	2.5
LARGE URBAN	1,835	0.1	−0.3	0.0	−0.3	−0.1	2.3
OTHER URBAN	1,317	−0.1	0.4	0.0	−0.2	0.1	3.0
RURAL HOSPITALS	2,055	0.2	0.2	0.3	1.6	0.0	2.8
TEACHING STATUS:							
NON-TEACHING	4,135	0.1	0.1	0.1	0.3	0.1	3.0
LESS THAN 100 RES.	841	0.0	0.0	−0.1	−0.3	0.0	2.5
100+ RESIDENTS	231	0.0	−0.4	−0.1	−0.3	−0.4	1.8
DISPROPORTIONATE SHARE HOSPITALS (DSH):							
NON-DSH	3,234	0.1	0.0	0.1	0.1	0.1	2.8
URBAN DSH:							
100 BEDS OR MORE	1,370	0.0	0.0	−0.1	−0.4	−0.1	2.3
FEWER THAN 100 BEDS	120	0.0	0.2	0.3	−0.6	0.2	3.3
RECLASSIFIED RURAL DSH:							
LARGE URBAN AND DSH	22	0.0	0.2	0.1	11.1	0.1	5.9
DSH ONLY	69	0.1	0.5	0.2	8.6	0.0	5.0
RURAL DSH:							
SOLE COMMUNITY (SCH)	136	0.2	0.0	0.1	0.1	0.0	2.1
REFERRAL CENTERS (RRC)	29	0.1	0.4	0.1	3.0	−0.2	2.9
OTHER RURAL DSH HOSP.:							
100 BEDS OR MORE	82	0.1	0.5	0.4	2.2	0.1	1.5
FEWER THAN 100 BEDS	145	0.0	0.7	0.7	0.1	0.1	3.6
URBAN TEACHING AND DSH:							
BOTH TEACHING AND DSH	667	0.0	−0.1	−0.1	−0.5	−0.3	2.1
TEACHING AND NO DSH	356	0.0	−0.1	−0.1	−0.2	0.0	2.5
NO TEACHING AND DSH	914	0.0	0.2	0.0	0.2	0.1	3.0
NO TEACHING AND NO DSH	1,215	0.1	−0.1	0.1	−0.3	0.2	3.0
RURAL HOSPITAL TYPES:							
NONSPECIAL STATUS:							
HOSPITALS	1,302	0.2	0.4	0.6	1.4	0.1	2.9
RRC	91	0.1	0.3	0.1	4.9	0.1	3.5
SCH/EACH	623	0.3	0.0	0.1	0.0	0.0	2.2
SCH/EACH AND RRC	39	0.2	0.0	0.0	0.3	−0.1	2.2
TYPE OF OWNERSHIP:							
VOLUNTARY	3,149	0.1	−0.1	0.0	−0.1	−0.1	2.5
PROPRIETARY	718	−0.1	0.0	0.0	0.3	0.2	2.9
GOVERNMENT	1,340	0.0	0.2	0.1	0.3	0.0	2.9
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:							
0–25	267	0.0	−0.3	0.0	−0.1	−0.2	2.1
25–50	1,356	0.0	0.0	−0.1	−0.3	−0.1	2.3

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1996 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Num. of hosps.[1] (0)	DRG recalibration[2] (1)	New wage data[3] (2)	New transfer policy[4] (3)	MGCRB reclassification[5] (4)	Day outlier policy changes[6] (5)	All FY 1996 changes[7] (6)
50–65	2,217	0.1	0.1	0.0	0.1	0.0	2.8
OVER 65	1,245	0.2	−0.1	0.1	0.1	0.0	2.7
UNKNOWN	122	0.4	−0.5	0.0	−0.1	−1.2	1.7
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD							
RECLASSIFICATION STATUS DURING FY95 AND FY96:							
RECLASSIFIED DURING BOTH FY95 AND FY96	453	0.1	0.3	0.1	4.8	0.0	2.9
URBAN	163	0.1	0.2	0.0	2.7	0.0	3.0
RURAL	290	0.1	0.3	0.2	8.0	0.1	2.9
RECLASSIFIED DURING FY96 ONLY	147	0.2	0.1	0.1	4.0	0.0	8.4
URBAN	31	0.3	−0.1	0.1	2.1	−0.2	7.7
RURAL	116	0.1	0.3	0.2	5.6	0.1	9.0
RECLASSIFIED DURING FY95 ONLY	284	0.0	0.1	0.0	−1.4	0.1	−0.7
URBAN	112	0.0	0.1	−0.1	−1.8	0.1	−0.4
RURAL	172	0.2	0.1	0.3	−0.4	0.1	−1.5
FY 96 RECLASSIFICATIONS:							
ALL RECLASSIFIED HOSP	602	0.1	0.2	0.1	4.7	0.0	4.0
STAND. AMOUNT ONLY	210	0.1	0.6	0.1	2.0	0.0	3.9
WAGE INDEX ONLY	258	0.1	0.2	0.1	7.1	0.0	4.3
BOTH	134	0.1	−0.1	0.0	4.3	0.0	3.8
NONRECLASSIFIED	4,578	0.0	0.0	0.0	−0.6	0.0	2.4
ALL URBAN RECLASS	195	0.1	0.2	0.0	2.6	0.0	3.7
STAND. AMOUNT ONLY	68	0.0	0.7	0.0	0.8	0.0	3.7
WAGE INDEX ONLY	35	0.1	0.1	−0.1	5.9	−0.2	4.8
BOTH	92	0.1	−0.2	0.0	2.0	0.0	3.0
NONRECLASSIFIED	2,747	0.0	−0.1	0.0	−0.6	0.0	2.4
ALL RURAL RECLASS	407	0.1	0.3	0.2	7.4	0.1	4.4
STAND. AMOUNT ONLY	142	0.1	0.4	0.3	3.8	0.0	4.1
WAGE INDEX ONLY	223	0.1	0.2	0.2	7.9	0.1	4.0
BOTH	42	0.0	0.5	0.1	13.1	0.1	6.3
NONRECLASSIFIED	1,831	0.2	0.2	0.3	−0.4	0.0	2.4
OTHER RECLASSIFED HOSPITALS (SECTION 1886(d)(8)(B))	27	0.1	0.0	0.4	−0.1	0.1	3.3

[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 1994, and hospital cost report data are from reporting periods beginning in FY 1992 and FY 1993.

[2] This column displays the payment impacts of the recalibration of the DRG weights, based on FY 1994 MedPAR data and the DRG classification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1992 cost reports.

[4] This column displays the payment impacts of revising the per diem methodology for transfer cases from the current flat per diem methodology to a graduated per diem methodology.

[5] Shown here are the combined effects of geographic reclassification by the Medicare Geographic Classification Review Board (MGCRB). The effects shown here demonstrate the FY 1996 payment impacts of going from no reclassifications to the reclassifications scheduled to be in effect for FY 1996. Reclassification for prior years has no bearing on the payment impacts shown here.

[6] This column illustrates the payment impacts of our changes affecting payments for outliers, in accordance with section 1886(d)(5) of the Act.

[7] This column shows changes in payments from FY 1995 to FY 1996. It incorporates all of the changes displayed in columns 1 through 5. It also displays the impacts of the updates to the FY 1996 standardized amounts, changes in hospitals' reclassification status in FY 1996 compared to FY 1995, and the difference in outlier payments from FY 1995 to FY 1996. The sum of the first five columns plus these effects may be slightly different from the percentage changes shown here, due to rounding errors and interactive effects.

B. The Impact of the Changes to the DRG Weights (Column 1)

In column 1 of Table I, we present the combined effects of the revised DRG classification system, and the subsequent recalibration of the DRG weights incorporating these revised DRGs, as discussed in section II of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us each year to 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. The impact of reclassification and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral.

The first row of Table I shows that the overall effect of these changes is budget neutral. That is, the percentage change when adding the FY 1996 GROUPER (version 13.0) to the FY 1996 baseline is 0.0. As described previously, all of the other payment parameters are held constant for the comparison in column 1, only the version of the GROUPER is different.

Consistent with the minor changes we are making to the FY 1996 GROUPER, the redistributional impacts across hospital groups are very small (an increase of 0.1 for large urban and 0.2 for rural hospitals and a decrease of 0.1 for other urban hospitals). Among other hospital categories, the net effects are

positive changes for small and medium-size (up to 200 beds) rural hospitals and slightly positive changes for small (up to 200 beds) urban hospitals.

The largest single effect on any of the hospital categories examined is a 0.5 percent increase for rural hospitals in the Middle Atlantic census division. We note that urban hospitals in this census division also show a positive increase, 0.4 percent. We attribute this to the changes in our methodology for identifying the statistical outliers that are eliminated from the data used to recalibrate the DRG weights (described in section II.C of the preamble to this final rule). In previous recalibrations, we eliminated all cases outside 3.0 standard deviations from the geometric mean of standardized charges per case for each DRG. In the DRG recalibration set forth in this final rule, we eliminated only cases that met both this current criterion and an additional criterion that the cases fall outside 3.0 standard deviations from the geometric mean of standardized charges *per day* for each DRG. Because hospitals in the Middle Atlantic census division have longer lengths of stay (as demonstrated by the impacts of phasing out the day outliers—see the discussion below concerning column 5), they would be likely to have cases that exceed the 3.0 standard deviation threshold for average charges per case but not the per day threshold. Thus, costly cases previously eliminated would be left in the recalibration, thereby influencing the weights of the DRGs to which they are assigned.

We also note that rural hospitals in Puerto Rico experience a 0.4 increase in payments. This is a function of the fact that only five hospitals are included in this category, making it susceptible to the influence of two hospitals whose case-mix index values increased by 0.8 percent.

