DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, and 489

[BPD–847–F]

RIN 0938–AH34

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1997 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the systems. 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, 1996. 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.

EFFECTIVE DATE: This rule is a major rule as defined in Title 5, United States Code, section 804(2). Pursuant to 5 U.S.C. section 801(a)(3), this rule may not take effect until 60 days after the report required by that section is submitted to the Congress, which is October 29, 1996. However, for purposes of the policy discussions in this document, we have assumed that the effective date of this final rule will be October 1, 1996, the earliest date by which this rule could take effect under 5 U.S.C. section 801 and the Medicare statute.

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FOR FURTHER INFORMATION CONTACT:

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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.

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 May 31, 1996 Proposed Rule

On May 31, 1996, we published a proposed rule in the Federal Register (61 FR 27444) setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs which would be effective for discharges occurring on or after October 1, 1996. The following is a summary of the major issues addressed and changes that we proposed to make:

- We proposed changes for FY 1997 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 1997. We also solicited comments on the possible expansion of the types of contract labor costs included in the wage index and on possible revisions in Puerto Rico labor market areas.
- We proposed revisions to the regulations governing the composition of the Medicare Geographic Classification Review Board (MGCRB).
- We proposed to use a rebased and revised hospital market basket in developing the FY 1997 update factor for the operating prospective payment rates, the capital prospective payment rates, and the excluded hospital rate-of-increase limits.
- We discussed several provisions of the regulations in 42 CFR parts 412, 413, and 489 and set forth proposed changes concerning the following:

—Sole community hospitals.
—Rural referral centers.
—Disproportionate share adjustment.
—Direct graduate medical education payments.
—Hospital distribution of ''An Important Message from Medicare.''

- We discussed several provisions of the regulations in 42 CFR part 412 concerning the prospective payment system for capital-related costs, including possible adjustments to the capital Federal and hospital-specific rates, and set forth a proposed change concerning the use of simplified cost accounting.
- We discussed clarifications concerning the calculation of payments to hospitals excluded from the prospective payment system.
- In the addendum to the proposed rule, we set forth proposed changes to the amounts and factors for determining

the FY 1997 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 1997 for hospitals and hospital units excluded from the prospective payment system.

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

• In Appendix B to the proposed rule, we set forth our technical appendix on the proposed FY 1997 capital acquisition model.

• In Appendix C to the proposed rule, we set forth the data sources used to determine the market basket relative weights and choice of price proxies.

• In Appendix D to the proposed rule, we included our report to Congress on our initial estimate of an update factor for FY 1997 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 E we provided our recommendation of the appropriate percentage change for FY 1997 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, 1996 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, 1996 report, which included its recommendations, as Appendix F to 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 this preamble, the addendum to this final rule, and the appendices are detailed discussions of the May 31 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. In addition, in section V.E.3 of this preamble, we address a recent statutory amendment to the Public Health Service Act that prohibits certain abortion-related discrimination by the Federal Government and State and local governments. The new statutory provision requires the Federal Government to deem accredited for certain purposes any postgraduate physician training program that would otherwise be accredited, except for the accrediting agency's reliance on certain standards concerning induced abortions.

C. Public Comments Received in Response to the May 31 Proposed Rule

A total of 511 items of correspondence containing comments on the proposed rule were received timely. We received over 300 letters on payments for direct graduate medical education programs. The main other areas of concern addressed by the commenters were the following:

• Requests for changes in DRG classification and relative weights.

• Issues related to the wage index.

• Disproportionate share adjustment.

• Possible adjustments to the capital Federal and hospital-specific rates.

II. Changes to DRG Classifications and Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 1996 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 1997 and other decisions concerning DRGs. These proposed changes and other revisions, the comments we received concerning them, our responses to those comments, and the final DRG changes are set forth below.

2. Pre-MDC DRGs

Effective October 1, 1994, ICD–9–CM procedure code 41.04, Autologous hematopoietic stem cell transplant, was created to capture the transplantation of stem cells obtained from bone marrow or peripheral blood. At that time, we designated the code as non-OR. When we created this code, we received comments requesting that it be designated as an OR procedure and assigned to DRG 481 (Bone Marrow Transplant) based on the resource use associated with the type of transplant. However, as we stated in the September 1, 1994 final rule (59 FR 45340), when a new code is introduced, our longstanding practice is to assign it to the same DRG category as its predecessor code. Because we could not separately identify the stem cell transplant cases from the other cases coded with 99.73 (the code previously used for stem cell transplant) in order to reclassify them and their charges to a new DRG, we were unable to predict the new weights of both the DRGs in which this code currently is classified and the new DRG to which it would be assigned. Therefore, we were prevented from redesignating code 41.04 as an OR procedure or assigning it to a DRG. However, we stated that we would analyze the stem cell cases as soon as the FY 1995 cases were available.

This year, the FY 1995 MedPAR file is available for use in DRG analysis and weight setting for FY 1997. Since the average resource use associated with stem cell transplant is similar to that associated with bone marrow transplant, we proposed to assign procedure code 41.04 to DRG 481 effective with discharges occurring on or after October 1, 1996. In addition, we proposed to designate stem cell transplant as an OR procedure. In the proposed rule, we noted that, as set forth in the Medicare Coverage Issues Manual at section 35–30.1 (see Transmittal No. 84, April 1996), autologous stem cell transplants are not covered when performed for the following conditions:

- Acute leukemia not in remission (diagnosis codes 204.00, 205.00, 206.00, 207.00 and 208.00).
- Chronic granulocytic leukemia (diagnosis codes 205.10 and 205.11).
- Solid tumors (other than neuroblastomas) (diagnosis codes 140.0 through 199.1).
- Multiple myeloma (diagnosis codes 203.00, 203.01, and 238.6).

We received five comments supporting our proposal to assign procedure code 41.04 to DRG 481, and we will include this change in the final DRG classifications. Two other commenters had specific questions concerning the assignment of cases to DRG 481.

Comment: One commenter questioned the DRG assignment of cases in which an autologous hematopoietic stem cell transplant is performed for one of the noncovered conditions such as acute leukemia not in remission or multiple myeloma. The commenter is unsure whether those cases would be assigned to DRG 481 or retain their current DRG assignment.

Response: When a stem cell transplant is performed for a noncovered condition, the case will *not* be assigned to DRG 481. If the only reason that the patient is admitted to the hospital is to receive the noncovered procedure, then the case receives no Medicare payment because the hospital stay is not covered. If a patient receives a noncovered stem cell transplant during an otherwise Medicare-covered stay, then the case is assigned to a DRG based on the patient's principal and secondary diagnoses as well as any other covered procedure the patient receives. The stem cell transplant will not be considered in the DRG assignment.

Comment: One commenter was concerned about the assignment of a case in which a kidney transplant patient receives an allogeneic bone marrow transplant (procedure code 41.03) from the kidney donor to reduce the incidence and magnitude of organ rejection. The commenter believes it is inappropriate to assign such a case to DRG 481 rather than DRG 302 (Kidney Transplant) and that we should therefore revise the pre-MDC surgical hierarchy.

Response: Allogeneic bone marrow transplants performed for purposes of reducing rejection during a kidney transplant have not yet been subject to a national coverage decision. Therefore, under HCFA policy, the Medicare contractors (Part A fiscal intermediaries and Part B carriers) determine, on a case-by-case basis, whether or not to cover and pay for such claims. If a contractor did decide that one of these claims should be covered, then it would be paid under DRG 481. If the contractor determines that the bone marrow transplant is not covered, the claim would be assigned to a DRG without considering the bone marrow transplant. In most cases, this assignment would be DRG 302.

3. MDC 1 (Diseases and Disorders of the Nervous System)

a. Sleep apnea. As discussed in the proposed rule, we have received correspondence requesting that we review the DRG assignment of cases in which surgery is performed to correct obstructive sleep apnea (diagnosis code 780.57). When coded as a principal diagnosis, sleep apnea is assigned to DRGS 34 and 35 (Other Disorders of the Nervous System)[1] in MDC 1.

[1] A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is

Recently, new surgical interventions to correct sleep apnea have been introduced. The procedures most frequently performed for this condition are the following:

Code	Description
27.69	Other plastic repair of palate.
29.4	Plastic operation on pharynx.
29.59	Other repair of pharynx.

Since none of these surgical procedures is assigned to MDC 1, cases of sleep apnea treated with one of these surgeries are assigned to DRG 468 (Extensive OR procedure Unrelated to Principal Diagnosis) or to DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis), depending on the procedure.

We proposed to address this situation by assigning the three surgical procedures to MDC 1. Based on the charges associated with these cases and the fact that they are not clinically similar to the other surgical DRGs in MDC 1, we proposed to include them in DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures).

We received two comments in support of the addition of codes 27.69, 29.4 and 29.59 to DRGS 7 and 8. The commenters agree that these procedures are frequently used as surgical interventions to correct sleep apnea and are appropriately classified to DRGs 7 and 8. We also received two comments that disagreed, as discussed below.

Comment: One commenter was opposed to moving the procedure codes to DRGS 7 and 8. The commenter stated that if the patient had obstructive sleep apnea, the more appropriate diagnosis code would be the underlying cause of the obstruction, such as upper airway blockage (diagnosis code 528.9, Other and Unspecified Diseases of the Oral Soft Tissues) or diagnosis code 478.29, Other Diseases of Pharynx for Redundant Pharyngeal Mucosa.

Response: We agree that if the medical record provides a precise diagnosis for the obstruction, then that condition should be coded. However, information supporting these codes is not always provided in the medical record. Physicians frequently document obstructive sleep apnea as the reason for the surgery. In these cases, medical record coders are assigning code 780.57. As explained above, we believe that it is inappropriate to continue to assign these cases to DRGS 468 and 477 and that the better policy is to assign the procedures to MDC 1.

Comment: We received one comment suggesting that obstructive sleep apnea reported in conjunction with procedure codes 27.69, 29.4, or 29.59 would be more appropriately classified to DRGs 76 and 77 (Other Respiratory System Procedures) in MDC 4 (Diseases of the Respiratory System). In addition, the commenter recommended that obstructive sleep apnea medical cases be assigned to DRGs 101 and 102 (Other Respiratory Diagnoses).

Response: In order to properly classify each case, a diagnosis code may be assigned to only one MDC. Diagnoses in each MDC correspond to a single organ system or etiology and in general are associated with a particular medical specialty. In order to classify cases of obstructive sleep apnea to DRGs 76, 77, 101, and 102, code 780.57 would have to be reassigned from MDC 1 to MDC 4. We believe that obstructive sleep apnea is more appropriately classified to MDC 1; therefore, these cases cannot be assigned to a DRG in MDC 4.

Comment: One commenter noted an error in the discussion of sleep apnea in the proposed rule. The second time we referred to the codes to be moved to MDC 1, we listed them as 25.59, 78.49, and 29.4 (see 61 FR 27447).

Response: In the proposed rule, we inadvertently referred to procedures codes 25.59 and 78.49. The codes that will be added to DRGs 7 and 8 are 27.69, 29.4 and 29.59.

b. Guillain-Barré Syndrome. Guillain-Barré syndrome (diagnosis code 357.0) is a post-infectious polyneuropathy in which severely affected patients may require ventilatory assistance and long stays in intensive care. In recognition of the high resource consumption associated with this diagnosis, effective with FY 1991, we reassigned code 357.0 from DRGs 18 and 19 (Cranial and Peripheral Nerve Disorders) to DRG 20 (Nervous System Infection Except Viral Meningitis). (See the September 4, 1990 final rule (55 FR 36024).)

We have recently received requests that we again review this assignment. These commenters stated that the treatment for these cases remains very costly and often entails long hospital stays. Therefore, we conducted an analysis of the cases assigned to DRG 20 using the 10 percent random sample of the FY 1995 MedPAR file that we use for analyzing possible classification changes.

Cases coded with 357.0 constitute approximately 20 percent of the cases assigned to DRG 20. The average standardized charges for these cases, approximately $22,400, was higher than the average charge for the DRG, approximately $17,100. However, the length of stay was virtually the same. Since we believe that DRG 20 is the appropriate assignment clinically for Guillain-Barré cases, we reviewed the other cases assigned to DRG 20 for possible change.

We found that herpes zoster of the nervous system, NOS (diagnosis code 053.10) and herpes zoster of the nervous system, NEC (diagnosis code 053.19) had average charges of only $7,700 and $7,100, respectively. They also had lower average lengths of stay (6.2 and 6.1 days, respectively). (In the proposed rule, we mistakenly cited these lengths of stay as 4.4 and 4.2, respectively (61 FR 27447).) Because these two diagnoses account for approximately 20 percent of the cases in DRG 20, their low average charge has the effect of significantly lowering the average charge for the DRG. We proposed to reassign these codes to DRGs 18 and 19.

Comment: We received two comments regarding our proposal to assign diagnosis codes 053.10 and 053.19 to DRGs 18 and 19, both of which supported the change. However, one commenter noted that even though these cases obviously do not consume the amount of resources as other cases assigned to DRG 20, clinically, they are more closely related to cases in DRG 20 than those in DRGs 18 and 19. The commenter also expressed an interest in the length of stay and charges for geniculate herpes zoster (diagnosis code 053.11), which we did not propose to move from DRG 20.

Response: We do not believe that reassigning these codes to DRGs 18 and 19 is clinically unsound. There are currently two other herpes zoster diagnoses classified to those DRGs (Postherpetic trigeminal neuralgia (code 053.12) and postherpetic polyneuropathy (code 053.13)). Further, as the commenter noted, the charges and length of stay for 053.10 and 053.19 are very close to those for the cases assigned to DRGs 18 and 19.

We had considered moving all three herpes diagnosis codes (035.10, 053.11, and 053.19) from DRG 20 to DRGs 18 and 19. However, the higher charges associated with geniculate herpes zoster ($11,000) and slightly higher length of stay (6.7 days) led us to decide instead to leave 053.11 in DRG 20 and to closely monitor these cases in upcoming years.

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

Effective for discharges occurring on or after October 1, 1995, we created a

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.

new code for insertion of a coronary artery stent (procedure code 36.06). Until creation of the new code, insertion of coronary artery stent had been included in the codes for percutaneous transluminal coronary angioplasty (PTCA) (procedure codes 36.01, 36.02, and 36.05).

When a new code is introduced, our longstanding practice is to assign it to the same DRG category as its predecessor code or codes. Therefore, in the September 1, 1995 final rule (60 FR 45785), we assigned procedure code 36.06 to DRG 112 (Percutaneous Cardiovascular Procedures), the DRG to which PTCA is assigned. We also stated that the resource use and other data associated with procedure code 36.06 will be available in the FY 1996 Medicare cases which are used for analysis as part of FY 1998 DRG changes. We will evaluate the DRG assignment of coronary artery stent insertion at that time.

Since publication of the September 1, 1995 final rule, we have received data on stent cases provided by the manufacturer of one of the two stent devices currently approved by the Food and Drug Administration (FDA). In addition, the manufacturer has provided us with an analysis of the charges and length of stay of approximately 7,500 Medicare patients who received stents in FY 1995.

The manufacturer's analysis found that the FY 1995 average charge for PTCA cases without stent is approximately $15,700 and the average charge for cases with stent is approximately $21,000. However, our analysis of the data shows that there is wide variation in the hospital standardized charges reported for cases with implant of coronary artery stent. Individual hospital average charges for these cases range from about $9,000 to over $45,000.

This inconsistency in the data illustrates why our policy of not reassigning new codes until we have collected an entire year of coded Medicare data for analysis is prudent. The uncertainty associated with using incomplete data collected outside the Medicare program that cannot be verified remains a problem. Therefore, we did not propose any DRG assignment change for implant of coronary artery stent.

Comment: We received five comments on this issue. One commenter agreed that the strategy of not assigning new codes into different DRGs until Medicare data have been collected and reviewed is appropriate. Four commenters requested that we take action this year. The commenters suggested various options for reassigning code 36.06: assign the code to its own DRG; move the code to a higher-weighted DRG (DRG 116, Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure was suggested); or increase the weight for DRG 112 to recognize that some of these cases involve stents.

One commenter believes that if we delay action, hospitals will not be able to provide stent therapy to Medicare beneficiaries, thereby depriving them of state-of-the-art technology and better outcomes. The commenter noted that although the literature has reported higher costs (for example, cost of the device itself, increased anticoagulation therapy, more frequent monitoring) related to this procedure, there has also been some offset noted because of the reduction in followup medical costs. There is also the potential that further improvement in stent design, implantation techniques, and other anticoagulant therapy could further increase this offset by reducing vascular complications or length of stay.

One commenter, the manufacturer of a coronary stent device, stated that the assignment of coronary stent implant to DRG 112 is inappropriate in light of the higher average lengths of stay and charges associated with this procedure compared to traditional angioplasty. The commenter argued that, given these differences, DRG reclassification of procedure code 36.06 would be consistent with the statutory mandate to adjust the DRG classifications and relative weights to ''reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.'' (Section 1886(d)(4)(C) of the Act.)

The commenter also cited 1,200 peer-reviewed clinical publications that demonstrate superior clinical outcomes with coronary stent implant. Finally, the commenter stated that the variation in hospital standardized charges for coronary stent implant cases is less than the variation in charges for all PTCA cases without stent implant.

Response: As we stated in the proposed rule (61 FR 27447) and in the September 1, 1995 final rule (60 FR 45785), our practice is to assign a new code to the same DRG or DRGs as its predecessor code. One compelling reason for this practice is our inability to move the cases associated with the new code to a new DRG assignment as part of the DRG reclassification and recalibration process. Because the code is new, we cannot identify the stent cases in DRG 112 to remove the charges from that DRG, revise the relative weight accordingly, and move those cases to another DRG and establish the revised weight of that DRG.

We do not disagree with the commenters that the stent implant cases are more costly, on average, than other PTCA cases. We also do not dispute the clinical superiority of this treatment for certain patients. However, until we can review actual Medicare data to determine exactly what the difference in charges is, we cannot make a reasoned decision as to whether those cases should be moved to another DRG or be assigned to a new DRG. We believe that waiting for appropriate data is entirely consistent with our statutory duty to adjust DRG classifications.

Regarding the comment on the variation in charges for stent versus nonstent PTCA cases, we note that the charges for a specific procedure should vary less than the charges for a set of cases that vary in severity and for which many different treatments may be performed. That is, the homogeneity of the patients who received a stent implant should reflect a lower degree of variation.

Finally, analysis of data provided by the stent manufacturer convinced us that Medicare beneficiaries have access to stent implants that is at least equal to the general population. Moreover, we note that it is a violation of a hospital's Medicare provider agreement to place restrictions on the number of Medicare beneficiaries it will accept for treatment unless it places the same restrictions on all other patients. We will carefully examine the PTCA cases with and without stent implant in the FY 1996 claims data file as soon as it is available. Any DRG changes we determine are supported by the data will be addressed in the FY 1998 proposed rule.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

In the proposed rule, we reviewed the DRG assignment in MDC 8 of bipolar hip replacement cases as a follow-up to a comment received last year. The commenter believed that the procedure for partial hip replacement (code 81.52), currently assigned to DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity), is very similar to the procedure for open reduction of fracture of the femur with internal fixation (code 79.35), which is assigned to DRGs 210, 211, and 212 (Hip and Femur Procedures Except Major Joint). Further, the commenter noted that partial hip replacement patients are more frail individuals than the population that elects total hip replacement and need longer hospital stays to recover.

After reviewing the FY 1995 MedPAR file, we concluded that the charges and lengths of stay for partial hip replacement cases assigned to DRG 209 were very similar to the other cases assigned to DRG 209. However, the average charge for cases in DRG 210 was significantly less than the partial hip replacement charges. We note that the length of stay for partial hip replacement cases was closer to the average length of stay for DRG 210. However, the higher charges of the partial hip replacement cases indicate that they are more resource-intensive than the cases in DRG 210 and similar to the cases in DRG 209. Therefore, we proposed to retain procedure code 81.52 in DRG 209.

We received three comments, all of which supported our proposal, and we will continue to assign partial hip replacement cases to DRG 209.

6. 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 relative 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 procedure'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weights 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 diagnosis 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. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of the proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of revised GROUPER software at the time the proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule.

We proposed to revise the surgical hierarchy for the Pre-MDC DRGs, MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat), and MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) as follows:

- In the Pre-MDC DRGs, we proposed to reorder Tracheostomy Except for Face, Mouth and Neck diagnoses (DRG 483) above Liver Transplant (DRG 480).
- In MDC 3, we proposed to reorder Cleft Lip and Palate Repair (DRG 52) and Sinus and Mastoid Procedures (DRGs 53 and 54) above Tonsillectomy and Adenoidectomy, Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58).
- In MDC 10, we proposed to reorder Adrenal and Pituitary Procedures (DRG 286) above Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders (DRG 285).

We received two comments in support of the three 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 incorporating these changes in this final rule.

7. 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 previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting any of the diagnosis codes on the CC list.

In the September 1, 1995 final rule (60 FR 45782), we added diagnosis code 008.49 (Bacterial enteritis) to the CC list.

In response to a request from one commenter that we also add diagnosis code 008.45 (Clostridium difficile), we stated that we would review that request as part of our DRG analysis for FY 1997. We have reevaluated diagnosis code 008.45 as well as the remainder of the ''family'' of codes assigned to the category of Intestinal infections due to other specified bacteria (008.41, 008.42, 008.43, 008.44, 008.46, and 008.47). Our analysis shows that all of these diagnoses, when present as a secondary condition, do lead to higher resource use. Therefore, we proposed to add the following diagnosis codes to the CC list:

008.41 Intestinal infections due to staphylococcus
008.42 Intestinal infections due to pseudomonas
008.43 Intestinal infections due to campylobacter
008.44 Intestinal infections due to yersinia enterocolitica
008.45 Intestinal infections due to clostridium difficile
008.46 Intestinal infections due to other anaerobes
008.47 Intestinal infections due to other gram-negative bacteria

These diagnoses would be considered CCs for any principal diagnosis not shown in Table 6f, Additions to the CC Exclusions List (see discussion of CC Exclusions list in section V of the addendum below).

This same commenter also requested that we add the following codes to the CC list:

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

Our analysis of these codes demonstrated that their presence as a secondary diagnosis did not significantly add to the resource use of the case. Therefore, we did not propose to add them to the CC list.

Finally, the commenter suggested that the following diagnoses be added as cardiovascular complications for DRG 121 (Circulatory Disorders with AMI and Cardiovascular Complications, Discharged Alive):

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

Based on our analysis, charges associated with those cases were indeed comparable to the other cases assigned to DRG 121. However, when we sought the advice of our medical specialists (physicians who work directly for or under contract with HCFA), they strongly opposed adding these codes to the list of conditions for DRG 121 based on the fact that these are not cardiovascular complications. Therefore, they are not clinically similar to other cases assigned to this DRG.

Our analysis of DRG 121 did reveal a large variation in the charges and lengths of stay within this DRG. We believe that a close examination of the list of complicating conditions assigned to DRG 121 is needed. Therefore, we plan to perform a thorough analysis of the cases assigned to that DRG as part of our DRG analysis agenda for FY 1998. In the meantime, we did not propose any change to DRG 121.

We received three comments supporting the addition of the remainder of the ''family'' of codes for intestinal infection due to bacteria to the CC list. We received one comment in support of our decision not to add 331.0, 423.9, 348.5, 333.4, 458.0, and 458.9 to the CC list.

Comment: Two commenters requested that we reconsider our decision not to add codes 434.xx (Occlusion of cerebral arteries) and 436 (Acute, but ill-defined, cerebrovascular disease) to the list of conditions that are designated cardiovascular complications for assignment to DRG 121 (Circulatory Disorders with AMI and Cardiovascular Complications, Discharged Alive). One commenter noted that even though these diagnoses are not cardiac in nature, they are vascular complications. The other commenter stated that there are other conditions assigned to DRG 121, such as acute renal failure, that are not strictly cardiovascular conditions. The commenter supports our decisions to completely review DRG 121, but believes diagnosis codes 434.xx and 436 should be added this year.

Response: As explained in the proposed rule (61 FR 27449), in our initial analysis, cases assigned to DRG 121 that had these diagnoses coded as secondary conditions contained charges that were indeed comparable to the other cases assigned to DRG 121. However, our analysis of DRG 121 and the list of cardiovascular conditions revealed large variations in the charges and lengths of stay for cases within this DRG. Because the diagnoses associated with codes 434.xx and 436 are not strictly cardiovascular in nature, we believe the better course would be to do a comprehensive review of DRG 121, including considering adding additional diagnosis as complicating conditions. We will address these issues as part of our DRG analysis agenda for FY 1998.

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

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

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

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended to be only a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCS were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition a CC. (See the September 30, 1988 final rule for the revisions made for the discharges occurring in FY 1989 (53 FR 38485); the September 1, 1989 final rule for the FY 1990 revisions (54 FR 36552); the September 4, 1990 final rule for the FY 1991 revisions (55 FR 36126); the August 30, 1991 final rule for the FY 1992 revision (56 FR 43209); the September 1, 1992 final rule for the

FY 1993 revisions (57 FR 39753); the September 1, 1993 final rule for the FY 1994 revisions (58 FR 46278); the September 1, 1994 final rule for the FY 1995 revisions (59 FR 45334); and the September 1, 1995 rule for the FY 1996 revisions (60 FR 45782).)

The proposed rule reflected 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, 1996, as well as the proposed CC changes described above. (See section II.B.8, below, for a discussion of ICD–9–CM changes.) These changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

The changes discussed above have been added to Table 6g, Additions to the CC Exclusions List, in section V of the addendum to this final rule.

Table 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, 1996. Each table shows the principal diagnoses with final 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 on or after October 1, 1996, 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 on or after October 1, 1996, 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 for the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $92.00 plus $6.00 shipping and handling and on microfiche for $20.50, plus $4.00 for shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number, (PB) 88–133970) should be made to the following address: National Technical Information Service; United States Department of Commerce; 5285 Port Royal Road; Springfield, Virginia 22161; or by calling (703) 487–4650.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, and 1996) 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, 1996.

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, is available for $195.00, which includes $15.00 for shipping and handling. Version 14.0 of this manual, which will include the final FY 1997 DRG changes, will be available in October 1996 for $195.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road; Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

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

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

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

All remaining OR procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures if performed with an unrelated principal diagnosis was published in Table 6c in section IV of the addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990, August 30, 1991, September 1, 1992, September 1, 1993, September 1, 1994, and September 1, 1995, we moved several other procedures from DRG 468 to 477. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, 59 FR 45336, and 60 FR 45783, 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 DRGs 468, 476, and 477 to ascertain if any of those procedures should be moved from one of these DRGs to another based on average charges and length of stay. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we moved one procedure from DRG 468 to DRG 477.

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 one procedure, Closed endoscopic biopsy of lung (code

33.27), a needle biopsy, that is significantly less resource-intensive than the other procedures assigned to DRG 468. Therefore, we proposed to move procedure code 33.27 to the list of procedures that result in assignment to DRG 477.

In reviewing the list of procedures assigned to DRG 477, we did not identify any procedures that should be assigned to either DRG 468 or 476. We did, however, identify the following procedures that we believe should be reassigned from an OR to a non-OR designation:

08.81 Linear repair of laceration of eyelid or eyebrow
08.82 Repair of laceration involving lid margin, partial-thickness
08.83 Other repair of laceration of eyelid, partial-thickness
08.84 Repair of laceration involving lid margin, full-thickness
08.85 Other repair of laceration of eyelid, full-thickness
08.86 Lower eyelid rhytidectomy
08.87 Upper eyelid rhytidectomy
08.89 Other eyelid repair

Our analysis of the data associated with these eyelid repair procedures leads us to conclude that the procedures are performed following accidental injury or falls, incurred while the patient is in the hospital. These procedures, which are normally performed at bedside and do not necessitate a trip to the operating room, are significantly less resource-intensive than other procedures designated as OR procedures. Therefore, we proposed to change the procedures from OR to non-OR procedures. We noted that these procedures are assigned to surgical DRGs in MDCs 2, 9, 21, 22, and 24. With this change, cases in which procedure codes 08.81 through 08.89 are the only OR procedure codes listed would no longer be assigned to a surgical DRG.

Comment: We received two comments that generally supported our proposal to move procedure code 33.27 to the list of procedures that result in assignment to DRG 477. However, one of the commenters was concerned because this code also includes transbronchial lung biopsy. The commenter believes that transbronchial lung biopsy is a high-risk procedure and questions whether this would be considered a nonextensive procedure.

Response: In analyzing the procedures that produce assignments to each of DRG 468, 476, and 477 for possible reassignment, we evaluate average charges and lengths of stay. The cases in DRG 468 with procedure code 33.27 are significantly less resource-intensive than the other procedures assigned to DRG 468, and more closely resemble the average charge and length of stay for procedures classified to DRG 477. Although transbronchial lung biopsy may be a more difficult procedure to perform than other procedures assigned to 33.27, we do not know how many of these cases are actually assigned to DRG 468, that is, how many times this procedure is performed for an unrelated principal diagnosis. It is possible that the lower charges associated with closed endoscopic biopsy of lung cases in DRG 468 do not include many transbronchial lung biopsy cases. We also note that in MDC 4, procedure code 33.27 is not assigned to the major procedures DRG (DRG 75). In any case, our data support the reclassification of these procedures to DRG 477. Therefore, we are reassigning procedure code 33.27 from DRG 468 to DRG 477, as proposed.

Comment: We received four comments regarding our proposal to designate procedure code category ''other repair of eyelid'' (codes 08.81 through 08.89) as non-OR. Two commenters supported our decision, although one of those commenters stated that even though these procedures may not require an operating room, they may require a specialist. One commenter requested that we consider designating these eyelid repair codes as non-OR procedures that affect DRG assignment when the procedure is the only one performed in connection with a related principal diagnosis. The fourth commenter understood that our reason for making this change had to do with our belief that many of these injuries are sustained during hospital stays. That commenter believes that the causes surrounding the injury are not necessarily indicative of the nature of the services furnished or the procedures performed and that we should not make this change unless we reviewed the resources consumed delivering these services.

Response: Our proposal to change the OR designation for these procedures was not based on where the injuries were incurred. Rather, we based the decision on our analysis of claims data as part of our annual review of procedures that result in assignment to DRGs 468, 476, and 477, and on the clinical opinions of our physician consultants. Cases in which 08.81 was coded as the only OR procedure, unrelated to the principal diagnosis, were the second most frequently assigned to DRG 477. Our evaluation of the average charges and length of stay for these cases was the deciding factor in our proposal. Both of these statistics were much lower for the eyelid repair cases than the average case assigned to DRG 477. In addition, the opinion of our medical staff was that these repairs would not normally necessitate a trip to the OR, even if they are performed by a specialist. Because there are so many cases of eyelid repair performed for unrelated diagnoses, we speculated that they were the result of injuries sustained while the patient was in the hospital.

Regarding the request to designate codes 08.81 through 08.89 as non-OR procedures that affect DRG assignment in the MDCs to which they were previously assigned, we analyzed the FY 1995 MedPAR file cases in which one of these codes is assigned to DRG 40 and 41 (Extraocular Procedures Except Orbit) in MDC 2 (Diseases and Disorders of the Eye) and DRG 268 (Skin, Subcutaneous Tissue and Breast Plastic Procedures) in MDC 9 (Disease and Disorders of the Skin, Subcutaneous Tissue and Breast). In both DRGs 40 and 268 (no cases were assigned to DRG 41 in FY 1995), there were no cases in which an eyelid repair was the only related procedure coded. That is, in every case, there was another OR procedure code present on the claim that would cause it to be assigned to either DRG 40 or 268. This means that assignment of cases to these DRGs will not be affected by changing the OR designation for the eyelid repair codes.

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

As discussed above in section II.B.1 of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee charged with the mission of maintaining and updating the ICD–9–CM. That mission includes approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the 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 field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on May 5 and November 30, 1995, and finalized the coding changes after consideration of comments received at the meetings and in writing within 30 days following the November 1995 meeting. The initial meeting for consideration of coding issues for implementation in FY 1998 was held on June 6, 1996. 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: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@nch11a.em.cdc.gov.

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; HCFA, Office of Hospital Policy; Division of Prospective Payment System; C5–06–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM codes changes that have been approved will become effective October 1, 1996. 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.

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, and 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, 1996. 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.

Based on the comments received and our own review, we have corrected a code title and added omitted secondary DRG assignments to several codes in Tables 6a and 6b. The code title corrected is 995.59, Other child abuse and neglect. The codes for which DRG changes have been made are as follows:

- In Table 6a, MDC 15 and DRG 391 were added to 752.51 and 752.52 because they are considered ''major problems'' in this DRG; 922.31, 922.32, and 922.33 were modified to add MDC 24 and DRGs 484, 485, 486, and 487; and MDC 15 and DRGs 387 and 389 were added to 998.11, 998.12, 998.13, 998.51 and 998.59 because they are considered ''major problems'' in these DRGs.
- In Table 6b, DRG 303 was added to code 59.03.

Comment: One commenter supported the creation of new procedure codes for partial cholecystectomies; however, the commenter disagreed with their assignment to DRGs 193 and 194 (Biliary Tract Procedures except only Cholecystectomy with or without C.D.E.). The commenter believes that partial cholecystectomy (code 51.21) is similar to cholecystectomy (code 51.22) and laparoscopic partial cholecystectomy (51.23) is similar to laparoscopic cholecystectomy (51.24). Therefore, procedure codes 51.21 and 51.23 should be assigned to the same DRGs as 51.22 and 51.24, respectively.

Response: We agree with the commenter. Partial cholecystectomies are clinically similar to cholecystectomies and laparoscopic partial cholecystectomies are clinically similar to laparoscopic cholecystectomies, as well as being similar in terms of resource use. Therefore, we have revised Table 6b to indicate that procedure code 51.21 is assigned to DRGs 195 and 196 (Cholecystectomy with C.D.E.) and DRGs 197 and 198 (Cholecystectomy except by Laparoscope) and 51.23 is assigned to DRGs 195 and 196 and DRGs 493 and 494 (Laparoscopic Cholecystectomy).

Comment: We received one comment on modifications made to the ICD–9–CM codes involving psychiatric diagnoses. The commenter had participated in the ICD–9–CM Coordination and Maintenance Committee meetings and had submitted written proposals for revisions. The commenter stated that although the proposed rule listed all final code revisions, it did not explain the final action on specific proposals or why that action was taken. The commenter suggested that this information be included in the final rule. The commenter also objected to changing the title of category V61.1 from ''Marital Problems'' to ''Counseling for Marital and Partner Problems'' because it narrows the use of the category.

Response: The National Center for Health Statistics (NCHS) has the lead responsibility for maintaining the diagnosis part of ICD–9–CM. As explained above, after receiving comments at the public meetings held by the Coordination and Maintenance Committee and reviewing subsequent written comments, NCHS proposes final revisions to ICD–9–CM diagnosis codes. These revisions are then jointly approved by NCHS and HCFA. The purpose of printing the final codes in the Federal Register is simply to notify the public and solicit comment on the proposed DRG classifications. We recommend that the commenter, or any other interested party, contact NCHS directly to discuss the final codes. If further revisions are sought, then these can be handled through future meetings of the Coordination and Maintenance Committee. We will forward the commenter's concerns on category V61.1 to NCHS for review.

Comment: One commenter supported the ICD–9–CM code revisions for October 1, 1996, but suggested that rules relating to the sequencing of the new code V66.7, Encounter for palliative care, should be developed prior to its use beginning on October 1, 1996.

Response: We agree with the commenter that medical records technicians and administrators will

need advice on coding this diagnosis. Specific directions in the form of a note within the tabular section of the ICD–9–CM will direct the coder to ''code first underlying disease'' when coding V66.7. The NCHS has also developed an extensive set of V code guidelines that will also clarify that V66.7 should be sequenced second. In addition, AHA routinely includes advice on the use of new and modified codes in the fourth quarter issue of their publication, *Coding Clinic for ICD–9–CM Coding.* This year's issue will clarify that V66.7 will be used only as a secondary diagnosis. The coding advice in *Coding Clinic* is a collaborative effort among HCFA, NCHS, AHA, and AHIMA. Information on ordering *Coding Clinic* can be obtained from the following: American Hospital Association, Central Office on ICD–9–CM, One North Franklin, Chicago, IL 60606, (312) 422–3366.

Comment: Although the Committee made no revisions to the pacemaker codes, a commenter noted that there have been advances in pacemaker technology that may have an effect on coding and DRG classification. One new pacemaker device functions as a dual-chamber pacemaker (procedure code 37.83) but has only a single lead (procedure code 37.71 or 37.73). If these pairs of codes are reported on a claim, the case is assigned to a medical DRG rather than DRG 115 or 116 (Permanent Cardiac Pacemaker Implant).

Response: This coding issue was addressed recently by the Editorial Advisory Board of the *Coding Clinic for ICD–9–CM.* After consultation with the manufacturer of the new pacemaker device, the Board decided that, although this pacemaker has a single lead, it functions as dual electrodes. Therefore, the insertion of this pacemaker should be coded with procedure codes 37.83 and 37.72 (dual lead insertion). If a hospital follows this coding advice, the case will be classified to DRG 115 or 116. This advice will be included in an upcoming issue of *Coding Clinic.* We will monitor this situation to determine if hospitals are following this coding advice or if a change in the DRG software is necessary.

C. Recalibration of DRG Weights

We used the same basic methodology for the FY 1997 recalibration as we did for FY 1996. (See the September 1, 1995 final rule (60 FR 45791).) That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1995 MedPAR file, rather than the FY 1994 MedPAR file. The MedPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The recalibrated DRG relative weights are constructed from FY 1995 MedPAR data, based on bills received by HCFA through June 1996, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1995 MedPAR file includes data for approximately 11.1 million Medicare discharges.

The methodology used to calculate the DRG relative weights from the FY 1995 MedPAR file is as follows:

- All the claims were regrouped using the final DRG classification revisions discussed above in section II.B of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as were used in computing the current weights. That is, we eliminated all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a fraction of a case based on the ratio of its length of stay to the geometric mean length of stay of the cases assigned to the DRG. That is, a 5-day length of stay transfer case assigned to a DRG with a geometric mean length of stay of 10 days is counted as 0.5 of a total case.
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1995 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition cost for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant for heart and heart-lung transplants); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We proposed to use that same case threshold in recalibrating the DRG weights for FY 1997. For this final rule, using the June 1996 FY 1995 MedPAR data set, there are 37 DRGs that contain fewer than 10 cases. We computed the weights for the 37 low-volume DRGs by adjusting the FY 1996 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs. We note that the FY 1996 weights for the low-volume DRGs were recalculated based on non-Medicare data we acquired from 19 States. This was the first update of the weights since they were initially calculated for FY 1984 based on data from Maryland and Michigan. For a complete description of this process, see the September 1, 1995 final rule (60 FR 45781).

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 assure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred by this provision, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs) (and New England County Metropolitan Areas), 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 requires that the wage index be updated annually beginning October 1, 1993. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services.

B. FY 1997 Wage Index Update

The final FY 1997 wage index (effective for hospital discharges occurring on or after October 1, 1996 and before October 1, 1997) is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1993 (the FY 1996 wage index is based on FY 1992 wage data). We used the same categories of data that were used in the FY 1996 wage index. Therefore, the FY 1997 wage index reflects the following:

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

Finally, we are making a minor revision to § 412.63(s)(1) to state clearly that we update the wage index annually as required by section 1886(d)(3)(E) of the Act.

Although we did not propose any changes in the reporting of hospital wage index data, we received comments regarding our current policies. (Comments specifically related to our policy on contract labor are addressed below in section III.D of this preamble.)

Comment: We received several comments concerning the treatment of Medicare Part A physician salaries in the wage index calculation. One commenter stated that we should immediately exclude all of these costs, using Worksheet A–8–2 of the Medicare cost report to identify physician Part A costs. Alternatively, the commenter suggested that we should include contracted Part A physician salaries in those States where hospitals are prohibited from employing physicians. Two other commenters suggested we should prepare an impact analysis of the effects of the exclusion of Part A physician salaries.

Response: As stated in the September 1, 1994 final rule (59 FR 45355), effective with cost reporting periods beginning on or after October 1, 1994, we revised the Medicare cost report to provide for the separate reporting of all salary costs for physicians (including teaching physicians), interns and residents, and certified registered nurse anesthetists. After evaluating these data, we will consider appropriate changes in developing the FY 1999 wage index update.

In response to the suggestion that we should use Worksheet A–8–2 to expedite our evaluation of excluding physician Part A salaries, we will explore the technical feasibility of using the data from that worksheet. Regarding the suggestion that we should allow contracted Part A physician salaries to be included in the wage index calculation in those States that do not allow hospitals to employ physicians directly, we note that, if we were to adopt such a policy it would not be effective until hospitals' FY 1997 cost reporting periods. Therefore, the data would not be available until the FY 2001 wage index. Because we are already collecting data that would allow us to exclude all physician Part A salaries by the FY 1999 wage index, we are not adopting this comment.

With respect to the comments that we should prepare an analysis of the impact on the wage index of excluding Part A physician salaries, any such analysis is, of course, contingent upon having reliable data to analyze. At this point, we do not foresee having such data prior to the availability of hospitals' FY 1995 cost reports.

Comment: A commenter stated that the wage index value of rural hospitals with swing-bed programs is unfairly deflated by the inclusion of the lower salaries related to skilled nursing level care provided to patients in swing-beds. The commenter indicated that since hospitals can separately identify these salaries, they should be excluded from total salaries to be consistent with the way salaries are reported for hospitals without a swing-bed program.

Response: Salaries related to skilled nursing level care provided to patients in swing-beds are not reported separately on the Medicare cost report. Salary costs for swing-beds are combined with those for general adult and pediatric care on the cost report at line 25 of Worksheet A. Therefore, it would not be possible under the current cost report format to remove from the wage index calculation these costs as we do for direct salaries associated with distinct part skilled nursing facilities and units. Furthermore, given the nature of the swing-bed program, we do not believe it would be appropriate to impose on hospitals the additional recordkeeping requirements that would be necessary to report these salaries.

1. Verification of Wage Data from the Medicare Cost Report

The data for the FY 1997 wage index were obtained from Worksheet S–3, Part II of the Medicare cost report. The data file used to construct the wage index includes FY 1993 data submitted to the Hospital Cost Report Information System (HCRIS). As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

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 submit requests for corrections if necessary (61 FR 27455). To be reflected in the final wage index, wage data corrections had

to be reviewed, verified, and transmitted to HCFA through HCRIS by June 17, 1996 (any changes after this date are limited to errors related to handling the data, as described below in section III.C of this preamble). All data elements that failed edits have been resolved and are reflected in this final rule.

2. Computation of the Wage Index

As noted above, we are basing the FY 1997 wage index on wage data reported on the FY 1993 cost reports. The final wage index is based on data from 5,231 hospitals paid under the prospective payment system and short-term acute care hospitals in waiver States. The method used to compute the final 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, 1992 and before October 1, 1993. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1992 and 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 1993 data.

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

Step 3—For each hospital, we adjusted the total salaries plus fringe benefits resulting from Step 2 to a common period to determine total adjusted wages. To make the wage inflation adjustment, we used the percentage change in average hourly earnings for each 30-day increment from October 14, 1992 through September 15, 1994, for hospital industry workers from Standard Industry Classification 806, Bureau of Labor Statistics Employment and Earnings Bulletin. The annual inflation rates used were 4.8 percent for FY 1992, 3.6 percent for FY 1993, and 2.7 percent for FY 1994. 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
10/14/92	11/15/92	1.044482
11/14/92	12/15/92	1.041408
12/14/92	01/15/93	1.038343
01/14/93	02/15/93	1.035287
02/14/93	03/15/93	1.032240
03/14/93	04/15/93	1.029203
04/14/93	05/15/93	1.026174
05/14/93	06/15/93	1.023154
06/14/93	07/15/93	1.020143
07/14/93	08/15/93	1.017141
08/14/93	09/15/93	1.014147
09/14/93	10/15/93	1.011163
10/14/93	11/15/93	1.008920
11/14/93	12/15/93	1.006683
12/14/93	01/15/94	1.004450
01/14/94	02/15/94	1.002223
02/14/94	03/15/94	1.000000
03/14/94	04/15/94	0.997782
04/14/94	05/15/94	0.995570
05/14/94	06/15/94	0.993362
06/14/94	07/15/94	0.991159
07/14/94	08/15/94	0.988961
08/14/94	09/15/94	0.986767

For example, the midpoint of a cost reporting period beginning January 1, 1993 and ending December 31, 1993 is June 30, 1993. An inflation adjustment factor of 1.020143 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 1993 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 direct patient care contract labor hours and home office hours to determine total hours.

Step 5—As part of our editing process, we deleted data for eight 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 reflected the relative wage levels in their labor market areas during their FY 1993 cost reporting period.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area prior to any reclassifications under sections 1886(d)(8)(B) or 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted wages obtained in Step 3 for all hospitals in that area to determine the total adjusted wages for the labor market area.

Step 7—We divided the total adjusted wages 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 wages 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 $19.5533.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

We note that on June 28, 1996, OMB announced the designation of the Pocatello, Idaho MSA comprising Bannock County, Idaho and the Jonesboro, Arkansas MSA comprising Craighead County, Arkansas and the addition of Chester County, Tennessee to the Jackson, Tennessee MSA. These changes are reflected in the final wage index.

3. Revisions to the Wage Index Based on Hospital Redesignation

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

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

the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals reduces the MSA wage index value 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.
- If including the wage data for the redesignated hospitals increases the MSA wage index value, the MSA and the redesignated hospitals receive the combined wage index value.
- 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 values increase as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage indexes 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 reduce the rural wage index value, and those urban areas whose wage index values are already below the rural wage index and would 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. These areas receive the prereclassified wage index value. The prereclassified wage index value will apply as long as the MSA remains empty.