Rural hospitals overall exhibit a positive effect in column 1. Because rural hospitals send out relatively more transfers, this effect is probably a reflection of the modification in the way we count transfer cases in the recalibration methodology (see section II.C of the preamble to this final rule). A study by the RAND Corporation for HCFA, ''An Evaluation of Medicare Payments for Transfer Cases'' (Contract Number 500–92–0023), identified 10 DRGs that account for more than half of all transfer cases. These DRGs experience, on average, almost an 8 percent increase in their relative weights under the recalibration, which contributes to the increases experienced by rural hospitals and select urban hospitals. In comparison, the average absolute change in the weights of all DRGs from FY 1994 to FY 1995 is approximately 1 percent.

C. The Impact of Updating the Wage Data (Column 2)

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 1996 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992. 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 2 shows the percentage changes in payments when going from our FY 1996 baseline—using the FY 1995 wage index (based on 1991 wage data) before geographic reclassifications and incorporating the FY 1996 GROUPER—to a model substituting the FY 1996 prereclassification wage index (based on FY 1992 data).

Section 1886(d)(3)(E) of the Act also requires that any updates or adjustments to the wage index be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. To comply with the requirements that the DRG and wage index changes must be implemented in a budget neutral manner, we compute a budget neutrality adjustment factor to apply to the standardized amounts. For the FY 1996 standardized amounts, this adjustment factor is 0.999306. This factor is applied to the standardized amounts reflected in this column to ensure that the overall effect of the wage index changes are budget neutral.

The results indicate that the new wage data do not have a significant overall impact on urban and rural hospitals. Virtually all prospective payment system hospitals (94 percent) would experience a change in their wage index of less than 5 percent. This column demonstrates that hospitals with significant changes in their wage indexes are not concentrated within any particular hospital group. For FY 1996, some of the largest changes are evident among both urban and rural hospitals grouped by census division. More census divisions experience payment increases, of greater magnitude, for rural hospitals than for urban hospitals. With the exception of urban Puerto Rico, all payments change by less than 1.0 percent. Although a degree of variation across census categories is evident in this column, our review of the wage data (as described below) indicates that most of the significant changes were attributable to improved reporting.

Besides urban Puerto Rico, the greatest increases are for rural hospitals in the East South Central division, 0.8 percent, and urban hospitals in West South Central, 0.7 percent. The greatest decreases are 0.7 and 0.6 percent for urban hospitals in the West North Central and Middle Atlantic regions, respectively, as well as 0.6 percent for rural Puerto Rico. This effect contributes to the 0.4 percent decline among major teaching hospitals—New York City's wage index falls by nearly 2.0 percent. The Middle Atlantic region also experiences a payment decrease of 0.5 percent for its rural hospitals. The Pacific region experiences an increase in payments to both urban and rural hospitals, with increases of 0.4 and 0.6 percent, respectively. The most dramatic shift occurs in urban Puerto Rico, where payments increase 2.7 percent. Of the six urban areas in Puerto Rico, five experience large increases in wage while only one experiences a slight decline. We note that while rural Puerto Rico had a decrease of 6.9 percent in the impact for the proposed rule, better reporting of data has greatly improved the rural Puerto Rico wage index values so the decrease is only 0.6 percent in the impact analysis for this final rule.

The FY 1996 wage index represents the third annual update to the wage data, and continues to include salaries, fringe benefits, home office salaries, and certain contract labor salaries. In the past, updates to the wage data have resulted in significant payment shifts among hospitals. Since the wage index is now updated annually and there are no changes to the types of costs included in the wage index data, we expect these payment fluctuations will be minimized.

Based on the FY 1996 wage index calculation (after reclassifications under sections 1886(d)(8)(B) and 1886(d)(10) of the Act) compared to the FY 1995 wage index, there are more labor markets that experience an increase of 5 percent or more in their wage index values, and fewer labor markets that experience a significant decrease of 5 percent or more. We reviewed the data for any area that experiences a wage index change of 10 percent or more to determine the reason for the fluctuation. When necessary, we contacted the intermediaries to determine the validity of the data or to obtain an explanation for the change. The following chart compares the shifts in wage index values (after reclassifications) for labor markets for FY 1996 with those

experienced as a result of last year's wage index update.

Percentage change in area wage index values	Number of labor market areas	
	FY 1996	FY 1995
Increase more than 10 percent	10	5
Increase between 5 and 10 percent	21	17
Decrease between 5 and 10 percent	6	13
Decrease more than 10 percent	0	10

Under the FY 1996 wage index, 92.7 percent of rural prospective payment hospitals and 95.0 percent of urban hospitals experience a change in their wage index value of less than 5.0 percent. Approximately 3.4 percent (2.1 percent of rural hospitals and 4.4 percent of urban hospitals) experience a change of between 5 and 10 percent, and 2.6 percent (5.3 percent of rural hospitals and 0.6 percent of urban hospitals) experience a change of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Percent of hospitals (by urban/rural)	
	Rural	Urban
Decrease more than 10 percent	1.5	0.1
Decrease between 5 and 10 percent	1.1	1.6
Change between −5 and +5 percent	92.7	95.0
Increase between 5 and 10 percent	1.0	2.8
Increase more than 10 percent	3.8	0.5

D. Transfer Changes (Column 3)

Column 3 of Table I shows the impacts of the change we are implementing in transfer payment policy. This change revises our methodology for payment for transfer cases under the prospective payment system to more appropriately compensate transferring hospitals for the higher costs they incur, on average, on the first day of a hospital stay prior to transfer. Our previous transfer policy paid a flat per diem amount for each day prior to transfer up to the full DRG amount. The per diem was calculated by dividing the full DRG amount by the geometric mean length of stay for that DRG. We are replacing this flat per diem methodology with a graduated methodology that pays twice the per diem amount for the first day, and the per diem amount for each day beyond the first up to the full DRG amount.

The payment impacts shown in column 3 illustrate the effects of this change, relative to the baseline simulation based on previous policy (a flat per diem transfer payment methodology). In order to simulate the effects of the changes, it was first necessary to identify current transfer cases. Current transfers are identifiable by the discharge destination code on the patient bill (see the RAND study for a thorough discussion of identifying transfer cases on the MedPAR file).

Next, to determine whether payment would be made under the per diem methodology, we compared the actual length of stay prior to transfer to the geometric mean length of stay for the DRG to which the case is assigned. A full discharge or a transfer case that received the full discharge payment would be counted as 1.0, while, under our current transfer policy, a transfer case that stayed 2 days in a DRG with a geometric mean length of stay of 5 days would count as 0.4 of a discharge, and would be paid 40 percent of the full DRG amount. In this manner, transfer cases are counted only to the extent that the transferring hospital received payment for them. To simulate our change to the per diem payment methodology, we added 1 day to the actual length of stay for transfer cases, thereby replicating paying double the per diem for the first stay and the flat per diem, up to the full DRG amount, for subsequent days.

Finally, we calculated transfer-adjusted case-mix indexes for each hospital. The adjusted case-mix indexes are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted number of cases. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the fraction of the length of stay for the case divided by the geometric mean length of stay for the DRG. By adjusting the DRG weights, nontransfer cases and transfer cases that have a length of stay at least as long as the geometric mean length of stay will be represented by the full DRG weight, while transfer cases with lengths of stay below the geometric mean length of stay for the DRG will be represented by a lower number, reflective of their payment.

The FY 1996 baseline model reflected in columns 1 and 2 incorporates transfer-adjusted discharges and case-mix indexes based on current policies. That is, cases transferred prior to reaching the geometric mean length of stay received payments based on the flat per diem. In column 3, our model substitutes transfer-adjusted discharges and case-mix indexes that reflect our policy change.

The first row in column 3 shows that the net effect of our change is budget neutral compared to total payments under current transfer policy. As specified in section 109 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), the Secretary is authorized to make adjustments to the standardized amounts so that adjustments to the payment policy for transfer cases do not affect aggregate payments. As described in section II.A.4.a of the Addendum to this final rule, we applied a budget neutrality factor of 0.997575 to the standardized amounts to account for the higher payments going to transfer cases based on our new payment policy.

The distributional effects of these changes are to increase payments to rural hospitals by 0.3 percent and decrease urban hospitals' payments by less than 0.1 percent (the overall change is 0.0 percent). Rural hospitals clearly benefit from the change in transfer payment methodology. RAND found that rural hospitals as a whole transfer 4.5 percent of their patients, compared to 1.7 percent in large urban hospitals and 1.6 percent in other urban hospitals. Therefore, one would expect rural hospitals to benefit from the change in the transfer payment methodology.

The impact on small hospitals is also positive, consistent with RAND's finding that hospitals with fewer than 50 beds transfer 6.1 percent of their cases, and hospitals with 50 to 99 beds transfer 4.9 percent of cases. Rural hospitals with fewer than 50 beds receive a 0.6 percent increase in per case payments, and rural hospitals with 50 to 99 beds receive a 0.4 percent increase. Urban hospitals with fewer than 100 beds experience a 0.3 percent rise in payments. Among rural hospital groups, nonspecial status hospitals benefit by 0.6 percent and hospitals receiving DSH payments that are not SCHs or RRCs receive increases of 0.4 percent for hospitals with 100 or more beds and 0.7 percent for hospitals with fewer than 100 beds.

E. Impacts of MGCRB Reclassifications (Column 4)

By March 30 of each year, the MGCRB makes reclassification decisions that will be effective for the next fiscal year, which begins on October 1. The MGCRB may reclassify a hospital for the purposes of using the other area's standardized amount, wage index value, or both.

To this point, all of the simulation models have assumed hospitals are paid

on the basis of their 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 RRCs and hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 4 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1996. As noted above, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, hospitals reclassified for the standardized amount also qualify to be treated as urban for purposes of the DSH adjustment.