The final wage index values for FY 1997 are shown in Tables 4a, 4b, and 4c in the Addendum to this final rule. The FY 1997 wage index values incorporate all hospital redesignations for FY 1997, withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process. For FY 1997, 385 hospitals are redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act). For hospitals that are redesignated, the wage index values are shown in Table 4c. For some areas, Table 4c shows more than one wage index value. 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, prior to the redesignation of hospitals, based on the FY 1993 wage data. In addition, Table 3C in the addendum to this final rule includes the adjusted average hourly wage for each hospital based on the FY 1993 data. Hospitals should use the average hourly wage published in this final rule in applying to the MGCRB for wage index reclassifications that would be effective for FY 1998. The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(s)(2). In such cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index.

C. Requests for Wage Data Corrections

In the proposed rule, we noted that we would make a diskette available in mid-August that contained the wage data used to construct the wage index values in this final rule. As with the diskette made available in March 1996, HCFA made the August diskette available to hospital associations and the public. (Please note that this data file is also available on HCFA's World-Wide Web page, public use files address (http://www.hcfa.gov/stats/stats.html).) This file is made available only for the purpose of identifying any potential errors made by HCFA or the intermediary in the handling of the final wage data that result from the process described above, not for the initiation of new wage data correction requests.

In addition, as noted above, Table 3C in the Addendum to this final rule contains each hospital's adjusted average hourly wage used to construct the wage index values. A hospital can verify its average hourly wage as reflected on its cost report (after taking into account any adjustments made by the intermediary), by dividing the adjusted average hourly wage in Table 3C by the applicable wage inflation adjustment factors as set forth above in Step 3 of the computation of the wage index.

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, after that point, neither the intermediary nor HCFA will accept the following types of requests in conjunction with this 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 17, 1996.
- 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 1996 data.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

If, after reviewing the data in the August diskette or 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. The letters should outline why the hospital believes an error exists and provide all supporting information. These requests must be *received* by HCFA and the intermediaries no later than September 16, 1996. We have set this year's deadline one week earlier than last year's deadline because we found the later deadline made it difficult to evaluate the requests and recalculate the wage index values before

the start of FY 1997 (that is, October 1, 1996). Requests sent to HCFA should be sent to: Health Care Financing Administration, Office of Hospital Policy, Attention: Stephen Phillips, Technical Advisor, Division of Prospective Payment System; C5–06–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Each request must also be sent to the hospital's fiscal intermediary. 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.

We believe the wage data correction process described above and in the proposed rule provides hospitals with sufficient opportunity to bring errors made during the preparation of the Worksheet S–3 to the intermediary's attention. Moreover, because hospitals had access to the 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 FY 1997 wage index on October 1, 1996. If hospitals avail themselves of this opportunity, 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 1997 (that is, by the September 16, 1996 deadline). As indicated earlier, since a hospital will have had the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

Comment: One commenter commended us for making the wage data file available on the HCFA home page. The commenter also suggested that the file be updated frequently and include such additional information as the MSA name where the hospital is located, the applicable inflation adjustment factors, and the MSA to which each hospital has been reclassified by the MGCRB, if applicable.

Response: The wage data file is currently updated twice a year, in mid-March and mid-August, in conjunction with the issuances of the proposed and final rules for the hospital inpatient prospective payment systems. This effort is very labor intensive, and since hospitals are able to submit cost reports throughout the year, it is impractical to update the wage data file more frequently. In addition, we would point out that the intent of making these data available is primarily to provide hospitals the opportunity to verify the data used in the calculation of their wage index. Updating this file more frequently is not necessary to fulfill this primary objective.

Regarding the suggestion to include additional information on the wage data file that we make available to the public, we note that the suggested data elements are not necessary for the purpose of allowing an opportunity for providers to verify the accuracy of their wage data. We note that we publish the MSA names and inflation adjustment factors in the proposed and final rules, and the MSAs to which hospitals are reclassified can be found on the PPS Payment Impact Public Use File, available shortly after publication of the proposed and final rules.

D. Contract Labor—Costs Included in the Hospital Wage Index

Our policy concerning inclusion of contract labor costs for purposes of calculating the wage index has evolved over the past several years. Primarily, this has occurred as we recognized the role of contract labor in meeting special personnel needs of many hospitals. In addition, improvements in the wage data have allowed us to more accurately identify contract labor costs and hours. As a result, effective with the FY 1994 wage index, we included the costs of direct patient care contract services in the wage index calculation. Effective with the FY 1999 wage index, which will use data from FY 1995 cost reports, we will begin to include the costs and hours of certain management contract services.

In the proposed rule, we provided a general overview of the issues related to including contract labor costs in the wage index calculation and solicited comments from the public regarding further expansion of the types of contract labor costs included in the wage index. We also listed nine specific issues on which we were seeking public comment. The following background material is identical to the overview included in the proposed rule, but we believe it is useful as a reference for responding to many of the comments we received.

1. Background

In the May 9, 1990 proposed rule (55 FR 19442), we reported the results of the 1988 wage index survey which collected, among other information, data on the costs and hours associated with direct patient care contract labor. All prospective payment hospitals completed the wage survey for their cost reporting periods ending in calendar year 1988. The survey data indicated that hospitals had difficulty in tracking and recording the actual hours worked associated with the contract labor. In addition, there were reporting inconsistencies. For example, some hospitals inappropriately reported patient care services furnished directly by physicians, which are not included in the wage data because they are paid under Medicare Part B rather than Part A.

In the May 9, 1990 proposed rule, we also discussed public comments we received in response to issues we raised related to including contract labor costs in the wage index. Specifically, in the May 8, 1989 proposed rule (54 FR 19647), we requested comment on the following issues:

- Should the wage index include data on contract labor?
- Should the definition of contract services in the wage index survey be expanded to include services indirectly related to patient care, such as billing or housekeeping services?

A majority of the commenters supported the inclusion of contract services, and many argued for the expansion of contract labor services to include indirect patient care services. Those opposed to including contract services, in addition to some commenters who supported including contract service costs, were concerned about the difficulty of accurately tracking and recording hours worked for all types of contract labor. Other commenters were also concerned that if a hospital contracts for services from outside its labor market area, the contract wages could artificially increase or decrease the hospital's area wage index. Based on the comments and the overall poor quality of the 1988 survey data, we decided to exclude all contract labor from the FY 1991 wage index.

We stated that we would continue our analysis of contract labor. In addition, we announced that we would develop a new wage index survey with improved

instructions and auditing criteria to facilitate the inclusion of contract labor in future wage index updates. The new survey, Worksheet S–3, Part II, was included in the hospital cost report effective with cost reporting periods beginning on or after October 1, 1989.

The Worksheet S–3, Part II consists of detailed information for use in the hospital wage index including contract labor for direct patient care services. In the instructions for completing this worksheet, contract labor costs and hours were limited to labor-related payments and hours attributable to direct patient care contract services, such as nursing services. Specifically, we instructed hospitals to exclude indirect patient care contract services (for example, management and housekeeping services), nonlabor-related expenses (for example, equipment and supplies), and any contract services for which labor-related payments and hours could not be accurately determined.

In the September 4, 1990 final rule (55 FR 36036), we discussed additional comments we received on the contract labor issue. Those commenters who supported the inclusion of contract labor stated that some hospitals, especially rural hospitals, are dependent on contract labor for nursing services, and it would be unfair not to include these wage data. Other commenters requested that the definition of contract labor be expanded to include indirect patient care services.

We also received several comments requesting that we continue to exclude contract labor from the wage index. These commenters stated that the contract labor data are not reliable because of the difficulty in tracking and reporting hours and the lack of consistency in the reporting of contract labor. In addition, inclusion of nonlabor contract costs would inappropriately drive up labor costs, and contract labor brought in from outside the labor market area would artificially increase or decrease the area wage index value. Finally, commenters were concerned that contract labor costs are too variable, temporary, and not reflective of true wage costs. Therefore, some suggested that contract labor should not be included in the wage index.

The FY 1994 wage index, which was based on the data collected on the Worksheet S–3, Part II, was the first to include direct patient care contract labor costs. In making the decision to include these costs, we analyzed hospitals' FY 1990 data to determine if it was sufficiently complete for inclusion in the wage index calculation (see the May 26, 1993 proposed rule (58 FR 30236)). We noted that, in most labor market areas, including contract labor in the wage index computation had little effect on the average hourly wage. We further stated that, based on our analysis of the data, including direct patient care contract labor would more accurately and fairly reflect wage levels across hospitals and MSAs. In the September 1, 1993 final rule, we also responded to comments from the hospital industry expressing concern that we did not recognize the costs of certain contract management services (58 FR 46296). In particular, many rural hospitals stated they were either unable to recruit or afford top managers such as hospital administrators and must contract for these services.

In the September 1, 1994 final rule (59 FR 45355), we expanded the definition of contract labor for purposes of determining the hospital wage index to include the personnel costs and hours associated with certain contract management personnel. Contract management services would be limited to individuals working in the top four positions in the hospital: the Chief Executive Officer/Hospital Administrator, Chief Operating Officer, Chief Financial Officer, and Nursing Administrator. We noted that while exact titles may vary, individuals should be performing essentially the same duties as customarily assigned these management positions.

We further noted that, since the cost report did not provide at that time for the collection of management contract data, this revised definition would not be effective until cost reporting periods beginning on or after October 1, 1994 (FY 1995). Hospitals were instructed to continue to exclude all management contract costs and hours until the FY 1995 data were reported (these data will be used to compute the FY 1999 wage index). In addition, we began requiring hospitals to provide descriptions and aggregate totals for all management contracts and complete details on all direct patient care contracts on the Form HCFA–339 (the Provider Cost Report Reimbursement Questionnaire). A hospital must file this form with its corresponding cost report.

We continue to receive requests that we expand our contract labor definition to include more types of contract services in the wage index. In particular, we have been asked to include the costs for pharmacy and laboratory services on the basis that these services are consistent with our definition of direct patient care (see the September 1, 1995 final rule (60 FR 45792)). Others have asked that we expand our definition to include all contracted services, both direct and indirect patient care services, in order to more appropriately calculate relative hospital wage costs.

We have limited the contract services that are included in the wage index to direct patient care services and specific management services for several reasons. First, hospitals reported difficulty in accurately tracking the hours associated with contract services, especially for off-site facilities that serve more than one hospital. Second, we are concerned about the contractor's ability to separate nonlabor costs from labor costs. We believe that the generally higher costs for contract labor compared to salaried labor, due at least in part to the added costs of overhead and supplies not separately identified in most contracts, may distort the wage index. Finally, we are concerned that it is difficult to remove the costs and hours for services such as legal and accounting from total management contracts.

Our goal is to ensure that our wage index policy continues to be responsive to the changing need for contract labor, allowing those hospitals that must depend on contract labor to supply needed services to reflect those costs in their wage data. At the same time, however, we wish to avoid providing an opportunity for hospitals to inflate their average hourly wage inappropriately by including nonlabor contract costs. The advantage of our approach of including only contract labor costs and hours associated with direct patient care and specific management services is that it minimizes distortions in the wage index that are due to a hospital's inability to identify and exclude nonlabor costs. While changes to the wage index values are made in a budget neutral manner and are not expected to affect aggregate payments, we strive for policies that are equitable for all hospitals.

Finally, due to the 4-year time lag between the cost reporting period itself and the fiscal year when data for that period are used in calculating the wage index, it is important that we anticipate any need to change our policy on contract labor. Therefore, in order to formulate the most responsive and responsible policy, we solicited comments on the following issues:

- To what extent do hospitals rely on the use of contract services?
- For which services are contracts typically used?
- Can hospitals accurately determine hours related to contract services?
- Can hospitals accurately isolate labor-related costs from nonlabor-related costs?
- Should the contract labor definition be expanded to include contract

services indirectly related to patient care?

- If contract labor remains limited to direct patient care, what categories of services, if any, in addition to those identified above, should be included?
- Would the wage index more accurately reflect relative wage levels if we did not limit contract labor to direct patient care (generally high wage) services?
- Would expanding the types of contract labor that are included in the wage index provide less incentive to hospitals to keep their labor costs low, as higher labor costs may result in a higher wage index value for that hospital or allow it to reclassify to a labor market with a higher wage index?
- What other issues should be considered in revising the policy for including contract labor in the wage index?

2. Discussion of Comments

We received 27 individual letters addressing the issue of contract labor in the wage index. We appreciate the time and attention of all of the commenters. The information provided has already increased our understanding of the issue, and we intend to include in our future analyses an evaluation of many of the points made by commenters. The remainder of this section discusses the comments—first by responding to the general comments we received and some specific policy questions, then summarizing all of the responses we received to the questions listed above. Although we do not respond directly to these latter comments, they will aid us in our future consideration of this issue.

Comment: One commenter who represents a national association of health systems noted that most of the issues raised by us in the proposed rule were addressed by a special wage index Medicare Technical Advisory Group (MTAG) work group. The commenter stated that ''(a)fter considering all these issues in the MTAG work group, HCFA decided to limit the inclusion of contract labor to direct patient care services. This was because, in general, these services are in revenue producing cost centers that have higher personnel costs (such as nursing services) where the treatment of contract labor in determining the wage index would have the greatest impact on hospitals. Also, these areas generally have had fewer problems than contract services provided in the overhead departments where average personnel costs are lower. Patient care contract labor is more often billed on an hourly rate, and because these are direct patient care services, they are generally performed by personnel working on the hospital premises and therefore include less indirect overhead cost from the contract organization. On the other hand, contract labor costs related to overhead departments normally has lower average cost, often includes more indirect overhead, and often the related hours are not available.''

Response: We appreciate this commenter's past contributions into the development of our contract labor policies and believe that the commenter has presented a generally correct characterization of our rationale for our current policy on contract labor costs. However, as noted above, we are concerned that our policy continue to accurately measure wage costs in a rapidly changing hospital environment and, therefore, have solicited public input into our future policy considerations.

Comment: Several commenters, including ProPAC, supported the principle that all contract labor costs should be included in calculating the wage index if they would have been included had the contract workers been employees of the hospital; but the commenters recognized the problems of accurately collecting contract labor costs. The Commission suggested that, in light of the increasing importance of adjusting payments to reflect input price variations in multiple settings with the accelerating integration of health care delivery, a need exists for a more comprehensive strategy for obtaining geographic input price data. Finally, ProPAC indicated it would ''be pleased to work with HCFA staff to develop and explore feasible approaches to a solution.''

Response: We agree that, in principle, the wage index should measure labor costs across hospitals without regard to who employs the workers if such costs reflect relative wage levels and can be identified. We also agree that, as health care delivery becomes more integrated, so do the labor costs. Of course, we have increasingly been concerned with this issue as we have worked to develop prospective payment systems for various provider types. Therefore, we appreciate ProPAC's offer of cooperation in this regard and look forward to working together to address these issues.

Comment: Several commenters disagreed with our definition of direct patient care contract labor, specifically, the exclusion of the costs of contracted laboratory and pharmacy services. One commenter stated that a preferable definition would include services that are directly identifiable and billable to individual patients. Laboratory and pharmacy services would be included in this definition. Another commenter called our exclusion discriminatory toward rural hospitals as rural hospitals are more likely to contract for a pharmacist than are urban facilities. This commenter stated that pharmacists do have direct patient care contact, noting that they dispense drugs to patients, provide patient education, and are required to participate on ''interdisciplinary patient care'' teams.

Response: While there may be some direct patient care contact in providing laboratory and pharmacy services, the amount varies across hospitals and is only a portion of the total time spent providing service to a hospital. As we noted in the proposed rule, one of the reasons we have limited the types of contract services included in the wage index calculation is that hospitals reported difficulty tracking the hours associated with off-site facilities that serve more than one hospital. Our experience and other comments we received indicate this is also the case for contracted laboratory and pharmacy services. For example, it is possible that a contracted pharmacist would spend part of an hour preparing medications for patients in more than one hospital.

We recognize the necessity for many hospitals, particularly small and rural hospitals, to contract for pharmacy and laboratory services, which are likely to be relatively costly. In fact, this is one of the issues that led us to solicit public input into how our contract labor policy may be improved. We believe that the insight from the comments we received, as well as continuing communication with the hospital industry, will ultimately help to resolve these difficult issues.

Comment: Several commenters representing hospital associations recommended that we reinstitute an MTAG to ''assist in developing the materials and definitions needed to implement these changes in collecting contract labor data * * *'' Other commenters recommended the initiation of a pilot study in selected regions to determine whether ''using (contract labor) costs in the wage index methodology are worth the collection effort.''

Response: Again, we appreciate the volume of the responses we received. Over the next few weeks, we will review our options for pursuing the reinstitution of an MTAG to evaluate the need to revise our policy on contract labor. We will also contact many of the national and State hospital associations that responded to our solicitation for further input.

Comment: Several commenters pointed to the need for greater clarity regarding our definition of contract labor. There was a call for a ''universal model and criteria'' for fiscal intermediaries to follow in determining allowable contract labor costs. One commenter submitted an example of what such a model could look like.

Response: We have provided more detailed cost report instructions for reporting contract labor in periods beginning on or after October 1, 1995. We will also include these more detailed instructions in the desk reviews of the FY 1995 cost reports. In addition, on FORM HCFA–339 (the Provider Cost Report Reimbursement Questionnaire), we require hospitals to provide detailed information on contract labor costs currently included in the wage index calculation. This information consists of descriptions and aggregate costs and hours for top management contracts and costs and hours for each type of direct patient care contract.

We will, however, continue to pursue opportunities for policy improvement. In that regard, we welcome the suggestions we received in response to the proposed rule, and encourage further input from interested parties in the future.

Below, we summarize the comments we received in response to the specific questions listed in the proposed rule. Again, we note that while we are not responding to these comments here, we intend to take them into consideration in our future analysis of this issue.

• To what extent do hospitals rely on the use of contract services?

According to the comments received, hospitals, particularly those in rural areas and smaller cities, rely on contract labor for a variety of services. In general, hospitals have begun to reduce ongoing labor costs by employing contract personnel in many operational areas. Because of fluctuating patient volumes, contract labor is a more cost effective alternative to direct hiring. Furthermore, some States prohibit the direct hiring of certain health care personnel; thus, these positions must be contracted. Hospitals located in areas experiencing shortages in health care personnel such as nurses and pharmacists also rely heavily on contract labor.

• For which services are contracts typically used? Virtually all of those who commented stated that hospitals contract for nursing and therapy (occupational, physical, respiratory, speech) services. Most commenters mentioned the following as services for which hospitals contract: radiology (including mammography and ultrasound); anesthesia; dietary (including therapeutic); psychological and social; pharmacy; laboratory and pathology; emergency room; medical records; housekeeping, laundry, and central supply; clerical; legal; accounting and audit; facility and equipment maintenance; and environmental. The following services were also mentioned by at least one commenter: surgery (technicians); air ambulance; management (e.g., medical director); information systems management; education; and biomedical engineering. Based on these comments, hospitals contract for every category of labor.

• Can hospitals accurately determine hours related to contract services?

Most commenters stated that hospitals could accurately determine hours related to contract services, particularly for contracts billed on an hourly basis and for services such as laboratory, pharmacy, and management. Some commenters explained that their hospitals have established methods for tracking hours, such as time sheets maintained for hourly workers, or invoices that include the hours worked and the hourly rate. Others commented that, if necessary, systems to track hours (for example, log-in sheets) could easily be instituted. Several others suggested that hospitals could more accurately report hours associated with contract services if HCFA clarified the contract labor definition, developed acceptable methods for tracking hours and associated costs, and developed a universal model and criteria for the fiscal intermediaries to follow in auditing contract labor costs and hours.

A few commenters stated concerns that hospitals may not be able to accurately report contract labor hours. One suggested there may be difficulty in reporting hours in situations where the contractor serves more than one client. One hospital explained that for some services, it does not report hours, or it relies on the contractor to supply the hours. For services such as physical therapy, this hospital pays contractors based on a percentage of revenue generated. One hospital association stated that hospitals may not be able to accurately determine the hours for services such as laundry, dietary, housekeeping, and maintenance. Another association explained that, while hospitals in its area are required to report contract hourly rates and hours for nonpatient care cost centers, evidence suggests that the data for many hospitals may not be completely accurate, reflecting the difficulty of capturing such detailed information.

• Can hospitals accurately isolate labor-related costs from nonlabor-related costs?

Several commenters stated that hospitals can accurately isolate labor-related costs from nonlabor-related costs using invoices. One commenter explained that for services with little or no nonlabor costs, such as laboratory, pharmacy, and management, there is no need to identify and isolate these costs.

On the other hand, one commenter suggested there may be difficulty in reporting hours in situations where the contractor serves more than one client. One hospital stated that it does not separate labor and nonlabor costs. One association stated that contracts for services such as laundry, dietary, housekeeping, and maintenance may include more nonlabor costs and may be more difficult for hospitals to isolate nonlabor costs. Another association believes that intermediaries are inconsistent in handling nonlabor costs and that HCFA needs to develop better guidelines.

• Should the contract labor definition be expanded to include contract services indirectly related to patient care?

The majority of the commenters support expanding the definition of contract labor to include services indirectly related to patient care. Two commenters stated that, in principle, all contract labor costs and hours should be included if they would have been included had the workers been employed by the hospital. Two commenters responded that excluding contract labor services understates the cost of providing patient services and puts hospitals at a disadvantage. Two others commented that HCFA's definition of direct patient care is too restrictive and should be revised to include services that can be identified and billed separately and are not included in the routine care charge. One commenter, although in support of including indirect patient care contract services, recognized that considerable review would be necessary to determine which labor costs should be included as contract labor. Another commenter noted that reporting additional types of contract labor should not be considered an unnecessary burden. Two associations expressed concern that excluding large labor expenses, for services such as dietary and housekeeping, may create inconsistencies across labor market areas. Some commenters also suggested that we include the following services (that we consider indirectly related to patient care) in the definition of contract labor: pharmacy, dietary, clerical,

housekeeping and environmental, accounting and audit, legal, consultant, and medical director.

Some commenters, including five large hospital associations, expressed concern over expanding the definition of contract labor to include indirect patient care services. Two commented it would add considerably to the complexity of tracking costs and determining which services should be included or excluded. One commenter added that, based on its analyses, it would be difficult to collect reliable data and that including contracted indirect patient care costs would have only a minor impact on the wage index. Another commented that problems that exist with contract labor data are more prevalent in nonrevenue producing areas.

• If contract labor remains limited to direct patient care, what categories of services, if any, in addition to those identified above, should be included?

Commenters named the following services as those that should be included in the direct patient care definition of contract labor: dietary, anesthesia, social, pharmacy, laboratory, pathology, medical records, equipment maintenance, environmental management, central supply, and all clinical services.

• Would the wage index more accurately reflect relative wage levels if we did not limit contract labor to direct patient care (generally high wage services)?

Five hospitals and ProPAC commented that the wage index would more accurately reflect relative wage levels if we did not limit contract labor to direct patient care. One stated that failure to include all contract labor could result in major biases in the wage index because contract services may vary substantially among types of hospitals and across labor market areas. Two rural hospitals argued that the current policy discriminates against rural hospitals because they are more likely to have to contract pharmacists and other personnel because of employee shortages in their wage areas.

Three associations and a hospital commented that the wage index would not more accurately reflect relative wage levels if we did not limit contract labor to direct patient care. One explained that the results would not be more accurate by adding or subtracting categories of care; rather, the key to an accurate calculation is that the components are consistent for all hospitals, not how many components are included. Another added that, based on its analyses, including contracted indirect patient care costs would have only a minor impact on the wage index. A third commenter expressed concern that the time necessary at the hospital level to obtain this information and the time necessary for the intermediary to review such information would not be cost effective.

• Would expanding the types of contract labor that are included in the wage index provide less incentive to hospitals to keep their labor costs low, as higher labor costs may result in a higher wage index value for that hospital or allow it to reclassify to a labor market with a higher wage index?

Commenters were unanimous in their belief that expanding the types of contract labor that are included in the wage index would not provide less incentive to hospitals to keep their labor costs low. Several commenters explained that hospitals in today's environment have every incentive to keep their costs down. Because Medicare is only one payer, allowing labor costs to increase for improved Medicare payment would put hospitals in an uncompetitive position as far as other payers are concerned. Also, it would take 4 years for those costs to be reflected in the wage index. One of them added that it is difficult to conceive of any situation in which a hospital would benefit from paying higher labor rates than necessary.

• What other issues should be considered in revising the policy for including contract labor in the wage index?

An association, located in a mostly rural State, suggested that changes to expand contract labor should be made as soon as possible to provide a more accurate and equitable wage index for all hospitals.

E. Puerto Rico Wage Index Values

For several years, hospitals in Puerto Rico have experienced large swings in their wage index values. We recognize that large shifts in the wage index values can cause shifts in the payment levels for a particular MSA. Because three of the six MSAs in Puerto Rico (Aguadilla, Arecibo, and Caguas) as well as the rural area have four or fewer hospitals, a large change in one hospital's wage data can cause a large increase or decrease in the wage index value for the entire MSA. One possible method to limit these annual swings in wage index values would be to create a single labor market area encompassing all the hospitals in Puerto Rico. That is, the six MSAs and the rural area could be combined into one area with one wage index value. A single labor market area would create a much larger set of hospitals to develop aggregate wage amounts and would mitigate situations where a change in the wage data of a single hospital has a large effect on the wage index of an MSA.

If we created a single labor market area for Puerto Rico, we would do so in a budget neutral manner; therefore, the effect would be to raise wage index values for some hospitals in Puerto Rico and to lower the values for others. Because of the negative effect on some hospitals, rather than propose such a change, we solicited comment on this approach for mitigating the fluctuations in wage index values for hospitals in Puerto Rico. We noted that the potential change would have no impact on hospitals outside Puerto Rico. We received five comments in response to our solicitation. These comments and our responses are set forth below.

Comment: All of the commenters expressed grave concern regarding the creation of a single MSA in Puerto Rico for purposes of the wage index. Most commenters objected to the negative impact this proposal would have on the wage index values of high wage areas. One commenter protested the elimination of large urban status for the San Juan MSA. Two commenters were concerned about the effect this change would have on hospitals that are able to reclassify through the MGCRB. One commenter noted that HCFA relies on OMB for MSA designations and OMB has not approved this change. Finally, a commenter stated that a single labor market area would not recognize the difference between tertiary and secondary hospitals.

Response: We solicited comment on consolidating Puerto Rico into one labor market area because it was one method for addressing swings in wage index values within Puerto Rico without adversely affecting hospitals outside Puerto Rico. Since commenters do not favor this approach, we will not pursue the option. We note that this approach would not have eliminated large urban status of the San Juan MSA for standardized amount purposes. Puerto Rico would have been treated as one labor market area solely for wage index purposes.

We have recently met with representatives of the Puerto Rico Hospital Association to explore other solutions to the problems faced by hospitals in the Commonwealth. In reviewing the latest Medicare cost report data available, we find that hospitals in Puerto Rico continue to demonstrate average Medicare operating margins comparable to all other prospective payment hospitals.

Comment: One commenter urged an add-on adjustment of not less than 7

percent to the Puerto Rico standardized amounts to account for the penalty resulting from the use of temporary cost allocation methods by government hospitals with a noncharge structure in Puerto Rico.

Response: We do not believe it is appropriate to adjust the standardized amounts of Puerto Rico for those government hospitals with a noncharge structure when we have not adjusted the national standardized amounts applicable to all other hospitals to account for government hospitals with noncharge structures that are located in the 50 States and the District of Columbia. We believe the prospective payment system should be fair and equitable to all hospitals, no matter where they are located.

Comment: A commenter requested that we establish a wage index floor for the labor market areas in Puerto Rico.

Response: The wage index measures relative wage levels across labor market areas. Since Puerto Rico labor market areas have not increased wages at the same average rate as all other hospitals, their wage index values have decreased accordingly. If we were to create a floor, it would improperly benefit labor market areas whose wages are not in line with the national experience. The hospitals receiving the floor wage index would receive artificially high DRG payments.

In addition, we note that, if such a change were to ever be adopted, it would be implemented in a budget neutral manner. Thus, a wage index floor for hospitals in Puerto Rico would result in lower payments to other hospitals.

Comment: Two commenters suggested that we eliminate the Puerto Rico rural area classification and classify those hospitals to the nearest MSA.

Response: We do not believe it is appropriate to offer special treatment to hospitals located in the rural area of Puerto Rico. While we acknowledge certain limitations in the current geographic classification system, we have yet to find a system that is demonstrably better. (See the discussion on labor market area research in the June 2, 1995 proposed rule (60 FR 29218).) Unless 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 rural hospitals in Puerto Rico may apply for geographic redesignation under the same criteria as all other hospitals and that some hospitals in rural Puerto Rico have been approved for reclassification.

Comment: One commenter suggested that OMB review the San Juan MSA for possible redesignation of certain San Juan municipalities to other urban areas.

Response: As acknowledged by the commenter, it is OMB that makes the determination of which municipalities are included in a particular MSA. We believe that OMB uses the same criteria to create the San Juan MSA as it does for all other MSAs. We urge the commenter to forward any suggestions directly to OMB for its consideration.

F. Changes to the MGCRB Composition and Criteria

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. Guidelines concerning the criteria and conditions for hospital reclassification are located at §§ 412.230 through 412.236. The purpose of these criteria is to provide direction, to both the MGCRB and those hospitals seeking geographic reclassification, with respect to the situations that merit an exception to the rules governing the geographic classification of hospitals under the prospective payment system. The composition of the MGCRB and the procedures it follows in making reclassification determinations are set forth in §§ 412.246 through 412.280.

In the May 31, 1996 proposed rule, we proposed one change to the MGCRB regulations. In addition, we requested comments on sources of data that could be used to identify the occupational mix in a given MSA.

1. MGCRB Composition (§ 412.246)

Section 1886(d)(10)(B)(i) of the Act provides that the MGCRB is composed of five members appointed by the Secretary. This provision is implemented in regulations at § 412.246(a). Two of the members must be representative of the concerns of rural hospitals and at least one member must be knowledgeable in the field of analyzing costs of providing inpatient hospital services. Under current § 412.246(b), the term of office for an MGCRB member is 3 years, and appointments are limited to two consecutive 3-year terms. This section further provides that to permit staggered terms of office, initial appointments may be for shorter terms. Finally, the Secretary is permitted to terminate a member's tenure before his or her full term has expired.

In the proposed rule, in order to allow the Secretary maximum flexibility to recruit and retain qualified Board members, we proposed to eliminate the current requirement at § 412.246(b) that a Board member can serve for only two consecutive 3-year terms and to provide that an appointment to the MGCRB may be for any term not to exceed 3 years.

Under the proposed revisions, the Secretary would continue to be able to terminate a member's tenure before his or her full term has expired.

We received no comments on this proposal, and we have incorporated it as final in this document.

2. Occupational Mix Adjustment

Section 1886(d)(10)(D)(i) of the Act requires the Secretary to publish guidelines to be used by the MGCRB in rendering decisions on applications submitted for geographic reclassification. Those are to include guidelines for ''comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.''

Section 412.230(e) describes the criteria for hospital reclassification for purposes of the wage index. One of the criteria relates to the relationship between the hospital's wages and those of the area to which it seeks reclassification. Specifically, § 412.230(e)(1)(iv) provides that the hospital must demonstrate that its wages are at least 84 percent of the average hourly wage of hospitals in the area to which it seeks reclassification, or that the hospital's average hourly wage weighted for occupational mix is at least 90 percent of the average hourly wage of hospitals in the area to which it seeks reclassification. Under §§ 412.232(c) and 412.234(b), a group of hospitals seeking to reclassify must demonstrate that its aggregate average hourly wage is at least 85 percent of the average hourly wage of the hospitals in the area to which it seeks reclassification. These sections also provide that the threshold for occupational-mix adjusted hourly wage for hospital groups is the same as that for a single hospital, that is, 90 percent.

In the September 6, 1990 interim final rule (55 FR 36760), we stated that the acceptable sources for occupational mix data were the American Hospital Association (AHA) or the Bureau of Labor Statistics. Since publication of that document, the Bureau of Labor has discontinued its hospital wage surveys. Thus, the only currently acceptable occupational mix data source is the AHA Survey Data. We have been informed by the AHA that the survey for 1993 will be the last survey to collect information on the Hospital Personnel by Occupational Category. Therefore,

requests filed on or before October 1, 1996 for FY 1998 reclassification, which use FY 1993 wage data, may be the last for which we have an appropriate source of occupational mix data.

As we stated in the June 4, 1991 final rule with comment period (56 FR 25458), the reclassification process requires the use of occupational mix data that are comparable across areas and can be consistently applied. We are unaware of any sources other than the AHA data that meet these criteria.

As noted in the proposed rule (61 FR 27459), we did not propose collecting occupational mix data ourselves in light of past experience. Instead, we solicited suggestions about any occupational mix data sources that are available on a national basis. In addition, we indicated that we were willing to consider suggestions about other methods that would account for occupational mix in the wage index reclassification process.

Comment: We received three comments on this issue. One commenter believes that collection of the occupational mix data is burdensome, that the data are unreliable, and that we should therefore eliminate the use of such data. One commenter urged that the AHA continue to collect the data for HCFA. The final commenter suggested that we consider using the Geographic Reference Report to obtain occupational mix information. That commenter noted, however, that this collection effort would have to be expanded for our use.

Response: The AHA has notified us that it does not have enough demand for these data to warrant continued collection. Generally, the AHA, as well as HCFA, have found that hospitals do not want to provide occupational breakdowns in a survey format. The Geographic Reference Report would have to be expanded and tailored to fit our needs, which means that it would be unavailable for at least several years as a data source for this purpose. As there is no readily available data source that can be used immediately to represent occupational mix data for the purposes of reclassification applications, it appears that we will be unable to continue to use such data as an alternative for hospital reclassification applications. However, since the 1993 AHA data are available for reclassification requests for FY 1998, we will not make a final decision in this rule. If a suitable source of occupational mix data becomes available in the next year, we will consider using it beginning with reclassifications for FY 1999.

Comment: We received one comment from a hospital that was concerned that it might not qualify for reclassification for purposes of using the wage index of a proximate area because it could not meet the 108 percent qualifying criteria. This commenter noted that the hospital is located in an area where it materially influences the average hourly wage in its area, but it does not dominate the area. The commenter believes that the current criteria disadvantages such a hospital, because it can no longer meet the 108 percent threshold for reclassification.

Response: We have addressed similar comments a number of times. The purpose of the reclassification wage criteria is to identify situations in which a hospital would receive more appropriate payments if it were redesignated to another area. The 108 percent criterion in particular is designed to identify situations in which a hospital is significantly disadvantaged by its current geographic classification. If a hospital's wages are less than 8 percent higher than the average hourly wage in the hospital's labor market area, we believe the hospital is not significantly disadvantaged by the payments it would receive and, therefore, geographic reclassification is not appropriate.

Comment: One commenter requested confirmation of the process by which a group of hospitals withdraw its application for reclassification. The commenter believes that all the hospitals must be a party to the withdrawal request.

Response: The commenter is correct. The regulations at § 412.273(b) clearly state that all hospitals that are party to the application must request the withdrawal in writing. Therefore, a request to withdraw an approved application by the MGCRB must be agreed upon and requested in writing by the entire group.

IV. Rebasing and Revising of the Hospital Market Baskets

A. Operating Costs

1. Background

Effective for cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital ''market basket'') for operating costs. Although ''market basket'' technically describes the mix of goods and services used to produce hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket'' as used in this document refers to the hospital input price index.

The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchase in order to furnish inpatient care. We first used the market basket to adjust hospital cost limits by an amount that reflected the average increase in the prices of the goods and services used to furnish hospital inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the hospital inpatient prospective payment system on October 1, 1983, we continued to use the hospital market basket to update each hospital's 1981 inpatient operating cost per discharge used in establishing the FY 1984 standardized payment amounts. In addition, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. Under section 1886(b)(3)(B)(i)(XII) of the Act, the prospective payment rates will be updated in FY 1997 by the projected increase in the hospital market basket minus 0.5 percentage points. A detailed explanation of the hospital market basket used to develop the prospective payment rates was published in the Federal Register on September 3, 1986 (51 FR 31461). For additional background information on general development of hospital input price indexes, we refer the reader to the article by Freeland, Anderson, and Schendler, ''National Hospital Input Price Index,'' *Health Care Financing Review*, Summer 1979, pp 37–61. We also refer the reader to the September 4, 1990 Federal Register (55 FR 35990) in which we discussed the previous rebasing of the hospital input price index.

The hospital market basket is a fixed-weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for mutually exclusive and exhaustive spending categories based upon type of expenditure. Then, the proportion of total costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price/wage variable, referred to as a price proxy. These price proxies are price levels derived from a publicly available statistical series published on a consistent schedule, preferably at least on a quarterly basis. Third and finally, the price level for each spending category is multiplied by the expenditure weight for that category. The sum of these products (that is, the

expenditure weights multiplied by the price levels) for all cost categories yields the composite index level in the market basket in a given year. Repeating this step for other years produces a series of market basket index levels over time. Dividing one index level by an earlier index level produces rates of growth in the input price index.

The market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services purchased subsequent to the base period are not considered. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed weight hospital market basket.

We believe that it is desirable to rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) in furnishing inpatient care. We last rebased the hospital market basket cost weights effective for FY 1991. This market basket, still used through FY 1996, reflected base year data from FY 1987 in the construction of the cost weights.

In its April 1, 1985 report to the Secretary (Appendix C of the June 10, 1985 proposed rule (50 FR 24446)), ProPAC supported HCFA's position on periodic rebasing, stating that the market basket cost weights should be recalculated or ''rebased'' at least every 5 years, or more frequently if significant changes in the weights occur. We note that there are separate market baskets for prospective payment hospitals and hospitals and hospital units excluded from the prospective payment system. The separate, excluded hospital market basket is set forth in section IV.A.5 of this preamble.

2. Rebasing and Revising the Hospital Market Basket

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, we are moving the base year cost structure from FY 1987 to FY 1992). Revising means changing data sources, cost categories, or price proxies used in the input price index.

We are adopting a rebased and revised hospital market basket in developing the FY 1997 update factor for the prospective payment rates. The new market basket has been rebased to reflect 1992, rather than 1987, cost data.

In developing the rebased and revised market basket, we reviewed hospital operating expenditure data for the market basket cost categories. In a change from the previous methodology, we relied primarily on Medicare hospital cost report data for the rebasing. For the rebased market baskets, we used data on hospital expenditures for four major expense categories (wages and salaries, employee benefits, pharmaceuticals, and a residual ''all other'') from hospital cost reporting periods beginning in FY 1992 (that is, periods beginning on or after October 1, 1991 and before October 1, 1992). We refer to these as PPS–9 cost reports (the 9th year of the prospective payment system (PPS)). The market basket was previously based on 1987 expense data from the 1988 American Hospital Association (AHA) Annual Survey.

Expenses for wages and salaries, employee benefits, and pharmaceuticals were determined using data from PPS–9 cost reports as reported in the Hospital Cost Report Information System (HCRIS) files. We determined total professional fees using AHA Annual Survey data. Total professional fees include medical and nonmedical professional fees. Since the medical professional fees included in the compensation of provider-based physicians are paid under Medicare Part B, we analyzed HCRIS data to determine the professional component of provider-based physician compensation and subtracted it from total professional fees to obtain an estimate of nonmedical professional fees. Malpractice insurance costs were determined using the cost share for PPS–6 (cost reporting periods beginning in FY 1989), the last year these costs had to be treated separately from all other administrative and general costs, trended forward to 1992 based on the relative importance of malpractice costs found in the previous market basket. The All Other Expenses category was calculated in two steps. First, from PPS–9 cost reports, total operating expenses were tabulated by subtracting capital-related expenses, direct medical education expenses, and the medical professional fees from total expenses. Second, we subtracted the total of the five cost category expenses already determined from total operating expenses to obtain the All Other Expenses category.

After totals for these main cost categories (wages and salaries, employee benefits, professional fees, pharmaceuticals, malpractice insurance, and all other expenses) were calculated, we then determined the proportion each category represents of the total costs. These proportions represent the major rebased market basket weights. The differences between the six major categories for the 1992-based index and the previous 1987-based index are summarized in Table 1 below.

TABLE 1.—COMPARISON OF 1992 AND 1987 PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS

Expense categories	Rebased 1992 hospital market basket	1987-based hospital market basket
Wages and salaries	50.244	52.2
Employee benefits	11.146	9.5
Nonmedical professional fees	2.127	1.6
Malpractice insurance	1.189	1.4
Pharmaceuticals	4.162	3.9
All other	31.132	31.4
Total	100.000	100.0

Note: Although we rounded the weights to the tenths decimal position in the 1987-based market basket as published in the September 4, 1990 final rule, we are presenting the 1992 weights in greater specificity.

Table 2 sets forth the market basket cost categories, weights, and price proxies. Weights for the ''Utilities'' and the ''All Other'' cost categories, as well as the subcategories, were determined using the 1987 Department of Commerce's Bureau of Economic Analysis (BEA) Input-Output Table, from which data for the hospital industry were extracted. The BEA Input-Output database, which is updated at 5-year intervals, was most recently described in the Survey of Current Business, ''Benchmark Input-Output Accounts for the U.S. Economy, 1987'' (April 1994). To date, the Department of Commerce has not released final 1992 cost data. Therefore, we plan to incorporate these data into the FY 1998 proposed rule.

We aged the 1987 cost shares to 1992 using historical price changes between 1987 and 1992 for each category. The aged shares were normalized to be consistent with the 1992 hospital cost report data. Relative weights for the new base year were then calculated for various expenditure categories. This work resulted in the identification of 26 separate cost categories in the rebased hospital market basket, two fewer categories than were included in the 1987-based market basket. Detailed

descriptions of each category and respective price proxy are provided in Appendix C to this final rule.

TABLE 2.—1992–BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	Rebased 1992 hospital market basket	Price proxy
1. Compensation	61.390	
A. Wages and salaries*	50.244	HCFA occupational wage index.
B. Employee benefits*	11.146	HCFA occupational benefits index
2. Professional fees*	2.127	ECI—compensation for professional, specialty and technical.
3. Utilities	2.469	
A. Fuel, oil, and gasoline	0.345	PPI refined petroleum products.
B. Electricity	1.349	PPI commercial electric power.
C. Natural gas	0.670	PPI commercial natural gas.
D. Water and sewerage	0.106	CPI–U water and sewerage maintenance.
4. Professional liability insurance	1.189	HCFA professional liability insurance premium index.
5. All other	32.824	
A. All other products	24.033	
(1.) Pharmaceuticals	4.162	PPI ethical (prescription) drugs.
(2.) Food	3.459	
a. Direct purchase	2.363	PPI processed foods and feeds.
b. Contract service	1.096	CPI–U food away from home.
(3.) Chemicals	3.795	PPI industrial chemicals.
(4.) Medical instruments	3.128	PPI medical instruments and equipment.
(5.) Photographic supplies	0.399	PPI photographic supplies
(6.) Rubber and plastics	4.868	PPI rubber and plastic products.
(7.) Paper products	2.062	PPI converted paper and paperboard products.
(8.) Apparel	0.875	PPI apparel.
(9.) Machinery and equipment	0.211	PPI machinery and equipment.
(10.) Miscellaneous products	1.074	PPI finished goods.
B. All other services	8.792	
(1.) Business services*	3.823	ECI—compensation for private workers in business services.
(2.) Computer services*	1.927	AHE computer and data processing services.
(3.) Transportation services	0.188	CPI–U transportation.
(4.) Telephone services	0.531	CPI–U telephone services.
(5.) Postage*	0.272	CPI–U postage.
(6.) All other: labor intensive*	1.707	ECI—compensation for private service occupations.
(7.) All other: nonlabor intensive	0.344	CPI–U all items.
Total	100.000	

*Labor-related.
NOTE: Due to rounding, weights may not sum to total.

The 1987-based market basket included a separate Blood Services cost category. In the 1992-based market basket, Blood Services is contained within the Chemicals cost category. In addition, the 1987-based cost category for Fuel Oil, Coal, etc. has been combined with the 1987-based Motor Gasoline cost category to form the 1992-based Fuel, Oil and Gasoline cost category. Both of these changes are based on revised cost categories from BEA. For comparison purposes, the 1987-based cost categories are set forth in Table 3.

TABLE 3.—1987-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	1987 hospital market basket	Price proxy
1. Compensation	61.7	
A. Wages and salaries*	52.2	HCFA occupational wage index.
B. Employee benefits*	9.5	HCFA occupational benefits index.
2. Professional fees*	1.6	ECI—wages and salaries for professional, specialty and technical.
3. Utilities	2.4	
A. fuel, oil, coal, etc.	0.6	WPI light fuel oils.
B. Electricity	1.1	WPI industrial power.
C. Natural gas	0.3	WPI natural gas.

TABLE 3.—1987-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES—Continued

Expense categories	1987 hospital market basket	Price proxy
D. Motor gasoline	0.2	WPI gasoline.
E. Water and sewerage	0.0	CPI–U water and sewerage maintenance.
4. Professional liability insurance	1.4	HCFA professional liability insurance premiums.
5. All other	32.8	
A. All other products	21.8	
(1.) Pharmaceuticals	3.9	WPI prescription drugs.
(2.) Food	3.3	
a. Direct purchase	2.1	WPI processed foods.
b. Contract service	1.2	CPI–U food away from home.
(3.) Chemicals	3.1	WPI industrial chemicals.
(4.) Medical instruments	2.7	WPI medical instruments and equipment.
(5.) Photographic supplies	2.6	WPI photographic supplies.
(6.) rubber and plastics	2.3	WPI rubber and plastic products.
(7.) Paper products	1.4	PPI converted paper and paperboard products.
(8.) Apparel	1.1	WPI textile house furnishings.
(9.) machinery and equipment	0.4	WPI machinery and equipment.
(10.) Miscellaneous products	0.8	WPI finished goods.
B. All other services	11.1	
(1.) Business services*	3.8	AHE business services.
(2.) Computer services*	2.0	AHE computer and data processing services.
(3.) Transportation services	1.2	CPI–U transportation.
(4.) Telephone services	1.0	CPI–U telephone services.
(5.) Blood services*	0.6	WPI blood and derivatives.
(6.) Postage*	0.4	CPI–U postage.
(7.) All other: labor intensive*	1.2	ECI—wages and salaries for private service occupations.
(8.) All other: nonlabor intensive	0.8	CPI–U all items.
Total	100.0	

*Labor-related.
NOTE: Due to rounding, weights may not sum to total.