The FY 1996 standardized payment amounts and wage index values incorporate all of the MGCRB reclassification decisions that will be effective for FY 1996. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions and any reclassification withdrawal requests that were received by the MGCRB. These Administrator decisions and withdrawals may affect the number of reclassified hospitals relative to those shown in the June 2, 1995 proposed rule. They may also determine whether a redesignated hospital receives the wage index of the area to which it is redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals.

The overall effect of geographic reclassification is required to be budget neutral by section 1886(d)(8)(D) of the Act. Therefore, we applied an adjustment of 0.994011 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule).

Rural hospitals benefit from geographic reclassification. Their payments rise 2.3 percent, while payments to urban hospitals decline 0.4 percent. Large urban hospitals lose 0.5 percent because, as a group, they have the smallest percentage of hospitals that are reclassified, approximately 4 percent. Enough hospitals in other urban areas are reclassified to limit the decline in payments stemming from the budget neutrality offset to 0.1 percent. Among urban hospitals grouped by bedsize, payments fall between 0.3 and 0.5 percent.

Rural hospitals that reclassify for purposes of the standardized amount and receive DSH payments experience a significant increase in payments as a result of receiving higher DSH payments as urban hospitals. Rural hospitals reclassifying to large urban areas and also receiving DSH receive an 11.1 percent increase in payments. The difference between the large urban standardized amount and the other urban amount is 1.6 percent, and the remainder is due to DSH payments and to any wage index increase that hospitals reclassified for both the wage index and the standardized amount receive.

Rural hospitals reclassifying to other urban areas for purposes of the standardized amount receive an 8.6 percent increase in payments. Since there are no longer separate rural and other urban standardized amounts, this large increase is attributable to the higher DSH payments these 69 hospitals receive as a result of being classified as urban (as well as any increase in their wage index for those hospitals reclassified for both the wage index and standardized amount). Under our revised rules for MGCRB reclassification, these hospitals will no longer be eligible to reclassify solely to receive higher DSH payments effective with reclassifications for FY 1997.

Among rural hospitals designated as RRCs, 57 hospitals are reclassified for the wage index only and experience a 4.9 percent increase in payments overall. This positive impact on RRCs also appears in the category of rural hospitals with 200 or more beds, which have a 5.4 percent increase in payments.

Rural hospitals reclassified for FY 1995 and FY 1996 experience an 8.0 percent increase in payments, the greatest of any group in the category. 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 1996 alone experience a 5.6 percent increase in payments. Urban hospitals reclassified for FY 1995 but not FY 1996 experience a 1.8 percent decline in payments overall. This appears to be due to the combined impacts of the budget neutrality adjustment and a number of hospitals in this category that experience a 6 percent drop in their wage index after reclassification. Urban hospitals reclassified for FY 1996 but not for FY 1995 experience a 2.1 percent increase in payments.

The FY 1996 reclassification section of Table I shows the changes in payments per case for all FY 1996 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). It illustrates that the large impact for reclassified rural hospitals is due to reclassifications for both the standardized amount and the wage index. These hospitals receive a 13.1 percent increase. In addition, rural hospitals reclassified for the wage index only receive a 7.9 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 4.7 percent for FY 1996.

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, approximately the geographic reclassification budget neutrality factor. Rural nonreclassified hospitals decrease slightly less, experiencing a 0.4 percent decrease. This occurs because the wage index values in some rural areas increase after reclassified hospitals are excluded from the calculation of those values.

The number of reclassifications for the standardized amount, or for both the standardized amount and the wage index, has declined from 496 in FY 1995 to 344 in FY 1996. This is not surprising because the rural standardized amount is now equal to the standardized amount for other urban areas. Some rural hospitals are reclassifying for purposes of the large urban amount, thereby receiving a payment rate even higher than they would receive from the other national amount. Rural hospitals also may be reclassifying for the standardized amount even though they are only eligible to reclassify to an other urban area in order to either meet the lower eligibility requirements for DSH payments, or to receive higher DSH payments. The payment impact upon hospitals reclassified for the standardized amount only, however, is significantly lower than it is for hospitals reclassifying for either the wage index alone, or for both the wage index and the standardized amount.

F. Outlier Changes (Column 5)

Medicare provides extra payment in addition to the regular DRG payment amount for extremely costly or extraordinarily lengthy cases (cost outliers and day outliers, respectively). Section 1886(d)(5)(A)(v) of the Act requires the Secretary to phase out payment for day outliers in 25 percent increments beginning in FY 1995 from FY 1994 day outlier levels. Day outliers in FY 1996 will account for

approximately 16 percent of total outlier payments (50 percent of 1994 levels). This reduction in day outlier payments will be offset by an increase in payments for cost outliers. For FY 1996, we are setting the day outlier threshold equal to the geometric mean length of stay for each DRG, plus the lesser of 23 days or 3.0 standard deviations. The marginal cost factor for day outliers will be 44 percent.

The statute also authorizes the Secretary to set a fixed loss per case threshold for cost outliers. For FY 1996, a case will receive cost outlier payments if its costs exceed the DRG amount plus $15,150. We are also maintaining the marginal cost factor for cost outliers at 80 percent.

The payment impacts of these changes are minimal. The largest impacts appear to be related to geographic location in terms of census divisions. Urban hospitals in the Middle Atlantic census division have payment reductions of 0.8 percent per case. Rural Middle Atlantic hospitals have a 0.3 percent decline. In New England, urban hospitals experience decreases of 0.2 percent. Since the changes to outlier policy result in a shift in payments from cases paid as day outliers to cases paid as cost outliers, this indicates that these areas have higher percentages of day outliers. This is consistent with our previous analysis indicating above average impacts related to day outlier policy changes in the northeastern portion of the country. (See the June 4, 1992 proposed rule (57 FR 23824).)

The largest negative impact occurs among hospitals for which we could not determine Medicare utilization rates. This group experiences a 1.2 percent fall in payments per case. The bulk of the decline is attributable to a group of New York hospitals included in this category that experience significant drops in outlier payments.

G. All Changes (Column 6)

Column 6 compares our estimate of payments per case for FY 1996 to our estimate of payments per case in FY 1995. It includes the 1.5 percent update to the standardized amounts and the hospital-specific rates for SCHs and EACHs, and the 1.1 percent lower than estimated outlier payments during FY 1995, as described in the introduction and the Addendum.

A single geographic reclassification budget neutrality factor of 0.994011 was applied to the FY 1996 standardized amounts, compared to the FY 1995 factor of 0.994055. The budget neutrality adjustment factor for the updated wage index and the DRG recalibration is 0.999306, compared to the FY 1995 factor of 0.998050. Although the net effect of these changes is small, they are reflected in the payment differences shown in this column.

There may 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 6 may not equal the sum of the previous columns plus the other impacts that we are able to identify.

We also note that column 6 includes the impacts of FY 1995 geographic reclassifications compared to the payment impacts of FY 1996 reclassifications. Therefore, the percent changes due to FY 1996 reclassifications shown in column 4 may be offset by the effects of reclassification on hospitals' FY 1995 payments. For example, the impact of MGCRB reclassifications on rural hospitals' FY 1995 payments was a 2.2 percent increase, compared to a 2.3 percent increase for FY 1996. Therefore, the net increase for rural hospitals in FY 1996 payments due to reclassification is 0.1 percent.

The overall payment increase from FY 1995 to FY 1996 for all hospitals is a 2.6 percent increase. This reflects the 0.0 percent net change in total payments due to the changes for FY 1996 shown in columns 1 through 5, the 1.5 percent update for FY 1996, and the 1.1 percent higher outlier payments in FY 1996 compared to FY 1995, as discussed above.

Hospitals in rural areas experience the largest payment increase, a 3.1 percent rise in payments per case over FY 1995. The increase in estimated outlier payments over FY 1995 for rural hospitals is 0.7 percent, below the 1.1 percent difference for all hospitals. As noted above, the net increase for rural hospitals in FY 1996 due to geographic reclassification is 0.1 percent. They also benefit from DRG recalibration, the new wage index, and the change in the transfer payment policy.

Urban hospitals' overall payments increase 2.5 percent. Hospitals in large and other urban areas experience 2.2 percent and 3.0 percent increases, respectively. Both large and other urban hospitals experience 1.1 percent increases in payments for FY 1996 due to the larger outlier payout, plus the 1.5 percent update. In addition, large urban hospitals' 0.5 percent decline due to reclassification is identical to the FY 1995 impact of reclassification, thus the net impact is 0.0. The FY 1995 reclassification impact on other urban hospitals was also 0.0 percent, compared to the 0.1 percent decline in column 4 of Table I, for a net decrease of 0.1 percent from FY 1995 to FY 1996.

Among urban bed size groups, column 6 shows changes in payments are higher for the smallest urban hospitals compared to larger urban hospitals. The relatively smaller increases for the larger urban hospitals appears to be due to the negative impacts of the new wage data, as shown in column 2, and to the new transfer policy (column 4). Among rural bed size groups the impacts are less varied, ranging from 2.6 percent to 3.4 percent.

Two census divisions are well below the average payment increase: urban Middle Atlantic and urban West North Central (both increase less than 2.0 percent). The reason for the relatively small increase for urban hospitals in the Middle Atlantic is that they have sizeable negative impacts due to the new wage data and the phase-out of day outliers. Urban hospitals in the West North Central division also experience a negative impact from the new wage data.

Conversely, rural New England hospitals experience a 3.8 percent increase, and urban West South Central hospitals see a 3.7 percent payment increase. By far the largest increase among all of the census divisions is in urban Puerto Rico, with a 5.5 percent increase. This large increase is primarily attributable to the effects of the new wage data, as discussed above.

The only hospital groups with negative payment impacts from FY 1995 to FY 1996 are hospitals that were reclassified for FY 1995 and are not reclassified for FY 1996. Overall, these hospitals lose 0.7 percent, with 112 urban hospitals in this category losing 0.4 percent and 172 rural hospitals losing 1.5 percent. On the other hand, hospitals reclassified for FY 1996 that were not reclassified for FY 1995 would experience the greatest payment increase: 7.7 percent for 31 urban hospitals in this category and 9.0 percent for 116 rural hospitals.

Reclassification appears to be a significant factor influencing the payment increases for a number of rural hospital groups with above average overall payment increases in column 6. For example, among hospital groups identified in the discussion of the impacts of MGCRB reclassifications for FY 1996 (column 4), almost all have overall increases of 3.0 or greater. This outcome highlights the redistributive effects of reclassification decisions upon hospital payments. This impact is illustrated even more clearly when one examines the rows categorizing hospitals by their reclassification status for FY 1996. All nonreclassified hospitals have an average payment increase of 2.4 percent. The average

payment increase for all reclassified hospitals is 4.0 percent.

Major teaching hospitals with 100 or more residents have a payment increase of only 1.8 percent. This is attributable to the combined negative impacts of the new wage data, reclassification, and the continued phase-out of day outliers. As discussed above, teaching hospitals located in New York City account for much of this impact. (They also account for much of the below average increase for hospitals for which we do not have Medicare utilization data (1.7 percent increase), along with several Puerto Rico hospitals.)

Finally, among hospitals that are SCH/EACHs, and those that are both SCH/EACH and RRCs, the payment increase is 2.2 percent. The primary reason for this below average increase is the minimal impact upon these hospitals of the higher FY 1996 outlier payments. Because these hospital groups receive their hospital-specific rate if it exceeds the applicable Federal amount (including outliers), there is less of an impact due to changes in outlier payment levels, which are not applied to the hospital-specific rate.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1996 OPERATING PROSPECTIVE PAYMENT SYSTEM

[PAYMENTS PER CASE]

	Number of hospitals (1)	Average FY 1995 payment per case (2) [1]	Average FY 1996 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION)				
ALL HOSPITALS	5,207	6,274	6,436	2.6
URBAN HOSPITALS	2,942	6,772	6,940	2.5
LARGE URBAN AREAS	1,647	7,284	7,443	2.2
OTHER URBAN AREAS	1,295	6,073	6,255	3.0
RURAL AREAS	2,265	4,259	4,391	3.1
BED SIZE (URBAN):				
0–99 BEDS	755	4,596	4,727	2.8
100–199 BEDS	925	5,733	5,903	3.0
200–299 BEDS	595	6,266	6,432	2.7
300–499 BEDS	489	7,198	7,369	2.4
500 OR MORE BEDS	178	8,794	8,971	2.0
BED SIZE (RURAL):				
0–49 BEDS	1,179	3,533	3,643	3.1
50–99 BEDS	665	3,965	4,097	3.4
100–149 BEDS	227	4,449	4,562	2.6
150–199 BEDS	109	4,508	4,657	3.3
200 OR MORE BEDS	85	5,235	5,404	3.2
URBAN BY CENSUS DIV.:				
NEW ENGLAND	164	7,205	7,359	2.1
MIDDLE ATLANTIC	441	7,464	7,598	1.8
SOUTH ATLANTIC	435	6,448	6,617	2.6
EAST NORTH CENTRAL	490	6,500	6,668	2.6
EAST SOUTH CENTRAL	164	5,920	6,083	2.7
WEST NORTH CENTRAL	196	6,432	6,557	1.9
WEST SOUTH CENTRAL	387	6,260	6,491	3.7
MOUNTAIN	132	6,619	6,767	2.2
PACIFIC	485	7,793	8,009	2.8
PUERTO RICO	48	2,473	2,609	5.5
RURAL BY CENSUS DIV.:				
NEW ENGLAND	53	5,142	5,334	3.8
MIDDLE ATLANTIC	84	4,735	4,875	3.0
SOUTH ATLANTIC	300	4,396	4,530	3.0
EAST NORTH CENTRAL	305	4,240	4,394	3.6
EAST SOUTH CENTRAL	278	3,816	3,950	3.5
WEST NORTH CENTRAL	529	4,018	4,132	2.9
WEST SOUTH CENTRAL	354	3,846	3,947	2.6
MOUNTAIN	214	4,797	4,904	2.2
PACIFIC	143	5,314	5,494	3.4
PUERTO RICO	5	1,961	2,006	2.3
(BY PAYMENT CATEGORIES)				
URBAN HOSPITALS	3,152	6,682	6,852	2.5
LARGE URBAN AREAS	1,835	7,123	7,287	2.3
OTHER URBAN AREAS	1,317	5,983	6,163	3.0
RURAL AREAS	2,055	4,216	4,333	2.8
TEACHING STATUS:				
NON-TEACHING	4,135	5,165	5,318	3.0
FEWER THAN 100 RESIDENTS	841	6,680	6,848	2.5
100 OR MORE RESIDENTS	231	10,346	10,531	1.8
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,234	5,475	5,628	2.8

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1996 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[PAYMENTS PER CASE]

	Number of hospitals (1)	Average FY 1995 payment per case (2) [1]	Average FY 1996 payment per case (3) [1]	All changes (4)
URBAN DSH:				
100 BEDS OR MORE	1,370	7,414	7,587	2.3
FEWER THAN 100 BEDS	120	4,689	4,844	3.3
RECLASS. RURAL DSH:				
LARGE URBAN AND DSH	22	4,764	5,047	5.9
DSH ONLY	69	4,474	4,696	5.0
RURAL DSH:				
SOLE COMMUNITY (SCH)	136	4,747	4,848	2.1
REFERRAL CENTERS (RRC)	29	5,319	5,474	2.9
OTHER RURAL DSH HOSP.:				
100 BEDS OR MORE	82	3,933	3,992	1.5
FEWER THAN 100 BEDS	145	3,298	3,417	3.6
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	667	8,386	8,564	2.1
TEACHING AND NO DSH	356	6,831	6,998	2.5
NO TEACHING AND DSH	914	5,841	6,014	3.0
NO TEACHING AND NO DSH	1,215	5,275	5,434	3.0
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	1,302	3,616	3,722	2.9
RRC	91	4,869	5,038	3.5
SCH/EACH	623	4,758	4,864	2.2
SCH/EACH AND RRC	39	5,547	5,668	2.2
TYPE OF OWNERSHIP:				
VOLUNTARY	3,149	6,442	6,602	2.5
PROPRIETARY	718	5,688	5,852	2.9
GOVERNMENT	1,340	5,837	6,006	2.9
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	267	8,264	8,440	2.1
25–50	1,356	7,601	7,779	2.3
50–65	2,217	5,739	5,899	2.8
OVER 65	1,245	4,930	5,065	2.7
UNKNOWN	122	7,744	7,877	1.7
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD				
RECLASSIFICATION STATUS DURING FY95 AND FY96:				
RECLASSIFIED DURING BOTH FY95 AND FY96	453	5,674	5,840	2.9
URBAN	163	6,593	6,789	3.0
RURAL	290	4,738	4,874	2.9
RECLASSIFIED DURING FY96 ONLY	147	5,222	5,661	8.4
URBAN	31	6,687	7,201	7.7
RURAL	116	4,430	4,828	9.0
RECLASSIFIED DURING FY95 ONLY	284	5,964	5,924	−0.7
URBAN	112	6,956	6,931	−0.4
RURAL	172	4,239	4,175	−1.5
FY 96 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSP	602	5,580	5,803	4.0
STAND. AMT. ONLY	210	5,060	5,256	3.9
WAGE INDEX ONLY	258	5,707	5,952	4.3
BOTH	134	6,042	6,269	3.8
NONRECLASS	4,578	6,381	6,534	2.4
ALL URBAN RECLASS	195	6,605	6,851	3.7
STAND. AMT. ONLY	68	5,833	6,050	3.7
WAGE INDEX ONLY	35	8,463	8,871	4.8
BOTH	92	6,383	6,578	3.0
NONRECLASS	2,747	6,785	6,947	2.4
ALL RURAL RECLASS	407	4,659	4,862	4.4
STAND. AMT. ONLY	142	4,240	4,415	4.1
WAGE INDEX ONLY	223	4,801	4,992	4.0
BOTH	42	5,050	5,370	6.3
NONRECLASS	1,831	4,052	4,149	2.4
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	4,391	4,535	3.3

[1] These payment amounts per case do not reflect any estimates of annual case mix increase.

Table II presents the projected average payments per case under the changes for FY 1996 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 1996 with the average estimated per case payments for FY 1995. 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 6 of Table I.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have data that were unavailable for analyzing the impact changes in the capital prospective payment system for previous fiscal years. Specifically, we have cost report data for the second year of the capital prospective payment system (cost reports beginning in FY 1993) available through the June 1995 update of the Hospital Cost Report Information System (HCRIS). We also have information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of such 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 an individual hospital.
- Moreover, our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the 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 to be used in the FY 1996 capital cost projections. We discuss in Appendix B the assumptions and computations we employ to generate the amount of obligated capital commitments for use in the FY 1996 capital cost projections.

In Table III of this appendix, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 1996. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of FY 1996 capital payment policies by the standard prospective payment system hospital groupings. We caution that 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 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. This means that we continue to be unable to predict accurately an individual hospital's FY 1996 capital costs; however, with the more recent data on the experience to date under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

We present the transition payment methodology by hospital grouping in Table IV. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model. This table presents the aggregate impact of the FY 1996 payment policies.