In the September 4, 1990 final rule, for purposes of determining the labor-related portion of the standardized amounts, we summed 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) in the hospital market basket. This summation resulted in a labor-related portion of the hospital market basket of 71.4 percent and nonlabor-related portion of 28.6 percent. Under sections 1886 (d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of payments that are labor-related. Since October 1, 1990, then, we have considered 71.4 percent of costs to be labor-related for purposes of the prospective payment system.

In connection with the rebasing of the hospital market basket, we have reestimated the labor-related share of the standardized amounts. Based on the relative weights of the 1992-based prospective payment hospital market basket, as described in Table 2, the labor-related portion that is subject to hospital wage index adjustments (based on wages and salaries, employee benefits, professional fees, business services, computer and data processing, postage, and all other labor-intensive services) is 71.246 percent and the nonlabor-related portion is 28.754 percent. To implement this change, effective with discharges occurring on or after October 1, 1996, we recomputed the labor-related and nonlabor-related shares of the large urban and other areas' standardized amounts used to establish the prospective payment rates.

The amounts in Table 4 reflect the revised labor-related and nonlabor-related portions. Due to the Bureau of Economic Analysis' reclassification of Blood Services to Chemicals, we now allocate Blood Services to a nonlabor cost category. We note that, although there are revisions of the labor and nonlabor portions, due to both weight changes and the Blood Services category change, the labor-related portions of the rates published in Table 4 have remained essentially the same. The labor-related portion has decreased by 0.146 percentage points.

TABLE 4.—LABOR-RELATED SHARE

Cost category	Weight
Wages and salaries	50.244
Employee benefits	11.146
Professional fees	2.127
Business services	3.823
Computer services	1.927
Postal services	0.272
All other labor intensive	1.707
Total labor related	71.246
Total nonlabor related	28.754

Comment: Several commenters noted that because the prospective payment system hospital input price index directly measures changes in the price of labor for the overall economy as well as the changes in the prices of goods and services purchased by hospitals, if legislation is passed increasing the minimum wage in the United States the market basket update should be revised to reflect this change.

Response: The commenters are correct in asserting that an increase in the minimum wage should be appropriately reflected in the prospective payment system hospital input price index. The structure of the prospective payment

system hospital input price index is designed to track the historical increases in compensation for workers comparable to those employed in the hospital sector (as well as the prices of goods and services comparable to those purchased by hospitals). The blend of occupational data represents a composite of the types of labor that hospitals employ in the production of their services. The proxies selected by HCFA to represent these inputs are Employment Cost Indexes (ECIs) compiled by the Bureau of Labor Statistics for the relevant occupational categories. When the historical data for the period of the minimum wage increase becomes available, the ECIs automatically reflect the impacts of increases in the minimum wage. These proxies will therefore reflect any increases in wages and benefits associated with the legislated increase in the minimum wage.

The second quarter 1996 DRI/McGraw-Hill forecast of the prospective payment system hospital input price index, which is included in this final rule, reflects an anticipated increase in the minimum wage.

In the first quarter of 1996, HCFA commissioned DRI/McGraw-Hill to consider the effects of an increase in the minimum wage on the HCFA input price indexes. In its analysis, DRI/McGraw-Hill stated that the critical factor in determining the relative impact on each of HCFA's input price indexes in comparison with the economy-wide impact is the distribution of minimum wage workers associated with the occupational mix within each health sector. Data from the 1990, 5-percent Public Use Micro Data Survey (scaled for consistency with the nonfarm aggregate from the 1994 Current Population Survey) indicate that the share of all hourly workers at or below the minimum wage is approximately 3.3 percent for the health sector as a whole, versus an economy wide share of 3.6 percent. There is a wide variation in the importance of minimum wage workers across health industry sectors as well, ranging from a low of 2.0 percent for the workforce in hospitals, to a high of 9.3 percent for nursing-care related facilities. For the key wage proxies in the prospective payment system hospital input price index (ECI Civilian Hospital workers and the ECI for Professional-Technical workers) the share of minimum wage workers is negligible. The expected increase in minimum wage will likely affect the annual rates of increase in the prospective payment system hospital input price index in the range of about 0.1 percent.

Comment: One commenter noted that there are few who can afford to spend the time necessary to study the proposal to rebase and revise the hospital market baskets in its present form or hire an economist for an interpretation. The commenter suggests that HCFA could save valuable resources and, at the same time, simplify a process that is extremely complicated by using the overall cost data from the cost reports as a means of simplifying and arriving at an accurate market basket.

Response: The Medicare cost report is designed to track hospitals' costs for services that are covered by Medicare. Expenditures or costs are determined by the price of inputs for a particular good or service times the quantity of that input good or service that is used. An increase in costs could result from input price growth (inflation) or growth in the quantity of services used. It is essential to understanding the growth in Medicare program costs to have a rigorous framework for distinguishing the effects of input price growth from the effects of increases in the quantity of inputs. A measure based upon overall cost data from the cost reports, while appearing to simplify the process, would not separate input price changes from changes in the quantity of inputs and consequently would not serve the needs of government or industry.

We do appropriately use Medicare cost report data in developing weights for the Medicare input price indexes. The 1992 base year weights for the four core operating categories (wages and salaries, employee benefits, pharmaceuticals, and all other) were derived from Medicare cost report data on hospitals' relative shares of costs in these four categories in 1992. By holding the weights constant at their 1992 relative values, and applying proxies to measure price change over time, it is possible to estimate the effect of pure input price inflation while holding quantity and quality of inputs constant. This is the purpose of the prospective payment system hospital input price index.

Comment: A commenter stated that, in rebasing the market basket, HCFA has chosen to put malpractice costs into a separate category. In doing so, this cost was taken from 1989 cost reports and ''trended'' forward. The commenter suggested that, because this cost cannot be taken from cost reports in future years, it would be better to consolidate malpractice cost within an ''all other'' category.

Response: Malpractice has appropriately been a separate cost category since the inception of the prospective payment system hospital input price index. We are modifying the Medicare cost report to again include relevant malpractice cost questions, so that we will not have to estimate the malpractice share of costs.

3. Selection of Price Proxies

After computing the 1992 cost weights for the rebased hospital market basket, it was necessary to select appropriate wage and price proxies to monitor the rate of increase for each expenditure category. Most of the indicators are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

- Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. For example, we used the PPI for ethical drugs, rather than the Consumer Price Index (CPI) for prescription drugs. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs. The PPIs we used measure price change at the final stage of production.
- Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by the producer, the consumer price indexes were used if no appropriate PPI was available, or if the expenditure was more similar to that of retail consumers in general rather than a purchase at the wholesale level. For example, the CPI for food purchased away from home was used as a proxy for contracted food services.
- Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are not affected by shifts in employment mix.
- Average Hourly Earnings—Average Hourly Earnings (AHEs) measure the rate of change of hourly earnings for various occupations within a given industry, and, therefore, reflect a weighted occupational mix within a particular industry. The AHE series is calculated by dividing gross payrolls by total hours and measures actual earnings rather than pure wage rates. It is a current-weight series rather than a fixed-weight index and thus reflects shifts in employment mix. An AHE rather than an ECI is used when there is no corresponding ECI category that is an appropriate measure of growth for a

given labor category or when the ECI does not have sufficient length of history to be useful for our purpose.

Our price proxies for the rebased prospective payment hospital market basket are shown in Table 2 above and are summarized in Appendix C to this final rule.

Comment: One commenter believes that the most recent available Medicare cost report and other data should be used to establish the cost weights, particularly because the hospital industry and its cost structure are changing so rapidly.

Response: The prospective payment system hospital input price index was designed to be rebased at 5-year intervals, consistent with the scheduled release of the Commerce Department data on detailed cost structure by industrial sector of the U.S. economy. The Gross Domestic Product (GDP) and other related government statistics are on the same schedule of 5-year intervals between updates. Therefore, when planning for rebasing, HCFA adopted a base year that was 5 years from the most recent previous base year, 1987. We note that the Department of Commerce has not yet made its planned release of the 1992 detailed data on cost structure by industrial sector of the U.S. economy. However, in the proposed rule for FY 1998, we intend to modify the input price indexes for both the prospective payment system and excluded hospitals by incorporating the 1992 detailed cost structure data.

Comment: One commenter requested that we provide a more complete rationale in the final rule concerning the proposed price-proxy changes.

Response: The following discussion is offered to further explain our rationale for the price proxy changes we are adopting.

a. Nonmedical professional fees: The ECI for Compensation for Professional and Technical Workers replaced the ECI for Wages and Salaries for Professional and Technical Workers. The new index measures the growth in input prices associated with employee benefits as well as wages and salaries. Since the nonmedical professional fees category represents the hospital costs associated with obtaining these services, a price measure that accounts for aggregate compensation costs is preferable to one that measures only the wages and salaries component. When the ECI was first collected, it measured only growth in wages and salaries (not employee benefits). We changed the price proxy to reflect the improved data from the Bureau of Labor Statistics (BLS).

b. In an effort to improve the general accuracy and validity of the index's measurement of price growth, we made four minor producer price index changes:

- *Fuel Oil and Gasoline:* In the 1992-based index, the Fuel Oil and Gasoline category represents a combination of the Fuel Oil and Coal category and the Motor Gasoline category from the 1987-based index. The weight for motor gasoline was too small to keep it as a separate category. The price proxy used for the combined group in the 1992-based index, the Producer Price Index for Refined Petroleum Products, encompasses both PPIs used in the 1987-based index.
- *Electricity:* The PPI for Industrial Power was replaced with the PPI for Commercial Electrical Power to reflect information from the hospital industry and utility industry that commercial rates of change for utility costs are generally more appropriate than industrial rates.
- *Paper Products:* The weighted average of the percentage change in the price of converted paper and paperboard products and the percentage change in the price of paper excluding newsprint and packaging paper was replaced by the PPI for converted paper and paperboard products to better reflect the composition of costs in hospitals.
- *Apparel:* The PPI for textile house furnishings was replaced by the PPI for Apparel to better reflect the composition of costs in hospitals.

c. Business Services: The Average Hourly Earnings (AHE) for Business Services (AHE73NS) was replaced by the ECI for Compensation for Business Services. Compensation, which reflects both fringe benefits and wages, more appropriately measures the cost of business services. In addition, the ECI measurement holds the skill mix constant, measuring just the change in the cost of compensation, whereas a change in the AHE for Business Services can reflect a change in skill mix as well as a change in earnings. At the time of publication of the 1987-based index, the ECI for Business Services was not available.

d. All Other Services, Labor Intensive: The ECI Wages and Salaries for Private Service workers was replaced by the ECI Compensation for Private Service workers. A compensation price proxy reflects both a change in the price of benefits as well as a change in the price of wages and salaries.

4. The HCFA Blended Compensation Index

Compensation includes the two largest categories of the rebased market basket: wages and salaries, and employee benefits. Wages and salaries account for 50.244 percent and employee benefits account for 11.146 percent of the total weight in the prospective payment hospital market basket.

The HCFA Blended Compensation Index groups hospital occupations into nine broad categories. For eight of those occupational groups, we believe that hospitals compete for labor generally with employers outside the health care sector. Accordingly, we use economy-wide employment cost indexes (ECI) as price proxies for these eight occupational groups. In the case of compensation for nurses, as well as for certain other health care technicians and professionals, the hospital labor market may be predominant. However, hospitals do compete with other industries to obtain certain skilled professional and technical staff (for example, computer programmers). Therefore, for professional and technical workers, we believe a price proxy that reflects an equal blend of internal and external compensation variables is appropriate.

Similar to the methodology used for the previous rebasing, the weights for the nine cost categories in the occupational blend index were derived from the 1992 Current Population Survey (CPS) produced by BLS. Using the CPS, private hospital workers were classified into the nine occupational categories. Private hospitals better reflect the mix of occupations used to produce acute care services for the prospective payment system hospital input price index. Government hospitals were excluded because their occupational mix reflects the subset of nonacute care hospitals. Once private hospital workers were sorted by occupation into one of the nine occupational groups, weights were estimated using the share of wages and salaries for each of the nine occupations. These shares formed the basis of the weights that were used for the market basket of occupational categories.

An additional adjustment was made for contract labor costs. Rather than treat contract labor as a distinct noncompensation cost category, it was integrated into the occupational blend as a component of hospitals' compensation costs for purposes of the market basket index. Thus, contract labor is treated the same as other labor expenses. Contract labor was allocated to the professional and technical and service occupation categories. After adjusting the professional and technical and service workers' shares to account for contract labor, the weights for the

nine occupational blend categories were renormalized to equal 100.00 percent. The weights and proxies for the nine cost categories of the HCFA Blended Wages and Salaries Index are shown in Table 5.

TABLE 5.—HCFA BLENDED WAGES AND SALARIES INDEX (WAGES AND SALARIES COMPONENT OF THE 1992-BASED MARKET BASKET)

Cost category	Weight	Price proxy
Professional and technical	65.729	Equal blend of ECI for wages and salaries of civilian hospital workers and ECI for wages and salaries of professional, specialty and technical workers.
Managers and administrators	9.554	ECI for wages and salaries for executive, administrative and managerial workers.
Sales	0.402	ECI for wages and salaries for sales workers.
Clerical workers	12.379	ECI for wages and salaries for administrative support including clerical workers.
Craft and kindred	1.689	ECI for wages and salaries for precision production, craft and repair workers.
Operatives except transport	0.437	ECI for wages and salaries for machine operators, assemblers and inspectors.
Transport equipment operatives	0.122	ECI for wages and salaries for transportation and material moving workers.
Nonfarm laborers	0.084	ECI for wages and salaries for handlers, equipment cleaners, helpers and laborers.
Service workers	9.606	ECI for wages and salaries for service occupations.
Total wages and salaries	100.000	Total weight for wages and salaries is 50.2.

Note: Due to rounding, weights may not sum to total.

Comment: One commenter suggested that the manner in which hospital-specific wages and benefits price proxies are incorporated into the market basket should be changed, so that the internal hospital industry wage and benefit price proxies represent more of the compensation weights in the market basket. The ECI for hospital workers should be blended 50–50 for all labor cost categories, not just the professional and technical worker cost group. Although nonprofessional and technical workers may be employed in other settings, many of these workers have skills that are specific to the hospital industry.

Response: The blended compensation index of nine broad occupational groups with the ECI for Hospital Workers that is included in the prospective payment system hospital input price index reflects HCFA's judgment that, except for the professional and technical occupational category, hospitals compete primarily in the economy-wide labor market. Accordingly, HCFA uses Employment Cost Indexes (ECIs) for the private sector of the economy for eight of the nine occupation groups. For one broad occupational group, professional and technical workers, HCFA has recognized that certain subcategory occupations, such as registered nurses and physical therapists, are so specialized that hospitals are the predominant employers. Other types of professional and technical workers such as computer programers and biological researchers are distributed more evenly throughout the private sector economy. Therefore, a blend of the ECI for ''Private Professional Specialty and Technical Workers'' and the ECI for Civilian Hospital workers is used to measure growth in compensation prices for professional and technical. Since none of the other eight occupational categories are likely to use substantial proportions of hospital specific occupations, extending the blend to other labor categories is not appropriate.

As a practical matter, there is virtually no difference in the overall hospital input price index that results from using only a 50–50 blend of the ECI for Professional-Technical Workers and the ECI for Hospital Workers versus using a 50–50 blend for each of the nine ECI occupation groups with the ECI for Civilian Hospital Workers. The following table illustrates this point:

Difference in the Rate of Increase in the Hospital Index 50–50 Blend of Professional-Technical Workers Versus 50–50 Blend of All Occupations

FEDERAL FISCAL YEAR PERCENT CHANGE

	1997	1998	1999
50–50 blend of ECI P&T and ECI civilian hospital workers	2.5	2.9	3.1
50–50 blend of all nine occupations and ECI civilian hospital workers	2.5	2.8	3.1

The latest forecast of the rate of increase in the hospital input price index indicates that there is no difference for the FY 1997 update. For FY 1998, the current forecasts have a 0.1 percent difference. For FY 1999, the forecasts are identical. We will continue to monitor the effect on the hospital input price index that results from the alternative construction of the compensation sub-index. If a material difference develops between the two versions, we will reevaluate our position on the construction of the compensation sub-index.

Comment: One commenter, noting Table 5, ''HCFA Blended Wages and Salaries Index (Wages and Salaries Component of the 1992–Based Market Basket) (61 FR 27463), which lists the nine occupational categories, stated that HCFA is of the opinion that hospitals compete with the general labor market with the first category entitled ''Professional and Technical.'' The commenter questioned how HCFA arrives at this conclusion. The commenter recommended that, unless there is evidence that ''Professional and Technical'' workers provide an accurate proxy for wages in the hospital industry, the ''blend'' be dropped and be replaced by a hospital industry measure.

Response: The professional and technical workers category includes computer programmers, computer systems analysts, social workers, accountants, scientists, and lawyers. To varying degrees, hospitals employ each of these types of personnel. As noted in the previous comment and response, these occupations are also in significant demand outside the hospital industry, and hospitals must compete with employers in other industries as well as with other hospitals. For these types of occupations, competitive market forces that affect the compensation levels paid to workers in the nonhospital sector directly influence the compensation that prudent buyer hospitals pay. In order to account for this, it is appropriate to use the ECI Compensation for Private Professional-Technical Workers.

Hospitals are also major employers of other types of workers such as physical therapists, respiratory therapists, and registered nurses. Because hospitals demand substantial proportions of these types of workers, it is appropriate to reflect, at least in part, hospital industry-specific compensation.

The blend of professional-technical workers with the hospital industry specific compensation ECI is also used mitigate the effect of potential labor market imperfections in the hospital industry. Licensure requirements and the existence of third party insurance are believed by some to have enabled certain occupations to command compensation premiums that are above what can be explained by traditional predictors such as education, skill, experience, and location. Because certain professional and technical workers tend to have licensure restrictions that are more limiting than other occupations in the health care industry, there is some reason to believe that workers with the strictest licensure requirements are most able to realize a compensation premium. A blend provides a reasonable way to recognize that hospital compensation of professional and technical workers is influenced by both economy-wide and hospital sector-specific forces and that licensure requirements may influence compensation in ways different from a competitive market.

The advent of managed care may have diminished the ability of certain health sector labor occupations to achieve compensation premiums. This is suggested by the fact that recently the rate of increase in the ECI for Hospital workers has declined relative to the ECI for economy-wide professional-technical workers while in earlier periods the reverse held. Since FY 1992, the ECI for Hospital Workers has grown at a slower rate than the ECI for Private Professional and Technical workers. We will continue to monitor the ECIs and other data to detect changes in the market dynamics for the types of workers that hospitals employ.

Employment Cost Index Hospital Industry Workers Versus Economywide Professional and Technical Occupations

FEDERAL FISCAL YEAR PERCENT CHANGE

	1992	1993	1994	1995
ECI civilian hospital industry workers	4.3	3.7	3.1	2.5
ECI private P&T occupations	4.5	4.0	3.2	2.6

Comment: One commenter believed that the hospital industry does not compete with the general labor market for the cost category entitled ''Managers and Administrators.'' Therefore, the price proxy for this category should be the ECI for hospital workers, a hospital sector-specific proxy.

Response: Occupations in this category require a knowledge of and the capability to put into effect management principles, practices and techniques. The skills that these personnel possess are in demand in the overall economy as well as the hospital sector.

Since FY 1994, the ECI Compensation for Hospital Workers has grown at a slower rate than the ECI Compensation for Private Executive Administrative and Managerial Workers. Recent projections of these price proxies by DRI/McGraw-Hill suggest that this trend will continue.

Comment: One commenter suggested that, as an alternative to using the ECI for Hospital Industry Workers as a price proxy for all nine occupational categories, HCFA could use the data base it has developed over the last few years dealing with hospital wages.

Response: We assume that the commenter's reference to the data base that HCFA has developed over the last few years refers to the Hospital Area Wage Index. This index was developed pursuant to a statutory requirement that the Secretary adjust the standardized amounts for area differences in hospital wage levels. This index is designed to measure geographic differences in wage levels, not changes in wages over time. Also, because the area wage index is computed using total adjusted compensation divided by the sum total hours worked in a labor market (see section III of this preamble), it does not hold constant the skill-mix of employees from year to year. Therefore, any year-to-year index based upon the area wage index would include both price and quantity effects. The hospital input price index is appropriately designed to measure pure price inflation.

5. Separate Market Basket for Hospitals and Hospital Units Excluded from the Prospective Payment System

In its March 1, 1990 report, ProPAC recommended that we establish a separate market basket for hospitals and hospital units excluded from the prospective payment system. Effective with FY 1991, HCFA adopted ProPAC's recommendation to implement separate market baskets. (See the September 4, 1990 final rule (55 FR 36044).) Prospective payment and excluded hospitals tend to have different case mixes, practice patterns, and composition of inputs. The fact that these hospitals are not included under the prospective payment system in part reflects these differences.

Studies completed by HCFA, ProPAC, and the hospital industry have documented different weights for excluded hospitals and prospective payment hospitals. Table 7 compares major weights in the rebased 1992 market basket for excluded hospitals with weights in the rebased 1992 market basket for prospective payment system hospitals. Wages and salaries are 52.152 percent of total operating costs for excluded hospitals compared to 50.244 percent for prospective payment hospitals. Employee benefits are 11.569 percent for excluded hospitals compared to 11.146 percent for prospective payment hospitals. As a result, compensation costs (wages and salaries plus employee benefits) for excluded hospitals are 63.721 percent of costs compared to 61.390 percent for prospective payment hospitals. Noncompensation costs are 36.279 percent for excluded hospitals and 38.610 of costs for prospective payment hospitals.

Two significant differences in the category weights occur in Pharmaceuticals and Business Services. Pharmaceuticals represent 4.162 percent of costs for prospective payment hospitals and 3.070 percent for excluded hospitals. Business services represent 3.823 percent of costs for prospective payment hospitals and 2.337 percent for excluded hospitals. The weights for the excluded hospital market basket were derived using the same data sources and methods as for the prospective payment market basket (see Appendix C to this final rule).

Differences in weights between the excluded hospital and prospective payment hospital market baskets do not necessarily lead to significant differences in the rate of price growth for the two market baskets. If the individual wages and prices move at the approximately same annual rate, both market baskets may have about the same price growth even though weights may differ substantially because both market baskets use the same wages and prices. Also, offsetting price increases for various cost components can result in similar composite price growth in both market baskets.

The wage and price proxies are the same for the excluded hospital and prospective payment hospital market baskets. As discussed in section IV.A.2 of this preamble, all of the cost expenditure weights for both the prospective payment and excluded hospital market baskets are subject to refinement when the U.S. Department of Commerce 1992 data are released, analyzed by HCFA, and incorporated in

the PPS and exempt final market baskets.

The excluded hospital market basket is a composite set of weights for Medicare participating psychiatric, long-term care, rehabilitation, and children's hospitals. We are using cost report data for excluded hospitals and units whose average length of stay for Medicare patients is within 15 percent (that is, 15 percent higher or lower) of the facility average length of stay for all patients. This is a change from the 1987-based market basket, for which data for all excluded hospitals and units were used. We believe that limiting our sample to hospitals with a Medicare average length of stay within 15 percent of the total facility average length of stay provides a more accurate reflection of the structure of costs for Medicare. We note that the forecast for FY 1997 differs by only 0.1 percent when we included all excluded hospitals in the calculation of weights. The forecast for the limited index was 2.5 percent, while the forecast for the full set of excluded hospitals was 2.6 percent.

TABLE 6.—COMPARISON OF SIGNIFICANT WEIGHTS FOR 1992-BASED EXCLUDED HOSPITAL AND PROSPECTIVE PAYMENT HOSPITAL MARKET BASKETS

Category	Excluded hospitals	Prospective payment hospitals
Wages and salaries	52.152	50.244
Employee benefits	11.569	11.146
Professional fees	2.098	2.127
Pharmaceuticals	3.070	4.162
All other	31.111	32.321
Total	100.000	100.000

TABLE 7.—1992-BASED EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	Rebased 1992 excluded hospital market basket	Price proxy
1. Compensation	63.721	
A. Wages and salaries	52.152	HCFA occupational wage index.
B. Employee benefits	11.569	HCFA occupational benefits index.
2. Professional fees	2.098	ECI—Compensation for professional, specialty and technical.
3. Utilities	2.557	
A. Fuel, oil, and gasoline	0.357	PPI refined petroleum products.
B. Electricity	1.396	PPI commercial electric power.
C. Natural gas	0.694	PPI commercial natural gas.
D. Water and sewerage	0.110	CPI–U water and sewerage maintenance.
4. Professional liability insurance	1.081	HCFA professional liability insurance premiums index.
5. All other	30.543	
A. All other products	23.642	
(1.) Pharmaceuticals	3.070	PPI ethical (prescription) drugs.
(2.) Food	3.581	
a. Direct purchase	2.446	PPI processed foods and feeds.
b. Contract service	1.135	CPI–U food away from home.
(3.) Chemicals	3.929	PPI industrial chemicals.
(4.) Medical instruments	3.238	PPI medical instruments and equipment.
(5.) Photographic supplies	0.413	PPI photographic supplies.
(6.) Rubber and plastics	5.039	PPI rubber and plastic products.
(7.) Paper products	2.134	PPI converted paper and paperboard products.
(8.) Apparel	0.906	PPI apparel.
(9.) Machinery and equipment	0.218	PPI machinery and equipment.
(10.) Miscellaneous products	1.112	PPI finished goods.
B. All other services	6.901	
(1.) Business services	2.337	ECI—compensation for private workers in business services.
(2.) Computer services	1.415	AHE computer and data processing services.
(3.) Transportation services	0.195	CPI–U transportation.
(4.) Telephone services	0.549	CPI–U telephone services.
(5.) Postage	0.282	CPI–U postage.
(6.) All other: labor intensive	1.767	ECI—compensation for private service occupations.
(7.) All other: nonlabor intensive	0.356	CPI–U all items.
Total	100.000	

NOTE: Due to rounding, weights may not sum to total.

Table 8, below, shows what the excluded hospital weights would be if cost data for all excluded hospitals had been used.

TABLE 8.—1992 EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PROXIES USING DATA FROM ALL EXCLUDED HOSPITALS

Expense categories	Rebased 1992 excluded hospital market basket	Price proxy
1. Compensation	68.074	
A. Wages and salaries	55.714	HCFA occupational wage index.
B. Employee benefits	12.360	HCFA occupational benefits index.
2. Professional fees	2.073	ECI—compensation for professional, specialty and technical.
3. Utilities	2.191	
A. Fuel, oil, and gasoline	0.306	PPI refined petroleum products.
B. Electricity	1.196	PPI commercial electric power.
C. Natural gas	0.595	PPI commercial natural gas.
D. Water and sewerage	0.094	CPI–U water and sewerage maintenance.
4. Professional liability insurance	1.081	HCFA professional liability insurance premiums index.
5. All other	26.582	
A. All other products	20.333	
(1.) Pharmaceuticals	2.704	PPI ethical (prescription) drugs.
(2.) Food	3.069	
a. Direct purchase	2.096	PPI processed foods and feeds.
b. Contract Service	0.973	CPI–U food away from home.
(3.) Chemicals	3.367	PPI industrial chemicals.
(4.) Medical instruments	2.775	PPI medical instruments and equipment.
(5.) Photographic supplies	0.354	PPI photographic supplies.
(6.) Rubber and plastics	4.319	PPI rubber and plastic products.
(7.) Paper products	1.829	PPI converted paper and paperboard products.
(8.) Apparel	0.777	PPI apparel.
(9.) Machinery and equipment	0.187	PPI machinery and equipment.
(10.) Miscellaneous products	0.953	PPI finished goods.
B. All other services	6.248	
(1.) Business services	2.337	ECI—compensation for private workers in business services.
(2.) Computer services	1.213	AHE computer and data processing services.
(3.) Transportation services	0.167	CPI–U transportation.
(4.) Telephone Services	0.471	CPI–U telephone services.
(5.) Postage	0.242	CPI–U postage.
(6.) All Other: Labor Intensive	1.514	ECI—compensation for private service occupations.
(7.) All Other: Nonlabor Intensive	0.305	CPI–U all items.
Total	100.000	

The relatively small differences in weights between the excluded hospital market basket data from excluded hospitals that have a Medicare length of stay within 15 percent of the total facility average length of stay and the excluded hospital market basket using data from all excluded hospitals do not lead to significant changes in the rate of price growth for these two market baskets. If all individual wages and prices move at about the same annual rate, both market baskets could have about the same price growth even if weights are somewhat different. Also, offsetting price increases for various costs components can result in the price growth being the same.

To examine the sensitivity of the change to the limited set of excluded hospitals, we developed a comparison for the period 1988–1998. Using historical data and forecasts for the market baskets, we compared limited and full sets of excluded hospitals.

TABLE 9.—A COMPARISON OF THE EXCLUDED HOSPITAL MARKET BASKET AND THE EXCLUDED HOSPITAL MARKET BASKET REBASED USING ALL EXCLUDED HOSPITALS, PERCENT CHANGE, 1988–1998

Federal fiscal year	Excluded (+/−15%) hospital market basket—1992 base	Excluded hospital market basket using all excluded hospitals—1992 base	Difference
Historical: 1988	4.9	4.8	0.1
1989	5.6	5.5	0.1
1990	4.6	4.7	(0.1)
1991	4.3	4.4	(0.1)

TABLE 9.—A COMPARISON OF THE EXCLUDED HOSPITAL MARKET BASKET AND THE EXCLUDED HOSPITAL MARKET BASKET REBASED USING ALL EXCLUDED HOSPITALS, PERCENT CHANGE, 1988–1998—Continued

Federal fiscal year	Excluded (+/−15%) hospital market basket—1992 base	Excluded hospital market basket using all excluded hospitals—1992 base	Difference
1992	3.0	3.2	(0.2)
1993	3.1	3.1	(0.0)
1994	2.6	2.7	(0.1)
1995	3.3	3.2	0.1
Forecasted: 1996	2.5	2.7	(0.2)
1997	2.5	2.6	(0.1)
1998	2.8	2.9	(0.1)
Historical average: 1988–1995	3.9	4.0	(0.1)
Forecasted average: 1996–1998	2.6	2.7	(0.1)

Note that the historical average rate of growth from 1988 to 1995 for the excluded hospital market basket including only excluded hospitals with Medicare average length of stay within 15 percent of total facility average length of stay is virtually identical to that for the excluded hospital market basket with all excluded hospitals. The rates of growth using the two methodologies are within 0.1 percent for FY 1996, 1997, and 1998.

Comment: A commenter requested a more detailed explanation about the rationale for dropping from the calculation of the excluded facility market basket those excluded hospitals and units with Medicare average lengths of stay that vary by more than 15 percent from the facility's overall average length of stay. The commenter stated that there is no description of the hospitals being dropped or their characteristics (e.g., if these facilities have low Medicare shares, it may be appropriate to exclude them). More information is needed before the appropriateness of the 15-percent screen can be assessed.

Response: To the extent possible, we used total reimbursable facility costs to determine the weights for Medicare costs. If the patterns of practice for Medicare patients differ significantly from the overall patient population, we believe that total facility costs for facilities with high shares of Medicare patients are more representative of the Medicare population. We chose to compare the average length of stay for all patients to that of Medicare beneficiaries as the test of the similarity of the practice patterns for non-Medicare patients versus Medicare patients. Our method results in retaining hospitals that had a share of patient days attributable to Medicare that was approximately three times that of hospitals that were excluded. Our goal is to measure cost shares that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries.

Comment: A commenter questioned whether there will be a need for a separate market basket for each type of excluded hospital once prospective payment systems are developed for psychiatric and rehabilitation hospitals and units. The commenter recommended that HCFA consider whether it would be beneficial to begin identifying a separate market basket for each type of excluded hospital.

Response: We agree with the commenter that HCFA will have to consider whether to use separate market baskets for each type of excluded hospital once prospective payment systems are developed for psychiatric and rehabilitation hospitals. However, until those systems are designed we believe it is premature to develop separate market baskets.

B. Capital Costs

Rebasing the Capital Input Price Index

1. Background

Effective for cost reporting periods beginning on or after October 1, 1995, the Capital Input Price Index (CIPI) is used to determine the price increase associated with prospective payment hospital capital-related expenses. Capital-related expenses are defined as depreciation expenses, capital-related interest expenses, and other capital-related expenses, such as insurance and taxes. The CIPI measures the input price change of these capital-related expenses, and is included in the capital prospective payment update framework to determine a rate of increase in capital prospective payments.

Like the prospective payment hospital operating input price index, the CIPI is a fixed-weight price index. A fixed-weight price index measures how much it would cost at a later date to purchase the same mix of goods and services purchased in the base period. For the prospective payment hospital operating and capital input price indexes, the base period is selected and cost category weights are determined using available data on hospitals. Next, appropriate price proxy indexes are chosen for each cost category. Then a price proxy index level for each expenditure category is multiplied by the comparable cost category weight. The sum of these products (that is, weights multiplied by price proxy index levels) for all cost categories yields the composite index level of the market basket for a given year. Repeating the step for other years produces a time series of composite market basket index levels. Dividing an index level by a later index level produces a rate of growth in the input price index. Since the percent change is computed for the fixed mix of total capital inputs with a 1992 base, the index is called fixed-weight.

Like the operating input price index, the CIPI measures the price changes associated with costs during a given year. In order to do so, the CIPI must differ from the operating input price index in one important aspect. The CIPI must reflect the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions).

An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year. Using Medicare cost reports, AHA data, and Securities Data Corporation data, a vintage-weighted price index was developed to measure price increases associated with capital expenses.

Comment: A commenter suggested that HCFA's model is overly complicated and relies excessively on assumptions given that capital costs make up approximately 10 percent of total hospital costs. The commenter recommended that HCFA adopt a simpler approach to update the Federal rate for capital-related costs for hospital inpatient services.

Response: Capital payments for prospective payment hospitals are expected to be about $8.6 billion in FY 1997, a significant amount that warrants an appropriate input price index. It would not be appropriate to use a simpler index if it does not accurately reflect the price increases associated with capital costs. Capital costs are inherently complicated and are determined by complex capital purchasing decisions over time, which are based on such factors as interest rates and debt financing decisions. Also, capital is depreciated over periods of time instead of being consumed in the same period it is purchased. The CIPI accurately reflects the annual price increases associated with capital costs, and is a useful simplification of the actual capital accumulation process. By appropriately accounting for the vintage nature of capital in the CIPI, HCFA is able to provide an accurate, stable annual measure of price increases. Annual, non-vintage price changes for capital are highly unstable due to the volatility of interest rate changes. These unstable annual price changes do not reflect the actual annual price changes for Medicare capital-related costs. The HCFA CIPI reflects the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

The most recent discussion on the CIPI and methodological background was published in the May 31, 1996 proposed rule (61 FR 27466). The following Federal Register documents describe development and revisions of the methodology involved with the construction of the CIPI: September 1, 1992 (57 FR 40016), May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), and September 1, 1995 (60 FR 45815).

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Previously, both the operating input price index and the CIPI are based to FY 1987. We are updating the base year cost structure to FY 1992, the most recent year with relatively complete data for purposes of rebasing. We explain the process of rebasing the cost structure weights for the CIPI below.

2. Rebasing the Capital Input Price Index

We are using a rebased capital input price index (CIPI) in developing the FY 1997 capital update factor for capital prospective payment rates. The new CIPI is rebased to reflect the 1992, rather than the 1987, structure of capital costs. In developing the rebased CIPI, we reviewed hospital capital expenditure data for capital cost categories (depreciation, interest, and other). Two sets of weights had to be developed in order to compute the rebased CIPI: (1) cost category weights which identify the proportion of total hospital capital expenditures attributable to each capital expenditure category, and (2) relative vintage weights for depreciation and interest which identify the proportion of capital expenditures within a cost category that are attributable to each year over the life of capital assets in that category. Because capital expense data in the Medicare Cost Reports is not available prior to 1980 for use in computing vintage weights, the two sets of weights are measured using the best data sources available as explained below and in Appendix C to this final rule. The computations involved with rebasing the CIPI are explained for each of these sets of weights.

a. Capital Cost Category Weights. The capital cost category weights in Table 10 below were computed using a combination of the FY 1992 Medicare Cost Reports and 1992 AHA Annual Survey data. FY 1992 marked the first year for expanded capital data available in the Medicare Cost Reports. After reviewing the data, we determined that much of the data had been reclassified into different expense categories. Therefore, we removed prospective payment hospital reports that appeared to have reclassified data, and matched the remaining reports to the corresponding reports in the AHA Annual Survey data set. These remaining 2724 prospective payment hospital reports were used to compute capital cost category weights and the expected life of capital, which is used in determining vintage weights for depreciation and interest.

In reviewing the data, we determined that the Medicare Cost Reports provided accurate data for depreciation and other capital expenses, but had reclassified interest data. We determined that AHA Annual Survey data more accurately reflected interest expense, based on past trends in interest rates. Therefore, we used the AHA Annual Survey interest levels along with the Medicare Cost Report levels for depreciation and other capital expenses to develop a more robust capital cost data base.

After removing depreciation, interest, and other capital expenses from total capital expenses, the remainder constitutes lease expenses. Lease expenses are not a separate cost category in the CIPI. They are distributed to the other cost categories (depreciation, interest, other), reflecting an assumption that the underlying cost structure of leases is similar to capital costs in general. We assigned 10 percent of lease expenses to the other capital expenses cost category as overhead, and the remaining lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses. (We base this assignment of 10 percent of lease expenses to overhead on the common assumption that overhead is 10 percent of costs.)

We also used the 1992 Medicare cost reports to determine weights for the building and fixed equipment category and the movable equipment category. Expenses for building and fixed equipment and for movable equipment were determined using the same sample of prospective payment hospital reports as was used to compute the major cost category weights. The split between building and fixed equipment and movable equipment was also used to compute the vintage weights described below. Table 10 presents a comparison of the rebased 1992 capital cost weights and the 1987 capital cost weights.

We only used those hospital reports which we considered to have capital data that was not reclassified. Because we did not use all hospital reports, we were concerned that the hospitals used may not be representative of the universe. Therefore, we compared the distribution of costs for the hospitals used with the data re-weighted to reflect the characteristics of the total universe of hospitals. From this analysis we validated that the cost weights derived from the subset we used were

representative of the cost weights for the entire universe of hospitals.

TABLE 10.—COMPARISON OF 1987 AND 1992 COST CATEGORY WEIGHTS

Expense categories	FY 1987	Rebased FY 1992	Price proxy
1. Building and fixed equipment depreciation	0.3054	0.3009	Boeckh Institutional Construction Index—vintage weighted (22 yrs)
2. Movable equipment depreciation	0.3456	0.3475	PPI for machinery and equipment—vintage weighted (10 yrs)
Total interest	0.3274	0.3184	
1. Government/nonprofit interest	0.2783	0.2706	Average yield on domestic municipal bonds (bond buyer 20 bonds)—vintage weighted (22 yrs)
2. For-profit interest	0.0491	0.0478	Average yield on Moody's Aaa Bonds—vintage weighted (22 yrs)
Other	0.0216	0.0332	CPI(U) for residential rent
Total	1.0000	1.0000	
Total depreciation	0.6510	0.6484	

Source: 1992 Medicare Cost Reports, PPS year 9; 1992 AHA Annual Survey.

Note: Due to rounding, weights may not sum to totals.

Comment: The price proxy for ''for-profit interest'' was listed in Table 10 of the May 31, 1996 Federal Register (61 FR 27468) as the Average Yield on Moody's AAA Corporate Bonds. A commenter pointed out that Moody's highest ratings is Aaa instead of AAA.

Response: As the commenter pointed out, the correct Moody's rating is Aaa. While publications other than Moody's may not be as precise in their presentation of Moody's ratings, HCFA will use the more precise definition of Aaa and refer to the price proxy for for-profit interest as the Average Yield on Moody's Aaa Corporate Bonds throughout this final rule.

We had planned to incorporate the 1992 data from the Department of Commerce for developing capital cost category weights. However, these data are not available for inclusion in this final rule.

b. Relative Vintage Weights for Prices. As we have explained in previous Federal Register documents (most recently the September 1, 1995 final rule at 60 FR 45817), the CIPI was developed to capture the vintage nature of capital; that is, because capital is acquired and consumed over time, the capital expenses in any given year are determined by past and current purchases of physical and financial capital. Therefore, a vintage-weighted CIPI was developed which used vintage weights for depreciation (physical capital) and interest (financial capital) to capture the long-term consumption of capital. These vintage weights reflect the purchase patterns of building and fixed equipment and movable equipment over time. Because depreciation and interest expenses are determined by the amount of past and current capital purchases, we use the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense, which is the purpose of the CIPI.

To compute the vintage weights for depreciation and interest expenses, we used a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The Medicare cost reports did not have sufficient capital data to meet this need. The AHA Panel Survey provides a consistent database back to 1963. While the AHA Panel Survey data does not provide annual capital purchases, it does provide a time series of depreciation and interest expenses, which can be used to infer capital purchases over time. The process of using the AHA data to estimate a time series of capital purchases, and eventually vintage weights, is explained in detail below.

In order to estimate capital purchases from AHA data on depreciation and interest expenses, the expected life for building and fixed equipment, for movable equipment, and for debt instruments is needed. The expected life is used in the calculation of vintage weights for building and fixed equipment, movable equipment, and debt instruments as we explain below.

We used the same sample of prospective payment hospitals from FY 1992 Medicare cost reports and the 1992 AHA Annual Survey explained above in computing cost category weights to compute the expected life of building and fixed equipment and movable equipment. (The AHA Panel Survey is a monthly survey of a sample of hospitals, while the AHA Annual Survey is a more detailed survey of all hospitals.) The expected life of any piece of equipment can be determined by dividing the historical asset cost (excluding fully depreciated assets) by the current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation continued at current year levels, assuming straight-line depreciation, which is the only depreciation method allowed under Medicare. From the FY 1992 costs reports, the expected life of building and fixed equipment was determined to be 22 years, and the expected life of movable equipment was determined to be 10 years. By comparison, the expected life using FY 1987 data was 25 years for building and fixed equipment and 10 years for movable equipment.

It was also necessary to compute the expected life of debt instruments held by hospitals. As in prior exercises, we used hospital issuances of municipal and commercial bonds from Securities Data Corporation to determine the expected life of hospital debt instruments, which is used in the estimation of vintage weights for interest expense. This data source produced a weighted average life for the two types of bonds of 22 years for FY 1992, the same expected life as was computed for the 1987-based CIPI.

An annual series of total expenses and depreciation expenses was obtained from the AHA Panel Survey. For the calculation of vintage weights, this expense data was needed back to 1963. However, the depreciation expense data in the AHA Panel survey was available only back to 1976. We noticed an increasing trend in depreciation expenses as a percentage of total expenses. We performed a regression on this percentage, and used the regression

equation to estimate depreciation expenses back to 1963. We then used the fixed and movable weights derived from the FY 1992 Medicare cost reports to partition the AHA Panel Survey depreciation expenses into annual amounts of building and fixed depreciation and movable depreciation.

Multiplying the annual depreciation amounts by the expected life calculations from the FY 1992 Medicare cost reports, year-end asset costs for building and fixed equipment and movable equipment were determined. Then by subtracting the previous year asset costs from the current year asset costs, annual purchases of building and fixed equipment and movable equipment were estimated back to 1963. This capital purchase time series is then used to compute the vintage weights for building and fixed equipment, movable equipment, and debt instruments. Each of these sets of vintage weights is explained in detail below.

For building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh institutional construction index. Because building and fixed equipment has an expected life of 22 years, the vintage weights for building and fixed equipment were deemed to represent the average purchase pattern of building and fixed equipment over 22-year periods. With real building and fixed equipment purchase estimates available back to 1963, nine 22-year periods could be averaged to determine the average vintage weights for building and fixed equipment. Averaging different periods produces vintage weights that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 22-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 22-year period. For example, for the 22-year period of 1964–1985, the vintage weight for year 1 is calculated by dividing the real annual capital purchase amount of building and fixed equipment in 1964 into the total amount of real annual capital purchases of building and fixed equipment over the entire 1964–1985 period. This calculation is done for each year in the 22-year period, and for each of the nine 22-year periods. An average is taken of the nine 22-year periods to determine the FY 1992 average building and fixed equipment vintage weights, presented in Table 11 with the FY 1987 vintage weights.

For movable equipment vintage weights, the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was produced by deflating the nominal annual purchase amount by the movable equipment price proxy, the Producer Price Index for machinery and equipment. Because movable equipment has an expected life of 10 years, the vintage weights for movable equipment were deemed to represent the average purchase pattern of movable equipment over 10-year periods. With real movable equipment purchase estimates available back to 1963, 21 10-year periods could be averaged to determine the average vintage weights for movable equipment. Averaging different periods produces vintage weights which are representative of average movable equipment purchase patterns over time. Vintage weights for each 10-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 10-year period. For example, for the 10-year period of 1976–1985, the vintage weight for year 1 is calculated by dividing the real annual capital purchase amount of movable equipment in 1976 into the total amount of real annual capital purchases of movable equipment over the entire 1976–1985 period. This calculation is done for each year in the 10-year period, and for each of the 21 10-year periods. The average of the 21 10-year periods is used to determine the FY 1992 average movable equipment vintage weights, presented in Table 11 with the FY 1987 vintage weights.

For interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel Survey were used. Nominal annual purchase amounts were used to capture the value of the debt instrument. Because debt instruments have an expected life of 22 years, the vintage weights for interest were deemed to represent the average purchase pattern of total equipment over 22-year periods. With nominal total equipment purchase estimates available back to 1963, nine 22-year periods could be averaged to determine the average vintage weights for interest. Averaging different periods produces vintage weights which are representative of average capital purchase patterns over time. Vintage weights for each 22-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 22-year period. For example, for the 22-year period of 1964–1985, the vintage weight for year 1 is calculated by dividing the nominal annual capital purchase amount of total equipment in 1964 into the total amount of nominal annual capital purchases of total equipment over the entire 1964–1985 period. This calculation is done for each year in the 22-year period, and for each of the nine 22-year periods. The average of the nine 22-year periods is used to determine the FY 1992 average interest vintage weights, presented in Table 11 with the FY 1987 weights.

TABLE 11.—VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment		Movable equipment		Interest	
	Fiscal Year 1987 25 yrs	Rebased Fiscal Year 1992 22 yrs	Fiscal Year 1987 10 yrs	Rebased Fiscal Year 1992 10 yrs	Fiscal Year 1987 22 yrs	Rebased Fiscal Year 1992 22 yrs
1	0.015	0.019	0.064	0.069	0.007	0.007
2	0.019	0.020	0.072	0.075	0.009	0.008
3	0.022	0.023	0.077	0.083	0.010	0.010
4	0.024	0.026	0.085	0.091	0.011	0.012
5	0.023	0.028	0.095	0.097	0.013	0.014
6	0.022	0.030	0.101	0.103	0.015	0.016
7	0.020	0.031	0.109	0.109	0.017	0.018
8	0.021	0.032	0.122	0.115	0.020	0.021
9	0.025	0.036	0.132	0.124	0.023	0.024
10	0.030	0.039	0.142	0.133	0.027	0.029
11	0.033	0.043	.....	.....	0.032	0.035
12	0.034	0.047	.....	.....	0.038	0.041
13	0.034	0.050	.....	.....	0.043	0.047
14	0.035	0.052	.....	.....	0.050	0.052
15	0.038	0.055	.....	.....	0.057	0.059
16	0.043	0.059	.....	.....	0.064	0.067
17	0.049	0.062	.....	.....	0.074	0.074
18	0.053	0.065	.....	.....	0.083	0.081
19	0.056	0.067	.....	.....	0.090	0.088
20	0.057	0.069	.....	.....	0.098	0.093
21	0.060	0.072	.....	.....	0.105	0.099
22	0.066	0.073	.....	.....	0.114	0.103
23	0.071	.....	.....	.....	.....	.....
24	0.075	.....	.....	.....	.....	.....
25	0.077	.....	.....	.....	.....	.....
Total	1.000	1.000	1.000	1.000	1.000	1.000

Sources: AHA Panel Survey, 1963–1993; 1992 Medicare Cost Reports; Securities Data Corporation.

Comment: ProPAC again commented that HCFA's capital update framework could be improved, and that ProPAC's capital update framework is similar to the operating update framework. The ProPAC framework also includes a discretionary financing policy adjustment for use in extended periods of unusually high or low interest rates.

Response: The HCFA CIPI measures the annual price increase associated with vintage-weighted capital expenses, making it consistent with the HCFA operating input price index, which measures the annual price increase associated with operating expenses. The ProPAC market basket reflects the price increase of capital purchases from one year to the next, and does not capture the vintage nature of capital that is captured by the HCFA CIPI. Therefore, we believe the HCFA CIPI accurately measures annual price increases in capital expenses, as we stated before in the May 26, 1993 (58 FR 30451), September 1, 1993 (58 FR 46492), May 27, 1994 (59 FR 27889), September 1, 1994 (59 FR 45521), June 2, 1995 (60 FR 29233), and the September 1, 1995 (60 FR 45823) Federal Registers. ProPAC has presented no criteria (objective or subjective) for determining when a discretionary financing policy adjustment would be appropriate. HCFA believes that interest rates are intrinsic to a technically sound and fair measure of price increases in capital expenses (which are defined as depreciation, interest, and lease expenses, and insurance and taxes), just as all expense components are appropriately included in the HCFA operating input price index.

3. Selection of Price Proxies

After the 1992 capital cost category weights were computed, it was necessary to select appropriate price proxies to monitor the rate of increase for each expenditure category. Our price proxies for the FY 1992 based CIPI are the same as those for the FY 1987 based CIPI. The rationale for selecting the price proxies is explained in the June 2, 1995 proposed rule (60 FR 29227) and the September 1, 1995 final rule (60 FR 45817). The price proxies are presented in Table 10.

Comment: A commenter contended the average yield on bonds rated Aaa is not representative of the bond rating the for-profit hospital industry is obtaining. The commenter examined the bond rating of some of its member companies and found them to range from A3 (highest) to B1 (lowest). The commenter recommended the selection of a price proxy that better reflects interest costs of taxpaying hospitals.

Response: The commenter is correct that the average yield on lower-rated corporate bonds is different from the average yield on higher-rated corporate bonds, and that some for-profit hospitals have lower ratings than Aaa. However, the interest component for for-profit hospitals in the HCFA CIPI is based on percent changes in yields and not the yields themselves. We analyzed the percent change in the yield for two bond ratings: Aaa and Baa. Despite the yields for the two bond ratings being significantly different for the 15 years between 1981–1995, the percent changes in the yields for the two bond ratings were nearly identical. We used the percent changes in both yields to calculate the CIPI and determined the impact of the different yields on the overall CIPI was essentially zero. Because our analysis did not reveal any significant difference in the percent change in yields for corporate bonds with different ratings, we believe the average yield for Moody's Aaa corporate bonds is an appropriate price proxy for for-profit interest expense.

4. Forecast of the CIPI for Federal Fiscal Year 1997

DRI forecasts a 1.3 percent increase in the rebased 1992 CIPI for FY 1997, as indicated in Table 12. This is the outcome of a 2.4 percent increase in projected depreciation prices (building and fixed equipment, and movable equipment) and a 2.2 percent increase in other capital expense prices in FY 1997, partially offset by a 1.8 percent decline in vintage-weighted interest rates in FY 1997.

TABLE 12.—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 (fiscal year 1992)	1.0000	0.6484	0.3009	0.3475	0.3184	0.0332
VINTAGE-WEIGHTED PRICE CHANGES						
1979	5.4	7.4	7.0	7.7	2.7	7.1
1980	6.9	8.0	7.3	8.5	5.4	8.6
1981	8.7	8.5	7.7	9.1	9.1	8.8
1982	9.2	8.5	8.0	9.0	10.2	8.0
1983	6.7	8.1	7.9	8.2	4.8	6.3
1984	6.3	7.3	7.6	7.1	4.9	5.0
1985	5.2	6.3	7.0	5.8	3.5	5.9
1986	3.7	5.7	6.4	5.1	0.7	6.2
1987	3.1	5.1	5.9	4.5	−0.1	4.5
1988	3.0	4.6	5.4	4.0	0.3	3.8
1989	2.6	4.4	5.2	3.7	−0.5	3.8
1990	2.3	4.0	4.9	3.2	−0.7	4.2
1991	2.0	3.6	4.6	2.7	−1.1	3.9
1992	1.5	3.2	4.4	2.1	−2.0	2.6
1993	1.1	2.9	4.1	1.8	−2.8	2.4
1994	1.1	2.7	3.9	1.7	−2.7	2.3
1995	1.3	2.6	3.8	1.6	−2.0	2.5
1996	1.1	2.5	3.6	1.5	−2.4	2.4
1997	1.3	2.4	3.5	1.5	−1.8	2.2
1998	1.2	2.4	3.3	1.5	−2.2	3.1
1999	1.2	2.4	3.3	1.5	−2.2	2.2
2000	1.3	2.4	3.3	1.5	−2.3	3.1

5. Comparison of Percent Changes in the FY 1992–Based CIPI and the FY 1987–Based CIPI

Rebasing the CIPI from 1987 to 1992 decreased the percent change in the FY 1997 forecast by only 0.2 percentage points, from 1.5 to 1.3 as indicated in Table 13. The effect of rebasing is analyzed by comparing the 1992-based CIPI forecasted percent changes to the 1987-based CIPI forecasted percent changes using the same DRI forecast of component prices. As shown in Table 13, there is only a 0.2 percentage point difference between the percent changes in the 1992-based CIPI and the 1987-based CIPI using the second quarter 1996 forecast. The difference reflects changes to: (1) cost category weights, (2) expected life, and (3) vintage weights. The changes to cost category weights coupled with the wide disparity in price changes between the different cost categories contributed to lowering the CIPI percent change in the FY 1997 forecast. This was the case with fixed depreciation, which has faster price growth than the other cost categories and now has a lower weight by nearly one-half of a percentage point because of rebasing to 1992. Also contributing to the 0.2 percentage point difference in FY 1997 forecast is the change in the expected life of building and fixed equipment and the change in the vintage weights for all three components: building and fixed equipment, movable equipment, and interest. The shorter expected life (22 years in 1992 versus 25 years in 1987) of building and fixed equipment slightly decreased the FY 1997 forecast CIPI percent change because years with higher price increases were not included as they had been before. The change in vintage weights also tended to decrease the FY 1997 CIPI percent change because vintage weights in all cases changed to be spread more evenly over the life of the asset, decreasing the weight of more recent years and increasing the weight of past years. In the years around FY 1997, prices for depreciation and interest are projected to increase slightly faster than prices in earlier years.

TABLE 13.—COMPARISON OF 1987 AND 1992 BASED CAPITAL INPUT PRICE INDEX USING THE SAME DRI FORECAST, PERCENT CHANGE, 1979–1997

Federal fiscal year	CIPI	
	1987	Rebased 1992
1979	5.6	5.4

TABLE 13.—COMPARISON OF 1987 AND 1992 BASED CAPITAL INPUT PRICE INDEX USING THE SAME DRI FORECAST, PERCENT CHANGE, 1979–1997—Continued

Federal fiscal year	CIPI	
	1987	Rebased 1992
1980	7.1	6.9
1981	8.8	8.7
1982	9.3	9.2
1983	6.7	6.7
1984	6.3	6.3
1985	5.1	5.2
1986	3.7	3.7
1987	3.1	3.1
1988	3.0	3.0
1989	2.7	2.6
1990	2.4	2.3
1991	2.1	2.0
1992	1.7	1.5
1993	1.3	1.1
1994	1.3	1.1
1995	1.5	1.3
1996	1.4	1.1
1997	1.5	1.3

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

A. Sole Community Hospital Criteria (§ 412.92)

Under the prospective payment system, special payment protections are provided to hospitals that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. The criteria a hospital must meet to be classified as a sole community hospital (SCH) as well as the special payment adjustments available are set forth in the regulations at § 412.92.

One of the ways in which a hospital can qualify for sole community status is to be located between 25 and 35 miles from other like hospitals and prove that no more than 25 percent of residents who become inpatients or no more than 25 percent of the Medicare beneficiaries who become inpatients in the hospital's ''service area'' are admitted to other like hospitals located within a 35-mile radius of the hospital (or its service area, if larger).

In the final rule published on September 30, 1988, we stated: ''A hospital may delineate its service area by identifying the zip codes of all its inpatients for the cost reporting period ending before the date it applies for SCH status. The lowest number of zip codes accounting for at least 75 percent of its inpatients would then constitute its service area.'' (53 FR 35810).

In March 1990, we issued a revised manual which inadvertently reflected policy prior to October 1, 1988; specifically, section 2810 A.2.c of the Medicare Provider Reimbursement Manual, Part 1 (HCFA Pub. 15–1) stated, ''A hospital may define its service area as the lowest number of *contiguous* zip codes from which the hospital draws at least 75 percent of its inpatients.'' (Emphasis added.) As discussed in the proposed rule, some hospitals have raised questions about the definition of service area. Therefore, we clarified that our definition of ''service area'' for purposes of determining SCH status does not require contiguous zip code areas. We have applied this definition since October 1, 1988 (the effective date of the September 30, 1988 final rule). We also indicated that we intended to revise the current manual accordingly at our earliest opportunity.

Comment: Two commenters responded to our clarification on the use of zip codes to determine a hospital's service area for SCH purposes. One commenter did not object to the policy clarification, but requested that we also clarify whether use of zip codes and use of a statewide health planning agency are the only two methods of defining a service area. The other commenter believes our current policy may lead to unfair results for some hospitals in sparsely populated areas. The commenter requested that we permit a hospital to use either the lowest number of zip codes or the lowest number of contiguous zip codes to determine its service area.

Response: We discussed the definition of a hospital's service area for SCH purposes at some length in the preamble of the September 30, 1988 final rule (53 FR 38511). In that document, we stated that a hospital's service area is the area from which it draws at least 75 percent of its inpatients for the 12-month cost reporting period ending before it applies for SCH classification.

We noted that not all States have Statewide health planning commissions that identify hospitals' service areas and we offered the zip code methodology as one alternative. We also noted that ''(t)he important consideration is that a hospital be able to define its service area as the area from which it draws 75 percent of its inpatient admissions, as stated in the regulations text at § 412.92(c)(3).''

We have not restricted a hospital's source of data for defining its service area to the use of zip codes or to Statewide planning commissions. These are merely the two most common methods and, thus, are the two we have

discussed in detail. There have been instances where a State hospital association has been the source of data used to define the hospital's service area. If a hospital does not wish to use the zip code methodology to define its service area, we will review data from any independent source that can supply documented data to identify the hospital's service area. The important consideration is that we must be able to verify supportable evidence that a hospital drew at least 75 percent of its inpatients from the defined service area.

In regard to the commenter who requested that a hospital be permitted to define its service area using either the lowest number of zip codes *or* the lowest number of contiguous zip codes, we do not agree. Since October 1, 1988, any hospital choosing to define its service area using the zip code methodology has been required to use the lowest number of zip codes from which it drew at least 75 percent of its inpatients during its most recently completed cost reporting period.

We have not permitted any hospital to define its service area using the lowest number of contiguous zip codes because we do not believe this method presents as accurate a picture of a hospital's true service area as does the actual lowest number of zip codes. Although the commenter presented an elaborate example of how a hospital might meet the market share test if its service area is based on contiguous zip codes, but not meet the market share test when service area is defined strictly as the lowest number of zip codes, we do not believe such a scenario is likely to occur with any frequency. And, as noted above, a hospital is not required to use the zip code methodology to define its service area. If a hospital does not qualify using the lowest number of zip codes, it can look to other sources such as a State hospital association, Statewide planning commission, or any other independent body that can present documentable data to verify that at least 75 percent of its inpatients came from the identified area.

Comment: One commenter was concerned about the interim payments that sole community hospitals receive during the year. Specifically, the commenter was troubled by the method we use to account for outlier payments. Because our pricing methodology assumes that all sole community hospitals will receive ''average ''outlier payments, the aggregate interim payments for a hospital with few outliers are less than the amount ultimately due the hospital. Although the difference is paid to the hospital during its cost report settlement, the commenter claimed that the delay in receiving the money due the hospital has caused dire financial consequences.

Response: One of the difficulties in making interim payments during the year for sole community hospitals is not knowing precisely the amount of outlier payments the hospital is going to receive. Currently, we simply use the overall national expected rate of approximately 5.1 percent to adjust the Federal payment rate. That is, we take the hospital's Federal payment rate, already adjusted for the wage index, indirect medical education factor, and disproportionate share factor, and further adjust the rate by assuming that the hospital's outlier payments will be 5.1 percent of its total DRG payments. Then, we compare this amount to the hospital-specific amount and, if the hospital-specific amount is higher, we make the difference an add-on to the Federal payment rate in making interim payments.

Some sole community hospitals, however, actually receive much less in outlier payments than the national average of 5.1 percent. This causes our estimate of their outlier-adjusted Federal payments to be higher than is really the case. Therefore, the hospital does not receive all of its add-on payments during the year, because the difference between the hospital-specific rate and the estimated adjusted Federal payment rate is understated. The effect is a potentially large payment to the hospital at the time of settlement. We note that for sole community hospitals with higher than average outlier payments, the opposite problem results. That is, the hospitals are overpaid during the year and must repay monies to the Federal Government at cost report settlement.

We believe an assumption based on the expected percentage of overall national outlier payments is reasonable, but we will explore this problem in more detail during the next year and try to determine if use of a hospital-specific outlier adjustment factor for this limited purpose would be more appropriate, as well as feasible.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban rather than the rural standardized amount. As of that date, the other urban and rural standardized amounts 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 follow 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 1995 (October 1, 1994 through September 30, 1995) and included bills posted to HCFA's records through December 1995. 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,

1996, a hospital's case-mix index value for FY 1995 would have to be at least—

- 1.3332; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located. (See the table set forth in the May 31, 1996 proposed rule at 61 FR 27472.)

Based on the latest data available (FY 1995 bills received through June 1996), the final national case-mix value is 1.3347 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)	1.2249
2. Middle Atlantic (PA, NJ, NY)	1.2230
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3396
4. East North Central (IL, IN, MI, OH, WI)	1.2471
5. East South Central (AL, KY, MS, TN)	1.2933
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2125
7. West South Central (AR, LA, OK, TX)	1.3116
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3339
9. Pacific (AK, CA, HI, OR, WA)	1.3303

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 1995 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 1994 (that is, October 1, 1993 through September 30, 1994). 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, 1996, the number of discharges a hospital must have for its cost reporting period that began during FY 1995 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, 1996 proposed rule at 61 FR 27472.)

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

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6771
2. Middle Atlantic (PA, NJ, NY)	8486
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7504
4. East North Central (IL, IN, MI, OH, WI)	7384
5. East South Central (AL, KY, MS, TN)	6386
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5794
7. West South Central (AR, LA, OK, TX)	4806
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7553
9. Pacific (AK, CA, HI, OR, WA)	5617

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1996, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1995 must be at least 3,000.

3. Retention of Referral Center Status

Section 412.96(f) states 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 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 1997 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 1997, a hospital must meet the criteria in § 412.96(c) for FY 1997 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
1996	1994	1994	September 1, 1995.
1995	1993	1993	September 1, 1994.
1994	1992	1992	September 1, 1993.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1994. The hospital has fewer than 275 beds. Its 3-year status as a referral center is protected through June 30, 1997 (the end of its cost reporting period beginning July 1, 1996). 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, 1994, July 1, 1995, and July 1, 1996. The hospital must meet the criteria in effect either for its cost reporting period beginning July 1, 1997, 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, 1995, the hospital's case-mix index value during FY 1993 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 1, 1994 final rule with comment period. The hospital's total number of discharges during its cost reporting year beginning July 1, 1993, must have equaled or exceeded 5,000 or the regional standard as published in the September 1, 1994 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. We received no comments on the rural referral center criteria.

C. Disproportionate Share Adjustment (§ 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. The disproportionate share adjustment, which was added to the prospective payment system by section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), was intended to address the higher Medicare costs associated with treating a large number of low-income patients. Under this provision, patients who are eligible for Medicaid and Supplemental Security Income (SSI) benefits were used as a proxy measure of the proportion of low-income patients.

A hospital's disproportionate share adjustment is generally determined by calculating the sum of two patient percentages (Medicare Part A/ Supplemental Security Income (SSI) covered days to total Medicare Part A covered days, and Medicaid but not Medicare Part A covered days to total inpatient hospital days). Based on the location and size of the hospital, a formula determines if the hospital's patient percentage qualifies the hospital for an adjustment and how much that adjustment will be. There is also a limited exception providing for disproportionate share adjustments for large urban hospitals that receive substantial state and local revenues for indigent (non-Medicare, non-Medicaid) care.

With respect to the Medicare-SSI calculation, hospitals have expressed dissatisfaction with these proxy measures, and have challenged HCFA's implementation of them in recent litigation. Since SSI beneficiary information is confidential, hospitals do not have access to lists of patients who are eligible for both Medicare Part A and SSI benefits. Hospitals are increasingly frustrated by their inability to monitor these data.

With respect to the Medicaid fraction, hospitals have complained that, because of Medicaid coverage restrictions, Medicaid covered days may not be a consistent measure of indigent care across States. Medicaid reforms under consideration by the President and Congress may further interfere with the utility of Medicaid covered days as a measure of the proportion of low-income patients.

Because of these concerns, we have been examining alternative measures of indigent care. Some of the measures we have explored using are estimates of patient income in a hospital's service area, hospital levels of bad debt, and proportion of emergency room admissions in a hospital. Because of data and other limitations, however, we have yet to find an alternative that appears promising as a replacement to the present measure. Therefore, in the proposed rule, we solicited comments from the industry on better and more direct measures of indigent care than the present measure that relies on SSI and Medicaid data. We also discussed ProPAC's recommendations concerning DSH payments (61 FR 27474).

Comment: A large number of commenters responded to our request for input on the Medicare disproportionate share adjustment calculation and the SSI and Medicaid data that go into its development. Some commenters believe that the current method of identifying disproportionate share hospitals is acceptable. Other commenters stated that we should implement a revised formula only if it captures the current base of eligible hospitals as well as additional facilities. Finally, several commenters believe that the current calculation is flawed beyond repair and that we should reevaluate the current base of hospitals that are eligible for payments under the disproportionate share adjustment and revise the formula dramatically. The suggestions we received follow:

- Use the current formula, but expand Medicaid days to include all days that a person eligible for Title XIX spends in the hospital, whether or not Medicaid paid. Further, in the case of States that have replaced traditional Medicaid programs with alternate health care programs for their low-income population, include all days that a person who is covered by the State's program spends in the hospital, whether or not that person would have been eligible for Title XIX benefits.
- Use the current formula and include outpatient data as well as inpatient data.
- Use data from the Department of Commerce based on income levels and zip code information to determine median income levels within designated service areas. These data can then be compared to Federal poverty guidelines to establish the appropriate level of disbursement of disproportionate share payments.
- Combine charity care and bad debts as reported on the hospital's financial statements and multiply by the hospital's overall cost-to-charge ratio. Then, divide these costs by the hospital's net patient revenue excluding Medicare, Medicaid, Medicare health maintenance organization (HMO), and Medicaid (HMO) data. This method is similar to the current qualifying criteria for an exception under the disproportionate share adjustment calculation set forth at § 412.106(c)(2).
- Use the low-income utilization rate that is currently used in the administration of Medicaid disproportionate share adjustments. This is a combination of a hospital's Medicaid revenues and its State and local subsidies divided by its total revenues and its inpatient charity care charges minus its State and local inpatient subsidies divided by total charges.

Some of the commenters referred to the decisions in court cases in the 6th and the 8th Circuits that require the inclusion of days that would have been paid by Medicaid but for a State day limitation in the disproportionate share calculation. These commenters encouraged HCFA to implement the Court's ruling at the national level. Other commenters were concerned

about the inclusion of HMO and other managed care utilization data in the calculation. Many of these commenters suggested that HCFA should require States to more accurately identify the Medicaid enrollees who receive services under a waiver program, possibly by providing these enrollees with encrypted insurance cards to reflect Title XIX eligibility.

Several commenters believe that the adjusted average per capita cost (AAPCC) payment rate for Medicare managed care plans should be revised to exclude any adjustment for disproportionate share and that those payments should be made directly to the eligible hospitals. Several commenters offered to work with HCFA on this issue.

Response: We appreciate the responses that we received on the disproportionate share adjustment issue. Members of the hospital industry and its representatives carefully considered the question of data sources, targeted hospitals, and the indigent population. In general, commenters believe that compensation for hospitals that treat a disproportionate share of the indigent population is valid. However, as noted above, there are conflicting ideas about how to target that set of hospitals.

Although many of these comments will require further analysis, we will address some suggestions here. First, in the current formula, we believe that Medicaid covered days is the correct measure and the correct interpretation of Congressional intent as we have outlined on numerous previous occasions, most notably in the September 1, 1986 final rule (54 FR 31460–31461). Given the current statute, we believe it is not reasonable to include days that a person spent in the hospital while that person was not eligible for Medicaid under any circumstances. The statute clearly states that title XIX eligibility is a requirement under any circumstances. If a State chooses to adopt some sort of a waiver program and elects to cover people who would not have otherwise been eligible for care, those persons will not be included as Medicaid days in the current formula. Further, inpatient data are used in the Medicare disproportionate share adjustment calculation because the payment add-on is applied to the Medicare inpatient payment. It is not designed to reflect either Medicaid shortfalls or outpatient data, since there is a separate Medicaid disproportionate share adjustment, and payment for outpatient services is not made through a prospective payment system.

Data from the Department of Commerce based on the U.S. Census are collected only during decennial census periods. Thus, while the data look promising on first analysis, they become increasingly unrepresentative of the population's income trends as they relate to geographic areas as the years pass from the base year for which the data are collected. We also have a problem with any data that may be reported on a hospital's financial statements but that are not reported on its annual Medicare cost report. The Medicare cost report data are collected annually and subject to a settlement process. The financial statements of hospitals vary from facility to facility, are audited on an erratic schedule, and are not currently collected by Medicare for evaluation.

Finally, we would not want to duplicate the procedure by which the Medicaid disproportionate share adjustment is determined since the Medicaid program already pays hospitals an adjustment under Medicaid based on these criteria.

Regarding commenters' concerns on HMO days, currently we collect data on HMO utilization for use in the disproportionate share adjustment calculation. However, it is up to the hospital, in securing the contract with the HMO, to obtain an agreement from the HMO that allows the hospital to be able to distinguish those Medicare and Medicaid patients that are utilizing services so that it may report those days to the fiscal intermediary. We note that the President's FY 1997 budget includes a provision that would mandate the removal of disproportionate share payments from the AAPCC calculation and allow these payments to be made directly to the eligible hospital.

While there appears to be no easy or quick solution to improving the disproportionate share payment adjustment, we appreciate the comments that the hospital industry provided on this issue. Our concern is that Medicaid data will continue to vary more and more from State to State and SSI data will continue to be protected from the hospital industry's examination by the Privacy Act. Therefore, we will continue to examine the inconsistencies in the current Medicare disproportionate share adjustment calculation and ways to improve the data and the calculation to better target those hospitals that treat a disproportionate share of the indigent population.

D. Direct Graduate Medical Education (§ 413.86)

1. Initial Residency Period Limitations

As discussed in the proposed rule, we are updating the Initial Residency Period Limitations for direct graduate medical education (GME), originally published in the Federal Register on September 29, 1989 (54 FR 40286). The regulations in § 413.86(g)(1) state that, ''[e]ffective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.''

The update reflects the following:

- Effective July 1, 1995, section 1886(h)(5)(F) of the Act, as amended by Public Law 103–66, defines an initial residency period as the minimum number of years required for initial board eligibility. Previously, this period had been defined as minimum number of years ''plus one.'' The prior listing had included the additional year, not to exceed five years.
- Changes in curriculum requirements regarding the number of years needed for board eligibility for previously approved programs.
- Addition of newly approved graduate medical education programs.

The table of initial residency periods published in the proposed rule (61 FR 27475) did not constitute a proposal in the usual rulemaking sense because we were simply updating the tables in accordance with current policy. Nevertheless, we received many comments that reflected a misunderstanding of the meaning of ''initial residency period'' in general. The initial residency period, as that term is used in section 1886(h)(5) (F) and (G) of the Act and in § 413.86 refers to the minimum number of years necessary to satisfy the requirements for initial board eligibility in a specialty. During the initial residency period, each full-time resident is weighted at 1.0 full-time equivalent (FTE) for purposes of determining GME payments. Once the resident has worked the minimum number of years required for board eligibility in a specialty, any subsequent training in an approved program is weighted at 0.5 FTE.

The comments on the updated listing also brought to our attention information that has resulted in changes in the table of initial residency periods. We have added allopathic allergy and immunology with an initial residency period of 3 years, osteopathic preventive medicine/aerospace medicine with an initial residency of 4 years, and osteopathic combined programs in internal medicine/emergency medicine and internal medicine/pediatrics with

an initial residency period of 4 years. We have also modified the table by listing pathology/anatomic and pathology/clinical with respective initial residency periods of 3 years and pathology/anatomic and clinical with an initial residency period of 4 years. Finally, in the proposed rule, emergency medicine was listed with an initial residency period of 3/4 years due to our understanding that these programs have been approved for both 3 and 4 years. However, since the Accreditation Council for Graduate Medical Education (ACGME) has approved 3-year programs, the *minimum* number of years of training to become board eligible in emergency medicine is actually 3 years. Accordingly, we are including the appropriate initial residency period limitation of 3 years in the table in this final rule.

INITIAL RESIDENCY PERIOD LIMITATIONS

Residency type	Initial residency period limitation (No. of years)
ALLOPATHY	
ALLERGY AND IMMUNOLOGY	3
ANESTHESIOLOGY	4
Critical Care Medicine	4
Pain Management	4
COLON AND RECTAL SURGERY	5
DERMATOLOGY	4
Dermatopathology	4
Clinical & Laboratory Dermatological Immunology	4
EMERGENCY MEDICINE	3
Sports Medicine	3
FAMILY PRACTICE	3
Geriatric Medicine	5
Sports Medicine	3
INTERNAL MEDICINE	3
Adolescent Medicine	3
Cardiovascular Disease	3
Clinical Cardiac Electrophysiology	3
Clinic & Laboratory Immunology	3
Critical Care Medicine	3
Endocrinology, Diabetes, and Metabolism	3
Gastroenterology	3
Geriatric Medicine	5
Hematology	3
Hematology and Oncology	3
Infectious Disease	3
Medical Oncology	3
Nephrology	3
Pulmonary Disease	3
Pulmonary Disease and Critical Care Medicine	3
Rheumatology	3
Sports Medicine	3
MEDICAL GENETICS	4
NEUROLOGICAL SURGERY	5
Pediatric Neurological Surgery	5
NEUROLOGY	4
Child Neurology	4
Clinical Neurophysiology	4
NUCLEAR MEDICINE	3
OBSTETRICS AND GYNECOLOGY	4
Critical Care Medicine	4
Gynecological Oncology	4
Maternal and Fetal Medicine	4
Reproductive Endocrinology	4
OPHTHALMOLOGY	4
ORTHOPAEDIC SURGERY	5
Adult Reconstructive Orthopaedics	5
Foot and Ankle Orthopaedics	5
Hand Surgery	5
Musculoskeletal Oncology	5
Pediatric Orthopaedics	5
Spinal Cord Injury	5
Sports Medicine	5
OTOLARYNGOLOGY	5
Neurotology/Otolaryngology	5
Pediatric Otolaryngology	5
PATHOLOGY, ANATOMIC	3
PATHOLOGY, CLINICAL	3
PATHOLOGY, ANATOMIC AND CLINICAL	4
Blood Banking/Transfusion Medicine	4
Chemical Pathology	4

INITIAL RESIDENCY PERIOD LIMITATIONS—Continued

Residency type	Initial residency period limitation (No. of years)
Cytopathology	4
Dermatopathology	4
Forensic Pathology	4
Hematology	4
Immunopathology	4
Medical Microbiology	4
Neuropathology	4
Pediatric Pathology	4
PEDIATRICS	3
Adolescent Medicine	3
Clinical and Laboratory Immunology	3
Neonatal-Perinatal Medicine	3
Pediatric Cardiology	3
Pediatric Critical Care Medicine	3
Pediatric Emergency Medicine	3
Pediatric Endocrinology	3
Pediatric Gastroenterology	3
Pediatric Hematology/Oncology	3
Pediatric Infectious Disease	3
Pediatric Nephrology	3
Pediatric Opthamology	3
Pediatric Pulmonology	3
Pediatric Rheumatology	3
Pediatric Sports Medicine	3
PHYSICAL MEDICINE AND REHABILITATION	4
PLASTIC SURGERY	5
Hand Surgery	5
PREVENTIVE MEDICINE	3
Aerospace Medicine	3
Medical Toxicology	3
Occupational Medicine	3
Public Health & General Preventive Medicine	3
PSYCHIATRY	4
Addiction Medicine	4
Child & Adolescent Psychiatry	4
Forensic Psychiatry	4
Geriatric Psychiatry	5
RADIOLOGY, DIAGNOSTIC	4
Neuroradiology	4
Nuclear Radiology	4
Pediatric Radiology	4
Vascular and Interventional Radiology	4
Radiation Oncology	4
SURGERY, GENERAL	5
Critical Care Medicine	5
Hand Surgery	5
Pediatric Surgery	5
Thoracic Surgery	5
Vascular Surgery	5
UROLOGY	5
Pediatric Urology	5
OSTEOPATHY	
ANESTHESIOLOGY	4
Critical Care Medicine	4
DERMATOLOGY	4
Dermatopathology	4
MOHS Micrographic Surgery	4
EMERGENCY MEDICINE	4
Sports Medicine	4
FAMILY PRACTICE	3
Adolescent and Young Adult Medicine	3
Geriatrics	5
Sports Medicine	3
INTERNAL MEDICINE	4
Clinical Allergy and Immunology	4
Cardiology	4
Endocrinology	4
Gastroenterology	4
Hematology	4
Infectious Diseases	4

INITIAL RESIDENCY PERIOD LIMITATIONS—Continued

Residency type	Initial residency period limitation (No. of years)
Nephrology	4
ONCOLOGY	4
Pulmonary Diseases	4
Rheumatology	4
Clinical Cardiac Electrophysiology	4
Critical Care Medicine	4
Geriatrics	6
Sports Medicine	4
NUCLEAR MEDICINE	4
In-Vivo and In-Vitro Nuclear Medicine	4
Nuclear Cardiology	4
Nuclear Imaging and Therapy	4
NEUROLOGY	4
Child Neurology	4
PSYCHIATRY	4
Child Psychiatry	4
OBSTETRICS/GYNECOLOGY	5
Maternal and Fetal Medicine	5
Gynecological Oncology	5
Reproductive Endocrinology	5
FACIAL PLASTIC SURGERY	5
OPHTHALMOLOGY	4
OTORHINO/FACIAL PLASTIC SURGERY	5
OTORHINOLARYNGOLOGY	5
ORTHOPEDIC SURGERY	5
PATHOLOGY, ANATOMIC	4
PATHOLOGY, ANATOMIC/LABORATORY MEDICINE	5
PATHOLOGY, LABORATORY MEDICINE	4
Forensic Pathology	5
Blood Banking/Transfusion Medicine	5
Chemical Pathology	5
Cytopathology	5
Dermatopathology	5
Hematology	5
Immunopathology	5
Medical Microbiology	5
Neuropathology	5
PEDIATRICS	3
Adolescent and Young Adult Medicine	3
Neonatal Medicine	3
Pediatric Allergy/Immunology	3
Pediatric Cardiology	3
Pediatric Hematology/Oncology	3
Pediatric Infectious Diseases	3
Pediatric Intensive Care	3
Pediatric Nephrology	3
Pediatric Pulmonology	3
Pediatric Sports Medicine	3
PREVENTIVE MEDICINE	4
PREVENTIVE/AEROSPACE MEDICINE	4
PROCTOLOGY	3
RADIATION ONCOLOGY	4
RADIOLOGY, DIAGNOSTIC	5
Angiography and Interventional Radiology	5
Diagnostic Ultrasound	5
Neuroradiology	5
Nuclear Radiology	5
Radiological Imaging	5
Pediatric Radiology	5
REHABILITATION MEDICINE	4
Sports Medicine	4
GENERAL SURGERY	5
NEUROSURGERY	5
PLASTIC AND RECONSTRUCTIVE SURGERY	5
THORACIC CARDIOVASCULAR SURGERY	5
UROLOGICAL SURGERY	5
GENERAL VASCULAR SURGERY	5
CRITICAL CARE SURGERY	5
OSTEOPATHIC MANIPULATIVE MEDICINE	3
PODIATRY	
ROTATING PODIATRIC RESIDENCY(PRIMARY CARE)	2

INITIAL RESIDENCY PERIOD LIMITATIONS—Continued

Residency type	Initial residency period limitation (No. of years)
PODIATRIC ORTHOPEDIC RESIDENCY	2
PODIATRIC SURGICAL RESIDENCY	2
DENTISTRY	
DENTAL PUBLIC HEALTH	1
ENDODONTICS	2
ORAL PATHOLOGY	3
ORAL AND MAXILLOFACIAL SURGERY	4
ORTHODONTICS	2
PEDIATRIC DENTISTRY	2
PERIODONTICS	3
PROSTHODONTICS	3
PROSTHODONTICS/MAXILLOFACIAL	3
GENERAL DENTISTRY	1
ADVANCED GENERAL DENTISTRY	2
ALLOPATHY COMBINED PROGRAMS*	
FAMILY PRACTICE(3) AND PSYCHIATRY(4)	4
INTERNAL MEDICINE(3) & EMERGENCY MEDICINE(3)	3
INTERNAL MEDICINE(3) & FAMILY PRACTICE(3)	3
INTERNAL MEDICINE(3) & NEUROLOGY(4)	4
INTERNAL MEDICINE(3) & PEDIATRICS(3)	3
INTERNAL MED(3) & PHYS MED & REHABILITATION(4)	4
INTERNAL MEDICINE(3) & PREVENTIVE MEDICINE(5)	5
INTERNAL MEDICINE(3) & PSYCHIATRY(4)	4
NEUROLOGY(4) & PHYS MEDICINE AND REHAB(4)	4
PEDIATRICS(3) & EMERGENCY MEDICINE(3)	3
PEDIATRICS(3) & PHYSICAL MEDICINE AND REHAB(4)	4
PEDIATRICS(3)/PSYCHIATRY(4)/CHILD&ADOL PSYCH(4)	4
PSYCHIATRY(4) AND NEUROLOGY(4)	4
OSTEOPATHY COMBINED PROGRAMS*	
INTERNAL MEDICINE/EMERGENCY MEDICINE	4
INTERNAL MEDICINE/PEDIATRICS	4

*For residents participating in combined programs, Medicare limits the initial residency period to the time required for individual certification in the longer of the two programs.

2. Combined Residency Programs

As discussed in the proposed rule, when we updated the listing of the Initial Residency Period Limitations for GME, we noted many new programs that were combined specialty residency programs. The combined programs run concurrently for a period of time that is longer than the required time for certification in either specialty, but shorter than would be required if the programs were taken sequentially. Residents completing these programs are eligible for board certification in both specialties.

We use the Internal Medicine and Pediatrics combined program as an example: Taken individually, Internal Medicine is a 3-year program and Pediatrics is also a 3-year program. However, taken as a combined program, Internal Medicine and Pediatrics is a 4-year program, with eligibility for certification in both specialties.

Currently, we are aware of 13 allopathic and 2 osteopathic combined programs, including Internal Medicine/Pediatrics, Pediatrics/Emergency Medicine, Family Practice/Psychiatry, and Neurology/Physical Medicine and Rehabilitation. Due to the increasing prevalence of combined residency programs since our September 29, 1989 final rule, we proposed to clarify how the definition of initial residency period applies in such cases. As discussed in detail in the proposed rule (61 FR 27477), we proposed to clarify the definition of the initial residency period for combined programs as the time required for individual certification in the longer of the two programs. Continuing to use Internal Medicine and Pediatrics as an example, we would define the initial residency for Internal Medicine and Pediatrics as 3 years. The remaining year of the combined program would be treated as 0.5 FTE, in accordance with § 413.86(g)(3). We received numerous comments on this policy, and the issues raised by the commenters are discussed below.

Comment: Many commenters disagreed with our clarification concerning initial residency periods for combined programs. These commenters stated that residents in combined programs are not board eligible in either specialty until they have completed the entire combined program. Some commenters asserted that we did not understand that training in combined programs does not occur sequentially. One commenter noted that the *Graduate Medical Education Directory* states that ''applicants may not appear for certifying examinations until all training has been completed.'' Many commenters stated that the law states that a resident is to be counted as a 1.0 FTE during the resident's initial residency period, which is defined as the ''period of board eligibility'' in section 1886(h)(5)(F) of the Act. These commenters do not believe we have the authority to establish an initial residency period that is shorter than the length of the combined program, because Medicare will not be paying for residents at 1.0 FTE for the period of initial board eligibility.

Several commenters noted that a resident enrolled in a combined program is enrolling in one program and receives a single certificate upon completion. One commenter stated that the directors of combined programs have not sought to independently certify their graduates with a single examination administered by a single

board. This commenter added that similar to family practice, combined programs are not a composite of separate specialties and should be recognized as a single discipline. Other commenters noted that training in combined internal medicine/pediatrics programs is more intensive than family practice and the initial residency period should recognize this superior training in adult and pediatric medicine. Some commenters believe our proposal implies that training in a second specialty is ''superfluous, nonessential or less important.''

Response: We have always recognized that the training in combined programs does not occur sequentially, and we acknowledge that residents participating in combined programs are not board eligible in either specialty until they have completed all of their training requirements. We agree that combined training is more intensive than training in each specialty taken separately, and we never stated or meant to imply that training in a second specialty is unimportant or superfluous. Our intent is simply to establish a reasonable policy, consistent with the statute, that provides for full Medicare payment for training in one speciality.

We believe our policy is consistent with section 1886(h)(5)(F) of the Act, which defines ''initial residency period'' as ''the period of board eligibility.'' Section 1886(h)(5)(G) defines the ''period of board eligibility'' as ''the *minimum* number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.'' (Emphasis added.)

The statute does not address how to count the initial residency period in combined programs, perhaps because such programs were not contemplated at the time the statute was enacted. We believe the statutory scheme indicates congressional intent to allow ''full'' Medicare payment only for the minimum period required to train in *one* specialty. Contrary to the suggestion of the commenters, it is clear that the statute does not require Medicare to apply a weighting factor of 1.0 for a resident until the resident actually becomes board eligible. Rather, the statute requires a weighting factor of 1.0 only for the ''minimum number of years necessary to satisfy the requirements for initial board eligibility''; for time beyond the ''minimum'' period, the statute provides that the weighting factor is 0.5. Thus, the statute contemplates Medicare payments for the costs of graduate medical education, but it does not impose an open-ended obligation for Medicare to pay full costs until a resident becomes board eligible.

The statute defines the initial residency period as the ''minimum number of years'' necessary to satisfy the requirements for the ''particular specialty'' for which the resident is training. Based on the public comments we received, we are not persuaded that combined residency programs are ''particular specialties'' in and of themselves. As we understand it, graduates of these combined residency programs are *not* certified by a single examination by a single board. Rather, they must take each board's examination separately. Thus, these residents can become board eligible for each distinct specialty (for example, Internal Medicine and Pediatrics). It appears that combined programs simply combine training in separate specialties (whose requirements may overlap). As always, we are willing to consider further information on this issue.

We believe our policy on combined programs is reasonable. Residents in combined programs complete all of the training requirements for two specialties, but the *minimum* number of years required to become board eligible in either specialty is less than the length of the combined program. We believe it is reasonable to define the initial residency period for combined programs as the longer of the initial residency periods for the two specialties. Our policy is consistent with the manner in which Medicare payment would be made if the resident trained in two specialties in a sequential manner. In such cases, the resident would be counted as a full 1.0 FTE during the training for the first specialty, and as 0.5 FTE for later years.

Comment: Many commenters stated that Congress established the initial residency period limitation with the intent of discouraging subspecialty training and increasing the primary care work force. These commenters do not believe that Congress intended to limit training in combined programs consisting of two primary care specialties. Similarly, other commenters noted that graduates of combined programs are more likely to enter primary care practice in rural and medically underserved areas than are graduates of other programs. These commenters said that our proposal conflicts with Congress' goal to provide medical care to rural and medically underserved areas.

Response: The initial residency period limitation on full Medicare payment applies to all types of programs, both primary care and non-primary care, and is not intended to discourage primary care practice. We agree with these commenters that in general Federal policy should encourage more training in primary care and that programs designed to encourage practice in rural and medically underserved areas should continue to be an important component of Federal health policy. However, we believe that these concerns are more properly addressed in other contexts. We note that section 1886(h)(2)(D) of the Act provides updates to the per resident amounts for primary care residents, but the statute does not distinguish between primary and non-primary care specialties for purposes of determining the initial residency period.

Comment: Some commenters were concerned that our policy clarification would lead to the dismantling of combined residency programs.

Response: As we have stated, we believe this policy clarification is necessary to avoid full Medicare payments, beyond the time required to train in one specialty. We note that hospitals will continue to be paid for residents in combined programs beyond their initial residency period, with the residents weighted at 0.5 FTE.

Comment: Several commenters were concerned that HCFA developed this policy, in part, to control Medicare's graduate medical education payments. These commenters noted that there are few of these programs in existence with only a small number of graduates who will be affected. Accordingly, Medicare savings resulting from this policy clarification will be small.

Response: This policy clarification is based on considerations concerning the appropriate application of the statute and does not arise solely from a goal of limiting payments. However, we acknowledge that Medicare's payment liabilities will be less under this policy than if hospitals were allowed to weight residents as 1.0 FTE throughout the entire training period in the combined program. We believe that combined training programs may have grown in recent years as physicians seek additional qualifications in a competitive job market. Our understanding is that there are more than 1,400 students in combined programs. Given that only a portion of these students are beyond the initial residency period under this clarification, we agree that any budgetary impact is small relative to the total number of residents participating in approved programs.

Comment: One commenter noted that osteopathic residency programs allow 4 years for internal medicine but that allopathic residency programs allow 3

years. This commenter suggested that if we modified the initial residency periods so that both were of the same duration, the 4-year combined residency could be accommodated.