B. Projected Impact Based on the FY 1996 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1995 to FY 1996 using a capital acquisition model. The FY 1996 model, 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 1993 received through the June 1995 HCRIS update, 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 July 1, 1995 in the Provider-Specific file. We used this data to determine the FY 1996 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 1993, and we age that capital by a formula described in Appendix B. We therefore need to randomly generate only new capital acquisitions for any year after FY 1993. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 1996 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will increase at the following rates during these periods:

AVERAGE PERCENTAGE INCREASE IN CAPITAL

Fiscal year	Costs per discharge
1995	4.91
1996	5.03

- The Medicare case-mix index will increase by 1.4 percent in FY 1995 and 0.8 percent in FY 1996.
- The Federal capital rate as well as the hospital-specific rate will be updated 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 proposed FY 1996 update factor was 1.50 percent. In this final rule, the FY 1996 update factor is 1.20 percent (see section V.A of the preamble to this final rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1995 to FY 1996. 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, 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

Type of hospital	Percent of hospitals	FY 1996 percent of discharges	FY 1996 percent of capital costs	FY 1996 percent of capital payments
Low Cost Hospital	65	62	51	55
High Cost Hospital	35	38	49	45

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital in 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 have continued 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 1995 to FY 1996 using the above described actuarial model.

TABLE III.—IMPACT OF FINAL RULE CHANGES FOR FY 1996 ON PAYMENTS PER DISCHARGE

[FY 1995 Payments Per Discharge]

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment
Low Cost Hospitals	3,400	6,602,508	$259.45	43.00	$195.17	$45.18	$14.62	$514.42
Fully Prospective	1,703	3,344,802	240.13	40.00	230.91	.....	4.65	475.69
Rebase—Fully Prosp.	1,352	2,385,894	239.62	40.00	216.38	.....	32.61	488.61
Rebase—100% Fed Rate	154	427,893	655.26	100.00	.....	.....	2.19	657.45
Rebase—Hold Harmless	191	443,918	130.12	21.69	.....	671.91	5.02	807.05
High Cost Hospitals	1,797	4,116,329	357.04	56.85	.....	385.28	3.41	745.72
100% Federal Rate	684	1,735,792	650.39	100.00	.....	.....	0.35	650.74
Hold Harmless	1,113	2,380,537	143.14	23.40	.....	666.20	5.63	814.97
Total Hospitals	5,197	10,718,837	296.93	48.45	120.22	175.78	10.31	603.25

[FY 1996 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
Low Cost Hospitals	3,400	6,602,508	$401.00	53.74	$198.52	$33.50	$12.90	$645.93	25.56
Fully Prospective	1,703	3,344,802	371.28	50.00	234.90	.....	5.11	611.29	28.50
Rebase—Fully Prosp.	1,352	2,385,894	370.33	50.00	220.06	.....	26.10	616.49	26.17
Rebase—100% Fed Rate	214	594,762	791.33	100.00	.....	.....	7.35	799.08	21.54
Rebase—Hold Harmless	131	277,050	185.05	24.97	.....	798.45	5.31	988.81	22.52
High Cost Hospitals	1,797	4,116,329	577.66	74.25	.....	277.19	2.86	857.71	15.02
100% Federal Rate	1,027	2,631,255	783.04	100.00	.....	.....	0.48	783.52	20.40
Hold Harmless	770	1,485,074	213.78	27.80	.....	768.33	7.07	989.18	21.38
Total Hospitals	5,197	10,718,837	468.84	61.82	122.28	127.09	9.05	727.26	20.56

Under section 1886(g)(1)(A) of the Act, estimated aggregate payments under the capital prospective payment system for FY 1992 through 1995 respectively, were to equal 90 percent of estimated payments that would have been payable on a reasonable cost basis in each year. With the expiration of the capital budget neutrality provision, we

estimate that there will be an aggregate 20.56 percent increase in FY 1996 Medicare capital payments over the FY 1995 payments.

We project that low capital cost hospitals will experience an average increase in payments per case of 25.56 percent, and high capital cost hospitals will experience an average increase of 15.02 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 40 percent to 50 percent and the hospital-specific rate payment percentage will decrease from 60 to 50 percent in FY 1996.

The Federal rate payment percentage for a hospital 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 hospitals receiving a hold-harmless payment for old capital will increase from 23.40 percent to 27.80 percent.

Despite the reduction in the hospital-specific rate blend percentage from 60 percent in FY 1995 to 50 percent in FY 1996, we expect that the average hospital-specific rate payment per discharge will increase from $120.22 in FY 1995 to $122.28 in FY 1996. This is due to the large increase (21.10 percent) in the FY 1996 hospital-specific rate compared to FY 1995.

We proposed no changes in our exceptions policies for FY 1996. As a result, the minimum payment levels will be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or 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 decrease from 1.71 percent of total capital payments in FY 1995 to 1.24 percent of payments in FY 1996. This is due to the large increase in the rates—as rate-based payments increase, exceptions payments decrease. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1996 EXCEPTIONS PAYMENTS

Type of hospital	No. of hospitals	Percent of exceptions payments
Low Capital Cost	217	88
High Capital Cost	118	12
Total	335	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	5,197	17.3	23.9	58.8
Large urban areas (populations over 1 million)	1,640	20.2	31.3	48.5
Other urban areas (populations of 1 million or fewer)	1,294	21.8	27.9	50.3
Rural areas	2,263	12.7	16.2	71.1
Urban hospitals	2,934	20.9	29.8	49.3
0–99 beds	749	24.8	21.9	53.3
100–199 beds	923	25.0	31.4	43.6
200–299 beds	595	17.0	35.5	47.6
300–499 beds	489	14.7	32.3	53.0
500 or more beds	178	13.5	28.7	57.9
Rural hospitals	2,263	12.7	16.2	71.1
0–49 beds	1,177	10.0	11.1	78.8
50–99 beds	665	14.4	18.8	66.8
100–149 beds	227	17.2	29.1	53.7
150–199 beds	109	17.4	20.2	62.4
200 or more beds	85	17.6	27.1	55.3
By Region:				
Urban by Region	2,934	20.9	29.8	49.3
New England	163	9.2	23.3	67.5
Middle Atlantic	441	12.7	28.3	59.0
South Atlantic	433	25.4	34.6	40.0
East North Central	490	15.3	26.3	58.4
East South Central	164	29.9	28.7	41.5
West North Central	196	19.9	27.6	52.6
West South Central	387	37.2	37.2	25.6
Mountain	128	20.3	38.3	41.4
Pacific	484	18.6	27.3	54.1
Puerto Rico	48	20.8	12.5	66.7
Rural by Region	2,263	12.7	16.2	71.1
New England	53	11.3	11.3	77.4
Middle Atlantic	84	8.3	16.7	75.0
South Atlantic	300	15.3	22.3	62.3
East North Central	305	11.5	10.2	78.4
East South Central	278	14.7	25.9	59.4
West North Central	529	8.7	12.7	78.6

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
West South Central	352	14.2	18.8	67.0
Mountain	214	14.0	13.1	72.9
Pacific	143	18.2	10.5	71.3
By Payment Classification:				
All hospitals	5,197	17.3	23.9	58.8
Large urban areas (populations over 1 million)	1,828	19.7	31.0	49.3
Other urban areas (populations of 1 million or fewer)	1,316	22.0	27.4	50.7
Rural areas	2,053	12.2	15.3	72.4
Teaching Status:.				
Non-teaching	4,125	17.8	23.0	59.2
Fewer than 100 Residents	841	17.0	27.7	55.3
100 or more Residents	231	10.4	26.0	63.6
Disproportionate share hospitals (DSH):				
Non-DSH	3,225	17.1	20.1	62.8
Urban DSH:				
100 or more beds	1,436	18.9	33.1	47.9
Less than 100 beds	144	20.8	25.7	53.5
Rural DSH:				
Sole Community (SCH/EACH)	136	13.2	14.7	72.1
Referral Center (RRC/EACH)	29	17.2	17.2	65.5
Other Rural:				
100 or more beds	82	14.6	32.9	52.4
Less than 100 beds	145	8.3	20.0	71.7
Urban teaching and DSH:				
Both teaching and DSH	667	13.5	30.3	56.2
Teaching and no DSH	356	18.3	23.9	57.9
No teaching and DSH	913	23.2	34.1	42.7
No teaching and no DSH	1,208	23.4	27.2	49.4
Rural Hospital Types:				
Non special status hospitals	1,300	8.8	16.8	74.5
RRC/EACH	91	20.9	23.1	56.0
SCH/EACH	623	17.7	11.4	70.9
SCH, RRC and EACH	39	20.5	12.8	66.7
Type of Ownership:				
Voluntary	3,139	17.2	24.1	58.8
Proprietary	718	30.4	39.3	30.4
Government	1,340	10.7	15.2	74.0
Medicare Utilization as a Percent of Inpatient Days:				
0–25	267	24.0	21.0	55.1
25–50	1,356	19.5	28.5	52.0
50–65	2,217	16.2	24.3	59.5
Over 65	1,245	13.9	18.7	67.4

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 10 of the 5,207 hospitals in our data base. Consequently, the payment methodology distribution is based on 5,197 hospitals. This 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 under the hold-harmless methodology.

The percentage of hospitals paid fully Federal (100 percent of Federal rate) is expected to increase to 23.9 percent in FY 1996. As noted above, these hospitals constitute approximately 58 percent of all hold-harmless hospitals. In comparison, only 16.6 percent of hospitals were paid fully Federal in FY 1995, representing only about 39 percent of all hold-harmless hospitals. The cause of this increase is the expiration of the budget neutrality provision, which resulted in a large rate increase in the capital Federal rate. Due to the increase in the Federal rate, more hold-harmless hospitals will fare better under the fully Federal payment method.

Table IV indicates that 58.8 percent of hospitals are paid under the fully prospective payment methodology. (This figure, unlike the figure of 65 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.4 percent and 74.0 percent, respectively by payment classification) are being paid

under the fully prospective methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 30.4 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 1996 actuarial model to estimate the potential impact of our changes for FY 1996 on total capital payments per case, using a universe of 5,197 hospitals. The individual hospital payment parameters are taken from the best available data, including: the July 1, 1995 update to the Provider-Specific file, cost report data, and audit information supplied by intermediaries. Table V presents estimates of payments per case for FY 1995 and FY 1996 (columns 2 and 3). Column 4 shows the total percentage change in payments from FY 1995 to FY 1996. Column 5 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 5 include the 22.6 percent increase in the Federal rate, a 0.8 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 Medicare Geographic Classification Review Board. Column 4 includes the effects of the Federal rate changes represented in column 3. Column 4 also includes the effects of all other changes. Those other changes include: the change from 40 percent to 50 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 and (2) payment classification and payment region.

The simulation results show that, on average, capital payments per case can be expected to increase 20.6 percent in FY 1996. The results show that the effect of the Federal rate changes alone is to increase payments by 11.7 percent. In addition to the increase attributable to the Federal rate changes, an 8.9 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows that urban hospitals will gain slightly less than rural hospitals from the final rule changes (rates of increase of 20.4 percent and 21.6 percent, respectively). Urban hospitals will gain at approximately the same rate as rural hospitals (11.7 and 11.6 percent) from the Federal rate changes. Urban hospitals will gain slightly less than rural hospitals (8.7 percent compared to 10.0 percent) from the effects of all other changes.

By region, there is relatively little variation compared to some previous years. All regions are estimated to receive large increases in total capital payments per case, due to the expiration of the budget neutrality provision. Increases by region vary from a low of 15.3 and 16.0 percent (rural Mountain and urban East South Central regions respectively) to a high of 26.1 and 25.9 percent (rural hospitals of the New England and Middle Atlantic regions respectively).

By type of ownership, proprietary hospitals are projected to have the lowest rate of increase (16.7 percent, of which 11.7 percent is due to Federal rate changes and 5.0 percent to the effects of all other changes). In our proposed rule, proprietary hospitals had the highest rate of increase. We believe that one factor contributing to the higher estimated rate of increase for proprietary hospitals in the proposed rule was the treatment of tax costs. Proportionately more proprietary hospitals are subject to capital-related taxes than other categories of hospitals. Proprietary hospitals experience the same rate of increase attributable to Federal rate changes as all other hospitals (11.7 percent). Since this final rule does not incorporate the proposed adjustment to the Federal rate for capital-related taxes, the estimated rate of increase for proprietary hospitals is lower than that in the proposed rule. Payments to voluntary hospitals will increase 21.0 percent (11.6 percent due to the Federal rate changes and 9.4 percent due to the effects of all other changes) and payments to government hospitals will increase 21.5 percent (12.3 percent due to Federal rate changes and 9.2 percent due to the effects of all other changes).

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review Board (MGCRB). Hospitals may apply for reclassification for purposes of the wage index, standardized amount, or both. 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 reclassification on the hospitals being reclassified for FY 1996 compared to the effects of reclassification for FY 1995, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1996 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.

As a whole, hospitals reclassified during FY 1996 are projected to experience a 22.5 percent increase in payments (12.2 percent attributable to Federal rate changes and 10.3 percent attributable to the effects of all other changes). Nonreclassified hospitals will gain less (20.3 percent) than reclassified hospitals (22.5 percent) overall. Nonreclassified hospitals will gain slightly less than reclassified hospitals from the Federal rate changes (11.6 percent compared to 12.2 percent); they will also gain slightly less from the effects of all other changes (8.7 percent compared to 10.3 percent).

In the proposed rule, Table V included two additional categories of hospitals, according to whether they paid property taxes. We showed these two additional categories of hospitals because of the expected differences in the impact on each category of hospital of our proposed changes with regard to capital-related taxes. Since we are not implementing the proposed change concerning capital-related taxes, we are not showing these categories of hospitals in Table V of this final rule.

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1995 Payments Compared to FY 1996 Payments]

	Number of hospitals	Average FY 1995 payments/case	Average FY 1996 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location					
All hospitals	5,197	603	727	20.6	11.7
Large urban areas (populations over 1 million)	1,640	690	835	21.1	12.0
Other urban areas (populations of 1 million or fewer)	1,294	605	721	19.3	11.2
Rural areas	2,263	396	482	21.6	11.6
Urban hospitals	2,934	654	787	20.4	11.7
0–99 beds	749	501	596	18.9	10.6
100–199 beds	923	597	709	18.8	11.1
200–299 beds	595	615	739	20.2	12.1
300–499 beds	489	668	810	21.1	12.0
500 or more beds	178	806	978	21.4	11.5
Rural hospitals	2,263	396	482	21.6	11.6
0–49 beds	1,177	298	373	25.4	12.0
50–99 beds	665	362	440	21.7	11.9
100–149 beds	227	429	517	20.4	12.1
150–199 beds	109	429	520	21.1	10.7
200 or more beds	85	510	616	20.7	11.1
By Region					
Urban by Region	2,934	654	787	20.4	11.7
New England	163	633	778	22.8	12.9
Middle Atlantic	441	683	842	23.3	12.1
South Atlantic	433	661	777	17.6	10.6
East North Central	490	602	732	21.6	11.9
East South Central	164	615	714	16.0	9.2
West North Central	196	640	770	20.2	11.5
West South Central	387	687	799	16.2	11.5
Mountain	128	652	779	19.4	13.6
Pacific	484	724	886	22.5	12.4
Puerto Rico	48	263	315	19.6	10.8
Rural by Region	2,263	396	482	21.6	11.6
New England	53	524	661	26.1	9.6
Middle Atlantic	84	400	503	25.9	13.4
South Atlantic	300	414	499	20.5	12.3
East North Central	305	385	470	21.9	11.1
East South Central	278	372	447	20.2	11.6
West North Central	529	368	453	23.2	12.1
West South Central	352	380	460	21.1	11.2
Mountain	214	445	513	15.3	9.2
Pacific	143	449	558	24.3	11.7
By Payment Classification					
All hospitals	5,197	603	727	20.6	11.7
Large urban areas (populations over 1 million)	1,828	677	821	21.3	12.0
Other urban areas (populations of 1 million or fewer)	1,316	598	711	18.9	11.1
Rural areas	2,053	382	465	21.7	11.6
Teaching Status:					
Non-teaching	4,125	525	627	19.3	11.6
Fewer than 100 Residents	841	632	767	21.2	11.6
100 or more Residents	231	885	1,087	22.8	12.0
Disproportionate share hospitals (DSH):					
Non-DSH	3,225	547	661	20.8	11.4
Urban DSH:					
100 or more beds	1,436	684	823	20.3	11.9
Less than 100 beds	144	467	554	18.6	12.4
Rural DSH:					
Sole Community (SCH/EACH)	136	370	439	18.8	10.2
Referral Center (RRC/EACH)	29	456	547	20.0	10.6
Other Rural:					
100 or more beds	82	376	463	23.2	13.3
Less than 100 beds	145	297	369	24.5	14.6
Urban teaching and DSH:					
Both teaching and DSH	667	749	911	21.6	12.0
Teaching and no DSH	356	650	795	22.2	11.2
No teaching and DSH	913	594	701	18.1	11.7

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1995 Payments Compared to FY 1996 Payments]

	Number of hospitals	Average FY 1995 payments/case	Average FY 1996 payments/case	All changes	Portion attributable to Federal rate change
No teaching and no DSH	1,208	567	678	19.4	11.5
Rural Hospital Types:					
Non special status hospitals	1,300	336	417	24.1	13.0
RRC/EACH	91	476	575	20.9	11.0
SCH/EACH	623	392	466	19.0	10.0
SCH, RRC and EACH	39	494	583	17.9	9.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY95 and FY96:					
Reclassified During Both FY95 and FY96	453	549	669	21.8	11.7
Reclassified During FY96 Only	147	499	626	25.4	14.2
Reclassified During FY95 Only	275	636	727	14.3	9.0
FY96 Reclassifications:					
All Reclassified Hospitals	602	539	660	22.5	12.2
All Nonreclassified Hospitals	4,568	613	738	20.3	11.6
All Urban Reclassified Hospitals	195	624	766	22.9	12.0
Urban Nonreclassified Hospitals	2,739	656	789	20.2	11.7
All Reclassified Rural Hospitals	407	462	564	22.0	12.4
Rural Nonreclassified Hospitals	1,829	362	439	21.4	11.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	27	438	527	20.4	10.5
Type of Ownership:					
Voluntary	3,139	616	745	21.0	11.6
Proprietary	718	634	740	16.7	11.7
Government	1,340	507	616	21.5	12.3
Medicare Utilization as a Percent of Inpatient Days:					
0–25	267	669	820	22.5	11.1
25–50	1,356	719	869	20.9	11.6
50–65	2,217	561	674	20.2	11.7
Over 65	1,245	500	600	20.2	11.9

Appendix B—Technical Appendix on the Capital Acquisition Model and Required Adjustments

Section 1886(g)(1)(A) of the Act requires that for FY 1992 through FY 1995 aggregate prospective payments for operating costs under section 1886(d) of the Act and prospective payments for capital costs under section 1886(g) of the Act be reduced each year in a manner that results in a 10 percent reduction of 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 expires 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. We continue to use the capital acquisition model to determine these factors.