Response: Allopathic and osteopathic specialty boards set different requirements for board certification. The first year of postgraduate osteopathic training consists of a rotating internship which is followed by subsequent specialty training. Most allopathic training programs do not require similar training. In the September 29, 1989 GME regulation published in the Federal Register (54 FR 40293), we stated that the osteopathic rotating internship, like the transitional year required by some allopathic medical residency programs, would not count as an additional year beyond initial board eligibility.

Comment: One commenter questioned the limitation on the number of years noted on the table for geriatric psychiatry. The listing of the initial residency periods permits an additional year for training in geriatric medicine as a subspecialty of internal medicine and family practice but not as a subspecialty of psychiatry. This commenter noted that there is a minimum requirement of 4 years of training in psychiatry and requested that the initial residency period be extended to 5 years for training in geriatric psychiatry. Another commenter noted that section 1886(h)(5)(F) of the Act provides that a 2-year geriatric residency or fellowship program is treated as part of the initial residency period, ''but shall not be counted against any limitation on the initial residency period.'' This commenter stated that the law clearly provides that geriatric psychiatry programs should be eligible for full funding under the special geriatric medical education provision described in the law. Other commenters noted that the Accreditation Council for Graduate Medical Education (ACGME) only accredited geriatric subspecialty programs in family and internal medicine when the 1989 regulations were published but now recognizes geriatric subspecialty programs in psychiatry.

Response: We agree that the initial residency period for geriatric psychiatry programs should be revised. When the September 29, 1989 regulation (54 FR 40286) was published, the ACGME was in the process of approving training programs in geriatrics as a subspecialty of internal medicine and family practice. At that time, we proposed to consider expanding the exception to the initial residency period limitation to fellowships in other programs when the appropriate national organizations establish criteria for approving these programs. Subsequently, the ACGME established criteria for accrediting 12-month programs in geriatric psychiatry, and the American Board of Psychiatry and Neurology recognizes applicants with the required training for certification in geriatric psychiatry. Accordingly, we are including geriatric psychiatry in the table above with an initial residency period of 5 years, which includes a 1-year exception to the 4-year initial residency period for psychiatry. We are also modifying the definition of ''approved geriatric program'' in § 413.86(b) to reflect that the ACGME is accrediting, and boards are recognizing, training in geriatric medicine in specialties other than internal medicine and family practice.

3. Statutory Provision Regarding Prohibition on Abortion-Related Discrimination in Training and Licensing of Physicians (§§ 412.105(g) and 413.86(b))

Congress recently enacted a statutory provision that prohibits certain abortion-related discrimination by the Federal Government and State and local governments. In section 515 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 1996 (see section 101(d) of the Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104–134), enacted April 26, 1996, Congress added a new section 245 to the Public Health Service Act to provide that:

> ''The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—
>
> (1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions;
>
> (2) the entity refuses to make arrangements for any of the activities specified in paragraph (1); or
>
> (3) the entity attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide or refer for training in the performance of induced abortions, or make arrangements for the provision of such training.''

For purposes of section 245, the statute defines ''financial assistance'' to include ''governmental payments provided as reimbursement for carrying out health-related activities,'' and defines ''health care entity'' to include individual physicians, postgraduate physician training programs (which includes residency training programs), and participants in a program of training in the health professions.

The new section also addresses accreditation of postgraduate physician training programs. Specifically, the statute provides that:

> ''In determining whether to grant a legal status to a health care entity (including a license or certificate) or to provide such entity with financial assistance, services or other benefits, the Federal government, or any State or local government that receives Federal financial assistance, shall deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such accreditation standard provides exceptions or exemptions.''

The statute further requires that the government involved ''shall formulate such regulations or other mechanisms, or enter into such agreements with accrediting agencies, as are necessary to comply with this subsection.''

Under the terms of the statute, the provisions of section 245 shall not ''prevent any health care entity from voluntarily electing to be trained, to train, or to arrange for training in the performance of, to perform, or to make referrals for induced abortions.'' Similarly, the provisions of section 245 shall not ''prevent an accrediting agency or a Federal, State or local government from establishing standards of medical competency applicable only to those individuals who have voluntarily elected to perform abortions.''

In this document, we are making conforming changes to the regulations at § 412.105(g) and § 413.86(b) to reflect the accreditation provisions of section 245. These technical changes merely conform the regulations text to the express requirements of the statute, and do not involve an exercise of discretion by the agency.

E. Distribution of an ''Important Message from Medicare'' (§ 489.27)

Under § 489.27 of our provider agreement regulations, all hospitals that participate in Medicare (including those not paid under the prospective payment system) must agree to furnish each Medicare beneficiary with a notice, at or about the time of admission, that explains the patient's discharge rights. This statement, entitled ''An Important Message from Medicare,'' advises a beneficiary of his or her rights to be fully informed about decisions affecting

Medicare coverage or payment and about his or her appeal rights in response to any hospital's notice to the effect that Medicare will no longer cover the patient's care. The ''Important Message'' also advises the patient of what to do when he or she receives such a hospital statement and how to elicit more information.

In November 1993, the Medicare Technical Advisory Group (M–TAG) established the Beneficiary Protection and Documentation Issues Task Force. The task force consists of HCFA staff as well as representatives from health care industry organizations, beneficiary advocate groups, fiscal ntermediaries, and peer review organizations (PROs). The task force was charged with reviewing various issues that impact beneficiaries and the health care community, including how to improve the effectiveness of ''An Important Message from Medicare.''

We proposed to adopt a recommendation of this task force that would respond to numerous requests for clarification on the timing of the written notice of discharge rights that must be given to hospital inpatients. As noted above, existing § 489.27 specifies that a hospital must distribute the statement ''at or about the time of admission.'' We understand that for monitoring purposes some PROs have interpreted this requirement to mean ''within 24 hours preceding or following the admission.'' However, we agree with the task force's determination that the PRO's interpretation is unnecessarily narrow. We believe that during the first 24 hours of a patient's admission, the hospital is primarily concerned with ensuring appropriate treatment of the patient's illness or injury. Therefore, we proposed to change § 489.27 to specify that the hospital must provide timely notice during the course of the hospital stay.

For purposes of this requirement, we would consider the course of the hospital stay to begin when the hospital provides the individual with a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. This would give hospitals more flexibility in meeting the requirement, as well as encourage the distribution of the ''Important Message'' at a time when the beneficiary is better able to receive and more likely to understand its contents. In complying with the requirement to provide timely notice during the course of the patient's hospital stay, the hospital must give the patient the ''Important Message'' far enough in advance of the hospital's written notice regarding continued stay to provide the beneficiary time to appeal the hospital's decision. Finally, ''timely notice'' would also include adherence to any State requirements on the provision of patient rights notices.

We received only one comment on this proposal.

Comment: One commenter agreed with the proposal to permit hospitals to provide timely notice during the course of the hospital stay. However, the commenter stated that the ''Important Message'' is currently ineffective in meeting its intended purpose, regardless of the timing, because people are too sick and frightened to comprehend the information at the point of hospitalization. The commenter suggested instead using mass mailings to Medicare beneficiaries when they are healthy and have no immediate plans to be hospitalized.

Response: While we agree that making this information available to the Medicare beneficiary prior to hospitalization may enhance comprehension, we believe that the ''Important Message'' may be ignored during a mass mailing because the information would not be considered needed at the time. Moreover, it is a statutory requirement that the ''Important Message'' be provided during an individual's hospitalization; therefore, we cannot accept the commenter's suggestion. Furthermore, in our proposal, while we did not intend to address the effectiveness or the content of the ''Important Message'' in this regulation, we recognize the need to review its contents. Therefore, an internal HCFA workgroup has begun the process to revise the ''Important Message,'' including further consideration of the recommendations for revision made by the Beneficiary Protection and Documentation Issues Task Force of the Medicare Technical Advisory Group (M–TAG). The goals of the Workgroup are to improve clarity for increased comprehension and to improve efficiency of its distribution to Medicare beneficiaries. Comments on the revision will be solicited from selected outside parties in the near future.

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

A. Consistent Cost Finding During the Capital Transition Period (§ 412.302(d))

Section 412.302(d) requires that during the transition period to full prospective payment for capital-related costs, a hospital must follow consistent cost-finding methods for classifying and allocating capital-related costs. Specifically, the regulation requires that unless there is a change of ownership, a hospital must continue the same cost-finding methods for old capital costs, including its practices for direct assignment of costs and its cost-allocation bases, that were in effect in the hospital's last cost-reporting period before becoming subject to payment under the capital prospective payment transition system. A hospital may request a change in its cost-finding methods for new capital, provided that the request is made in a timely fashion as provided in the regulation, the hospital provides justification for the change, and the intermediary determines that the justification is reasonable.

It is important to note that, while the regulation does permit changes in cost-finding methods for new capital, such changes are only permitted where they do not involve any changes in cost-finding for old capital. In practice, this means that if a hospital claims any old capital, the intermediary cannot permit a change in any of the allocation bases on Worksheet B–1 of the cost report from the bases used in the last cost reporting period prior to the capital prospective payment system transition period. Otherwise, the consistency rule governing old capital cost-finding would be violated.

In response to concerns expressed by the hospital industry about the costs of the recordkeeping required under the cost-reporting rules, HCFA has developed new cost reporting instructions, which will be released later this year, that permit hospitals to voluntarily adopt a simplified cost allocation methodology. This methodology reduces the number of statistical bases that a hospital is required to maintain. Under the new instructions for HCFA Form 2552–96 (the cost report instructions for FY 1996 cost reporting periods), hospitals may request the simplified cost allocation methodology. However, hospitals that elect this methodology must employ a prescribed list of statistical bases with no deviations. Hospitals may not pick and choose among the prescribed statistics for the combination that is most advantageous. The election of the simplified method cannot be used to shift costs inappropriately. Furthermore, a hospital that elects the simplified methodology must continue to use it for at least 3 years, unless a change of ownership occurs. In the proposed rule (61 FR 27478), we proposed to add a new paragraph (d)(4) to § 412.302, to provide that hospitals may elect to adopt the simplified cost allocation

methodology, as will be provided in the instructions for HCFA Form 2552–96.

Comment: One commenter agreed with our proposal to revise § 412.302(d)(4) to allow for a simplified cost allocation methodology, but suggested that we make a technical change to existing § 412.302(d)(1) to reflect the availability of the simplified methodology option.

Response: We are adopting the commenter's recommended change to the regulations. Section 412.302(d)(1) will now read: ''For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the hospital must follow consistent cost finding methods for classifying and allocating capital-related costs, except as otherwise provided in paragraph (d)(4) of this section.''

Comment: In response to our proposal on the simplified cost allocation methodology, one commenter argued that the general capital consistency rule is flawed. The commenter stated that a provider should be able to request that the fiscal intermediary reassign capital costs from the acute care hospital portion of a facility to exempt areas of the facility if the provider is using the space differently than it was used during the capital base year, such as using the space as a skilled nursing facility or a rehabilitation unit.

Response: This comment concerns the underlying intent of the capital consistency rule itself rather than the subject of our May 31, 1995 proposed rule. In the August 30, 1991 final rule that implemented the capital prospective payment system (56 FR 43396), we explained the rationale for the capital consistency rule. We explained that the capital consistency rule is necessary: (1) to prevent cost shifting to outpatient departments through changes in cost finding methods, and (2) to provide consistency with the determination of the hospital-specific rate used in the base year. For these reasons, it is important that the hospital continue the same bases of cost allocation for old capital throughout the transition.

Throughout the transition to a fully prospective payment system for capital, the provider must continue to allocate any space that was part of the acute care hospital in the base year in the same way. However, if the provider opens a new section of the facility as a skilled nursing facility or excluded unit, capital costs in those areas could be allocated directly to those areas.

B. Possible Adjustments to the Capital Prospective Payment System Federal Rate and Hospital-Specific Rates (§§ 412.308(b) and 412.328)

In the proposed and final rules for FY 1996 (60 FR 29238–29239 and 60 FR 45830–45831), 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 the budget neutrality provision, we set the capital-prospective payment system rates during FY 1992 through FY 1995 so that payments were projected to equal 90 percent of Medicare payments that would have been made on a reasonable cost basis for each fiscal year. As a result of the provision's expiration in FY 1996, the capital-prospective payment system rates and payments under the transition system increased significantly. The FY 1996 Federal rate is 22.59 percent higher than the FY 1995 Federal rate. We now estimate that aggregate capital payments will increase 27.5 percent in FY 1996 relative to FY 1995, and that payments will exceed capital costs by 8.8 percent in FY 1996. Under current law and regulations, we estimate that aggregate payments will further increase by 6.8 percent in FY 1997, for an increase of 36.1 percent over 2 years. We also estimate that payments will exceed capital costs by 7.5 percent in FY 1997.

In the May 31, 1996 proposed rule, we stated that we continue to believe that such large increases in capital payments are neither necessary nor warranted. We identified several possible approaches for establishing a more appropriate level for the rates and discussed the options we considered in developing the proposed rule (61 FR 27479). These options included freezing the inflation updates for the rates in FY 1997 or making downward adjustments in the base rates, as discussed below:

- Reduce the standard Federal rate by 7.38 percent and the hospital-specific rates by 9.48 percent to reflect revised data on base year costs used to determine the rates.
- Implement the provision contained in the Administration's budget plan to reduce the base Federal and hospital-specific rates by 15.7 percent.

As discussed in detail in the proposed rule, the rationale for reducing the base rate derives from an analysis of current data compared to data on which the rate was originally based. Under § 412.308, 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.

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. The purpose of that reduction was to reflect revised inflation estimates as of May 1993, for the increases in Medicare capital costs per discharge during FY 1989 through FY 1992. We now have extensive cost report data for FY 1992 that shows an audit-adjusted FY 1992 Medicare inpatient capital cost per discharge that is an additional 7.38 percent lower that the estimate on which the Federal rate is currently based. Accordingly, the rate could be reduced to reflect accurate FY 1992 capital cost per discharge data.

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 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. In order to adjust the hospital-specific rate to reflect actual FY 1992 data, the rates must be reduced by 9.48 percent.

The reduction reflected in the President's budget plan is based on a different consideration. That reduction would build the budget neutrality adjustment for FY 1995 (0.8432, or −15.68 percent) permanently into the base rates, effectively using the FY 1995 base payment rate as the base for future years. The actual payment rates for future years would then be determined by applying the analytical update framework that we adopted in the final rule for FY 1996 (60 FR 45815–45829). Our last analysis (60 FR 45826–45829) suggested that the estimated FY 1992 capital costs used to set the Federal and hospital-specific capital rates exceeded by approximately 28 percent the level that could be accounted for by known factors. This unaccounted for difference

in the rates justifies a 15.7 percent reduction to the rates.

We seriously considered proposing one of these options in the proposed rule, and we invited public comment on their merits and on the advisability of implementing one or the other in the final rule, in the absence of legislative action.

We received many comments on our discussion of possible adjustments to the capital Federal rate, and these comments and our responses are presented below. Although we continue to believe that any of these options is justified on the basis of current data and analysis, we are not implementing any freeze or reduction to the capital Federal rates in this final rule. The President's budget bill includes numerous proposals to reform the Medicare program, including a reduction to the capital prospective payment rate. At this time, we believe it would be more appropriate to adopt a change to the rate in the context of more global changes to the Medicare program than to implement this one specific provision of the President's budget through regulation. Therefore, we are not implementing any of the possible reductions to the capital Federal rate that were discussed in the proposed rule but instead are updating the capital rates in accordance with the capital update framework, as discussed in section III of the addendum to this final rule.

In general, commenters opposed freezing or reducing the capital Federal rate as suggested in the proposed rule. Commenters cited various reasons why the suggested changes were inappropriate or unnecessary. One commenter, ProPAC, agreed that continued significant increases in capital payments are unjustified and supported reductions to the capital rate. ProPAC suggested several options for our consideration, such as using the FY 1995 rates as the base for future years, or rebasing the FY 1992 capital payment rates and updating them to the current year using an analytic framework. As explained earlier, although we agree with ProPAC that a reduction in the rates is warranted, we have decided not to proceed with reducing the rates by regulation at this time. We discuss the comments on the possible changes in more detail below.

Comment: Some commenters contended that it would be illegal for HCFA to implement any of the identified reductions to the rates (including an efficiency adjustment) because HCFA does not have the authority to rebase the capital payment rate. 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. Another commenter opposed any reduction in the capital Federal rate undertaken without legislative direction.

Finally, one commenter noted that when Congress specified the 7.4 percent reduction in the Federal rate as part of OBRA 93, Congress referenced the capital Federal rate ''as described in § 412.308(c).'' That regulation describes the methodology for defining the Federal rate. The commenter believes that the regulation does not contemplate the substitution of actual cost data for periods in which estimated data were used initially. The commenter believes that because Congress cited this section of the regulations, it implicitly approved the continued use of estimated data for setting the rates rather than the use of actual data.

Response: Section 1886(g) of the Act states that ''the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for [capital-related] costs in accordance with a prospective payment system established by the Secretary.'' The statute gives the Secretary wide discretion in determining the particular features of the prospective payment system for capital-related costs, including the appropriate level of payment rates.

We believe that, consistent with this broad authority, it is appropriate to make prospective adjustments to the capital rates. We believe that any rate revision implemented prospectively would satisfy the principle of certainty and predictability under a prospective system. We have never contemplated a retroactive adjustment to payment rates used in prior years.

The provision of OBRA 93 cited by the commenter does not indicate that we cannot make other adjustments to the capital Federal rate in future years. Section 412.308(c) describes the process for determining the Federal rate by adjusting the standard Federal rate by an update factor each year. We believe that Congress cited this section solely to identify the rate to which we applied the 7.4 percent reduction.

Since the inception of the capital prospective payment system, rates have been set on the basis of FY 1992 capital costs. Since we set initially set rates before FY 1992 started, we necessarily had to project capital costs for FY 1992. We used FY 1989 costs as the basis for projecting FY 1992 costs because they were the latest cost report data available at that time. (Even the FY 1989 data required an estimated adjustment for the effect of audits not yet performed.) We applied estimated adjustment factors to the FY 1989 data to derive estimated FY 1992 capital costs. We used this estimated FY 1992 cost level to set rates beginning in FY 1992.

When Congress legislated that the unadjusted standard Federal rate be reduced by 7.4 percent in 1993, the size of the adjustment was based on more recent data on FY 1992 costs available at that time. The latest available data now indicate an additional 7.36 percent reduction is appropriate. Again, although we are not implementing this adjustment, we believe that we have the authority to do so and that it would represent a logical extension of our policy of basing the capital Federal rate on FY 1992 capital costs.

Comment: Several commenters stated that the discussion in the proposed rule of the possibility of implementing reductions to the capital Federal rate through the final rule did not constitute sufficient notice to the public of proposed regulatory changes. The commenters asserted that before implementing a reduction in the capital payment rates, HCFA was obligated to provide ''formal'' public notice and time for the public to respond.

Response: As noted above, we do not intend to implement any reduction to the capital Federal rate at this time. However, we believe that the discussion in the proposed rule would have satisfied the requirements of the Administrative Procedure Act by (1) describing in some detail three potential options for cutting the capital rate, (2) informing the public that we might implement one of these options if Congress and the Administration did not act to cut the rate, and (3) soliciting public comment on the possible options. We stated that it was our intention to consider all of the options in light of the comments received. Moreover, in the FY 1996 proposed rule (60 FR 29238), we discussed in some detail and invited comments on two options for adjusting the Federal and hospital specific rate, to account for the overestimation of the FY 1992 Medicare inpatient capital cost per discharge, and to compensate for the effects of the expiration of budget neutrality. Finally, since FY 1992 we have printed seven discussions of the efficiency issue, and providers have long known that we

might make an adjustment in the rate to account for possible inefficiency.

Comment: Some commenters stated that we should not adjust the Federal rate to reflect the actual level of FY 1992 capital spending because the FY 1992 level is lower than was projected. The commenters asserted that FY 1992 capital cost levels are lower than projected because hospitals responded in FY 1992 to the incentives of the prospective payment system and modified their capital spending behavior. Some commenters argued that hospitals responded to the possible implementation of a capital prospective payment system even prior to FY 1992. These commenters asserted that in order to get a true sense of the impact of the capital prospective payment system on hospital capital expenditure behavior, one must look further back to when hospitals believed implementation of such a system was imminent.

One commenter explained that one reason actual increases in capital costs in FY 1992 were less than projected was because lengthy certificate of need (CON) approval processes prevented hospitals from beginning building projects as planned. The commenter also stated that if rates were reduced, hospitals in States with strict CON processes should not be subjected to the same rate reductions as hospitals in States without such processes. The commenter asserted that facilities in the commenter's State are undercapitalized relative to facilities in the rest of the country.

Finally, some commenters believe that the overestimation of FY 1992 capital costs (discussed above) stems not from a forecast error in the FY 1992 capital cost per case but from a change in the treatment of allowable interest that was implemented in the first capital prospective payment system final rule published on August 30, 1991. Thus, they believe the overestimation resulted from a change in the rules regarding capital and that the proposed reduction based on a revised FY 1992 capital cost data is not justified.

Response: Since the inception of the capital prospective payment system, we have based capital rates on FY 1992 cost levels. We believe it is appropriate for the rate to reflect actual FY 1992 capital spending, even if hospitals had modified capital spending behavior before the current system was implemented.

We agree that the prospective payment system provides an incentive for hospitals to modify their capital spending behavior, and that it is likely that hospitals have done so. However, we do not believe that the magnitude of the difference between the projection for FY 1992 capital costs and the latest measurement of FY 1992 capital costs can be completely explained by changes in capital spending behavior caused by the incentives of the prospective payment system. First, most of the capital costs in FY 1992 would be attributable to capital acquired before FY 1992 that was still being depreciated. Second, most capital acquired in FY 1992 would have been planned and committed prior to FY 1992. Thus, only a small proportion of FY 1992 capital spending would have been impacted by the implementation of the capital prospective payment system. Consequently, the implementation of the prospective payment system would have had little, if any, effect on capital growth in FY 1992. Moreover, the anticipated onset of the prospective payment system for capital-related costs may have encouraged some hospitals to limit spending, but we are aware of several situations in which hospitals actually hastened building projects in order to qualify for possible old capital protections.

We recognize that CON processes may well delay hospital building projects. However, the commenter does not explain why these effects would have been greater in FY 1992 than in previous years. Our data on the cumulative percentage change in capital-related cost per case, which we presented in the September 1, 1995 final rule (60 FR 45828), demonstrate that the growth of capital costs has slowed considerably in recent years, from a high of 19.9 percent per year in 1986 to a low of 2.9 percent per year in 1992. The most recent FY 1992 HCRIS data available show that hospitals' actual FY 1992 capital costs per discharge are an additional 7.36 percent lower than the estimate on which the capital Federal rate is currently based (taking into consideration the adjustment mandated by Public Law 103–66). We believe it is appropriate for the rate to reflect actual costs.

In designing the prospective payment system for capital costs, we recognized the unique position of hospitals in States with CON programs by developing special rules with regard to obligated capital. Those special rules (see § 412.302(c)(2), ''Lengthy certificate-of-need process'') are designed to ensure that hospitals in States with CON programs receive equitable treatment in terms of recognition ''old capital costs.'' Essentially, this provision permits certain obligated capital costs in CON States to be treated in the same manner as actual capital expenditures in non-CON States. We believe these provisions adequately address the concerns of hospitals in states with CON processes.

Finally, we do not agree that the August 30, 1991 final rule implemented any change in the treatment of allowable interest. Section 412.302(b)(2)(v), which defines old capital costs for purposes of the prospective payment system for capital-related costs, states that ''Investment income, excluding income from funded depreciation accounts, is used to reduce old capital interest expense based on the ratio of total old capital interest expense to *total allowable interest expense* in each cost reporting period. ''(Emphasis added.) The commenter apparently believes that this statement reflects a change in the treatment of allowable interest because § 413.130(g)(2), which defines capital-related interest expense net of investment income (under our reasonable cost reimbursement rules), provides that in determining the proportion of investment income to be offset, the ratio is to be based on capital-related interest to total interest. However, § 413.130(g) derives from § 413.130(a)(7), and § 413.130(a)(7) addresses only ''allowable interest expense'' (that is, interest expense as determined under § 413.153), so the ratio expressed in § 413.130(g) is reasonably interpreted to refer to ''total *allowable* interest expense.''

Comment: Commenters also addressed the possible adjustment based in part on an efficiency analysis. A few commenters stated that higher than expected capital costs per case for FY 1992 were not the result of inefficient use of capital resources, but rather a reaction to pent-up demand in States that had restrictive certificate of need (CON) policies. Another commenter argued that no overexpansion of health facilities has occurred in the commenter's State, because it is highly regulated, and that the average age of hospitals' physical plants in the State is among the oldest in the country. This commenter too believes that it is inappropriate to apply a rate reduction equally in all States.

Some commenters agreed with our statement 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 over purchased capital, they conversely had to under employ operating inputs. Thus, 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.

Finally, one commenter suggested that we obtain an independent evaluation of HCFA's capital model and the factors that account for the known increase in costs per case, such as the inflation in capital input prices, quality enhancing intensity increases, and real case-mix growth, as well as the factors that may be responsible for the unexplained growth in capital costs per case.

Response: As noted in our September 1, 1995 final rule in response to a similar comment (60 FR 45829), we agree that the conjunction of rate-based payment for operating costs and cost-based payment for capital costs 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.

As we stated in our September 1, 1995 final rule in response to a similar comment (60 FR 45828), our analysis suggests a significant measure of inefficiency in capital costs, and was based on national figures. Therefore, since we are evaluating an efficiency adjustment in the national Federal rate, our analysis does not consider regional differences, such as the existence of CON requirements in some States. The national Federal rate is based on an average; thus, we recognize that some States will have higher costs than the average and other States will have lower costs. We note, however, that although we did not make adjustments for CON policies for purposes of this particular analysis, § 412.302(c)(2) does provide for differential treatment of hospitals in CON States in terms of the recognition of obligated capital (as discussed in more detail above).

In response to the commenter's suggestion that a group of independent economists should evaluate the capital model and our theory about the possible cause of the unexplained growth in capital costs per case, we note that ProPAC has also analyzed the current capital rate and has discussed possible reductions to the capital rate, implicitly endorsing a reduction to the capital rate in the order of magnitude that we discussed in the proposed rule.

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: Our data indicate that there is ample room to cut the capital rate without a major adverse affect on facilities in any region. Before the implementation of the prospective payment system for capital-related costs, facilities were paid only 85 percent of their capital costs. In the proposed rule, we estimated that payments would exceed capital costs by 9.6 percent in FY 1996 (61 FR 27479). We now estimate that capital payments will exceed capital costs by 8.8 percent in FY 1996 and 7.5 percent in FY 1997.

C. Possible Adjustment to Capital Prospective Payment System Minimum Payment Levels

Section 412.348(b) of the regulations provides that, during the capital prospective payment system transition period, a hospital may receive an additional payment under an exceptions process if its total inpatient capital-related payments under its payment methodology (that is, fully prospective or hold-harmless) are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment levels are established by class of hospitals under § 412.348(c). 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 for previous cost reporting periods exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

Section 412.348(h) further provides that total estimated exceptions payments under the exceptions process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year. In the final rule implementing the prospective payment system for capital-related costs we stated that the minimum payment levels in subsequent transition years would be revised, if necessary, to keep the projected percentage of payments under the exceptions process at no more than 10 percent of capital prospective payments.

In section III of the addendum to the proposed rule (61 FR 27499), we discussed the factors and adjustments used to develop the FY 1997 Federal and hospital-specific rates. In particular, we discussed the FY 1997 exceptions payment reduction factor. This factor adjusts the annual payment rates for the estimated percentage of additional payments for exceptions in FY 1997. In the proposed rule, we estimated that exceptions would equal 6.07 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We indicated that it might be necessary to implement adjustments to the minimum payment levels in the final rule and that it will almost certainly be necessary to adjust the minimum payment levels for FY 1998. We therefore provided public notification that adjustments to the minimum payment levels were imminent, discussed our ideas on the most appropriate method for adjusting the minimum payment levels, and solicited public comment.

We stated that, when it does become necessary to adjust the minimum payment levels, we intended to adjust each of the existing levels (that is, 90 percent for sole community hospitals, 80 percent for large urban DSH hospitals, and 70 percent for all other

hospitals) by 5 percentage point increments until estimated exceptions payments are within the 10 percent limit.

Current estimates indicate that we will not reach the 10 percent exception limit in FY 1997. Therefore, we are not making adjustments to the minimum payment levels at this time; the minimum payment levels for exception payments will remain at the current levels.

We received several comments regarding the necessity and methodology of adjustments to the minimum payment levels.

Comment: Some commenters objected to the proposed method for handling necessary reductions to the minimum payment levels. One commenter suggested that we develop a more sophisticated methodology that would allow more refined adjustment of the minimum payment levels. Another commenter suggested a 1 or 2 percent reduction increment, rather than the proposed 5 percent increment.

Response: As stated above, in this final rule the minimum payment levels for exception payments will remain at the current levels, since our current forecasts indicate that we will not reach the 10 percent limit in FY 1997. All comments received on this issue will be taken under advisement and considered at such time as it becomes necessary to make such an adjustment.

Comment: Some commenters believe that HCFA's capital acquisition model (see appendix B to this final rule for a detailed discussion) projects excessive growth in exception payments. These commenters objected to any reduction in the capital minimum payment levels based on projected rapid growth in exceptions and requested further explanation. The commenters further stated that they could not understand why exception payments would be so large when average payments exceed costs.

Response: Since payments under the capital prospective payment system are based on averages, not on an individual hospital's costs, some hospitals may receive payments exceeding their costs, while other hospitals may receive payments less than their costs. Even if aggregate payments exceed aggregate costs, some hospitals may have costs so much higher than payments that they qualify for large exceptions payments.

It is these large exceptions payments that are driving the aggregate exception payments toward the 10 percent ceiling on exception payments. We have reviewed the cost reports for the first 3 years under the capital prospective payment system. The number of hospitals receiving exceptions payments and the aggregate amount paid for exceptions have increased each year. We expect this trend to continue throughout the transition period, as some hospitals' payments deviate even more from their actual costs. Our model is consistent with these findings. The model projects, as expected, that exceptions payments will continue to grow.

''Low cost'' hospitals are paid a blend of their hospital-specific rate, and a higher Federal rate. ''High cost'' hospitals are paid 85 percent of their old capital plus their ratio of new capital to total capital applied to the Federal rate. In both cases, the capital the hospitals had at the time the capital prospective payment system was implemented is addressed by the standard payments.

Capital prospective payment rates for FY 1992 were designed to adequately address capital costs that existed at the time the prospective payment system began. Since then, hospitals have acquired additional capital, with some hospitals acquiring more than others. With each passing year, more additional capital is accumulated. In some cases, this additional capital is large, and the affected hospitals' capital costs greatly exceed their standard payments. Exceptions payments mitigate the financial impact on these hospitals.

High cost hospitals are more likely to qualify for exceptions payments. Their old capital costs are encompassed in the hold harmless payments, while their new capital costs are reimbursed at a fraction of the Federal rate. If their new capital costs are high, these high cost hospitals will need the full benefit of the exceptions process. Since high cost hospitals will acquire more additional capital over time, more hospitals will qualify for exceptions payments. In fact, high cost hospitals showed rapid growth in exceptions in the first three years under the capital prospective payment system. We expect this rapid growth to continue.

Comment: Regarding minimum payment levels, one commenter suggested we reconcile exceptions payments retrospectively and recoup any overpayments on a pro rata basis by reducing future payments to hospitals. The commenter recommends reductions in subsequent Medicare payments to hospitals.

Response: Section 412.348(d) states that ''Total estimated payments under the exceptions process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) *for the same fiscal year.*'' (Emphasis added.) We believe reconciling actual exceptions payments with estimated exceptions payments on a retroactive basis would fundamentally undermine the prospectivity of the system. Moreover, recouping ''overpayments'' on a retroactive basis may be potentially unfair to individual hospitals. An individual hospital that qualifies for an exception payment in one year may not also qualify for an exception in the later year in which a ''retroactive'' exception payment is to be made. Hospitals would not be able to predict the effects of retroactive adjustments to supposedly prospective payment rates.

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

Application of Ceiling in Calculating Payment for Hospital Inpatient Operating Costs (§ 413.40 (d) and (g))

Section 1886(b)(1)(B) of the Act provides for an additional payment to a hospital excluded from the prospective payment system when the hospital's reasonable operating costs exceed its target amount. The additional payment is based on the lesser of 50 percent of the amount by which the operating costs exceed the target amount, or 10 percent of the target amount. The Medicare statute further provides that this comparison is made ''after any exceptions or adjustments are made to such target amount for any cost reporting period.'' The regulations, at 42 CFR § 413.40(d)(3), state that the total payment to the hospital for inpatient operating costs (including the additional payment described above) is based on the lesser of the following: the ceiling (target amount multiplied by the number of Medicare discharges) plus 50 percent of the allowable net inpatient operating costs in excess of the ceiling, or 110 percent of the ceiling. However, the regulations do not explicitly include the additional statutory requirement regarding the effect of exceptions or adjustments.

As discussed in the proposed rule (61 FR 27481), we understand that there are questions about the calculation of the additional payment under the regulations, which require comparison of two amounts: the ''ceiling'' plus 50 percent of the difference between allowable costs and the ceiling, and 110 percent of the ''ceiling.'' Specifically, where a hospital has received an adjustment to the target amount under § 413.40(g), there has been confusion as to whether the ''ceiling'' used for purposes of calculating the additional payment under § 413.40(d) is the unadjusted ceiling (the amount determined without consideration of

any adjustments granted to the hospital) or the adjusted ceiling.

To address any confusion about these issues, we proposed to revise § 413.40(d)(3) to indicate specifically that calculation of payments for hospital inpatient operating costs under that provision reflects the adjusted ceiling amount (the amount determined after an adjustment under § 413.40(g)). This would apply to all adjustments, including adjustments based on a longer average length of stay in the hospital's rate year as compared to the base year and adjustments for increased routine services.

We received only two comments on this proposal. Both commenters supported the proposal, and we will adopt as final the proposed changes to the regulations at § 413.40(d)(3).

VIII. ProPAC Recommendations

As required by law, we reviewed the March 1, 1996 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 (61 FR 27482). 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, we have not repeated the recommendation and response in the discussion below. The update factors for inpatient operating costs and the update factor for hospitals excluded from the prospective payment system and distinct-part units (ProPAC recommendations 10 and 12, respectively) are discussed in Appendix E to this final rule. Capital payment rates (recommendation 11) are discussed in section VI of this final rule. Disproportionate share hospitals (recommendations 17 and 18) are discussed in section V of this final rule. The remaining recommendations on which we received comments are discussed below.

A. Discharges From Hospitals to Other Facilities (Recommendation 19)

Recommendation: Medicare payments should be modified to account for the shift in services from acute to postacute settings. Broadening the definition of transfer cases, however, is not an appropriate approach.

Response in the Proposed Rule: In both the September 1, 1994 and September 1, 1995 final rules, we expressed our concern that the current trend of declining average lengths of stay as hospitals discharge Medicare patients into alternative health care settings (other than acute care prospective payment hospitals) in less time may result in a misalignment of payments and costs under our existing payment systems (59 FR 45362; 60 FR 29221). In particular, we expressed concern over the potential for hospitals paid under the prospective payment system to shift costs (for which they are compensated through the DRG payments) to alternative settings, which are in turn paid on a cost basis. Although we solicited comments on possible solutions to this problem, we did not propose any change in policy.

The President's FY 1997 budget includes a proposal to redefine discharges from acute care hospitals to excluded hospitals and units and skilled nursing facilities as transfers for payment purposes. Currently, for cases transferred from one acute care hospital paid under the prospective payment system to another like hospital, the sending hospital is paid a per diem rate instead of the full DRG amount. For cases transferred to an excluded hospital or unit or to a skilled nursing facility (as well as cases discharged home or home with home health care), hospitals receive the full DRG payment amount, regardless of the length of stay in the hospital. Under the per diem transfer payment methodology, hospitals receive a per diem amount (doubled for the first day of the stay) until the full DRG amount is reached. Therefore, under the President's budget proposal, hospitals transferring patients to excluded facilities or skilled nursing facilities prior to the geometric mean length of stay for the DRG, minus one day (to account for the double per diem on the first day), would receive less than the full DRG amount for that case.

The basis for ProPAC's opposition to this proposal is that it ''* * * thinks this policy would discourage the use of postacute providers. Moreover, it could result in longer inpatient stays, which may not be desirable or cost effective in the long run.'' We acknowledge that the change in the definition of a transfer is not the ultimate solution to this health care trend. In response to immediate concerns about overpaying hospitals for the reduced services they are providing and the rate of increase in expenditures for postacute care services, however, we believe this is an appropriate interim measure while we continue to explore long-term policy alternatives that will better integrate our payment systems for care provided to Medicare beneficiaries across the acute and postacute care settings.

Comment: We received several comments on this response. ProPAC repeated its concern that redefining transfers may not be the right approach, indicating that ''(m)ore needs to be known about the relationships among these services before implementing a policy that assumes that hospitals are being overpaid for cases who use post-acute care.'' Two other commenters expressed their objections to the redefinition of transfers from acute care hospitals. Generally, both of these commenters agreed with ProPAC's assessment that this would lead to longer inpatient stays and discourage the use of postacute care. Also, both commenters objected to ProPAC's suggestion that HCFA bundle acute and postacute care payments. Finally, one commenter recommended that ''the total Medicare funding for hospitals be reduced to recognize the shift of patient days away from the hospital setting.''

Response: We agree with ProPAC that a better understanding of this phenomenon is needed, and we are well aware of the improved efficiency claims made by those who advocate even greater use of postacute care. However, while we continue to explore potential refinements to reflect the shift in services from acute to postacute settings, we believe it is appropriate to concurrently explore interim measures for responding to the undisputed trends showing continuing declining lengths of hospital inpatient stays and increasing postacute care utilization, particularly for certain DRGs. The present overlaps between our acute and postacute payment methodologies demand immediate attention, given our responsibility for preserving the Medicare Trust Fund.

We also understand the commenters' concerns about the transfer redefinition. In evaluating any such interim measures two fundamental questions need to be answered: Will this approach protect beneficiaries' access to quality, effective health care and will it adequately compensate the providers of that care for their costs? To the extent that increasing utilization of postacute care allows hospitals to release patients earlier, redefining transfers would better match payments with costs, as well as eliminate some of the potential incentive for premature discharges.

With regard to the comments we received about ProPAC's suggestion that bundling might be a potential alternative, we intend to continue to evaluate all potential payment approaches. For example, implementing an offset to the hospital inpatient standardized amounts to reflect cost

shifting is another approach under examination.

B. Prospective Payment for Postacute Care (Recommendation 20)

Recommendation: Prospective payment systems should be implemented for all postacute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control volume of postacute service use, such as bundling services for a single payment.

Response in the Proposed Rule: We agree that HCFA should develop prospective payment systems for all postacute services, and we have made significant progress in this area. As we discuss in our responses to Recommendations 22 and 23, we have developed detailed implementation plans for interim prospective payment systems for skilled nursing facilities (SNFs) and home health agencies (HHAs) that do not require patient classification systems. Execution of these plans will, of course, require legislative action.

Beyond our interim plan, we have developed a strategy for developing a full-fledged prospective payment system for SNFs. In the absence of legislation, we have been pursuing data that could be used to support a case-mix prospective payment system through our Multi-State Case Mix Demonstration Project. This demonstration project, now in its operational phase, is collecting data on patient case mix using a modified version of the minimum data set, the assessment tool SNFs use in developing patient care plans. Through the course of the demonstration, we hope to gather data on the full range of SNF resources needed for each resource utilization group. We are proceeding to require by regulation that all facilities provide resident assessment data. Consolidated billing of SNF services (that is, requiring SNFs to bill for all services furnished to their patients) and uniform coding of SNF services are also prerequisites for a SNF prospective payment system. Consolidated billing and uniform coding are needed to determine the appropriate payment for the ancillary services component of SNF services and to provide useful data on the range of services SNFs furnish.

We have also been working on a strategy to develop a full-fledged prospective payment system for HHAs. We have funded a project to develop outcome measures for home care that can be used for an outcome-based quality improvement system. These measures will be based largely on a core standard assessment data set that includes items measuring sociodemographic, environmental, support system, health status, functional status, and health service utilization characteristics of patients. Many of the data items included in the core standard assessment data set are not only essential for assessing patient outcomes but are also critical for designing an adequate case-mix system for payment purposes. To test and refine Medicare's approach to outcome based quality improvement for home health care, HCFA is currently sponsoring the Medicare Quality Assurance and Improvement Demonstration, which uses this instrument. We plan to publish regulations identifying the required data elements and addressing the collection of information from the core standard assessment data set. We also plan to sponsor additional research that would lead to an appropriate case mix adjuster that can be used in a national prospective payment system.

In addition to the developmental work underway on SNF and HHA prospective payment systems, we have begun work on the preliminary steps necessary for the development of a prospective payment system for hospital inpatient rehabilitation services. The biggest obstacle we have faced in this effort is the lack of appropriate patient classification systems for the types of patients treated by rehabilitation hospitals. We have recently contracted with the Rand Corporation to evaluate a rehabilitation coding system known as the Functional Independence Measure (FIM), which is a scoring system that measures the degree of functional independence of rehabilitation patients. These researchers will also evaluate the patient classification system known as function related groups (FRGs), which are based on the FIM, as a possible basis for a Medicare prospective payment system for rehabilitation services. If the research confirms functional status measures can be used to develop an appropriate patient classification system, we will begin the additional work necessary to put a prospective payment system into place. This would require collecting patient assessment data from Medicare rehabilitation hospitals and units and developing all the necessary components of the new payment system. It will take at least 3 years to design and implement such a system. To facilitate implementation, we are considering initiating collection of patient assessment data in advance of legislation establishing a prospective payment system. We will be seeking public input on whether to proceed with a requirement for patient assessment data in the absence of legislation and what data elements should be included in a core data set that could be used not only as the basis for a patient classification system but also to assess outcomes.

We recognize that there are advantages to a coordinated approach in developing prospective payment systems for postacute services and we will be evaluating how to make them as consistent as possible. We also recognize that the demand for implementation of prospective payment systems for postacute services is sufficiently immediate so that there may not be time for the broad study, data collection, and research needed to develop a ''unified'' system using similar resource grouping principles. Most of the current legislative proposals, including the Administration's proposals, would require implementation dates within the next several years. It may not be feasible to develop a ''unified'' system within the time frames contemplated by the current legislative proposals. Trade-offs may be required between continuation of the interim payment systems versus the prospective payment systems on one hand, and the separate versus ''unified'' prospective payment systems on the other hand.

Comment: One commenter strongly supported adoption of a prospective payment system for inpatient rehabilitation and believes that the RAND research project will likely produce such a system. The commenter noted that we are considering initiating the collection of patient assessment data in advance of legislation establishing a prospective payment system and urged us to begin collecting the data at the earliest possible date. The commenter believes that imposition of a reporting requirement based on the FIM should not be a great burden on the industry since rehabilitation hospitals and units are already using the FIM or similar patient evaluation measures. Systematizing collection of such data would expedite introduction of a prospective payment system based on FRGs and would considerably reduce the 3-year minimum implementation period suggested in HCFA's response in the proposed rule. The commenter also urged, as a means toward developing a payment system that is consistent across payment sites based on patient characteristics, that HCFA expand the RAND research project to determine the feasibility of using an FRG-based payment system for rehabilitation patients in skilled nursing facilities.

Response: Since the collection of patient assessment data in advance of legislation establishing a prospective payment system would expedite implementation of the system, we are exploring whether we can initiate the collection of data from rehabilitation facilities without legislative action. Our estimate of 3 years to design and implement a payment system includes beginning data collection at the earliest possible time and continuing the collection over a period sufficient to ensure the validity and stability of the components of a payment system, such as payment rates, relative weights of patient groups, outlier payments, and facility payment adjustments, in addition to ensuring the validity of coding within and across hospitals.

We agree with the commenter that, as a step toward developing a payment system that is consistent across delivery sites, it would be desirable to explore the usefulness of FRGs in a payment system for rehabilitation services in skilled nursing facilities. We will, therefore, evaluate our ability to expand the RAND project given the limits of available resources. We note that we are also engaged in research on other case-mix measures for SNF and home health services and we will investigate the suitability of these measures for rehabilitation hospital services.

C. Case-Mix Measures for Postacute Services (Recommendation 21)

Recommendation: Reliable case-mix measurement is important in prospective payment systems to account for resource use and to analyze treatment patterns and costs across sites. The Secretary should coordinate case-mix research across postacute care settings, using consistent methods for measuring patient acuity and resource use.

Response in the Proposed Rule: We are attempting to coordinate our work on case-mix adjustment for home health care, long-term and SNF care, and rehabilitative services. To develop a case-mix adjustment system for SNF care, time studies were conducted in order to measure resource utilization. Similarly, as noted above in response to Recommendation 20, we have funded a new home health case-mix study.

In addition, in the case-mix work to date for both home health care and SNF care, dependence in activities of daily living is the biggest predictor of resource utilization. Some of the other predictors differ across SNF care and home health care due to differences in the treatment settings and the availability of information for a classification system.

As also noted in the preceding response, researchers at the University of Pennsylvania have developed a classification system based on FIMs called Function Related Groups (FIM–FRGs). This system appears promising for use in a case-mix adjusted prospective payment system for rehabilitation and long-term care facilities, and we are working with the Rand Corporation on a research project to evaluate the suitability of FIM–FRGs for this purpose.