The following data are used in the capital acquisition model: the June 1995 update of the PPS–IX (cost reporting periods beginning in FY 1992) and PPS–X (cost reporting periods beginning in FY 1993) cost reports, the July 1, 1995 update of the provider-specific file, and the March 1994 update of the intermediary audit file. The available data still lack certain items that were required for the determination of budget neutrality, including each hospital's projected new capital costs for each year, its projected old capital costs for each year, and the projected obligated capital amounts that will be put in use for patient care services and recognized as old capital each year.

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 then developed FY 1992, FY 1993, FY 1994, and FY 1995 hospital-specific rates using the provider-specific file, the intermediary audit file, and when available, cost reports. (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 also ensured that the FY 1993 increase in the hospital-specific rate was at least 0.62 percent (the net FY 1993 update), that the FY 1994 hospital-specific rate was at least as large as the FY 1993 hospital-specific rate decreased by 2.16 percent (the net FY 1994 update), and that the FY 1995 increase in the hospital-specific rate was at least 0.05 percent (the net FY 1995 update). We were able to match hospitals to the files as shown in the following table.

Source	Number of hospitals
Provider-Specific File Only	97
Provider-Specific and Audit File	5109
Neither File	1
Total	5207

Seventy-one of these hospitals had unusable or missing data. We were able to backfill a hospital-specific rate for 61 of these hospitals from the cost reports as shown in the following table.

Source	Number of hospitals
PPS–V Cost Reports	3
PPS–VII Cost Reports	2
PPS–VIII Cost Reports	1
PPS–IX Cost Reports	9
PPS–X Cost Reports	21

Source	Number of hospitals
PPS–XI Cost Reports	25
Total	61

We did not have data for 10 hospitals, and had to eliminate them from the capital analysis. These hospitals likely are new hospitals or hospitals with very few Medicare admissions. This leaves us with 5197 hospitals and should not affect the precision of the required adjustment factors.

Next, we determined old and new capital amounts for FY 1992 using the PPS–IX cost reports as the first source of data. For FY 1993 we used PPS–IX and PPS–X cost reports as the first source of data, weighting each cost report by the number of days in FY 1993. We were able to match 5,125 PPS–IX cost reports and 5,090 PPS–X cost reports. In cases where cost reports could not be matched, we used the provider-specific file for old capital information. Even in cases where a cost report was available, the breakout of old and new capital was not always available. In these cases, we used the old capital amounts and new capital ratios from the provider-specific file. If these were missing, we derived the old capital amount from the hospital-specific rate.

Finally, we used the intermediary audit file to develop obligated capital amounts. Since the obligated amounts are aggregate projected amounts, we computed a Medicare capital cost per admission associated with these amounts. We adjusted the aggregate amounts by the following factors:

(1) Medicare inpatient share of capital. This was derived from cost reports and was limited to the Medicare share of total inpatient days. It was necessary to limit the Medicare share because of data integrity problems. Medicare share of inpatient days is a reasonably good proxy for allocating capital. However, it may be understated if Medicare utilization is high, and may be overstated because it does not reflect the outpatient share of capital.

(2) Capitalization factor. This factor allocates the aggregate amount of obligated capital to depreciation and interest amounts. Consistent with the assumptions in the capital input price index, we used a 25-year life for fixed capital and a 10-year life for movable capital, and an average projected interest rate of 6.7 percent. We also assumed that fixed capital acquisitions are about one-half of total capital. In conjunction with the useful life and interest rate assumptions, the resulting capitalized fixed capital is about one-half of total capitalization. This is consistent with the allocations between fixed and movable capital found on the cost reports. The ratio we developed is 0.137, which produces the first year capitalization based on the aggregate amount.

(3) A divisor of Medicare admissions to derive the capital per discharge amount. Since we must project capital amounts for each hospital, we continued to use a Monte Carlo simulation to develop these amounts. (This model is described in detail in the August 30, 1991 final rule (56 FR 43517).) The Monte Carlo simulation is now used only to project capital costs per discharge amounts for each hospital. We analyzed the distributions of capital increases, and noted a slightly negative correlation between the dollar level of capital cost per admission, and the rate of increase in capital. To determine the rate of increase in capital cost per admission, we multiplied the lesser of $3,000 or the capital cost per admission by .00006 and subtracted this result from 1.2. (Increases for capital levels over $3,000 were not influenced by the level of capital, so this part of the calculation was capped at $3,000.) We selected a random number from the normal distribution, multiplied it by 0.17 (the standard deviation) and added it to −0.04 (the mean) and then added 1 to create a multiplier. This random result was multiplied by the previous result to assign a rate of increase factor which was multiplied by the prior year's capital per discharge amount to develop a capital per discharge amount for the projected year.

To model a projected year, we used the old and new capital for the prior year multiplied by 0.96 (aging factor). The 0.96 aging factor is the average of changes in capital over its life. The aged new and old capital is subtracted from the projected capital described in the previous paragraph. The difference represents newly acquired capital. We assume that the hospital would accrue only a half year of costs for newly acquired capital in the year in which the capital comes on line. This is because, on average, new capital will come on line in the middle of the year. We make the same assumption for obligated capital. If the hospital has obligated capital, the lesser of one half of the adjusted costs (as described in the succeeding paragraph) for newly acquired capital or one half of the costs (for FY 1993, all of the costs) for obligated capital are deemed to apply to the current year. The full year's costs for new or obligated capital are assumed to apply for the following year. For FY 1994, one half of the costs for any outstanding obligated capital were deemed to apply to FY 1994; a full year's costs were deemed to apply to FY 1995. With the exception of certain hospitals about whom we have information to the contrary, we assume that hospitals would meet the expiration dates provided under the obligated capital provision. The on-line obligated amounts are added to old capital and subtracted from the newly acquired capital to yield residual newly acquired capital, which is then added to new capital. The residual newly acquired capital is never permitted to be less than zero.

Next, we computed the average total capital cost per discharge from the capital costs that were generated by the model and compared the results to total capital costs per discharge that we had projected independently of the model. We adjusted the newly acquired capital amounts proportionately, so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

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. If available, the model uses the payment methodology indicated in the PPS–IX cost reports or the provider-specific file. Otherwise, the model determines the methodology by comparing the hospital's FY 1992 hospital-specific rate to the adjusted Federal rate applicable to the hospital. 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 1994 MedPAR file using the FY 1996 DRG relative weights published in this rule. The case-mix index is increased each year after FY 1994 consistent with the continuing trend in case-mix increase.

We analyzed the case-mix increases for the recent past and found that case-mix increases have decelerated to about 1.53 percent in FY 1992, 0.80 percent in FY 1993, and 0.75 percent in FY 1994. It appears that the case-mix increase for FY 1995 will be around 1.4 percent. It is too early to determine if the FY 1995 increase is a one time event, or if it is the start of an accelerating trend. Because case-mix increases have been

decelerating, we expect future case-mix increases to be moderate. Therefore, in the model we have used a case-mix increase of 1.4 percent in FY 1995 and a projected case-mix increase of 0.8 percent in FY 1996. (Since we are using FY 1994 cases for our analysis, the FY 1994 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 1886(g)(1)(A) of the Act requires that, for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent. Consequently, the model reduces the unadjusted standard Federal rate by 7.4 percent effective in FY 1994. Since budget neutrality expires effective with FY 1996, this adjustment affects the Federal rate starting in FY 1996.

The change in the method of paying transfer cases affects total capital payments. We are making the effect of this change budget neutral. To determine the budget neutrality adjustment factor for transfers, we followed the methodology described in section VI.D of Appendix A to this proposed rule. We computed the transfer-adjusted number of discharges and case-mix under the current transfer policy, and the proposed transfer policy for each hospital. We multiplied the corresponding number of discharges and case-mix numbers for each hospital and added all hospitals together. The number computed under the current transfer policy divided by the number computed under the proposed transfer policy yielded the transfer adjustment factor of 0.9972. This adjustment factor is applied to both the hospital-specific rate and the Federal rate.

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 1995, the budget neutrality adjustment factor was 1.0031. To determine the factor for FY 1996, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1996 based on its applicable payment methodology. We then compared estimated aggregate Federal rate payments based on the FY 1995 DRG relative weights and FY 1995 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1996 relative weights and the FY 1996 geographic adjustment factor. In making the comparison, we held the FY 1996 Federal rate portion constant and set the other budget neutrality adjustment factor and exceptions reduction factor to 1.00. We determined that to achieve budget neutrality for the changes in the geographic adjustment factor and DRG classifications and relative weights, an incremental budget neutrality adjustment of 0.9994 for FY 1996 should be applied to the previous cumulative FY 1995 adjustment of 1.0031 (the product of the FY 1993 incremental adjustment of 0.9980, the FY 1994 incremental adjustment of 1.0053, and the FY 1995 incremental adjustment of 0.9998), yielding a cumulative adjustment of 1.0025 through FY 1996.

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 weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low income patients or the large urban add-on.

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 estimated exceptions payments and the exceptions reduction factor. This exceptions reduction factor ensures that estimated aggregate payments under the capital prospective payment system, including exceptions payments, equal estimated aggregate payments 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 FY 1992, FY 1993, FY 1994, FY 1995, FY 1996, and the estimated factors that would be applicable through FY 2000. We caution that, except with respect to FY 1992, FY 1993, FY 1994, FY 1995 and FY 1996, these are estimates only, and are subject to revisions resulting from continued methodological refinements, more recent data, and any payment policy changes that may occur. In this regard, we note that in making these projections we have assumed that the cumulative DRG/GAF adjustment factor will remain at 1.0025 for FY 1996 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1996.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	Federal rate (after outlier reduction)
1992	N/A	0.9813	0.9602	415.59
1993	6.07	.9756	.9162	[1] 417.29
1994	3.04	.9485	.8947	[2] 378.34
1995	3.44	.9734	.8432	[3] 376.83
1996	1.20	.9849	N/A	[4] 461.96
1997	1.70	.9822	N/A	468.53
1998	1.90	.9747	N/A	473.78
1999	1.90	.9608	N/A	475.90

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	Federal rate (after outlier reduction)
2000	1.90	.9406	N/A	474.75

[1] Note: Includes the DRG/GAF adjustment factor of 0.9980 and the change in the outlier adjustment from 0.9497 in FY 1992 to 0.9496 in FY 1993.