We agree that a compatible cross-provider measure of resource use would be the best multiplier in any universal postacute system. We also believe that such measures do not now exist and to produce them would require the program to incur significant costs and impose significant data reporting and collection requirements on providers. We would prefer to obtain explicit legislative direction before we incur these costs and impose these burdens. Even so, we believe several years would be required to gather the data and develop the case-mix measures. For these reasons, we believe that interim prospective payment systems of the types contained in the President's FY 1997 budget should be put in place.

Comment: One commenter agreed with ProPAC's recommendation to develop a unified case-mix prospective payment system for postacute care, but expressed concern that such a prospective payment system based on ICD–9–CM codes will require the development of uniform coding guidelines that do not currently exist.

Response: We have not yet decided whether it would be appropriate to use ICD–9–CM codes in connection with a postacute prospective payment system. We will keep the overall concern of uniform coding guidelines in mind as we progress in our evaluation of postacute prospective payment.

D. Update to the Composite Rate for Dialysis Services (Recommendation 24)

Recommendation: The Secretary should develop methods to control total Medicare per capita expenditures for end stage renal disease (ESRD) beneficiaries. In the meantime, the composite rate should be updated by 2.7 percent for hospital-based dialysis facilities and by 2.0 percent for freestanding facilities for fiscal year 1997. The Secretary should also develop reliable measures of patient severity and outcomes to analyze the relationships among treatment processes, patient outcomes, and costs. These factors should be considered in evaluating the need for and the level of future payment updates.

Response in the Proposed Rule: One of ProPAC's suggestions is that HCFA consider opening enrollment for ESRD beneficiaries to participate in Medicare risk programs. The reason for this recommendation is the rapid growth in total Medicare spending for ESRD beneficiaries. A large part of this increase is attributable to the expanding ESRD population, especially older patients who require more services. These beneficiaries are using more acute inpatient, skilled nursing and other dialysis-related services than ever before. ProPAC suggests that to control these expenditures, Medicare examine the possibility of adopting a capitation payment system for ESRD services, since capitation rates have been successful in controlling expenditure growth for other populations. At a minimum, they are recommending that utilization review or other managed care techniques be used to control the total volume of services provided to ESRD beneficiaries across all sites of care.

Section 1876(d) of the Act currently prevents an individual with ESRD from enrolling in an HMO or a competitive medical plan. However, an individual who is enrolled in a prepaid health plan when he or she is determined to have ESRD may continue enrollment in that plan. A prepaid health plan may only disenroll a beneficiary as provided by regulations at § 417.460.

Congress addressed the issue of paying for ESRD services in a capitation setting in legislation. Section 13567(b) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) (August 10, 1993) amended section 2355 of Public Law 98–369 by requiring the Secretary to include the integration of acute and chronic care management for patients with ESRD through expanded community care case management services in a social health maintenance organization (SHMO). Initial legislation required the Secretary to grant demonstration waivers for SHMOs that provide for the integration of health and social services at a fixed annual prepaid capitation rate. In the January 26, 1996 Federal Register, we published a notice informing interested parties of the opportunity to apply for funds for a cooperative agreement to operate an ESRD Managed Care Demonstration (61 FR 2516). Two of the demonstration's purposes would be to test whether ESRD beneficiaries can and should be given access to HMOs during open enrollment and whether the statewide capitation rate can and should be adjusted. The demonstration would adjust rates for treatment status (such as dialysis, transplant, or a functioning graft), age groups and the cause of renal

failure (for example, diabetes). As the legislation requires, rates would be based on 100 percent of the adjusted average per capita costs (AAPCC); additional non-Medicare-covered benefits would be offered by the provider to justify the additional 5 percent beyond the 95 percent of the AAPCC paid to Medicare risk-contracting HMOs on behalf of ESRD enrollees. Based on the results of this demonstration, we would make recommendations to Congress concerning the appropriateness of paying for dialysis services in a capitation setting.

To improve the quality of care ESRD patients are receiving, we are in the process of developing proposed rules for ESRD conditions for coverage. The essence of the regulation is patient-centered and outcome-oriented. The proposed conditions for coverage will focus on facilities achieving an optimal level of health and well-being for all dialysis patients. The proposed rules will be published in Spring 1996 with expected implementation in late fiscal year 1997.

While we share ProPAC's concern that payment rates be sufficient to assure quality care for ESRD patients, we do not believe there is sufficient evidence at this point to conclude that more money is needed to provide appropriate care. Currently, the University of Michigan, as part of a National Institute of Health grant, is examining the relationship between facilities' costs and the level of KT/V. Also the National Institute of Diabetes and Digestive and Kidney Diseases is sponsoring a study on the impact of increasing dialysis as measured by KT/V and the use of high-flux-dialysis on ESRD patients. The results of these studies should help us analyze the relationship between patient outcomes and costs, and thus provide us with a basis for recommending an appropriate payment rate increase.

While we acknowledge that an increase in the composite rate may be appropriate in the next few years, we believe that any rate increase should be linked to implementation of the revised conditions for coverage. Moreover, any ESRD rate increase must be considered within the context of Medicare budgetary concerns and should have a direct link to improved patient outcomes. We will continue to monitor ESRD facility costs, and, if appropriate, we may recommend an update to the ESRD composite rate for FY 1998.

We note that ProPAC's recommendation provides for an across-the-board rate increase for all renal facilities. However, data show that high volume independent facilities (over 6,000 treatments per year) account for about 85 percent of independent dialysis treatments. These high volume facilities report margins between Medicare payments and costs that are higher than average. Therefore, in proposing a future rate increase, we would want to examine the need to adjust payment increases for volume. In addition, we believe that any update to the composite rate should include an update to the wage index currently used to adjust the labor portion of the rate. We are currently using an outdated wage index which is a blend of 1980 Bureau of Labor Statistics (BLS) and 1984 prospective payment system wage data and does not reflect the MSA revisions resulting from the 1990 census.

The Commission's final recommendation is that the Secretary closely monitor treatment patterns and patient outcomes to ensure that facilities use the payment increase to improve quality of care. The proposed ESRD conditions for coverage should address this issue. We expect the proposed rule to be published in the Federal Register before Summer 1996. Between the publication of the proposed and final rules, HCFA is planning to meet with the renal community to develop complete clinical data sets to monitor patient outcomes and medical conditions. These data will then be used to evaluate the quality of dialysis services furnished by individual facilities. Of course, this is a long-term project. In the short term, we are exploring the possibility of collecting limited patient outcome data such as KT/V and URR.

Comment: One commenter and the Commission reiterated that ProPAC's recommended update framework was appropriate. According to ProPAC, its analysis suggests that input costs are rising and large productivity gains may no longer be possible. Consequently, renal facilities may be unable to continue to provide quality dialysis without some payment increase.

Response: As discussed above, we recognize that an increase in the composite payment rate may be appropriate in the future, but we believe that any rate increase should be linked to implementation of the revised conditions for coverage for ESRD facilities. Until such implementation, we will continue to monitor facility costs and other factors to determine if it is appropriate to recommend a payment rate increase. At this time, the composite payment rate is set by statute.

IX. Other Required Information

A. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 provides for notice and comment when 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, in the proposed rule, we solicited public comment on each of these issues for the information collection requirement discussed below.

The only information collection or paperwork burden item contained in the FY 1997 proposed or final rules involves the requirement under § 489.27 that a hospital furnish each Medicare beneficiary with a notice of discharge rights supplied by HCFA, that is, ''An Important Message from Medicare.''

As discussed in section V of this preamble, we are revising the current requirement that a hospital must distribute the ''Important Message'' to each Medicare beneficiary at or about the time of admission. In order to permit hospitals more flexibility, but still ensure that beneficiaries are aware of their discharge rights, we are revising § 489.27 to specify that a hospital must provide the notice of discharge rights ''during the course of the hospital stay.'' We estimated that the paperwork burden associated with the requirement that hospital personnel distribute the ''Important Message'' to each Medicare beneficiary is approximately 1 minute per admission. Based on our most recent available data (1995 Data Compendium, HCFA Pub. No. 03364), there are approximately 11 million Medicare beneficiaries admitted to hospitals each year, resulting in an annual burden of approximately 183,000 hours.

This paperwork burden is not effective until it has been approved by OMB. A notice will be published in the Federal Register when approval is obtained.

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, and on the internet at HTTP://WWW.HCFA.GOV/STATS/PUBFILES.HTML. In our May 31, 1996 proposed rule, we published a list of data sets that are available for purchase (61 FR 27490).

C. Waiver of Notice of Proposed Rulemaking

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 impracticable, unnecessary, or contrary to public interest.

Most provisions of this final rule were directly addressed in the May 31, 1996 proposed rule (61 FR 27444) or were made in response to comments on that proposed rule. The only issue raised in this final rule for which we have not provided an opportunity for notice and comment concerns a recently enacted statutory provision. On April 26, 1996, Congress enacted the Omnibus Consolidated Rescissions and Appropriations Act of 1996. Among other things, the new statute requires that, for certain purposes, the Federal Government ''shall deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions.''

In this final rule, we are revising the regulations at § 412.105 and § 413.86 to conform the regulations to the new statutory provision. We find good cause to waive the procedure for notice and comment with respect to these conforming changes. We find that the procedure for notice and comment is unnecessary because these technical changes merely conform the regulations text to the express requirements of the statute and do not involve an exercise of agency discretion; moreover, delaying these technical changes would be contrary to the public interest because any perceived discrepancy between the regulations and the statute might cause confusion.

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 489

Health facilities, Medicare.

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

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

2. In § 412.63(s)(1), a new sentence is added at the end to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

* * * * *

(s) * * *

(1) * * * The wage index is updated annually.

* * * * *

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

3. In § 412.105, the introductory text of both paragraph (g)(1) and paragraph (g)(1)(i) is republished and a new paragraph (g)(1)(i)(D) is added to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(g) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.*

(1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

(i) The resident must be enrolled in an approved teaching program. An approved teaching program is one that meets one of the following requirements:

* * * * *

(D) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

* * * * *

Subpart L—The Medicare Geographic Classification Review Board

4. In § 412.246, paragraph (b) is revised to read as follows:

§ 412.246 MGCRB members.

* * * * *

(b) *Term of office.* The term of office for an MGCRB member may not exceed 3 years. A member may serve more than one term. The Secretary may terminate a member's tenure prior to its full term.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

5. In § 412.302, paragraph (d)(1) is revised and a new paragraph (d)(4) is added to read as follows:

§ 412.302 Introduction to capital costs.

* * * * *

(d) *Consistency in cost reporting*—(1) *General rule.* For cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001, the hospital must follow consistent cost finding methods for classifying and allocating capital-related costs, except as otherwise provided in paragraph (d)(4) of this section.

* * * * *

(4) Hospitals may elect the simplified cost allocation methodology under the terms and conditions provided in the instructions for HCFA Form 2552.

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 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart C—Limits on Cost Reimbursement

2. In § 413.40, paragraph (d)(3) is revised to read as follows:

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

* * * * *

(d) * * *

(3) *Net inpatient operating costs are greater than the ceiling.* For cost reporting periods beginning on or after October 1, 1991, if a hospital's allowable net inpatient operating costs exceed the hospital's ceiling (or the adjusted ceiling, if applicable), payment will be based on the lower of the—

(i) Ceiling (or the adjusted ceiling, if applicable) plus 50 percent of the allowable net inpatient operating costs in excess of the ceiling (or the adjusted ceiling, if applicable); or

(ii) One hundred-ten percent of the ceiling (or the adjusted ceiling, if applicable).

* * * * *

Subpart F—Specific Categories of Costs

3. In § 413.86, under paragraph (b), the definition of ''Approved geriatric program'' is revised and a new paragraph (4) is added to the definition of ''Approved medical residency program'' and a new sentence is added at the end of paragraph (g)(1) introductory text to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.*

* * * * *

Approved geriatric program means a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs.

Approved medical residency program * * *

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

* * * * *

(g) * * *

(1) * * * For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs.

* * * * *

C. Part 489 would be 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, and 1871 of the Social Security Act (42 U.S.C. 1302, and 1395hh).

Subpart B—Essentials of Provider Agreements

2. Section 489.27 is revised to read as follows:

§ 489.27 Beneficiary notice of discharge rights.

A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the notice of discharge rights HCFA supplies to the hospital to implement section 1886(a)(1)(M) of the Act. The hospital must provide timely notice during the course of the hospital stay. For purposes of this paragraph, the course of the hospital stay may begin with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. The hospital must be able to demonstrate compliance with this requirement.

(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, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 23, 1996.

Donna E. Shalala,

Secretary.

[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, 1996 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1996

I. Summary and Background

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

For discharges occurring on or after October 1, 1996, 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 in the determination of 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 this 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 1997

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 with discharges occurring on or after October 1, 1996. 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 1997.

In summary, the standardized amounts set forth in Tables 1a and 1c of section V of this addendum reflect—

- Updates of 2.0 percent for all areas (that is, the market basket percentage increase of 2.5 percent minus 0.5 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 1996 budget neutrality factor and applying a revised factor; and
- An adjustment to apply the revised outlier offset by removing the FY 1996 outlier offsets and applying a new offset.

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 1997 were made. That is, the standardization adjustments reflected in the FY 1997 standardized amounts are the same as those reflected in the FY 1996 standardized amounts.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1990, when the market basket was last rebased, we have considered 71.4 percent of costs to be labor-related for purposes of the prospective payment system. As discussed in section IV of the preamble, we are using a rebased market basket effective for FY 1997. Based on the rebased market basket, we are revising the labor and nonlabor proportions of the standardized amounts. Effective with discharges occurring on or after October 1, 1996, we are establishing a labor-related proportion of 71.2 percent and a nonlabor- related proportion of 28.8 percent. The standardized amounts in Table 1a of section V of this addendum have been recomputed to reflect the revised labor-related and nonlabor-related proportions. (We are revising the Puerto Rico standardized amounts by the average labor share in Puerto Rico of 82.8 percent. We are also revising the discharged-weighted national standardized amount to reflect the proportion of discharges in large urban and other areas from the FY 1995 MedPAR file.)

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 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 1995 population estimates published by the Bureau of the Census, 56 areas meet the criteria to be defined as large urban areas for FY 1997. These areas are identified by an asterisk in Table 4a.

Table 1a contains the two national standardized amounts that are applicable to all hospitals, except for sole community hospitals and hospitals in Puerto Rico. For a number of years, Table 1b had been used to set forth the 18 regional standardized amounts applicable for hospitals located in census areas subject to the regional floor. However, as provided in section 1886(d)(1)(A)(iii)(II) of the Act, the regional floor expires effective with discharges occurring on or after October 1, 1996. Therefore, all hospitals (except sole community hospitals and hospitals in Puerto Rico) will be paid solely on the basis of the national standardized amounts. 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. This table also includes the two standardized amounts that will be applicable to most hospitals in Puerto Rico.

We note that on June 28, 1996, the Office of Management and Budget announced the designation of the Pocatello, Idaho MSA and the Jonesboro, Arkansas MSA. In addition, Chester County was added to the Jackson, Tennessee MSA. We have incorporated these changes in this final rule.

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 1997 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XII) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 1997 is the market basket percentage increase minus 0.5 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 rebased hospital market basket increase for FY 1997 is 2.5 percent. For FY 1997, this yields an update to the average standardized amounts of 2.0 percent (2.5 percent minus 0.5 percent). (See section IV of the preamble to this final rule for a discussion of the market basket rebasing.)

As in the past, we are adjusting the FY 1996 standardized amounts to remove the effects of the FY 1996 geographic reclassifications and outlier payments before applying the FY 1997 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 1997 offsets to the standardized amounts for outliers and geographic reclassification, we estimate that there will be an actual increase of 1.8 percent to the large urban and other area standardized amounts.

We note that the FY 1996 standardized amounts reflected a budget neutrality factor of 0.997575 to account for the change in transfer payment policy implemented in FY 1996. See 60 FR 45854. In the proposed rule we stated that ''there will be no need for a further budget neutrality adjustment'' (61 FR 27573), but we incorrectly suggested that the FY 1996 budget neutrality adjustment for transfers should be removed in setting the FY 1997 rates. The budget neutrality adjustment for the transfer policy is built permanently into the unadjusted rates.

Although the update factor for FY 1997 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 1997 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 D to the proposed rule. 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 D to this final rule.

4. Other Adjustments to the Average Standardized Amounts

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

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

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we compared aggregate payments using the FY 1996 relative weights and wage index to aggregate payments using the FY 1997 relative weights and wage index. The same methodology was used for the FY 1996 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.998509. Based on the final FY 1997 relative weights and wage index, the final budget neutrality adjustment factor is 0.998703. This budget neutrality adjustment factor is applied to the standardized amounts without removing the effects of the FY 1996 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 continue to apply the same FY 1997 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1996, 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 1997 DRG weights and updated wage index. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8) (B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including indirect medical education and disproportionate share payments) prior to any reclassifications to total prospective payments after reclassifications. In the proposed rule, we applied an adjustment factor of 0.994059 to ensure that the effects of reclassification are budget neutral. The

final budget neutrality adjustment factor is 0.993514.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1996 budget neutrality adjustment factor. We note that the proposed FY 1997 adjustment reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 14, 1996. The final budget neutrality adjustment factor reflects the effects of all reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 1997 or from a hospital's request for the withdrawal of a reclassification request.

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

Beginning with FY 1995, section 1886(d)(5)(A) of the Act requires the Secretary to phase out payments for day outliers (correspondingly, payments for cost outliers would increase). Under the requirements of section 1886(d)(5)(A)(v), the proportion of day outlier payments to total outlier payments is reduced from FY 1994 levels as follows: 75 percent of FY 1994 levels in FY 1995, 50 percent of FY 1994 levels in FY 1996, and 25 percent of FY 1994 levels in FY 1997. We estimated the FY 1994 proportion of day outlier payments to total outlier payments at 31.3 percent in our September 1, 1993 final rule (58 FR 46348). Thus, the proportion of day outlier payments to total outlier payments in FY 1997 will be approximately 8 percent (25 percent of 31.3 percent). 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 1997 Outlier Payment Policies, Including Outlier Thresholds

For FY 1996, the day outlier threshold is 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 (the percent of Medicare's average per diem payment paid for each outlier day) is 44 percent for FY 1996. The fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $15,150 ($13,800 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1996 standardized amounts of 0.949054 for the large urban and other areas rates and 0.9526 for the capital Federal rate.

For FY 1997, we proposed to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations. Section 1886(d)(5)(A)(iii) of the Act, as amended by section 13501(c)(3) of Public Law 103–66, provides that additional payments for day outlier cases may be reduced below the marginal cost of care to meet the requirements of section 1886(d)(5)(A)(v) of the Act. We also proposed to reduce the marginal cost factor for each outlier day from 44 percent to 35 percent in FY 1997. The thresholds that we are establishing in this final rule will be the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations. Based on updated simulations, we are establishing in this final rule a marginal cost factor of 33 percent for each outlier day in FY 1997. We estimate that these policies will reduce the proportion of outlier payments paid to day outliers to approximately 8 percent, in accordance with section 1886(d)(5)(A) of the Act.

In the proposed rule, we proposed to maintain the marginal cost factor for cost outliers at 80 percent and proposed a fixed loss cost outlier threshold in FY 1997 equal to the prospective payment rate for the DRG plus $11,050 ($10,075 for hospitals that have not yet entered the prospective payment system for capital-related costs). In this final rule, based on simulations using updated data and a revised cost inflation factor (discussed below), we are establishing a fixed loss cost outlier threshold in FY 1997 equal to the prospective payment rate for the DRG plus $9,700 ($8,850 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, as proposed. We note that the FY 1997 cost outlier calculations are to be completed using the revised labor/nonlabor shares discussed above in section II.A.1 in this Addendum.

The final FY 1997 cost outlier threshold reflects a revised cost inflation factor. As explained in the proposed rule, in setting the proposed FY 1997 cost outlier threshold, we used a cost inflation factor of 0.0 percent to simulate payments using FY 1995 hospital bills (61 FR 27497). That is, to determine when a case should qualify for cost outlier payments in FY 1997, we calculated FY 1997 ''costs'' for each bill in the FY 1995 MedPAR file by applying a cost inflation factor of 0.0 percent. We indicated that we would reevaluate this factor in developing the final rule.

The latest available Medicare cost reports indicate that hospital cost per case *decreased* from FY 1993 to FY 1994 as well as from FY 1994 to FY 1995. Cost report data for 4,600 hospitals for cost reporting periods beginning in FYs 1993 and 1994 show that cost per case decreased 1.906 percent from FY 1993 to FY 1994. Preliminary data for cost reports beginning in FY 1995, which were unavailable when we developed the proposed rule, show that cost per case decreased 2.392 percent from FY 1994 to FY 1995. The latter figure is preliminary to the extent that it reflects only 1,800 hospitals and also reflects ''as submitted'' cost reports. Nevertheless, it suggests a continued trend in cost *deflation*. Accordingly, based on the more complete data for hospital cost reporting periods beginning in FYs 1993 and 1994, we have decided to use a cost inflation factor of minus 1.906 percent (a cost per case decrease of 1.906 percent) for purposes of setting the final FY 1997 outlier thresholds (as compared with our proposed FY 1997 cost inflation factor of 0.0 percent). We note that this is the first time we have deflated costs in making the outlier projection.

The use of a negative cost inflation factor results in lower FY 1997 ''costs'' for the set of cases analyzed. For example, if a bill in the FY 1995 MedPAR file reflects FY 1995 ''costs'' of $1,000, the FY 1997 ''costs'' will be

$$\$1{,}000 \times (1 - 0.01906) \times (1 - 0.01906)$$

(reflecting 2 years of cost deflation), or $962.24. These lower costs, in turn, result in a lower cost outlier threshold relative to a methodology using a positive or zero cost inflation factor (other things being equal). As stated above, the final FY 1997 cost outlier threshold is the DRG amount plus $9,700, rather than $11,050 as indicated in the proposed rule.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the FY 1997 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 1997 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.2 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1997 were as follows:

Operating standardized amounts	Capital Federal rate
0.948968	0.9476

The final outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1997 are as follows:

Operating standardized amounts	Capital Federal rate
0.948766	0.9481

As in the proposed rule, we apply the final outlier adjustment factors after removing the effects of the FY 1996 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. These Statewide average ratios will replace the ratios published in the September 1, 1995 final rule (60 FR 45922), effective October 1, 1996. 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 0.24265 or greater than 1.28879 and capital cost-to-charge ratios lower than 0.013243 or greater than 0.19730. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8a and 8b will be used for all cost reports settled during FY 1997 (regardless of the actual cost reporting period) when hospital-specific cost-to-charge ratios are either not available or outside the three standard deviations range.

iii. FY 1995 and FY 1996 Outlier Payments

In the proposed rule, we estimated that actual outlier payments for FY 1995 were approximately 3.7 percent of actual total DRG payments (lower than the 5.1 percent we projected in setting outlier policies for FY 1995). This percentage was computed by simulating payments using actual FY 1995 bill data available at the time of the proposed rule. Our current estimate is that actual outlier payments for FY 1995 were approximately 3.8 percent of actual total DRG payments. These estimates are based on simulations using the July 1996 update of the provider-specific file and the June 1996 update of the FY 1995 MedPAR file.

In the proposed rule, we estimated that actual outlier payments for FY 1996 would be approximately 4.2 percent of actual total DRG payments (lower than the 5.1 percent we projected in setting outlier policies for FY 1996). We currently estimate that FY 1996 outlier payments will approximate 4.0 percent of total DRG payments. This current estimate is based on simulations using the July 1996 update of the provider-specific file and the June 1996 update of the FY 1995 MedPAR file. We used these data to calculate an estimate of the actual outlier percentage for FY 1996 by applying FY 1996 rates and policies to the FY 1995 bills.

In the proposed rule, we discussed in detail our methodology for setting outlier thresholds, our periodic refinements to that methodology, and some possible explanations for the recent differences between projected and actual outlier percentages (61 FR 27496). We invited comments and suggestions for further refinements to the methodology. The comments on our outlier policies and methodology and our responses are set forth below.

Comment: A number of commenters are concerned that the percentages of actual outlier payments for FYs 1995 and 1996 are lower than we projected when we set the respective thresholds for those years. Some 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 actual outlier payments are not between 5 and 6 percent of projected actual total DRG payments. Other commenters requested that any difference between outlier payments and the amount set aside be used to offset the amount required in the next year. One commenter argued that it is fundamentally inequitable, even assuming that it is not illegal, not to make additional outlier payments after the end of the fiscal year to assure that we meet our 5.1 percent goal. The commenter cited historical figures on outlier payments from a pending court case in the United States District Court for the District of Columbia, *County of Los Angeles v. Shalala,* C.A. No. 93–0146 SSH (D.D.C).

Response: We have responded to similar comments a number of times, including the final rules for FY 1993 (57 FR 39784), FY 1994 (58 FR 46347), FY 1995 (59 FR 45408), and FY 1996 (60 FR 45856). As we have explained before and as explained below, we believe our outlier policies are consistent with the statute and the goals of the prospective payment system and are not inequitable.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we set outlier thresholds before a fiscal year so that outlier payments for the fiscal year are projected to be 5.1 percent of total DRG payments. In doing so, we use the best available Medicare discharge data and hospital-specific data.

Many of the factors used to set prospective payment amounts for a given fiscal year are based on estimates. These factors include not only the outlier thresholds, but also 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 do not believe that Congress intended for us to revise these factors in midyear. Similarly, we do not believe that Congress intended that the standardized amounts for a given fiscal year should be adjusted (upward or downward) to reflect any difference between projected and actual outlier payments for a past fiscal year. Payments for a given discharge in a given fiscal year are generally intended to reflect or address the average costs of that discharge in that year; that goal would be undermined if we adjusted prospective payment system payments to account for ''underpayments'' or ''overpayments'' in other years.

Moreover, the midyear or retroactive adjustments contemplated by the commenters would be extremely difficult or impracticable (if not impossible) to administer. Hospital bill data with respect to a given fiscal year continues to be added to the MedPAR file for some time after the end of the fiscal year. (We update the MedPAR file for 2 full years after the end of the respective fiscal year.) Therefore, precise figures on actual outlier payments for a given fiscal year cannot be determined until well after that fiscal year ends. We do publish estimates of ''actual'' outlier payments for recent fiscal years, but those estimates are based on available bills (and sometimes based on simulations using bills for a previous year, adjusted for estimates of inflation).

In short, we believe our outlier policies are consistent with the statute and the goals of the prospective payment system. In a recent court decision, the United States District Court for the Central District of California upheld the agency's interpretation of the statute as reasonable, writing in part that ''[a]ny retroactive adjustment would be inconsistent with [prospective payment system] because the incentives for cost reduction and efficiency would be eliminated.'' *Alvarado Community Hospital* v. *Shalala*, Case No. CV 94–0972 RMT (Ex) (C.D. Cal May 6, 1996), *appeal filed*, No. 96–55967 (9th Cir.). (There is pending litigation on the same issues in the U.S. District Court for the District of Columbia.)

Finally, we do not agree that our outlier policies are fundamentally inequitable. As we discussed in the proposed rule, we believe that one reason outlier payments have been lower than expected is that hospital costs are not increasing at the rate we expected, and costs may even be decreasing. Available data show that, beginning in FY 1994, for the first time since the inception of the prospective payment system, hospitals are experiencing actual decreases in cost per case from one year to the next. This information is confirmed by ProPAC in its June 1996 Report to Congress ''Medicare and the American Health Care System'' (Table 3–3, Annual Change in PPS Operating Costs and Payments, First 11 Years of PPS, p. 65). These actual decreases in cost per case follow a period of several years in which the rate of increase in operating cost per case declined from one year to the next.

The thresholds for a given fiscal year reflect a certain level of costs, so if hospitals are generally holding costs down, then fewer cases qualify for outlier payments and outlier payments are lower than expected. But if lower hospital costs result in lower than expected outlier payments, it also results in higher than expected ''profits'' (at least with respect to nonoutlier cases). Hospital, Medicare profit margins have rebounded to levels not seen since the middle of the 1980s. In the June 1996 report, ProPAC found the aggregate prospective payment system operating margin to be 6.0 percent for FY 1994 (Figure 3–2, Aggregate PPS Operating Margin, First 13 Years of PPS p. 68). ProPAC believes that aggregate prospective payment system margins are even higher for FYs 1995 and 1996.

Therefore, we believe that ''underpayments'' for outliers are not fundamentally inequitable because one factor contributing to this result—lower hospital costs—results in ''overpayments'' with respect to the standard DRG payments. We do not make retroactive adjustments to the standard DRG payments to account for the effect of actual costs being lower than expected; similarly, we do not make retroactive adjustments to outlier payments.

As we have stated previously, we believe the more appropriate action for addressing outlier payments is to continue to examine the outlier policy and try to refine our estimation methodology.

Comment: Two commenters stated that, after modeling the outlier payments, they were able to replicate HCFA's result of 5.1 percent for operating outlier payments, but that their analysis yielded only 4.8 percent for capital outlier payments as compared with HCFA's result of 5.2 percent.

Response: We have determined that the methodology used by the commenters contained several technical errors.

Comment: Two commenters requested that we develop an econometric hospital cost model to help us predict the cost inflation factors used for purposes of setting outlier thresholds.

Response: Currently, we calculate the cost inflation factor used to set outlier thresholds by analyzing hospital cost report data on cost per case for recent cost reporting periods. The nature of the econometric cost model contemplated by the commenters is not entirely clear to us, but we are interested in exploring such an approach and welcome specific suggestions for developing an econometric model. We believe such an approach might be helpful if the model could analyze data that are more recent than the data available in hospital cost reports.

We did not receive any specific suggestions for refinements to our outlier estimation methodology. We note that one commenter believes that the 0.0 percent cost inflation factor reflected in the proposed rule is warranted. As explained above, in this final rule, we are using a cost inflation factor of minus 1.906 percent to further reflect the decreases in cost per case.

B. Adjustments for Area Wage Levels and Cost of Living

The adjusted standardized amounts are divided into labor and nonlabor portions. Tables 1a and 1c, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble, we discuss certain revisions we are making to the wage index. 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 1997, 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, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section V of this addendum contains the relative weights that we will use for discharges occurring in FY 1997. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 1997

General Formula for Calculation of Prospective Payment Rates for FY 1997

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, 1996 and before October 1, 1997, except for sole community hospitals and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national 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.

The payment amount is determined as follows:

Step 1—Select the appropriate national standardized amount considering the type of hospital and designation of the hospital as large urban or other (see Tables 1a, 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 1997.—We are increasing the hospital-specific rates by 2.0 percent (the hospital market basket percentage increase of 2.5 percent minus 0.5 percentage points) for sole community hospitals located in all areas in FY 1997. 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 1997, is the market basket rate of increase minus 0.5 percentage points.

b. Calculation of Hospital-Specific Rate.—For sole community hospitals, the applicable FY 1997 hospital-specific rate will be calculated by multiplying a hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (2.0 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, 0.998703) 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, 1996, 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, 1996 and Before October 1, 1997

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 1997

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 based on 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 1997. The rates will be effective for discharges occurring on or after October 1, 1996.

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 were projected to 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 expired in FY 1996.

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 for operating costs under a special payment formula. These hospitals are paid a blended rate that consists 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 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 1996, the Federal rate was $461.96. In the proposed rule, we stated that the proposed FY 1997 Federal rate was $441.84. In this final rule, we are establishing an FY 1997 Federal rate of $438.92.

In the discussion that follows, we explain the factors that were used to determine the FY 1997 Federal rate. In particular, we explain why the FY 1997 Federal rate has decreased 4.99 percent compared to the FY 1996 Federal rate. We also explain that capital payments per case are estimated to increase by 3.92 percent. Taking into account the effects of increases in projected discharges, we estimate that aggregate capital payments will increase 6.77 percent.

The major factor contributing to the decrease in the FY 1997 rate in comparison to FY 1996 is the change in the exceptions reduction factor. We have expected the number and amount of exceptions payments generally to increase throughout the transition period.

Total payments to hospitals under the prospective payment system are relatively insensitive to changes in the capital prospective payments. Since capital payments are about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 1997 compared to FY 1996. Specifically, we estimate that aggregate payments in FY 1997 will be 6.77 percent higher than they were in FY 1996. Changes in aggregate payments include changes in capital payments per discharge and changes in the number of discharges. Under the prospective payment system for capital-related costs, payments per discharge (or case) are estimated to increase 3.92 percent in FY 1997 compared to FY 1996.

1. Standard Federal Rate Update

Section 412.308(c)(1)(ii) has provided that the standard Federal rate is updated based on an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for

case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor of 1.0 percent, based on the data available at the time. The final update factor for FY 1997 under that framework is 0.7 percent. This update factor is based on a projected 1.3 percent increase in the CIPI, and on policy adjustment factors of −0.6 percent. We explain the basis for the FY 1997 CIPI projection in section IV.B of the preamble to this final rule. Here we describe the policy adjustments that have been applied.

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 have adopted this CMI adjustment in the capital update framework as well.

For FY 1997, we are projecting a 1.6 percent increase in the case-mix index. We now estimate that real case-mix increase will be 1.0 percent in FY 1997. In previous years, we have assumed that real case mix will increase at about 1.0 percent per year. We expect this pattern to continue. The final net adjustment for case-mix change in FY 1997 is therefore 0.6 percentage points.

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

The 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 upcoming year. In any given year there may be unanticipated price fluctuations that may result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. In setting a prospective payment rate under the proposed framework, we make an adjustment for forecast error only if our estimate of the capital input price index rate of increase for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. Thus, for example, we would adjust for a forecast error made in FY 1996 through an adjustment to the FY 1998 update. Because we only introduced this analytical framework in FY 1996, FY 1998 is the first year in which a forecast error adjustment could be required.

Under the capital prospective payment system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component) and changes in real case mix. The use of total charges in the calculation of the 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 have therefore incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 1997, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1991–1995. In determining case-mix constant intensity, we found that observed case-mix increase was 2.8 percent in FY 1991, 1.8 percent in FY 1992, 0.9 percent in FY 1993, 0.8 percent in FY 1994, and 1.6 percent in FY 1995. For FY 1991, FY 1992 and FY 1995, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G.M. Carter, J.P. Newhouse, and D.A. Relles, R–4098–HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was 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. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1991 through FY 1995.

Given estimates of real case-mix increase of 1.0 percent for FY 1991 and FY 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, and 1.0 percent for FY 1995, we estimate that case-mix constant intensity declined by an average 1.1 percent during FY 1991 through FY 1995, for a cumulative decrease of 5.3 percent. If we assume that real case-mix increase was 1.4 percent for FY 1991 and FY 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, and 1.4 percent for FY 1995, we estimate that case-mix constant intensity declined by an average 1.2 percent during FY 1991 through FY

1995, for a cumulative decrease of 5.8 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 1997.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate used to calculate the hospital's inpatient capital-related payments (for example, 60 percent for cost reporting periods beginning in FY 1997 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, 1995 final rule, we estimated that outlier payments for capital in FY 1996 would equal 4.64 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9536 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 5.19 percent of inpatient capital-related payments based on the Federal rate in FY 1997. We are, therefore, applying an outlier adjustment factor of 0.9481 to the Federal rate. Thus, estimated capital outlier payments for FY 1997 represent a higher percentage of total capital payments than in FY 1996.

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 1997 is 0.9942 (.9481/.9536). Thus, the outlier adjustment decreases the FY 1997 Federal rate by 0.58 percent (1–0.9942) compared with the FY 1996 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that 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 based on 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 1996, we calculated a GAF/DRG budget neutrality factor of 0.9994. In the proposed rule for FY 1997, we proposed a GAF/DRG budget neutrality factor of 0.9992. In this final rule, based on calculations using updated data, we are applying a factor of 0.9987 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 1996 to FY 1997 is 0.9987. The cumulative change in the rate due to this adjustment is 1.0012 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, and FY 1997: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 = 1.0012$).

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 1997 geographic reclassification decisions made by the MGCRB compared to FY 1996 decisions. However, it does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated 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 1996, we estimated that exceptions payments would equal 1.51 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9849 (1–.0151) in determining the Federal rate. For FY 1997, we estimated in the May 31, 1996, proposed rule that exceptions payments would equal 6.07 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed to apply an exceptions reduction factor of 0.9393 (1–0.0607) to determine the FY 1997 Federal rate. For this final rule, we estimate that exceptions payments for FY 1997 will equal 6.42 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are, therefore, applying an exceptions payment reduction factor of 0.9358 to the Federal rate for FY 1997.

The final exceptions reduction factor for FY 1997 is thus 4.99 percent lower than the factor for FY 1996, and 0.37 percent lower than the factor in the FY 1997 proposed rule. As we have stated before, we have expected the number and amount of exceptions payments generally to increase throughout the transition period.

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 1997 Federal rate is 0.9358/0.9849, or 0.9501.

5. Standard Capital Federal Rate for FY 1997

For FY 1996, the capital Federal rate was $461.96. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1997 Federal rate would be $441.84. In this final rule, we are establishing an FY 1997 Federal rate of $438.92. The final Federal rate for FY 1997 was calculated as follows:

- The FY 1997 update factor is 1.0070, that is, the update is 0.70 percent.
- The FY 1997 outlier adjustment factor is 0.9481.
- The FY 1997 budget neutrality adjustment factor applied to the standard Federal payment rate for changes in the DRG relative weights and in the geographic adjustment factor is 0.9987.
- The FY 1997 exceptions payments adjustment factor is 0.9358.

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 1997 affected the computation of the final FY 1997 Federal rate in comparison to the FY 1996 Federal rate. The final FY 1997 update factor increases the Federal rate 0.70 percent compared to the rate in FY 1996, while the final geographic and DRG budget neutrality factor decreases the Federal rate by 0.13 percent. The final FY 1997 outlier adjustment factor decreases the Federal rate by 0.58 percent compared to FY 1996. The final FY 1997 exceptions reduction factor decreases the Federal rate by 4.99 percent compared to the exceptions reduction for FY 1996. The combined effect of all the changes is to decrease the Federal rate by 4.99 percent compared to the Federal rate for FY 1996.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1996 FEDERAL RATE AND FY 1997 FEDERAL RATE

		Change	Percent change
Update factor [1]:			
FY 1996	1.0120		
FY 1997	1.0070	1.0070	0.70
GAF/DRG adjustment factor [1]:			
FY 1996	0.9994		
FY 1997	0.9987	0.9987	–0.13
Outlier adjustment factor [2]:			
FY 1996	0.9536		
FY 1997	0.9481	0.9942	–0.58
Exceptions adjustment factor [2]:			
FY 1996	0.9849		
FY 1997	0.9358	0.9501	–4.99
Federal Rate:			
FY 1996	$461.96		
FY 1997	$438.92	0.9501	–4.99

[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 1996 to FY 1997 resulting from the application of the 0.9987 GAF/DRG budget neutrality factor for FY 1997 is 0.9987.

[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 1997 exceptions reduction factor is 0.9358/0.9849, or 0.9501.

We are also providing a chart that shows how the final FY 1997 Federal rate differs from the proposed FY 1997 Federal rate.

This chart shows the factors that contributed to the 0.66 percent decrease in the rate since the proposed rule. The update factor decreased 0.30 percent since the proposed rule. Another change since the proposed rule is seen in the exceptions reduction factor, decreasing 0.37 percent from the earlier estimate. The GAF/DRG reduction factor decreased only 0.05 percent since the proposed rule and the outlier reduction factor increased 0.05 percent since the proposed estimate.

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 1997 FEDERAL RATE AND FINAL FY 1997 FEDERAL RATE

		Net adjustment	Percent change
Update factor:			
Proposed FY 1997	1.0100		
Final FY 1997	1.0070	0.9970	−0.30
Outlier reduction factor:			
Proposed FY 1997	0.9476		
Final FY 1997	0.9481	1.0005	0.05
GAF/DRG reduction factor:			
Proposed FY 1997	0.9992		
Final FY 1997	0.9987	0.9995	−0.05
Exceptions reduction factor:			
Proposed FY 1997	0.9393		
Final FY 1997	0.9358	0.9963	−0.37
Federal rate:			
Proposed FY 1997	$441.84		
Final FY 1997	$438.92	0.9934	−0.66

6. Special Rate for Puerto Rico Hospitals

For FY 1996, the special rate for Puerto Rico hospitals was $355.35. With the changes we proposed to the factors used to determine the rate, the proposed FY 1997 special rate for Puerto Rico was $339.87. In this final rule, the FY 1997 capital rate for Puerto Rico is $337.63.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1997 be determined by adjusting the FY 1996 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 1997, the hospital-specific rate will be updated by a factor of 1.0070.

2. 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 1997, we estimated in the proposed rule that exceptions payments would be 6.07 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 0.9393. In this final rule, we estimate that exceptions payments will be 6.42 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are therefore applying an exceptions reduction factor of 0.9358 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 net adjustment to the FY 1997 hospital-specific rate is 0.9358/0.9849, or 0.9501.

3. Net Change to Hospital-Specific Rate

We are providing a chart to show the net change to the hospital-specific rate. The chart shows the factors for FY 1996 and FY 1997 and the net adjustment for each factor. It also shows that the cumulative net adjustment from FY 1996 to FY 1997 is 0.9568, which represents a decrease of 4.32 percent to the hospital-specific rate. The FY 1997 hospital-specific rate for each hospital is determined by multiplying the FY 1996 hospital-specific rate by the cumulative net adjustment of 0.9568.

FY 1997 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update factor:			
FY 1996	1.0100		
FY 1997	1.0070	1.0070	0.70
Exceptions payment adjustment factor:			
FY 1996	0.9849		
FY 1997	0.9358	0.9501	−4.99
Cumulative adjustments:			
FY 1996	0.9947		
FY 1997	0.9518	0.9568	−4.32

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 1996 to FY 1997 is 1.0070. 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 1996 to FY 1997 is 0.9358/0.9849, or 0.9501.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1997

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 is 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 1997 are 60 percent of the adjusted Federal rate and 40 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 60 percent Federal rate for discharges occurring in cost reporting periods beginning during FY 1997. Thus, a fully prospective hospital will receive 60 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1997. 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 1997 are published in section II.A.4.c of this addendum. For FY 1997, 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 $9,700. A case qualifies as a day outlier for FY 1997 if the length of stay is greater than the geometric mean length of stay for the DRG plus the lesser of 3 standard deviations of the length of stay or 24 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 1997 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 to Payment Rates for Excluded Hospitals and Hospital Units

A. Rate-of-Increase Percentages for Excluded Hospitals and Hospital Units

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). 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 is 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 1886(b)(3)(B) of the Act provides 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 1 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 is 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 FY 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 forecast of the market basket increase for FY 1997 for hospitals and hospital units excluded from the prospective payment system is 2.5 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 1994, we would use the rate of increase between the wage index based on 1982 wage data and the wage index based on the FY 1993 data, since the FY 1993 data are the most recent data currently available. Further, the comparison is made without regard to geographic reclassifications made by the MGCRB under sections 1886(d) (8) and (10) of the Act. Therefore, the comparison is made based on the wage index value of the labor market area in which the hospital is actually located.

We determine the amount of the adjustment for wage increases by considering three factors for the time between the base period and the period for which an adjustment is requested: the rate of increase in the hospital's average hourly wage; the rate of increase in the average hourly wage in the labor market area in which the hospital is located; and, the rate of increase in the national average hourly wage for hospital workers. The adjustment is limited to the amount by which the lower of the hospital's or the labor market area's rate of increase in average hourly wages significantly exceeds the national increase (that is, exceeds the national rate of increase by more than 8 percent). For purposes of computing the adjustment, the relative rate of increase in the average hourly wage for the labor market area is assumed to have been the same over each of the intervening years between the wage surveys.

To determine the rate of increase in the national average hourly wage, we use the average hourly earnings (AHE) 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 = 3.6 percent
1994 = 2.7 percent
1995 = 3.3 percent
1996 = 3.3 percent
1997 = 3.2 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, 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 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 1995 and Hospital Average Hourly Wage for Federal Fiscal Year 1997 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 V13.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 95 MEDPAR Update 06/95 GROUPER V14.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) August 1996
Table 8B—Statewide Average Capital Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) August 1996

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
$2,782.84	$1,125.64	$2,738.79	$1,107.83

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$2,759.22	$1,116.09	$2,759.22	$1,116.09
Puerto Rico	2,488.70	518.65	2,449.31	510.446

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$438.92
Puerto Rico	337.63

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1995

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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	01.4404	14.82	010095	00.9193	11.25	030004	01.0049	13.48	040003	01.0725	13.23	040106	01.2549	12.84
010004	00.9693	11.10	010097	00.9352	15.20	030006	01.5554	17.52	040004	01.4587	14.83	040107	01.1909	14.95
010005	01.1626	15.40	010098	01.1820	11.02	030007	01.3159	16.41	040005	01.0378	11.59	040109	01.1653	12.69
010006	01.4724	15.23	010099	01.1144	15.49	030008	02.0954	20.42	040007	01.8743	18.12	040114	01.8503	16.64
010007	01.1025	13.12	010100	01.1699	14.77	030009	01.2852	15.58	040008	01.0326	10.77	040116	01.3868	19.25
010008	01.1344	09.54	010101	01.1120	14.21	030010	01.4117	17.75	040010	01.2297	13.78	040118	01.1263	14.29
010009	01.1393	14.82	010102	00.9570	13.63	030011	01.5040	17.66	040011	00.9313	10.75	040119	01.0928	14.34
010010	01.1289	14.33	010103	01.7657	17.15	030012	01.2238	15.81	040014	01.1951	16.07	040124	01.2159	14.30
010011	01.6182	18.94	010104	01.6869	17.90	030013	01.2435	18.99	040015	01.1979	12.12	040126	00.9606	11.74
010012	01.2658	16.27	010108	01.1476	13.68	030014	01.4395	17.86	040016	01.7360	16.43	050002	01.5608	25.91
010015	01.0576	15.63	010109	01.0643	11.48	030016	01.2487	17.09	040017	01.2593	11.68	050006	01.3917	19.15
010016	01.2642	16.76	010110	01.0158	13.44	030017	01.5214	18.98	040018	01.1718	16.66	050007	01.5863	25.29
010018	00.9019	16.19	010112	01.1218	14.09	030018	01.7970	19.57	040019	01.1544	13.52	050008	01.5106	25.48
010019	01.2853	14.99	010113	01.6345	13.69	030019	01.2020	19.31	040020	01.5961	14.08	050009	01.7160	31.63
010021	01.2330	12.20	010114	01.3192	15.37	030022	01.5026	17.41	040021	01.2317	14.69	050013	01.8083	22.05
010022	01.0214	16.89	010115	00.8472	11.98	030023	01.2631	17.64	040022	01.6987	14.73	050014	01.1762	22.55
010023	01.4798	14.71	010117	00.8122	13.54	030024	01.7885	21.04	040024	01.1694	12.16	050015	01.3901	22.18
010024	01.4003	15.62	010118	01.2505	15.07	030025	01.1635	12.76	040025	00.9192	11.81	050016	01.1490	18.51
010025	01.4321	13.16	010119	01.4921	16.36	030027	01.0796	14.69	040026	01.5567	16.35	050017	02.0442	24.39
010027	00.8360	13.55	010120	00.9671	14.32	030030	01.6610	18.19	040027	01.2885	12.56	050018	01.3313	18.49
010029	01.4936	14.84	010121	01.2282	12.92	030033	01.2472	16.40	040028	01.0910	11.40	050021	01.4226	23.40
010031	01.1845	14.58	010123	01.2531	16.95	030034	01.0470	15.89	040029	01.2512	14.12	050022	01.4532	22.63
010032	00.9480	12.45	010124	01.2853	16.15	030035	01.3434	20.77	040030	00.8948	11.09	050024	01.3916	21.31
010033	01.9155	17.61	010125	01.0231	12.86	030036	01.1448	18.23	040032	01.0009	11.18	050025	01.7849	21.97
010034	01.0754	13.48	010126	01.1654	13.13	030037	02.0251	19.60	040035	01.0269	10.24	050026	01.4559	21.79
010035	01.2416	15.13	010127	01.2974	16.29	030038	01.6224	18.82	040036	01.4885	16.45	050028	01.4384	15.33
010036	01.1248	15.34	010128	00.9619	12.34	030040	01.1863	15.88	040037	01.1075	11.55	050029	01.3835	25.55
010038	01.3476	16.70	010129	01.0826	13.29	030041	00.9847	13.68	040039	01.2413	12.23	050030	01.3340	19.24
010039	01.7027	16.14	010130	01.0405	15.28	030043	01.1901	18.25	040040	01.0021	15.73	050032	01.2750	22.76
010040	01.5324	18.21	010131	01.3555	17.75	030044	01.0338	13.19	040041	01.3902	13.95	050033	01.4227	25.47
010043	01.1075	10.35	010134	00.9077	13.36	030046	00.9532	16.38	040042	01.2961	12.03	050036	01.6184	18.61
010044	01.0952	11.01	010137	01.2701	16.36	030047	00.9496	19.91	040044	00.9581	10.04	050038	01.4467	29.05
010045	01.2215	10.79	010138	00.9454	09.85	030049	00.9747	17.30	040045	01.0339	14.28	050039	01.6003	21.04
010046	01.5270	15.51	010139	01.6545	19.67	030054	00.8681	12.63	040047	01.0992	14.78	050040	01.0789	22.92
010047	01.0203	10.05	010143	01.1818	15.83	030055	01.2107	16.85	040048	01.2128	13.48	050041	02.8307	22.21
010049	01.1130	15.66	010144	01.3065	18.42	030059	01.2755	19.95	040050	01.1009	11.66	050042	01.3156	20.20
010050	01.0631	13.48	010145	01.3277	14.59	030060	01.2055	13.90	040051	01.0953	12.64	050043	01.5742	30.15
010051	00.8526	10.24	010146	01.1731	15.59	030061	01.6515	16.75	040053	01.1051	11.67	050045	01.2631	17.44
010052	00.9891	12.78	010148	00.9991	12.83	030062	01.2298	15.56	040054	01.0313	12.44	050046	01.1948	23.81
010053	01.0623	12.67	010149	01.3548	16.86	030064	01.6287	17.31	040055	01.4492	14.51	050047	01.6384	29.15
010054	01.1715	16.17	010150	01.0458	16.29	030065	01.6550	18.87	040058	01.0595	13.61	050051	01.1150	16.63
010055	01.4799	16.35	010152	01.5001	16.29	030067	01.0493	15.92	040060	00.9905	09.85	050054	01.1945	20.55
010056	01.3958	17.99	010155	01.0155	09.42	030068	00.9533	14.04	040062	01.6183	16.66	050055	01.3688	27.48
010058	01.0940	12.96	020001	01.4893	25.53	030069	01.3387	19.11	040063	01.4690	15.67	050056	01.3269	25.23
010059	01.0172	14.17	020002	01.0275	24.16	030071	00.9564	.....	040064	01.0568	10.49	050057	01.4831	20.22
010061	01.0121	14.70	020004	01.1018	25.46	030072	00.8597	.....	040066	01.1450	14.63	050058	01.4657	22.78
010062	01.0056	13.45	020005	00.9023	28.36	030073	00.9795	.....	040067	01.0823	11.34	050060	01.5871	24.25
010064	01.8006	17.85	020006	01.1404	23.19	030074	00.8590	.....	040069	01.1002	14.90	050061	01.4278	22.12
010065	01.3671	14.30	020007	00.8988	21.82	030075	00.8591	.....	040070	00.9422	14.98	050063	01.4169	21.44
010066	00.9765	10.87	020008	01.1004	26.45	030076	00.9802	.....	040071	01.5971	15.42	050065	01.6154	22.37
010068	01.2347	18.82	020009	00.9164	21.29	030077	00.8769	.....	040072	01.0869	13.39	050066	01.2719	24.33
010069	01.1593	13.06	020010	00.9035	22.13	030078	01.0972	.....	040074	01.2491	14.51	050067	01.3827	21.09
010072	01.2165	12.72	020011	01.0329	22.27	030079	00.7727	.....	040075	01.0588	11.57	050068	01.0946	19.05
010073	00.9681	09.66	020012	01.3114	23.99	030080	01.6582	20.82	040076	01.0307	14.71	050069	01.6194	23.15
010078	01.1765	15.50	020013	01.0331	24.03	030083	01.3074	21.70	040077	00.9164	10.72	050070	01.2861	30.65
010079	01.2797	13.72	020014	01.0795	24.52	030084	00.9397	.....	040078	01.4848	17.29	050071	01.3190	30.60
010080	01.0410	12.99	020017	01.5155	26.83	030085	01.5017	20.21	040080	01.0736	15.45	050072	01.3045	30.90
010081	01.9870	16.16	020018	00.8963	.....	030086	01.3255	18.76	040081	00.9292	09.91	050073	01.3242	31.28
010083	01.0482	13.25	020019	00.8718	.....	030087	01.6136	18.77	040082	01.2135	13.69	050074	01.2333	33.23
010084	01.4758	16.64	020020	00.8462	.....	030088	01.3530	19.90	040084	01.0970	14.83	050075	01.4037	30.63
010085	01.3193	17.11	020021	00.8338	.....	030089	01.5845	18.66	040085	01.2469	15.18	050076	01.7727	29.53
010086	01.0497	13.54	020024	01.0892	22.64	030092	01.5679	20.62	040088	01.3050	13.73	050077	01.6129	22.83
010087	01.6125	16.88	020025	01.0122	24.44	030093	01.3720	18.08	040090	00.8995	13.78	050078	01.3591	24.44
010089	01.1896	15.13	020026	01.3245	.....	030094	01.2482	18.57	040091	01.2939	18.25	050079	01.5793	28.30
010090	01.5738	16.40	020027	01.0132	.....	030095	01.2170	13.09	040093	00.9710	10.98	050080	01.2370	16.56
010091	00.9216	13.43	030001	01.3125	19.28	030098	00.9899	.....	040095	00.9117	10.56	050081	01.6631	24.01
010092	01.4203	15.35	030002	01.8022	20.25	040001	01.1237	12.37	040100	01.2420	12.81	050082	01.5000	21.34
010094	01.1427	16.76	030003	01.8995	21.05	040002	01.1641	13.07	040105	01.0034	11.90	050084	01.5602	22.33

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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
050088	01.1393	21.94	050188	01.3477	25.25	050295	01.4128	20.86	050419	01.3115	18.88	050542	01.2233	13.79
050089	01.3622	19.92	050189	00.9734	21.50	050296	01.2084	22.69	050420	01.4349	25.15	050543	00.9225	21.68
050090	01.2815	21.75	050191	01.5035	20.64	050298	01.2991	20.77	050421	01.4202	24.62	050545	00.8302	20.39
050091	01.2000	24.42	050192	01.1398	18.74	050299	01.3639	22.49	050423	00.9862	19.25	050546	00.7201	21.10
050092	00.8597	16.12	050193	01.3513	22.56	050300	01.3143	18.87	050424	01.8327	22.16	050547	00.9283	20.65
050093	01.5911	22.35	050194	01.2422	25.03	050301	01.3882	21.54	050425	01.2730	30.30	050549	01.7151	25.86
050096	01.1293	12.95	050195	01.5895	31.26	050302	01.4072	24.31	050426	01.3016	23.89	050550	02.3039	23.34
050097	01.4914	18.40	050196	01.4171	16.40	050305	01.5823	29.82	050427	00.9243	18.44	050551	01.3441	24.20
050099	01.4623	22.91	050197	01.8264	29.07	050307	01.4384	20.51	050430	00.9414	15.94	050552	01.1681	22.44
050100	01.7458	29.38	050199	00.8980	19.48	050308	01.5751	29.77	050431	01.0690	22.58	050557	01.4977	21.08
050101	01.4057	25.12	050204	01.5012	23.12	050309	01.3320	23.63	050432	01.5759	23.69	050559	01.3565	24.18
050102	01.4495	22.34	050205	01.4071	19.99	050310	01.2559	22.24	050433	01.0471	17.37	050560	01.1958	.....
050103	01.6149	26.74	050207	01.2968	20.58	050312	01.9778	23.66	050434	01.1429	18.08	050561	01.2258	30.34
050104	01.3954	21.73	050208	00.9598	27.60	050313	01.1978	20.90	050435	01.2450	18.98	050564	01.2054	24.02
050107	01.4293	22.92	050211	01.3146	29.60	050315	01.1780	20.82	050436	01.0070	15.77	050565	01.1520	21.26
050108	01.5836	22.79	050213	01.3874	21.12	050317	01.3273	20.90	050438	01.6314	23.33	050566	00.8825	19.75
050109	02.3476	24.68	050214	01.4375	21.76	050320	01.3287	27.27	050440	01.3954	19.93	050567	01.6587	23.01
050110	01.2507	18.72	050215	01.5190	27.75	050324	01.8319	25.93	050441	01.9149	28.55	050568	01.4204	18.28
050111	01.3798	18.81	050217	01.3643	18.44	050325	01.2523	20.87	050443	00.9587	15.95	050569	01.3542	22.93
050112	01.5220	22.15	050219	01.3321	20.37	050327	01.6010	21.00	050444	01.3523	22.19	050570	01.6980	24.91
050113	01.2853	28.23	050222	01.5922	24.56	050328	01.4495	32.92	050446	00.8940	17.25	050571	01.4204	22.37
050114	01.3991	21.65	050224	01.5653	22.17	050329	01.3164	20.34	050447	01.0844	18.59	050573	01.6397	23.66
050115	01.5990	21.11	050225	01.3294	20.67	050331	01.4127	27.08	050448	01.1051	19.82	050575	01.2273	.....
050116	01.4567	22.73	050226	01.3370	22.58	050333	00.9784	18.66	050449	01.3604	21.99	050577	01.3597	20.32
050117	01.2834	20.93	050228	01.3736	29.90	050334	01.7734	28.22	050454	01.8370	26.64	050578	01.1992	23.70
050118	01.2808	23.24	050230	01.2918	26.22	050335	01.2452	19.62	050455	01.9214	22.89	050579	01.5677	26.94
050121	01.4021	19.96	050231	01.6412	24.14	050336	01.3479	21.04	050456	01.1402	20.24	050580	01.3586	23.47
050122	01.7000	22.90	050232	01.7744	24.17	050337	01.1692	23.87	050457	01.9338	28.66	050581	01.4202	24.63
050124	01.2720	19.72	050233	01.2916	30.88	050342	01.3725	17.55	050459	01.1867	28.20	050583	01.5832	23.08
050125	01.3165	25.98	050234	01.3192	22.00	050343	01.0360	18.56	050464	01.8999	22.62	050584	01.2104	22.39
050126	01.4674	23.23	050235	01.5083	25.00	050348	01.5885	22.83	050468	01.3992	16.26	050585	01.2578	23.70
050127	01.2913	22.89	050236	01.6581	24.28	050349	00.9126	14.28	050469	01.0927	17.33	050586	01.3811	21.76
050128	01.5432	20.97	050238	01.4934	22.95	050350	01.3885	22.68	050470	01.1184	21.29	050588	01.3856	26.55
050129	01.5533	22.11	050239	01.5043	21.24	050351	01.4758	24.81	050471	01.7401	24.07	050589	01.3208	25.37
050131	01.2667	27.78	050240	01.3972	22.82	050352	01.2909	23.35	050476	01.3455	19.12	050590	01.4063	23.00
050132	01.4398	24.55	050241	01.2317	25.78	050353	01.5639	21.45	050477	01.5165	24.50	050591	01.2961	22.97
050133	01.3529	20.16	050242	01.4661	27.10	050355	00.9639	15.53	050478	00.9231	21.73	050592	01.3448	20.34
050135	01.3822	26.86	050243	01.5339	21.58	050357	01.7182	23.17	050481	01.4226	24.85	050593	01.5312	24.40
050136	01.3787	21.89	050245	01.3997	21.74	050359	01.2130	18.78	050482	00.9467	14.55	050594	02.0186	23.81
050137	01.3809	31.46	050248	01.2055	24.50	050360	01.4693	30.15	050483	01.1688	23.89	050597	01.2823	21.91
050138	01.8792	32.07	050251	01.0803	17.68	050366	01.3068	20.47	050485	01.6321	22.34	050598	01.4008	26.87
050139	01.3410	31.14	050253	00.7756	18.87	050367	01.2858	27.02	050486	01.4321	24.94	050599	01.6761	22.70
050140	01.4209	30.76	050254	01.1917	22.13	050369	01.3286	23.30	050488	01.3939	30.41	050601	01.3057	29.03
050144	01.5867	26.03	050256	01.7682	19.70	050373	01.4241	23.83	050489	00.9463	27.10	050603	01.4202	23.50
050145	01.3536	27.67	050257	01.0737	20.65	050376	01.3722	25.86	050491	01.2864	23.76	050604	01.5879	29.45
050146	01.3368	.....	050260	01.0937	21.96	050377	00.9038	15.01	050492	01.2453	23.05	050607	01.2965	21.79
050147	00.6982	20.55	050261	01.1916	17.91	050378	01.1132	22.45	050494	01.1689	24.95	050608	01.3088	15.23
050148	01.1363	19.62	050262	01.9314	26.89	050379	01.0922	19.04	050496	01.7816	31.64	050609	01.4337	31.39
050149	01.4384	21.97	050263	01.2879	24.44	050380	01.6730	28.31	050497	00.7940	.....	050613	01.1371	22.70
050150	01.2549	23.23	050264	01.3787	26.01	050382	01.4475	20.97	050498	01.2605	22.42	050615	01.7184	23.31
050152	01.4365	24.60	050267	01.5206	24.88	050385	01.3946	24.83	050502	01.6552	23.61	050616	01.3002	20.68
050153	01.6526	30.53	050270	01.2597	23.60	050388	00.9121	14.19	050503	01.3025	23.01	050618	01.0773	19.37
050155	01.1138	23.60	050272	01.3290	19.69	050390	01.2239	20.80	050506	01.4050	25.57	050623	01.1535	24.40
050158	01.6868	27.88	050274	00.9762	18.36	050391	01.2734	21.61	050510	01.3660	30.46	050624	01.3672	25.95
050159	01.2594	22.01	050276	01.2209	26.99	050392	00.9526	17.49	050512	01.4632	31.27	050625	01.5887	24.00
050167	01.4435	21.67	050277	01.3813	21.30	050393	01.4172	21.56	050515	01.3623	30.78	050630	01.3492	21.26
050168	01.6111	24.83	050278	01.5176	23.01	050394	01.5474	20.71	050516	01.6598	24.33	050633	01.2939	21.76
050169	01.5874	24.53	050279	01.2425	20.58	050396	01.6173	21.89	050517	01.2778	19.15	050635	01.4086	31.06
050170	01.5243	21.58	050280	01.6603	22.80	050397	01.0096	19.97	050522	01.3194	30.40	050636	01.4306	20.37
050172	01.2559	19.96	050281	01.4482	22.74	050401	01.1146	19.09	050523	01.2674	27.65	050638	01.0967	24.28
050173	01.2322	23.70	050282	01.3406	21.42	050404	01.1459	16.51	050526	01.3671	24.28	050641	01.2440	12.26
050174	01.6918	27.89	050283	01.1645	27.24	050406	01.1157	15.29	050528	01.3348	16.46	050643	00.7692	.....
050175	01.3877	21.97	050286	01.0345	17.99	050407	01.3194	27.06	050531	01.3097	23.60	050644	00.9068	26.86
050177	01.2949	18.76	050289	01.7959	27.38	050410	01.0758	17.45	050534	01.3868	23.83	050660	01.3466	.....
050179	01.2634	17.29	050290	01.6280	32.31	050411	01.4012	29.35	050535	01.3837	22.46	050661	00.8839	20.21
050180	01.5556	30.12	050291	01.2616	24.46	050414	01.2883	24.32	050537	01.2702	21.30	050662	00.8598	21.17
050183	01.1975	19.09	050292	01.0830	21.20	050417	01.3024	21.14	050539	01.2222	21.90	050663	01.0612	23.51
050186	01.2894	24.12	050293	01.0595	19.93	050418	01.4205	24.24	050541	01.5919	30.97	050666	00.7408	22.84

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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
050667	01.1376	24.88	060043	00.9469	11.78	080003	01.3117	19.32	100069	01.3695	17.29	100165	01.3116	13.45
050668	01.1691	28.20	060044	01.2667	17.32	080004	01.2876	17.59	100070	01.4431	17.56	100166	01.4649	20.31
050670	00.7582	20.12	060046	01.1210	16.56	080005	01.3302	16.82	100071	01.2985	16.98	100167	01.3941	20.54
050672	00.6286	23.77	060047	00.9812	11.40	080006	01.3946	20.49	100072	01.2499	17.24	100168	01.3762	19.35
050674	01.2103	29.09	060049	01.3584	17.47	080007	01.3608	17.99	100073	01.7985	20.61	100169	01.8614	18.29
050675	01.7287	16.32	060050	01.1733	13.77	090001	01.4141	19.64	100075	01.6343	17.85	100170	01.5053	16.56
050676	01.0181	13.83	060052	01.1025	12.56	090002	01.2979	20.51	100076	01.3934	17.15	100172	01.3679	13.38
050677	01.4291	32.99	060053	00.9924	13.73	090003	01.3037	24.74	100077	01.3130	17.25	100173	01.6821	16.33
050678	01.0695	24.07	060054	01.3339	16.80	090004	01.7183	23.49	100078	01.1660	15.14	100174	01.5414	18.20
050680	01.2184	26.13	060056	00.9638	13.37	090005	01.3403	27.07	100079	01.8349	16.01	100175	01.2188	16.18
050682	00.8554	14.98	060057	01.0526	21.45	090006	01.3699	19.52	100080	01.6185	19.40	100176	02.0480	21.95
050684	01.2032	21.30	060058	00.9353	12.54	090007	01.4082	19.58	100081	01.1190	13.33	100177	01.3381	18.55
050685	01.2265	26.94	060060	00.9689	12.21	090008	01.5337	24.06	100082	01.5411	17.93	100179	01.6547	19.03
050686	01.3481	30.96	060062	00.9518	15.85	090010	00.9987	21.70	100083	01.3214	17.50	100180	01.4234	17.67
050688	01.2759	27.89	060063	01.0378	11.12	090011	01.9774	24.77	100084	01.5306	16.53	100181	01.2716	17.59
050689	01.4006	29.12	060064	01.4255	20.21	090015	01.1679	.....	100085	01.4393	19.50	100183	01.3672	19.33
050690	01.4317	30.29	060065	01.3431	19.98	100001	01.5420	18.86	100086	01.3389	21.32	100186	01.4766	16.70
050693	01.9223	28.80	060066	00.9927	13.10	100002	01.4781	19.71	100087	01.8063	20.83	100187	01.4519	18.35
050694	01.3722	21.20	060068	01.2574	14.00	100004	01.0281	11.81	100088	01.6818	17.41	100189	01.3788	23.13
050695	01.1715	24.30	060070	01.0379	14.99	100005	01.0125	16.26	100090	01.4281	16.49	100191	01.3328	19.19
050696	02.0081	27.85	060071	01.2272	14.69	100006	01.5475	18.99	100092	01.4493	16.91	100199	01.4386	21.91
050697	01.1596	17.93	060073	00.9804	14.32	100007	01.8482	19.61	100093	01.5191	14.28	100200	01.3968	21.35
050698	01.1420	22.83	060075	01.3519	20.27	100008	01.7482	19.80	100098	01.1444	17.43	100203	01.2655	19.34
050699	00.5836	23.13	060076	01.3688	15.97	100009	01.5619	18.17	100099	01.2518	13.09	100204	01.6212	19.95
050700	01.4316	32.46	060085	00.9849	10.28	100010	01.5539	20.58	100102	01.1013	16.44	100206	01.3436	19.47
050701	01.3067	27.13	060087	01.6543	18.67	100012	01.6867	16.73	100103	01.1795	14.46	100207	01.4708	19.86
050702	00.8621	16.98	060088	01.0424	15.38	100014	01.4263	18.57	100105	01.4672	18.08	100208	01.6280	21.86
050704	01.2122	20.48	060090	00.9635	14.23	100015	01.2474	17.60	100106	01.0473	15.46	100209	01.6581	22.39
050706	00.9234	16.16	060096	01.0000	21.70	100017	01.6490	17.18	100107	01.4657	18.26	100210	01.6673	16.51
050707	01.1851	25.62	060100	01.4179	20.95	100018	01.2838	19.94	100108	01.1057	15.45	100211	01.3452	19.17
050708	00.9454	15.13	060103	01.2446	21.10	100019	01.4953	18.81	100109	01.3492	16.81	100212	01.6712	18.54
050709	01.3089	.....	060104	01.3185	20.32	100020	01.3391	18.31	100110	01.4144	18.91	100213	01.5487	20.00
050710	01.4032	.....	070001	01.7660	24.78	100022	01.8412	23.05	100112	00.9727	10.84	100217	01.2995	17.06
050711	02.3704	.....	070002	01.8658	24.78	100023	01.3492	15.88	100113	02.0782	18.19	100220	01.9605	19.66
050712	02.1009	.....	070003	01.1262	24.50	100024	01.3428	19.54	100114	01.4899	17.73	100221	01.5710	20.68
060001	01.5508	18.95	070004	01.1725	23.70	100025	01.8824	16.22	100117	01.3400	18.32	100222	01.3999	18.80
060003	01.2948	16.17	070005	01.3749	25.45	100026	01.6407	15.52	100118	01.2643	16.03	100223	01.4871	18.53
060004	01.2527	19.46	070006	01.3549	26.73	100027	00.9771	11.53	100121	01.3066	15.44	100224	01.4719	19.83
060006	01.1975	16.19	070007	01.3479	24.08	100028	01.2652	16.38	100122	01.4506	16.39	100225	01.3254	19.52
060007	01.2004	13.06	070008	01.3150	23.47	100029	01.4199	18.94	100124	01.3626	19.41	100226	01.3465	16.58
060008	01.0187	14.31	070009	01.2763	25.01	100030	01.2742	18.25	100125	01.1588	17.77	100228	01.3104	21.73
060009	01.4655	19.88	070010	01.5525	22.46	100032	01.9211	17.39	100126	01.4979	18.74	100229	01.3245	16.27
060010	01.5260	20.98	070011	01.3234	22.80	100034	01.7396	18.34	100127	01.6887	17.42	100230	01.5387	18.97
060011	01.3370	20.75	070012	01.2507	23.38	100035	01.6148	16.60	100128	02.2486	20.13	100231	01.6719	17.53
060012	01.3930	15.79	070013	01.2967	24.01	100038	01.6027	21.18	100129	01.2547	17.45	100232	01.2671	17.95
060013	01.2675	18.83	070015	01.3575	23.82	100039	01.7141	21.15	100130	01.2030	17.45	100234	01.5302	19.03
060014	01.7036	20.52	070016	01.3214	25.46	100040	01.6660	17.04	100131	01.3906	20.00	100235	01.4767	17.51
060015	01.5654	19.33	070017	01.3822	23.54	100043	01.4572	17.78	100132	01.4161	15.67	100236	01.4469	17.14
060016	01.0899	11.42	070018	01.3711	27.83	100044	01.5020	19.01	100134	01.0905	14.50	100237	02.1542	22.65
060018	01.2065	16.36	070019	01.2155	24.04	100045	01.4043	17.12	100135	01.5238	16.11	100238	01.4815	18.68
060020	01.5157	16.73	070020	01.3663	24.32	100046	01.5110	18.53	100137	01.3214	18.42	100239	01.4625	19.34
060022	01.6703	17.89	070021	01.3063	25.47	100047	01.9063	18.62	100138	00.9490	13.00	100240	00.8493	15.06
060023	01.6452	16.65	070022	01.7748	24.30	100048	01.0049	11.69	100139	01.0446	14.54	100241	00.9419	12.47
060024	01.8238	21.86	070024	01.3565	23.81	100049	01.3205	18.04	100140	01.2494	16.91	100242	01.4130	16.29
060026	01.4257	19.44	070025	01.7832	24.06	100050	01.2217	15.06	100142	01.1996	16.68	100243	01.4202	18.82
060027	01.6710	19.41	070026	01.2095	23.07	100051	01.1641	16.60	100144	01.1391	13.65	100244	01.4365	17.32
060028	01.4813	21.26	070027	01.2527	24.31	100052	01.3742	15.60	100145	01.3457	14.87	100246	01.3480	20.92
060029	00.9561	13.93	070028	01.4842	24.67	100053	01.2969	17.36	100146	01.2636	14.27	100248	01.7029	17.88
060030	01.3302	20.36	070029	01.3530	21.65	100054	01.2845	17.74	100147	01.1046	13.43	100249	01.3523	18.87
060031	01.6125	18.60	070030	01.3017	24.71	100055	01.3733	17.47	100150	01.3716	18.64	100252	01.2487	19.21
060032	01.5798	19.35	070031	01.2736	22.24	100056	01.4638	19.83	100151	01.8558	18.63	100253	01.4795	20.60
060033	01.1592	11.96	070033	01.2828	28.25	100057	01.3486	16.78	100154	01.5652	17.95	100254	01.5994	17.50
060034	01.4918	15.10	070034	01.3756	24.74	100060	01.8574	17.64	100156	01.2197	18.65	100255	01.3326	19.11
060036	01.1876	14.12	070035	01.3457	24.31	100061	01.5097	20.88	100157	01.6104	19.31	100256	01.8928	19.32
060037	01.0382	13.22	070036	01.4357	26.98	100062	01.7312	17.34	100159	00.9792	12.76	100258	01.6487	21.12
060038	01.0165	12.25	070039	00.9163	.....	100063	01.3440	16.12	100160	01.1077	18.07	100259	01.4550	16.36
060041	00.9131	16.53	080001	01.6108	23.66	100067	01.4273	16.38	100161	01.5218	19.76	100260	01.4008	20.44
060042	01.0563	15.65	080002	01.1901	17.34	100068	01.3898	17.42	100162	01.3906	14.53	100262	01.4078	19.32

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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
100263	01.3780	15.44	110061	01.0125	10.61	110154	00.8337	12.68	130009	00.9607	14.78	140042	01.0485	13.30
100264	01.3927	18.24	110062	00.9133	09.73	110155	01.2457	12.27	130010	00.9378	15.04	140043	01.1788	16.37
100265	01.3736	17.47	110063	01.0733	11.44	110156	01.0063	12.68	130011	01.2462	16.74	140045	01.0658	14.21
100266	01.2340	15.64	110064	01.2886	15.87	110161	01.3364	20.79	130012	01.0306	18.53	140046	01.3024	14.83
100267	01.3054	16.39	110065	01.0226	12.00	110162	00.8869	.....	130013	01.2406	17.21	140047	01.1337	13.20
100268	01.1963	22.00	110066	01.4492	15.93	110163	01.4519	18.52	130014	01.3064	16.43	140048	01.2661	21.68
100269	01.3576	19.07	110069	01.1724	15.22	110164	01.4148	19.63	130015	00.8651	12.43	140049	01.5736	19.35
100270	00.8215	12.95	110070	01.1711	11.37	110165	01.3220	17.47	130016	00.9236	16.18	140051	01.4909	19.14
100271	01.6484	19.22	110071	01.0312	10.29	110166	01.4938	16.67	130017	01.3329	13.03	140052	01.3125	17.02
100273	00.5356	19.72	110072	01.0247	11.53	110168	01.6565	19.22	130018	01.6907	17.60	140053	01.8943	17.53
100275	01.4323	21.96	110073	01.2039	12.67	110169	00.7217	19.70	130019	01.1299	13.74	140054	01.3596	.....
100276	01.3023	21.94	110074	01.4766	18.11	110171	01.4568	21.21	130021	01.0465	11.96	140055	00.9522	13.00
100277	01.0092	12.71	110075	01.2078	15.29	110172	01.3364	22.83	130022	01.1801	15.79	140058	01.2417	15.26
100279	01.3749	18.35	110076	01.3901	18.01	110174	01.0421	17.57	130024	01.0502	15.25	140059	01.1373	13.52
100280	01.3702	16.93	110078	01.6719	20.46	110176	01.1237	19.42	130025	01.1504	15.21	140061	01.0923	13.80
100281	01.2549	20.85	110079	01.3994	21.08	110177	01.4754	19.21	130026	01.1837	17.88	140062	01.2440	23.10
100282	01.0458	16.99	110080	01.1584	17.55	110178	01.3367	16.78	130027	00.9547	17.18	140063	01.4167	22.48
100283	01.5652	.....	110082	02.0181	20.36	110179	01.2418	21.56	130028	01.2487	16.08	140064	01.3103	16.15
110001	01.2981	17.40	110083	01.7259	20.66	110181	00.9808	12.59	130029	01.0228	17.07	140065	01.4933	23.68
110002	01.2392	15.22	110086	01.2202	13.76	110183	01.3677	17.07	130030	01.0169	16.20	140066	01.3703	13.39
110003	01.3058	15.41	110087	01.3382	19.17	110184	01.1756	17.58	130031	01.0188	13.26	140067	01.8244	18.24
110004	01.3077	16.17	110088	00.9695	11.17	110185	01.0884	12.23	130034	01.0391	16.38	140068	01.3717	19.00
110005	01.1844	21.40	110089	01.2124	15.37	110186	01.3073	15.75	130035	01.0662	15.37	140069	01.0074	14.23
110006	01.3576	18.87	110091	01.3396	19.15	110187	01.2468	17.19	130036	01.2648	12.50	140070	01.2760	16.18
110007	01.4531	16.31	110092	01.1806	12.55	110188	01.4230	18.00	130037	01.2740	14.58	140074	00.9717	14.60
110008	01.2394	15.47	110093	01.0117	09.81	110189	01.1532	19.78	130043	00.9512	14.61	140075	01.4676	21.53
110009	01.0428	15.71	110094	00.9605	12.06	110190	01.0880	14.41	130044	01.1521	12.37	140077	01.1406	17.05
110010	02.1537	21.39	110095	01.2790	13.86	110191	01.3522	18.06	130045	01.0312	12.15	140079	01.2381	20.90
110011	01.2831	16.01	110096	01.1394	14.30	110192	01.3947	22.17	130048	01.0694	11.90	140080	01.5767	19.60
110013	01.1303	14.36	110097	01.0211	15.58	110193	01.2332	16.16	130049	01.2951	17.55	140081	01.0786	13.92
110014	01.0358	14.48	110098	01.0943	11.76	110194	00.9677	11.77	130054	00.9652	17.12	140082	01.5017	22.10
110015	01.3568	16.52	110100	01.0953	12.27	110195	01.0807	10.50	130056	00.8422	09.45	140083	01.2513	16.51
110016	01.2935	14.21	110101	01.0963	09.24	110198	01.3335	22.58	130058	00.9768	12.87	140084	01.2323	17.94
110017	00.8913	11.01	110103	00.9600	10.35	110200	01.9391	15.79	130060	01.1395	18.38	140086	01.1440	13.93
110018	01.1312	17.20	110104	01.1190	13.28	110201	01.4569	16.13	130061	00.9484	.....	140087	01.3815	17.10
110020	01.2347	17.30	110105	01.1311	15.17	110203	00.9715	14.94	140001	01.2991	14.63	140088	01.6591	23.33
110023	01.2424	17.53	110107	01.8265	17.61	110204	00.8135	13.48	140002	01.2823	17.06	140089	01.2280	15.85
110024	01.4719	16.51	110108	00.9766	11.27	110205	01.1045	11.84	140003	01.0185	13.14	140090	01.5067	23.62
110025	01.4105	16.85	110109	01.1048	12.14	110207	01.0934	15.59	140004	01.0772	13.75	140091	01.8655	17.70
110026	01.1893	14.02	110111	01.1951	15.43	110208	00.9744	14.94	140005	00.9515	09.98	140093	01.1958	17.17
110027	01.1003	14.56	110112	01.1526	16.19	110209	00.8260	.....	140007	01.4661	20.56	140094	01.2893	18.81
110028	01.6029	17.75	110113	01.1372	12.86	120001	01.7306	24.22	140008	01.4816	20.57	140095	01.4253	.....
110029	01.3446	17.71	110114	01.0725	13.75	120002	01.1982	21.46	140010	01.3912	22.14	140097	00.9264	14.15
110030	01.2789	16.60	110115	01.6206	21.82	120003	01.1664	21.82	140011	01.1461	15.31	140100	01.2257	17.62
110031	01.3373	19.59	110118	01.0282	13.18	120004	01.2809	20.56	140012	01.2854	17.59	140101	01.2060	18.04
110032	01.2263	15.31	110120	01.0844	13.35	120005	01.2640	18.34	140013	01.6583	16.49	140102	01.0399	14.09
110033	01.5143	20.32	110121	01.1813	11.84	120006	01.2131	22.75	140014	01.0788	16.53	140103	01.3225	16.66
110034	01.5234	16.64	110122	01.3572	16.03	120007	01.6283	20.27	140015	01.2919	13.45	140105	01.3087	18.25
110035	01.4060	18.53	110124	01.0707	15.32	120009	00.9840	18.05	140016	00.9315	11.59	140107	01.0822	11.63
110036	01.6813	.....	110125	01.2239	15.97	120010	01.8462	22.11	140018	01.4546	18.85	140108	01.3622	20.00
110037	01.0852	10.18	110127	00.9150	14.43	120011	01.2509	30.31	140019	00.9900	11.80	140109	01.1367	12.95
110038	01.4649	15.04	110128	01.2059	17.54	120012	00.9944	20.30	140024	01.0188	13.59	140110	01.2343	14.51
110039	01.3761	17.93	110129	01.6793	14.06	120014	01.3609	21.25	140025	01.0804	15.88	140112	01.1043	13.55
110040	01.0393	16.26	110130	01.0709	10.57	120015	00.8375	21.01	140026	01.1408	15.58	140113	01.4630	19.21
110041	01.2212	16.43	110132	01.1522	12.87	120016	00.8646	21.94	140027	01.3210	15.96	140114	01.3392	18.95
110042	01.2049	14.63	110134	00.8920	11.65	120018	01.0071	21.16	140029	01.3790	19.62	140115	01.2253	19.32
110043	01.7109	15.17	110135	01.1993	13.83	120019	01.1783	19.48	140030	01.6766	21.46	140116	01.2899	19.68
110044	01.0952	14.31	110136	01.1192	13.74	120021	01.0173	19.68	140031	01.1664	13.02	140117	01.4908	17.63
110045	01.2460	22.04	110140	00.8194	15.03	120022	01.7340	17.83	140032	01.2528	16.44	140118	01.6836	23.01
110046	01.1964	15.07	110141	00.9075	11.65	120026	01.2870	22.30	140033	01.2626	19.10	140119	01.6901	19.58
110048	01.3156	12.97	110142	00.9799	11.15	120027	01.5254	21.16	140034	01.1754	16.74	140120	01.5071	14.72
110049	01.0670	13.71	110143	01.4049	18.27	130001	01.0518	17.21	140035	01.0183	10.70	140121	01.5259	10.91
110050	01.0687	14.00	110144	01.1632	16.44	130002	01.3744	14.66	140036	01.2342	15.03	140122	01.5567	21.02
110051	00.9846	16.35	110146	01.0267	09.43	130003	01.3166	18.11	140037	00.9837	12.24	140124	01.1235	23.06
110052	00.9986	09.11	110149	01.1280	12.17	130005	01.4466	18.49	140038	01.1512	15.00	140125	01.3444	15.60
110054	01.2820	16.57	110150	01.3562	16.56	130006	01.9033	18.19	140039	00.9224	11.51	140127	01.3521	17.11
110056	00.9698	12.61	110152	01.1389	13.06	130007	01.6435	19.45	140040	01.3038	14.34	140128	01.0617	16.10
110059	01.2862	14.39	110153	01.0201	15.49	130008	00.9993	10.28	140041	01.2502	15.01	140129	01.0511	13.18

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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
140130	01.2732	21.67	140224	01.3678	22.10	150039	01.0056	14.51	150125	01.4257	18.17	160068	01.1088	13.30
140132	01.4192	18.58	140228	01.7080	17.36	150042	01.2901	15.47	150126	01.5188	19.24	160069	01.4027	16.05
140133	01.3737	19.77	140230	00.9428	15.48	150043	01.0529	16.65	150127	01.0449	14.34	160070	01.0379	13.84
140135	01.3086	14.29	140231	01.6699	19.79	150044	01.2628	17.63	150128	01.2306	18.59	160072	01.0673	12.08
140137	01.0318	13.61	140233	01.7418	16.57	150045	01.0901	15.00	150129	01.2088	20.35	160073	01.0129	11.50
140138	00.9633	12.15	140234	01.1961	16.03	150046	01.5910	16.06	150130	01.1433	16.23	160074	01.1103	12.98
140139	01.0713	13.46	140236	01.0474	12.82	150047	01.6262	17.74	150132	01.3406	19.17	160075	01.1107	13.84
140140	01.1363	13.05	140239	01.5891	18.81	150048	01.1670	16.18	150133	01.2048	14.96	160076	01.0695	16.33
140141	00.9005	13.30	140240	01.5057	20.90	150049	01.0814	13.72	150134	01.3003	16.53	160077	01.1355	10.97
140143	01.0710	15.95	140242	01.5840	22.51	150050	01.1857	14.50	150136	00.9384	18.69	160079	01.4258	15.22
140144	00.9814	16.57	140245	01.1287	13.55	150051	01.3842	16.92	150138	01.1552	.....	160080	01.2094	15.46
140145	01.1986	14.80	140246	01.0547	12.03	150052	01.0656	12.93	150139	01.5412	.....	160081	01.0669	14.36
140146	00.9645	14.85	140250	01.3128	21.35	150053	01.0612	16.69	150141	01.1063	.....	160082	01.7526	17.09
140147	01.1905	13.32	140251	01.3100	18.25	150054	01.1373	12.39	150142	02.4300	.....	160083	01.5750	17.49
140148	01.7984	16.51	140252	01.4282	21.53	150056	01.7052	21.58	160001	01.2713	16.39	160085	01.0913	12.79
140150	01.5793	26.00	140253	01.4398	.....	150057	02.3094	15.06	160002	01.1942	13.14	160086	01.0153	12.88
140151	01.1069	17.61	140258	01.5311	20.98	150058	01.6859	18.64	160003	01.0183	11.87	160088	01.0346	13.10
140152	01.0701	22.68	140271	01.0187	13.54	150059	01.3219	18.93	160005	01.1028	12.93	160089	01.1654	14.12
140155	01.1892	16.91	140275	01.2297	18.20	150060	01.1301	12.79	160007	01.0097	12.02	160090	01.0018	13.98
140158	01.2623	21.41	140276	01.9808	20.48	150061	01.3042	15.86	160008	01.1070	13.93	160091	01.1032	10.56
140160	01.2330	15.34	140280	01.2730	16.16	150062	01.0694	15.20	160009	01.1682	13.54	160092	00.9729	12.93
140161	01.1376	17.05	140281	01.6371	20.19	150063	01.0497	18.88	160012	01.0622	14.05	160093	01.1433	15.20
140162	01.7733	18.38	140285	01.1995	14.75	150064	01.2128	16.48	160013	01.2233	16.64	160094	01.2151	14.79
140164	01.2955	16.01	140286	01.1484	17.59	150065	01.1479	15.94	160014	01.0356	12.21	160095	01.0295	12.30
140165	01.1122	13.06	140288	01.7729	22.68	150066	01.0006	12.89	160016	01.2891	15.68	160097	01.0918	13.47
140166	01.2945	16.62	140289	01.3068	15.73	150067	01.1174	14.35	160018	00.9441	13.19	160098	01.0813	13.90
140167	01.1593	14.64	140290	01.3353	19.21	150069	01.2347	16.53	160020	01.0854	12.11	160099	00.9773	12.80
140168	01.1855	15.02	140291	01.2791	22.84	150070	01.0425	16.70	160021	01.0514	13.85	160101	01.1119	17.71
140170	01.1292	12.39	140292	01.1677	19.04	150071	01.1521	12.69	160023	01.1553	13.66	160102	01.3846	15.69
140171	00.9125	12.53	140294	01.1871	16.10	150072	01.1943	15.32	160024	01.5685	17.39	160103	01.0159	12.95
140172	01.5367	18.29	140297	01.2576	21.42	150073	01.0179	15.49	160026	01.0997	15.21	160104	01.2441	19.21
140173	00.9787	13.11	140300	01.6558	24.90	150074	01.5921	18.63	160027	01.1632	13.22	160106	01.0809	14.18
140174	01.4289	18.89	150001	01.0902	16.95	150075	01.2189	13.82	160028	01.3375	17.78	160107	01.1459	13.78
140176	01.2609	18.83	150002	01.4428	19.23	150076	01.1446	19.89	160029	01.4982	17.46	160108	01.1575	14.09
140177	01.2794	16.44	150003	01.7127	18.32	150077	01.2631	16.21	160030	01.2329	16.67	160109	01.1710	12.01
140179	01.3313	19.51	150004	01.4240	20.15	150078	01.0858	17.20	160031	01.1857	13.26	160110	01.5051	17.76
140180	01.5279	20.22	150005	01.1897	17.17	150079	01.1456	13.01	160032	01.1518	14.66	160111	01.1008	10.75
140181	01.3085	18.82	150006	01.2020	16.72	150082	01.4952	18.38	160033	01.7266	15.82	160112	01.4058	14.48
140182	01.3245	19.11	150007	01.2261	17.95	150084	01.8742	21.80	160034	01.0638	13.81	160113	00.9632	11.39
140184	01.1998	14.20	150008	01.3450	18.38	150086	01.3003	15.76	160035	00.9589	11.91	160114	01.0691	14.13
140185	01.4563	16.35	150009	01.3279	16.97	150088	01.1875	16.71	160036	01.0735	12.83	160115	01.0315	13.87
140186	01.3197	18.48	150010	01.2026	16.10	150089	01.4010	18.99	160037	01.1648	14.80	160116	01.1763	15.46
140187	01.4891	16.33	150011	01.2227	16.76	150090	01.2547	19.34	160039	01.0629	15.23	160117	01.3429	15.52
140188	00.9624	10.54	150012	01.6885	20.57	150091	01.0744	15.66	160040	01.3465	16.04	160118	01.0327	12.42
140189	01.1723	15.74	150013	01.1612	13.09	150092	01.0659	12.44	160041	01.0613	12.88	160120	01.0161	09.94
140190	01.1204	13.36	150014	01.4250	18.85	150094	00.9984	16.65	160043	01.0335	13.38	160122	01.1556	14.96
140191	01.3847	23.16	150015	01.2351	17.85	150095	01.1097	15.78	160044	01.1566	13.36	160123	01.1606	12.18
140192	01.1887	16.51	150017	01.8496	17.26	150096	01.1003	17.15	160045	01.6893	17.48	160124	01.2587	15.35
140193	01.0150	12.24	150018	01.2888	17.47	150097	01.1268	16.64	160046	01.0357	11.92	160126	01.1485	13.82
140197	01.2770	16.05	150019	01.1204	13.82	150098	01.1387	11.81	160047	01.3555	15.87	160129	01.0397	13.07
140199	01.0179	15.13	150020	01.1507	13.19	150099	01.2979	17.10	160048	01.0230	11.76	160130	01.1619	13.04
140200	01.4263	20.12	150021	01.6805	18.22	150100	01.6831	18.15	160049	00.9816	12.04	160131	01.0980	12.63
140202	01.3108	20.09	150022	01.1445	17.62	150101	01.0919	14.46	160050	01.0242	14.12	160134	00.9706	11.37
140203	01.1567	19.02	150023	01.4993	17.81	150102	01.0920	14.61	160051	00.9990	12.90	160135	01.0543	13.24
140205	00.9105	13.88	150024	01.4398	16.96	150103	01.0356	17.63	160052	01.0599	14.80	160138	01.0612	13.48
140206	01.0979	19.58	150025	01.4540	16.32	150104	01.1461	15.09	160054	01.0268	10.82	160140	01.0940	14.86
140207	01.3773	26.85	150026	01.1855	16.69	150105	01.4058	16.61	160055	01.0383	11.48	160142	01.0318	13.60
140208	01.6155	23.94	150027	01.0681	16.04	150106	01.1387	15.58	160056	01.0434	12.84	160143	01.1292	13.03
140209	01.7014	17.46	150029	01.2766	20.57	150109	01.4513	16.04	160057	01.3212	15.92	160145	01.0839	13.74
140210	01.0830	12.87	150030	01.1946	16.20	150110	00.9917	14.72	160058	01.6811	18.42	160146	01.4188	15.32
140211	01.2257	20.44	150031	01.0622	15.93	150111	01.2066	12.88	160060	01.0858	13.82	160147	01.2744	15.02
140212	01.2970	22.65	150032	01.7930	18.85	150112	01.2228	16.84	160061	01.0104	14.19	160151	01.0694	12.75
140213	01.2892	20.44	150033	01.6075	20.07	150113	01.1843	16.78	160062	00.9605	11.95	160152	01.0169	13.30
140215	01.1640	13.22	150034	01.4013	18.15	150114	01.0253	13.44	160063	01.2810	14.24	160153	01.7061	17.05
140217	01.2388	21.09	150035	01.4004	17.90	150115	01.4004	17.31	160064	01.6369	16.41	170001	01.2005	15.90
140218	01.0502	13.64	150036	01.0404	17.35	150122	01.1415	17.55	160065	01.0755	14.51	170004	01.0839	13.18
140220	01.1066	14.22	150037	01.2647	17.06	150123	01.1703	12.81	160066	01.1226	14.06	170006	01.1973	13.48
140223	01.5408	25.37	150038	01.2712	16.65	150124	01.1239	15.00	160067	01.3756	16.70	170008	00.9787	13.35