[2] Note: Includes the 7.4 percent reduction in the unadjusted standard Federal rate. Also includes the DRG/GAF adjustment factor of 1.0033 and the change in the outlier adjustment from 0.9496 in FY 1993 to 0.9454 in FY 1994.

[3] Note: Includes the DRG/GAF adjustment factor of 1.0031 and the change in the outlier adjustment from 0.9454 in FY 1994 to 0.9414 in FY 1995.

[4] Note: Includes the transfer adjustment of .9972. Also includes the DRG/GAF adjustment factor of 1.0025 and the change in the outlier adjustment from 0.9414 in FY 1995 to 0.9536 in FY 1996. Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Appendix C—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Social Security Act (the Act) address the setting of update factors for services furnished in FY 1996 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XI) of the Act sets the FY 1996 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 2.0 percentage points for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1996 percentage increase to the hospital-specific rate applicable to sole community 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 2.0 percentage points. Section 1886(b)(3)(B)(ii) of the Act sets the FY 1996 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system equal to the rate of increase in the excluded hospital market basket minus the applicable reduction or, in the case of a hospital in a fiscal year for which the hospital's update adjustment percentage is at least 10 percent, the excluded hospital market basket percentage increase. Under section 1886(b)(3)(B)(v) of the Act, a hospital's update percentage increase for FY 1996 is the percentage increase by which the hospital's allowable operating costs of inpatient hospital services recognized under this title for the cost reporting period beginning in FY 1990 exceed the hospital's target amount for such cost reporting period, increased for each fiscal year (beginning with FY 1994) by the sum of any of the hospital's applicable reductions for previous years. The applicable reduction with respect to a hospital for FY 1996 is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for FY 1996.

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 for the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 1995 forecasted market basket increase of 3.5 percent for hospitals subject to the prospective payment system, the updates in the standardized amounts are 1.5 percent for hospitals in both large urban and other areas. The update in the hospital-specific rate applicable to sole community hospitals is 1.5 percent (that is, the market basket rate of increase of 3.5 percent minus 2.0 percentage points). The update for hospitals excluded from the prospective payment system is based on the percentage increase in the excluded hospital market basket (currently estimated at 3.4 percent) minus the applicable reduction factor. The applicable reduction factor is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage. Therefore, for excluded hospitals, the hospital-specific update can vary between 2.4 and 3.4 percent.

Sections 1886(e) (2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1 of each year an update factor that takes into account changes in the market basket rate of increase index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, 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. Under section 1886(e)(5) of the Act, we published the FY 1996 update factors recommended pursuant to section 1886(e)(4) of the Act as Appendix D of the June 2, 1995 proposed rule (60 FR 29380).

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

We received several public comments concerning our proposed recommendations. After consideration of the arguments presented, we have decided that our final recommendation will be the same as our proposed recommendation. That is, we are recommending that the standardized amounts be increased by an amount equal to the market basket rate of increase minus 2.0 percentage points for hospitals located in large urban and other areas. We are also recommending an update of the market basket rate of increase minus 2.0 percentage points to the hospital-specific rate for sole community hospitals. These figures are consistent with the President's budget recommendation.

In recommending these increases, we have followed section 1886(e)(4) of the Act, which requires that we take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC. We believe our analyses, which measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix, support our recommendations.

Comment: One commenter expressed concern with what appears to be a systematic bias in estimation of the market basket forecast. Because we have overestimated the market basket for

several years, the commenter believes that our model is likely to be incorrect in its parameters or methodology and suggested that we continue to revise the model or change the underlying estimation methodology.

Response: We agree with the commenter that there has been a pattern of high forecasts over the past few years in the market basket estimation. We have been working with our contractor during the past year to thoroughly review the forecast equations for the hospital input price indexes. This review produced substantial improvements in both the forecast equations and the processes used to forecast. HCFA and its contractor will closely monitor the future forecasts for accuracy. In this final rule, we present input price indexes that are forecasted using the improved forecast equations.

Comment: We received one comment recommending an adjustment to the market basket for new technologies. The commenter stated that this adjustment would reflect the change in the use of new resources that may increase costs and productivity.

Response: The hospital market basket is an input price index that measures changes in the prices paid for a fixed set of goods and services. We do not believe an adjustment to the market basket for changes resulting from use of new technology is appropriate. Although we do not adjust the hospital market basket for new technology, the update framework accounts for the role of new technologies in two ways. First, we account for cost-increasing, quality-enhancing new technologies in the intensity component of our update recommendation (which is an add-on to the market basket rate of increase). Second, we account for cost-decreasing new technologies through a productivity adjustment. This adjustment allows for those technologies that permit hospitals to treat their patients at lower cost.

Comment: We received two comments strongly urging us to consider how hospital-specific wages and benefits are incorporated into the market basket. They suggest increasing the internal hospital wage and benefit shares to 50 percent.

Response: We responded to a similar comment in detail in the September 4, 1990 final rule (55 FR 36047), when the current hospital market basket was implemented. We prefer to use 100 percent economy-wide proxies for those occupations that are generally employed inside and outside hospitals, such as managers, administrators, clerical, and maintenance workers. We believe that the economy-wide rate of increase is the more appropriate measure for these types of employees, since that is the relevant labor market for these employees. In contrast, we use a 50/50 blend of hospital-industry proxies and economy-wide proxies for professional and technical workers. We believe this is appropriate because the group includes workers, such as registered nurses, that are not hired in large numbers in other sectors of the economy.

Comment: ProPAC's comment stated several concerns about the single intensity adjustment included in HCFA's update framework and believes that each element should be quantified separately.

Response: We continue to disagree with ProPAC that accounting separately for changes in within-DRG complexity, science and technology changes, and practice patterns would be more accurate. In view of the interactive nature of these elements, we believe it is difficult to measure accurately the effects of each element separately. Instead, we believe that it is more appropriate and accurate to account for all three elements in a single measure. Thus, our intensity measure is designed to encompass the net effect of all three changes. With regard to practice pattern changes, which are also reflected in our intensity adjustment, we do not adjust for changes that have not taken place.

Comment: ProPAC questioned HCFA's continued use of projected case-mix change in the update formula instead of actual case-mix change.

Response: Our update analysis takes into account changes in case mix adjusted for changes attributable to improved coding practices and DRG reclassification and recalibration. In the past, we used the observed increase in case mix for the most recent year available. For example, we based our FY 1994 update on the observed increase in case mix from FY 1992. Recent data on case-mix change demonstrates that the growth of case-mix severity has slowed.

The use of projected case mix allows us to take into account emerging trends in case mix more quickly. We note that ProPAC uses an estimate of the total case-mix index in the year prior to the update as part of its update framework. We have decided it is best to use our estimate of what case-mix change will be in the year of the update. This is consistent with the use of the forecasted value of change in the market basket over the coming year.

Comment: ProPAC believes it is inappropriate to adjust the prospective payment amounts separately for case-mix changes that HCFA attributes to reclassification or recalibration, either through changing the weights or the standardized amounts.

Response: We believe that it is appropriate to account for case-mix index changes attributed to reclassification or recalibration within the update framework. This adjustment is determined by comparing the average case weight for the actual cases in a given year based on the DRG relative weights for that year with the average case weight for the same cases based on the DRG relative weights for the previous year. Since the same cases are used on both sides of the comparison, the difference in case-mix index reflects the change in aggregate payments attributable solely to the new GROUPER and relative weights.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

Our final recommendation will be that hospitals and hospital units excluded from the prospective payment system receive an update equal to the percentage increase in the market basket that measures input price increases for services furnished by excluded hospitals minus 1.0 percentage point. Thus, given the current estimate of the change in rate of increase in the market basket for excluded hospitals of 3.4 percent (compared with an earlier estimate of 3.6 percent used in the proposed rule), our final recommendation is for an update of 2.4 percent. We note that the updates for hospitals and units excluded from the prospective payment system as set in Public Law 103–66 is the market basket rate of increase minus 1.0 percentage point, adjusted to account for the relationship between the provider's allowable operating cost per case and its target amount.

We received the following comments concerning our proposed recommendation on the update factor for excluded hospitals and hospital units.

Comment: One commenter states that the Secretary provides no explicit framework to support her recommendation beyond what is included in current law. This commenter is concerned about forecasting errors that have resulted in updates that are too high and believes an explicit framework should be used in developing future recommendations. Another commenter recommends that we include an upward adjustment to the market basket rate of increase to account for new technology.

Response: The update for the prospective payment system for inpatient operating costs adjusts the

market basket for a number of factors including case mix, productivity and intensity. Currently, in the absence of any adjustment for patient severity, there is no mechanism for determining case mix for excluded hospitals and units. Nevertheless, we will examine the feasibility of establishing a framework for an appropriate rate-of-increase limit for services paid on the basis of reasonable costs. Changes in some factors, such as new services or more resources, may be more appropriately accommodated through the exceptions process. As we study developing an update framework for excluded hospitals and units, we will consider an adjustment for technology, if its impact on hospital costs can be accurately measured.

With regard to forecasting errors, as discussed above, we have been working with our contractor to review and make improvements in hospital input price indices. This review has produced substantial improvements in forecast equations and procedures, and we have implemented these changes in developing the input price indices used in this final rule.

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