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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
170009	01.1209	16.81	170089	00.9887	14.21	180011	01.1747	15.71	180103	02.0746	17.85	190060	01.4965	16.51
170010	01.2604	16.38	170090	01.0970	09.58	180012	01.3355	17.14	180104	01.5020	16.55	190064	01.5617	17.46
170011	01.4042	14.59	170092	00.8625	11.45	180013	01.5057	17.38	180105	00.9303	12.23	190065	01.4781	15.75
170012	01.4938	15.48	170093	00.9308	11.58	180014	01.6061	19.67	180106	00.9112	12.65	190071	00.8601	11.38
170013	01.3148	13.27	170094	01.0437	12.81	180015	01.2422	14.91	180108	00.8502	12.49	190077	00.9184	13.41
170014	01.0357	15.18	170095	01.0793	13.80	180016	01.3158	14.91	180115	01.0276	14.18	190078	01.1344	11.21
170015	00.9779	13.74	170097	01.0290	13.42	180017	01.2736	13.52	180116	01.3708	14.92	190079	01.2606	13.61
170016	01.6634	21.80	170098	01.0823	16.21	180018	01.2225	15.73	180117	01.1829	16.14	190081	00.8818	09.70
170017	01.1668	16.76	170099	01.3430	11.00	180019	01.3412	17.22	180118	01.0472	11.72	190083	00.9480	12.45
170018	01.0636	12.23	170100	00.9977	14.63	180020	01.0343	15.37	180120	01.0465	12.49	190086	01.3623	14.02
170019	01.1792	15.13	170101	00.9112	14.13	180021	01.1778	13.25	180121	01.2193	13.09	190088	01.1960	16.01
170020	01.3277	14.54	170102	01.0195	12.78	180023	00.8339	11.27	180122	01.0457	14.47	190089	01.1207	09.60
170022	01.1643	14.15	170103	01.2461	15.28	180024	01.3934	15.69	180123	01.4536	19.34	190090	01.0617	15.75
170023	01.4219	15.57	170104	01.4212	19.52	180025	01.1240	16.18	180124	01.4782	16.00	190092	01.3320	20.14
170024	01.1563	12.71	170105	01.0263	14.45	180026	01.1079	13.66	180125	00.9495	16.23	190095	00.9953	14.04
170025	01.1622	18.37	170106	00.8380	12.54	180027	01.2747	14.17	180126	01.1697	11.90	190098	01.5422	17.56
170026	01.0141	16.38	170108	00.9468	10.88	180028	00.9964	16.19	180127	01.2380	16.63	190099	01.1497	17.31
170027	01.3730	15.02	170109	01.0494	14.67	180029	01.2190	15.99	180128	01.1870	15.40	190102	01.5854	16.15
170030	01.0399	13.61	170110	01.0197	13.62	180030	01.1777	12.89	180129	01.0306	13.93	190103	00.8408	09.66
170031	00.9163	12.36	170112	00.9254	13.44	180031	01.0461	12.38	180130	01.4219	17.87	190106	01.1388	17.27
170032	01.1121	14.18	170113	01.1501	13.43	180032	00.9926	15.30	180132	01.2453	15.43	190109	01.1894	14.20
170033	01.3417	14.08	170114	00.9540	12.96	180033	01.1325	12.57	180133	01.2455	18.31	190110	00.9431	11.96
170034	00.9579	13.74	170115	00.9905	11.01	180034	01.0720	13.61	180134	01.0124	13.71	190111	01.5456	17.24
170035	00.9370	12.37	170116	01.0367	13.94	180035	01.5668	18.26	180136	01.5752	16.63	190112	01.5143	20.35
170036	00.8755	12.31	170117	00.9947	12.63	180036	01.2433	17.36	180137	01.6637	17.00	190113	01.3748	17.85
170037	01.1197	15.02	170119	00.9470	11.32	180037	01.2824	20.29	180138	01.2089	17.02	190114	01.0043	11.51
170038	00.9180	10.94	170120	01.2814	14.66	180038	01.4336	14.73	180139	01.0714	16.41	190115	01.2409	16.75
170039	01.1372	11.69	170122	01.9013	19.69	180040	02.0237	19.04	180140	01.0106	.....	190116	01.2969	14.97
170040	01.5594	18.21	170123	01.7740	17.69	180041	01.0904	13.03	190001	00.9354	16.67	190118	01.0464	11.87
170041	00.9886	11.41	170124	00.9495	12.10	180042	01.1215	13.43	190002	01.6389	16.28	190120	00.9281	12.89
170043	00.9329	13.41	170126	00.9261	11.07	180043	01.0168	15.31	190003	01.4461	17.16	190122	01.2732	12.96
170044	01.1174	14.73	170128	01.0762	14.31	180044	01.0336	14.68	190004	01.3781	14.81	190124	01.5748	18.80
170045	01.0311	13.54	170131	01.0910	10.54	180045	01.2089	16.86	190005	01.6913	14.94	190125	01.5826	16.74
170049	01.3345	18.05	170133	01.1401	14.09	180046	01.2073	16.81	190006	01.2839	14.07	190128	01.2172	17.04
170050	00.8380	09.63	170134	00.9226	12.10	180047	01.0087	13.79	190007	01.0054	12.79	190130	00.9983	11.74
170051	00.9591	13.31	170137	01.1832	16.81	180048	01.1345	15.53	190008	01.6481	17.79	190131	01.2691	17.33
170052	01.0675	13.31	170139	00.9838	11.66	180049	01.3619	14.47	190009	01.1897	13.40	190133	01.0518	15.09
170053	01.0064	13.09	170140	00.9990	11.17	180050	01.2650	15.58	190010	01.1104	15.31	190134	00.9992	12.16
170054	01.0821	12.86	170142	01.2590	16.10	180051	01.4236	14.35	190011	01.1162	14.08	190135	01.4027	17.70
170055	01.0629	17.05	170143	01.1201	12.53	180053	01.1138	14.22	190013	01.4152	15.27	190136	01.1264	10.66
170056	00.9457	10.99	170144	01.6225	18.74	180054	01.1573	14.02	190014	01.0568	15.36	190138	00.7080	15.62
170057	01.0529	13.75	170145	01.1678	17.02	180055	01.0383	13.61	190015	01.2394	16.38	190140	00.9434	11.60
170058	01.1738	17.54	170146	01.4164	17.58	180056	01.1035	16.68	190017	01.3740	17.22	190142	00.9384	12.20
170060	01.1254	12.73	170147	01.2279	18.33	180058	01.0125	12.85	190018	01.1705	13.78	190144	01.2227	18.82
170061	01.1532	12.59	170148	01.4736	18.35	180059	00.9719	11.98	190019	01.5074	17.57	190145	00.9867	13.77
170062	00.9501	10.45	170150	01.0772	13.13	180060	00.7427	13.48	190020	01.1936	15.83	190146	01.5911	18.99
170063	00.8993	09.30	170151	00.9962	11.69	180063	00.9643	10.28	190025	01.2979	12.36	190147	00.9929	13.30
170064	00.9472	11.38	170152	00.9812	13.27	180064	01.3019	14.40	190026	01.4497	15.65	190148	00.8949	11.81
170066	00.9901	12.26	170160	01.0305	11.25	180065	00.9850	09.05	190027	01.4805	15.62	190149	00.9972	11.02
170067	01.0335	11.05	170164	01.0288	13.87	180066	01.2107	16.87	190029	01.1364	14.09	190151	01.1567	12.30
170068	01.3864	14.01	170166	01.1446	13.49	180067	01.8972	15.96	190033	00.9673	09.64	190152	01.4477	20.50
170069	01.1712	13.20	170168	00.9486	09.97	180069	01.0363	16.08	190034	01.2482	14.93	190155	00.9246	10.54
170070	01.0193	11.83	170171	01.0923	11.15	180070	01.0919	14.86	190035	01.4173	20.27	190156	00.8872	11.89
170072	00.9565	11.53	170172	00.9841	11.07	180072	01.0544	13.80	190036	01.6581	21.15	190158	01.2399	20.36
170073	01.1115	12.66	170174	01.0916	11.58	180075	00.9745	13.08	190037	00.9667	11.05	190160	01.2163	15.56
170074	01.1546	12.86	170175	01.2906	16.30	180078	01.1237	17.35	190039	01.4275	16.41	190161	01.0457	12.98
170075	00.8688	10.55	170176	01.5023	18.40	180079	01.2461	13.75	190040	01.3850	19.03	190162	01.1677	21.04
170076	01.0722	11.15	170181	01.0745	.....	180080	01.0640	15.16	190041	01.4986	19.72	190164	01.2267	16.86
170077	00.9683	11.12	170182	00.8647	.....	180085	01.2920	17.49	190043	01.1369	12.38	190166	01.0709	14.81
170079	01.0838	11.81	170183	02.1585	.....	180087	01.0844	13.72	190044	01.1725	18.27	190167	01.2039	16.09
170080	00.9559	11.05	180001	01.2298	16.16	180088	01.5754	19.42	190045	01.3644	19.09	190170	00.9613	12.34
170081	00.9254	10.42	180002	01.0070	17.16	180092	01.0511	14.43	190046	01.4846	16.87	190173	01.4516	19.47
170082	01.0572	10.60	180004	01.0887	13.54	180093	01.3575	14.76	190048	01.0651	14.55	190175	01.2790	.....
170084	00.9830	11.06	180005	01.0375	17.40	180094	01.0158	11.93	190049	00.9679	14.74	190176	01.7076	18.06
170085	00.9074	12.01	180006	00.9157	08.63	180095	01.1597	12.78	190050	01.0446	13.90	190177	01.6056	22.02
170086	01.7241	18.04	180007	01.5430	14.17	180099	01.2008	11.72	190053	01.0575	11.98	190178	00.9842	11.20
170087	01.4580	18.87	180009	01.3358	17.70	180101	01.3403	18.84	190054	01.4118	13.67	190182	01.1627	20.12
170088	00.9068	10.59	180010	01.8318	16.91	180102	01.5134	16.31	190059	00.9449	13.58	190183	01.1310	13.81

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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
190184	01.0574	12.13	210002	01.9575	16.84	220028	01.4667	22.45	220162	01.0805	.....	230102	01.1047	.....
190185	01.3141	19.03	210003	01.5314	22.97	220029	01.1906	22.25	220163	02.0697	24.73	230103	01.0214	17.37
190186	00.9515	11.69	210004	01.3228	20.30	220030	01.0842	16.42	220171	01.6908	22.55	230104	01.6223	20.32
190187	00.7862	14.05	210005	01.2352	17.70	220031	02.0234	27.21	230001	01.2061	15.98	230105	01.6171	19.46
190189	00.9439	14.54	210006	01.1253	16.84	220033	01.3931	19.40	230002	01.2210	19.28	230106	01.1730	18.07
190190	00.9294	18.74	210007	01.6144	18.82	220035	01.2748	19.72	230003	01.0891	18.07	230107	00.8972	12.56
190191	01.3146	18.47	210008	01.3145	21.21	220036	01.6198	23.26	230004	01.6087	20.95	230108	01.2387	16.64
190194	01.1471	19.16	210009	01.7113	18.57	220038	01.2797	21.85	230005	01.2812	18.02	230110	01.3356	17.10
190196	00.9064	16.46	210010	01.2016	17.00	220041	01.2446	20.87	230006	01.1331	16.19	230111	00.9762	15.13
190197	01.2631	19.05	210011	01.2066	20.12	220042	01.2043	24.10	230007	01.0869	16.51	230113	00.9500	17.66
190199	01.3557	12.82	210012	01.4880	21.27	220046	01.3991	21.48	230013	01.2823	20.70	230114	00.6368	23.27
190200	01.5122	21.33	210013	01.2755	20.65	220049	01.2668	21.58	230015	01.1305	18.28	230115	01.0218	15.14
190201	01.2417	18.24	210015	01.2700	18.48	220050	01.0856	17.45	230017	01.5161	20.40	230116	00.9079	15.58
190202	01.4412	18.34	210016	01.7323	20.37	220051	01.2701	19.70	230019	01.5116	20.50	230117	01.9633	23.81
190203	01.5963	19.50	210017	01.1297	15.35	220052	01.2969	22.76	230020	01.7218	21.17	230118	01.2381	17.25
190204	01.5211	20.12	210018	01.2426	20.93	220053	01.2476	18.86	230021	01.5949	17.25	230119	01.3182	21.13
190205	01.8559	17.63	210019	01.3992	17.42	220055	01.3472	20.61	230022	01.2454	17.62	230120	01.2209	19.00
190206	01.4848	21.17	210022	01.4541	20.07	220057	01.4402	20.91	230024	01.4230	21.79	230121	01.2308	19.67
190207	01.1759	19.43	210023	01.2870	20.31	220058	01.0628	17.55	230027	01.0568	16.25	230122	01.3310	18.32
190208	00.8210	10.20	210024	01.5093	18.06	220060	01.2567	24.78	230029	01.5980	20.91	230124	01.1514	16.49
190218	01.1418	15.05	210025	01.3259	17.84	220062	00.6041	19.30	230030	01.2372	16.55	230125	01.3587	13.01
190223	00.4998	12.04	210026	01.3221	24.54	220063	01.2982	18.42	230031	01.4622	18.32	230128	01.3795	19.33
190227	00.8050	30.01	210027	01.2047	17.47	220064	01.2108	20.66	230032	01.7401	18.97	230129	01.8851	19.07
190230	00.8511	.....	210028	01.2362	16.66	220065	01.2162	20.00	230034	01.1936	16.64	230130	01.6896	22.37
190231	01.3052	.....	210029	01.3022	20.04	220066	01.2825	19.39	230035	01.1374	15.84	230132	01.5360	22.92
190232	01.6623	.....	210030	01.0938	15.77	220067	01.2910	22.82	230036	01.2859	19.78	230133	01.2321	14.06
190233	01.1753	.....	210031	01.6379	16.97	220068	00.5210	15.95	230037	01.1680	16.96	230134	01.1066	15.87
190234	01.0977	.....	210032	01.2064	18.42	220070	01.2693	17.77	230038	01.6453	21.18	230135	01.2023	19.88
200001	01.2668	15.74	210033	01.1813	17.38	220071	01.8550	24.38	230040	01.1967	18.35	230137	01.1665	17.78
200002	01.0219	16.15	210034	01.3999	20.29	220073	01.3821	25.34	230041	01.2106	19.17	230141	01.6842	20.84
200003	01.1282	15.90	210035	01.1950	17.25	220074	01.2579	21.18	230042	01.1517	19.03	230142	01.2118	18.71
200006	01.0627	14.95	210037	01.2862	16.14	220075	01.3235	20.09	230046	01.8323	24.65	230143	01.1404	15.23
200007	01.0052	16.86	210038	01.3397	19.90	220076	01.1791	22.47	230047	01.3036	19.61	230144	01.1171	21.06
200008	01.2463	18.34	210039	01.1588	15.25	220077	01.7205	22.32	230053	01.5335	23.82	230145	01.1817	15.41
200009	01.7644	19.84	210040	01.2948	20.32	220079	01.1871	21.28	230054	01.8245	19.74	230146	01.2933	19.49
200012	01.1610	16.11	210043	01.2538	20.04	220080	01.2723	17.77	230055	01.1799	17.36	230147	01.4832	19.34
200013	01.1360	15.32	210044	01.2025	20.28	220081	00.9625	23.55	230056	00.9745	14.17	230149	01.2487	14.92
200015	01.2341	17.15	210045	01.0197	11.73	220082	01.2932	19.28	230058	01.0807	17.42	230151	01.3634	21.32
200016	01.0283	16.10	210046	01.1047	12.34	220083	01.1845	19.80	230059	01.4913	19.00	230153	01.1245	15.61
200017	01.2444	16.86	210048	01.1780	22.47	220084	01.2361	22.24	230060	01.2802	16.90	230154	00.9519	12.09
200018	01.1671	14.27	210049	01.1482	16.57	220086	01.5481	24.60	230062	01.0313	13.61	230155	00.9759	13.80
200019	01.2445	18.01	210051	01.4488	13.94	220088	01.5772	21.76	230063	01.3188	18.41	230156	01.7043	21.57
200020	01.1821	19.86	210054	01.2726	20.17	220089	01.3301	22.99	230065	01.5013	18.63	230157	01.2036	19.67
200021	01.1844	17.66	210055	01.2866	22.48	220090	01.2380	20.78	230066	01.3628	18.72	230159	01.3967	18.93
200023	00.8848	14.61	210056	01.4106	16.51	220092	01.2548	20.86	230068	01.4399	22.29	230162	00.9885	13.73
200024	01.2892	19.16	210057	01.3623	.....	220094	01.2795	19.76	230069	01.1716	18.86	230165	01.8687	20.92
200025	01.2698	18.81	210058	01.6823	18.09	220095	01.2220	17.77	230070	01.4873	19.30	230167	01.3648	19.18
200026	01.0913	15.20	210059	01.2586	21.91	220098	01.2874	19.81	230071	01.1375	20.78	230169	01.4359	21.16
200027	01.1419	16.51	210060	01.1661	25.28	220099	01.1836	15.97	230072	01.2839	18.87	230171	00.9842	14.18
200028	00.9343	14.83	210061	01.0947	14.25	220100	01.2742	23.48	230075	01.5188	19.29	230172	01.3154	17.85
200031	01.2955	14.96	220001	01.1632	20.98	220101	01.5044	22.58	230076	01.3263	21.53	230174	01.2896	19.11
200032	01.3528	17.72	220002	01.5425	21.62	220104	01.2488	23.12	230077	01.9786	18.44	230175	04.1740	14.83
200033	01.7115	19.57	220003	01.0771	16.92	220105	01.2188	21.97	230078	01.0937	14.82	230176	01.2350	20.89
200034	01.1951	17.19	220004	01.1778	18.85	220106	01.2489	21.83	230080	01.1934	20.41	230178	01.0502	16.02
200037	01.2200	15.53	220006	01.4287	21.79	220107	01.1695	18.46	230081	01.2169	16.55	230180	01.0710	15.03
200038	01.1115	17.66	220008	01.2538	19.26	220108	01.1491	20.96	230082	01.1611	14.88	230184	01.2276	16.99
200039	01.2513	18.06	220010	01.2956	20.94	220110	01.9412	30.07	230085	01.1161	17.10	230186	01.3686	15.81
200040	01.0917	16.48	220011	01.1550	27.95	220111	01.2575	21.21	230086	00.9918	14.03	230188	01.1727	15.49
200041	01.2221	17.37	220012	01.3665	27.84	220116	01.9442	23.95	230087	01.0641	13.65	230189	00.8937	14.50
200043	00.5614	16.96	220015	01.1777	20.35	220118	02.0524	26.47	230089	01.3393	21.55	230190	01.0395	22.66
200050	01.1978	16.71	220016	01.3747	20.16	220119	01.3288	24.40	230092	01.3264	17.77	230191	00.8900	14.99
200051	00.9723	17.70	220017	01.4278	23.78	220123	01.0371	23.85	230093	01.2267	17.37	230193	01.2471	16.03
200052	00.9716	13.07	220019	01.1780	17.06	220126	01.3041	19.39	230095	01.2357	15.53	230194	01.2111	14.37
200055	01.1557	14.56	220020	01.2189	18.47	220128	01.1441	20.85	230096	01.1957	19.85	230195	01.2822	19.80
200062	00.9198	14.64	220021	01.3862	23.21	220133	00.8406	30.53	230097	01.5406	17.75	230197	01.2640	22.00
200063	01.1662	16.63	220023	01.1469	19.37	220135	01.2559	23.97	230099	01.2173	19.06	230199	01.1553	17.72
200066	01.1689	14.34	220024	01.1752	20.14	220153	01.0402	19.74	230100	01.1533	15.19	230201	01.2138	14.02
210001	01.4102	17.94	220025	01.1894	18.87	220154	00.9268	18.96	230101	01.0658	16.79	230204	01.3660	19.78

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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
230205	01.0570	14.54	240044	01.2004	16.02	240129	01.0159	12.18	250032	01.2599	15.70	250134	00.9882	12.70
230207	01.2586	19.85	240045	01.0731	18.49	240130	01.0112	14.54	250033	00.9948	11.57	250136	00.7904	16.84
230208	01.1857	16.10	240047	01.5172	18.27	240132	01.2360	21.80	250034	01.5348	12.99	250138	01.3513	16.94
230211	00.9823	13.86	240048	01.2728	20.43	240133	01.1709	16.16	250035	00.9044	11.82	250140	00.9213	09.37
230212	01.0970	21.13	240049	01.7768	20.33	240135	00.8166	11.38	250036	00.9786	11.34	250141	01.2098	15.50
230213	01.0251	12.69	240050	01.1319	19.89	240137	01.2521	15.40	250037	00.8704	09.53	250144	00.9384	11.18
230216	01.5269	17.91	240051	00.9956	15.97	240138	00.8994	13.09	250038	00.9851	12.52	250145	00.9432	.....
230217	01.2172	18.06	240052	01.2612	17.21	240139	00.9643	14.24	250039	01.0021	11.71	250146	01.0011	13.25
230219	01.0186	15.18	240053	01.5152	19.67	240141	01.0919	19.12	250040	01.2981	15.65	250148	01.1518	.....
230221	01.1845	18.15	240056	01.2438	20.13	240142	01.1289	15.16	250042	01.1494	13.78	250149	00.9174	.....
230222	01.3604	18.98	240057	01.7426	22.04	240143	01.0597	12.48	250043	01.0352	10.49	260001	01.6549	16.08
230223	01.3187	19.85	240058	00.9668	09.64	240144	00.9459	13.39	250044	00.9822	13.98	260002	01.4877	20.05
230227	01.5187	22.00	240059	01.0942	17.98	240145	00.9654	12.37	250045	01.1477	17.17	260003	00.9457	12.45
230228	01.2121	17.29	240061	01.7512	20.93	240146	00.9209	17.20	250047	00.9674	09.12	260004	01.0314	11.86
230230	01.5400	20.38	240063	01.4674	20.88	240148	00.9490	11.34	250048	01.4542	13.51	260005	01.6146	19.68
230232	01.0356	15.87	240064	01.2630	18.13	240150	00.8906	11.72	250049	00.9037	09.93	260006	01.5247	16.72
230235	01.1038	14.65	240065	01.1600	11.14	240152	01.0128	17.85	250050	01.2407	12.30	260007	01.4679	16.03
230236	01.3542	21.07	240066	01.4040	19.08	240153	01.0199	14.30	250051	00.8548	09.44	260008	01.2220	15.65
230239	01.1770	16.07	240069	01.1629	18.35	240154	01.0158	13.15	250057	01.1806	14.06	260009	01.2407	15.63
230241	01.1553	17.08	240071	01.1200	18.05	240155	00.9827	14.39	250058	01.1385	13.65	260011	01.6765	16.87
230244	01.3134	20.14	240072	01.0257	16.08	240157	01.1226	13.92	250059	01.0304	12.16	260012	01.0472	11.96
230253	01.0735	17.39	240073	00.9213	15.13	240160	01.0116	14.65	250060	00.8121	12.19	260013	01.1520	14.02
230254	01.2785	22.64	240075	01.2132	18.79	240161	00.9351	14.56	250061	00.8654	10.75	260014	01.7769	17.84
230257	01.1031	19.01	240076	01.1434	19.94	240162	00.9629	15.28	250063	00.8615	12.68	260015	01.2698	13.16
230259	01.1967	19.06	240077	01.0646	14.15	240163	00.9381	14.10	250065	00.8878	11.72	260017	01.2272	13.94
230264	00.9614	16.74	240078	01.4510	21.46	240166	01.1661	14.67	250066	00.9422	12.17	260018	00.9658	09.56
230269	01.3062	21.71	240079	01.0143	12.57	240169	00.9528	15.25	250067	01.1241	14.14	260019	00.9862	12.63
230270	01.2238	20.08	240080	01.3766	20.87	240170	01.1518	14.42	250068	00.8546	11.19	260020	01.7312	19.29
230273	01.6568	22.11	240082	01.1233	14.55	240171	00.9973	14.02	250069	01.1820	13.42	260021	01.5117	18.47
230275	00.5764	16.53	240083	01.3779	16.60	240172	01.0856	14.50	250071	00.9499	08.06	260022	01.3423	18.69
230276	00.8113	16.23	240084	01.3446	17.20	240173	00.9609	14.82	250072	01.2933	17.40	260023	01.2569	15.58
230277	01.2440	21.76	240085	00.9356	14.90	240179	00.9990	14.30	250076	00.9378	10.32	260024	01.0179	12.28
230278	02.1143	19.50	240086	01.0496	15.23	240180	01.0157	10.51	250077	00.9481	11.08	260025	01.3240	13.61
230279	00.7080	.....	240087	01.1088	15.69	240184	01.0352	11.31	250078	01.4504	14.21	260027	01.5963	18.92
230280	01.0737	.....	240088	01.4423	18.10	240187	01.2576	16.56	250079	00.8573	15.12	260029	01.1241	15.76
230281	01.8228	.....	240089	00.9966	15.23	240193	01.0505	14.73	250081	01.3046	15.19	260030	01.0922	09.73
240001	01.5705	21.24	240090	01.0889	13.57	240196	00.6134	22.50	250082	01.2852	12.30	260031	01.5029	18.49
240002	01.6951	19.40	240093	01.3149	16.49	240200	00.8945	13.34	250083	01.0297	11.01	260032	01.5899	17.59
240004	01.4733	20.16	240094	01.0470	17.26	240205	00.9066	.....	250084	01.0930	13.92	260034	00.9820	14.22
240005	00.9911	13.49	240096	01.0126	14.12	240206	00.8405	.....	250085	01.0146	11.42	260035	01.0725	11.44
240006	01.1243	19.75	240097	01.1262	17.05	240207	01.2516	21.47	250088	00.9555	15.43	260036	01.0697	15.72
240007	01.1114	15.15	240098	00.9639	16.41	240210	01.2558	21.44	250089	01.0349	11.77	260037	01.3946	15.17
240008	01.0447	15.22	240099	01.1186	11.00	240211	00.9295	11.18	250093	01.1144	12.17	260039	01.1393	11.17
240009	00.9722	14.18	240100	01.3180	19.58	240212	01.9942	.....	250094	01.2380	14.41	260040	01.6081	14.92
240010	01.9804	20.17	240101	01.1585	17.32	250001	01.6860	15.91	250095	00.9763	13.57	260042	01.4179	15.65
240011	01.1378	15.69	240102	00.8877	12.27	250002	00.7948	13.34	250096	01.3058	16.49	260044	01.0453	14.29
240013	01.3077	15.90	240103	01.0788	14.10	250003	01.0260	14.13	250097	01.1879	13.83	260047	01.3608	14.19
240014	01.0825	17.79	240104	01.2317	21.71	250004	01.4695	15.12	250098	00.8668	13.73	260048	01.2801	18.05
240016	01.3045	15.46	240105	01.0024	12.70	250005	00.9707	09.15	250099	01.2736	12.73	260050	01.0896	14.71
240017	01.1365	15.15	240106	01.3351	23.68	250006	00.9603	12.27	250100	01.2423	14.53	260052	01.3429	15.95
240018	01.2985	15.82	240107	00.9779	15.07	250007	01.2699	16.88	250101	00.9416	09.89	260053	01.1239	09.46
240019	01.2259	19.58	240108	00.9570	11.64	250008	00.9041	11.36	250102	01.5340	14.80	260054	01.3205	16.08
240020	01.1410	18.11	240109	00.9926	13.59	250009	01.1772	15.04	250104	01.3615	15.58	260055	01.0344	13.67
240021	00.9545	12.49	240110	01.0347	15.18	250010	01.0374	11.07	250105	00.9185	13.13	260057	01.1563	13.85
240022	01.1265	17.33	240111	00.9806	13.06	250012	00.9543	13.77	250107	00.9101	14.16	260059	01.1218	14.17
240023	01.0070	15.86	240112	01.0585	13.30	250015	01.0921	09.75	250109	00.9351	11.54	260061	01.1737	10.87
240025	01.1710	15.02	240114	00.9961	11.13	250017	01.0049	13.77	250112	00.9915	14.22	260062	01.1677	19.89
240027	00.9990	12.60	240115	01.6186	22.30	250018	00.9576	09.81	250117	01.0706	13.28	260063	01.1867	14.82
240028	01.1340	16.50	240116	00.9450	12.43	250019	01.4239	17.43	250119	01.2057	10.80	260064	01.3241	15.40
240029	01.1619	15.70	240117	01.0688	16.21	250020	01.0024	10.78	250120	01.0683	12.04	260065	01.7807	15.31
240030	01.2995	16.78	240119	00.8459	16.93	250021	00.8612	07.74	250122	01.2814	15.87	260066	01.0907	12.78
240031	00.9285	13.50	240121	00.8986	17.10	250023	00.8655	11.22	250123	01.3253	17.72	260067	00.9812	10.43
240036	01.5566	19.05	240122	01.0462	16.80	250024	00.9845	08.25	250124	00.9123	10.69	260068	01.6696	18.49
240037	01.0463	16.40	240123	01.0518	13.30	250025	01.1440	13.58	250125	01.3189	18.35	260070	01.0868	11.09
240038	01.4513	22.50	240124	01.0123	15.71	250027	01.0290	10.40	250126	00.9867	10.22	260073	00.9754	11.58
240040	01.2271	17.67	240125	00.9399	10.75	250029	00.8857	11.87	250127	00.7659	.....	260074	01.2444	11.49
240041	01.3105	14.43	240127	01.0272	12.51	250030	00.9703	11.39	250128	01.0941	12.64	260077	01.7237	16.30
240043	01.2029	16.83	240128	01.1234	14.55	250031	01.3147	17.20	250131	01.0545	09.36	260078	01.1752	12.39

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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
260079	00.9808	11.78	270002	01.1914	13.92	280024	01.0190	13.22	280111	01.2501	16.06	310014	01.7262	23.69
260080	00.9748	09.77	270003	01.2463	18.65	280025	00.9834	11.07	280114	00.9302	10.26	310015	01.7788	24.34
260081	01.4994	16.44	270004	01.6543	17.33	280026	01.1268	12.80	280115	00.9762	13.59	310016	01.2218	22.93
260082	01.1249	13.50	270006	01.0348	18.67	280028	01.0603	13.64	280117	01.2367	14.48	310017	01.3316	21.95
260085	01.5653	18.92	270007	00.9630	12.26	280029	01.0513	12.62	280118	00.9917	13.47	310018	01.2149	21.06
260086	01.0538	12.67	270009	01.0369	14.91	280030	01.7482	23.06	280119	00.8442	.....	310019	01.6444	20.84
260089	00.9595	13.31	270011	01.1240	16.46	280031	01.0457	12.48	280123	00.7968	.....	310020	01.1914	19.66
260091	01.6036	18.96	270012	01.5997	17.10	280032	01.3205	15.11	290001	01.6296	22.35	310021	01.3482	21.15
260094	01.1818	15.98	270013	01.2868	16.78	280033	00.9881	13.62	290002	00.9009	17.99	310022	01.2391	19.38
260095	01.4416	16.05	270014	01.7155	15.97	280034	01.2104	13.41	290003	01.6155	21.15	310024	01.2539	22.60
260096	01.5553	21.52	270016	00.8195	11.51	280035	00.9439	11.75	290005	01.4321	19.66	310025	01.2317	21.92
260097	01.1803	15.82	270017	01.2264	18.32	280037	01.0150	13.55	290006	01.2223	16.54	310026	01.2770	21.91
260100	00.9672	13.12	270019	01.0747	13.34	280038	01.0733	13.39	290007	01.9023	25.07	310027	01.3756	18.17
260102	01.0113	16.75	270021	01.1036	15.55	280039	01.1841	14.24	290008	01.2244	17.14	310028	01.1453	20.46
260103	01.3826	16.73	270023	01.2906	18.76	280040	01.5869	18.30	290009	01.6096	21.07	310029	01.8972	20.69
260104	01.6337	19.57	270024	00.9931	11.15	280041	00.9988	10.95	290010	01.2116	19.33	310031	02.6282	24.14
260105	01.8722	19.18	270026	00.8677	11.95	280042	01.0970	13.22	290011	00.8854	14.39	310032	01.2962	20.00
260107	01.3844	18.55	270027	01.0389	12.69	280043	01.1235	12.75	290012	01.4484	19.97	310034	01.2537	19.14
260108	01.8056	18.26	270028	01.0735	14.91	280045	01.1409	13.48	290013	01.0180	14.85	310036	01.2137	18.44
260109	00.9922	11.92	270029	00.9056	14.51	280046	01.0729	11.09	290014	01.0424	16.52	310037	01.3032	25.43
260110	01.6069	14.16	270031	00.8747	09.71	280047	01.1632	15.70	290015	00.9691	15.38	310038	01.9189	22.82
260111	00.9994	08.04	270032	01.1776	16.46	280048	01.0813	11.17	290016	01.1476	18.71	310039	01.2906	20.51
260112	01.4123	17.47	270033	00.8822	11.39	280049	01.0363	13.82	290019	01.2779	17.92	310040	01.2680	23.12
260113	01.1111	14.05	270035	01.0294	15.87	280050	00.9263	13.11	290020	01.0783	17.65	310041	01.3192	22.90
260115	01.2400	14.92	270036	00.9483	10.42	280051	01.0572	13.72	290021	01.5602	19.17	310042	01.2513	21.74
260116	01.1317	13.70	270039	01.0661	11.99	280052	01.0352	11.85	290022	01.7398	22.47	310043	01.2027	20.60
260119	01.1592	15.01	270040	01.0819	17.60	280054	01.2613	15.54	290027	00.9516	14.68	310044	01.2981	20.16
260120	01.1606	15.72	270041	01.0700	11.14	280055	00.9274	11.63	290029	00.9400	.....	310045	01.3866	25.76
260122	01.1407	13.12	270044	01.1997	13.40	280056	00.9925	10.99	290032	01.4088	18.66	310047	01.3405	23.05
260123	01.0309	11.17	270046	00.9328	13.50	280057	01.0060	14.48	290036	01.4927	.....	310048	01.1853	20.69
260127	00.9517	13.71	270048	01.0968	13.30	280058	01.3349	13.75	290038	01.1066	.....	310049	01.3247	23.54
260128	00.9877	08.95	270049	01.8369	18.19	280060	01.5930	18.38	300001	01.3969	20.70	310050	01.2623	20.88
260129	01.2126	13.51	270050	01.0374	15.96	280061	01.4692	14.76	300003	01.8661	20.92	310051	01.3232	24.26
260131	01.3183	16.32	270051	01.2969	18.02	280062	01.2236	11.92	300005	01.2669	18.65	310052	01.2516	20.53
260134	01.1485	13.87	270052	01.0663	18.02	280064	01.0732	12.61	300006	01.1225	16.24	310054	01.2937	23.19
260137	01.2635	13.71	270053	00.8716	09.53	280065	01.2934	16.22	300007	01.1477	16.76	310056	01.1800	20.11
260138	01.9683	20.66	270057	01.1700	17.35	280066	01.0101	11.38	300008	01.2465	16.95	310057	01.2906	20.10
260141	01.8935	16.53	270058	00.9419	11.20	280068	00.9716	09.31	300009	01.1071	17.45	310058	01.1047	25.35
260142	01.1604	14.50	270059	00.8676	19.21	280070	01.0712	10.75	300010	01.2380	17.80	310060	01.2112	17.55
260143	00.9437	10.52	270060	00.9653	11.92	280073	01.0399	12.78	300011	01.3508	21.36	310061	01.2156	19.85
260147	01.0490	12.81	270063	00.8933	12.94	280074	01.0981	12.87	300012	01.2779	21.64	310062	01.2941	23.90
260148	00.9639	09.33	270068	00.8629	12.38	280075	01.2063	12.90	300013	01.2250	16.87	310063	01.3515	20.78
260158	01.1355	11.80	270072	00.8526	14.88	280076	01.0602	12.54	300014	01.2336	18.41	310064	01.2988	21.35
260159	01.2962	18.17	270073	01.0764	11.06	280077	01.3589	17.36	300015	01.1776	17.37	310067	01.3199	21.14
260160	01.0683	14.07	270074	00.8861	.....	280079	01.0649	09.40	300016	01.3172	17.41	310069	01.1308	18.19
260162	01.6912	17.70	270075	00.8706	.....	280080	01.0842	11.34	300017	01.2081	20.49	310070	01.3980	22.16
260163	01.3188	14.11	270076	00.8386	.....	280081	01.5683	17.24	300018	01.2333	18.85	310072	01.2980	20.74
260164	00.9955	12.07	270079	00.9563	13.36	280082	01.1154	13.03	300019	01.2621	18.43	310073	01.5552	22.31
260166	01.2126	21.51	270080	01.1536	14.27	280083	01.0646	15.64	300020	01.2622	19.78	310074	01.4149	21.08
260172	01.0128	12.07	270081	01.0790	09.77	280084	01.0366	10.92	300021	01.1644	15.69	310075	01.2933	21.67
260173	00.9588	11.15	270082	01.0039	16.10	280085	00.7201	14.02	300022	01.1031	17.08	310076	01.3854	28.16
260175	01.1310	14.60	270083	01.1160	10.96	280088	01.8032	18.12	300023	01.3278	20.13	310077	01.5172	23.09
260176	01.6716	19.26	270084	00.9034	12.77	280089	01.0548	13.79	300024	01.2736	16.56	310078	01.3568	22.70
260177	01.3854	19.46	280001	01.0830	14.11	280090	00.9850	11.70	300028	01.2674	15.52	310081	01.2644	20.80
260178	01.4707	19.06	280003	01.9484	18.11	280091	01.1370	13.17	300029	01.3084	21.29	310083	01.2592	22.20
260179	01.5633	18.48	280005	01.3783	16.64	280092	00.8990	11.63	300033	01.1012	13.70	310084	01.2622	20.43
260180	01.6919	18.45	280009	01.7335	16.70	280094	01.1464	13.32	300034	01.9356	21.31	310086	01.1738	20.89
260183	01.6448	16.51	280011	00.9513	11.56	280097	01.0552	12.56	310001	01.7775	24.91	310087	01.2345	18.95
260186	01.2538	15.20	280012	01.2413	14.88	280098	01.0077	09.68	310002	01.7278	25.68	310088	01.2566	19.57
260188	01.2759	15.70	280013	02.0235	19.71	280101	01.1173	10.92	310003	01.2230	23.16	310090	01.1884	22.86
260189	00.9409	11.23	280014	00.9990	10.78	280102	01.1321	11.77	310005	01.2257	19.20	310091	01.2193	21.35
260190	01.2003	18.46	280015	01.0254	13.78	280104	00.9599	09.88	310006	01.2209	19.02	310092	01.3080	20.52
260191	01.1725	19.44	280017	01.1524	13.42	280105	01.2988	16.46	310008	01.2785	21.23	310093	01.2193	19.52
260193	01.2262	19.13	280018	01.1939	12.25	280106	00.9481	13.23	310009	01.2877	21.35	310096	01.9014	21.19
260195	01.1678	.....	280020	01.5198	18.97	280107	01.0284	12.36	310010	01.2966	21.05	310105	01.1914	22.41
260197	01.3273	20.38	280021	01.3322	14.01	280108	01.1433	13.26	310011	01.3050	21.71	310108	01.3940	21.08
260198	01.2292	14.98	280022	00.9740	11.07	280109	00.9424	10.61	310012	01.5915	23.53	310110	01.2108	19.69
260200	01.3542	19.14	280023	01.3802	13.73	280110	01.0201	10.88	310013	01.2813	19.91	310111	01.2536	19.70

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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
310112	01.2441	20.58	330024	01.9152	30.03	330126	01.2229	20.35	330230	01.5076	26.44	330396	01.2740	25.30
310113	01.2115	20.70	330025	01.1879	13.80	330127	01.3974	25.01	330231	01.1364	27.57	330397	01.3146	26.82
310115	01.1954	19.78	330027	01.4751	28.56	330128	01.3390	25.26	330232	01.2180	15.46	330398	01.2362	26.59
310116	01.2905	21.67	330028	01.3453	23.76	330132	01.1636	13.74	330233	01.5344	29.08	330399	01.3284	29.65
310118	01.1883	21.86	330029	01.1091	17.36	330133	01.3525	28.31	330234	02.1947	24.17	340001	01.4939	19.54
310119	01.5440	27.27	330030	01.2330	15.20	330135	01.2522	16.25	330235	01.1384	17.37	340002	01.8814	18.53
310120	01.0653	17.24	330033	01.2702	13.46	330136	01.2620	20.45	330236	01.3965	26.57	340003	01.1186	16.56
310121	01.0416	16.61	330034	00.7745	36.61	330140	01.7171	17.19	330238	01.1734	14.53	340004	01.4952	17.21
320001	01.4645	16.76	330036	01.3260	21.00	330141	01.3544	23.17	330239	01.2034	15.44	340005	01.2172	14.57
320002	01.4190	21.55	330037	01.1403	15.17	330144	00.9809	13.27	330240	01.3472	26.47	340006	01.2315	14.56
320003	01.1694	15.57	330038	01.2154	14.91	330148	01.0806	14.39	330241	01.8842	20.92	340007	01.1793	14.81
320004	01.2647	17.86	330039	00.8474	13.18	330151	01.0508	13.77	330242	01.3486	22.98	340008	01.1505	16.90
320005	01.3207	17.86	330041	01.3957	27.81	330152	01.4256	27.77	330245	01.2684	17.15	340009	01.3744	19.12
320006	01.3742	15.20	330043	01.2516	26.92	330153	01.6484	17.44	330246	01.2600	22.99	340010	01.3111	16.41
320009	01.5332	16.49	330044	01.2413	17.05	330154	01.5904	.....	330247	00.7043	26.49	340011	01.1105	13.98
320011	00.9883	17.79	330045	01.4206	24.83	330157	01.3111	18.41	330249	01.2271	15.89	340012	01.2599	15.82
320012	01.0365	16.57	330046	01.5166	30.08	330158	01.3798	24.33	330250	01.3148	16.01	340013	01.2783	16.58
320013	01.2196	18.28	330047	01.2282	16.63	330159	01.3217	17.55	330252	00.9107	15.40	340014	01.5898	22.15
320014	01.0172	13.13	330048	01.3029	16.10	330160	01.4707	26.09	330254	01.0280	15.94	340015	01.2409	16.44
320016	01.1611	12.00	330049	01.2452	17.52	330161	00.7237	16.00	330258	01.4226	25.28	340016	01.2062	15.18
320017	01.2209	17.34	330053	01.1285	14.39	330162	01.2663	26.18	330259	01.4498	21.99	340017	01.2587	15.96
320018	01.4884	16.61	330055	01.5084	29.02	330163	01.2137	17.75	330261	01.2244	24.35	340018	01.1282	14.78
320019	01.4863	19.01	330056	01.4474	28.37	330164	01.3963	18.96	330263	00.9929	17.00	340019	01.0519	13.69
320021	01.7092	20.62	330057	01.7158	16.48	330166	00.9723	14.11	330264	01.2681	20.00	340020	01.1686	17.33
320022	01.1787	16.34	330058	01.3270	15.85	330167	01.6440	27.45	330265	01.3105	15.78	340021	01.2198	15.08
320023	01.0348	13.29	330059	01.6224	29.66	330169	01.4303	31.95	330267	01.2786	22.78	340022	01.0527	14.56
320030	00.9822	16.54	330061	01.2977	23.38	330171	01.2804	22.28	330268	00.9740	15.79	340023	01.3923	18.44
320031	00.9008	14.78	330062	01.1779	14.99	330175	01.1255	14.11	330270	01.9655	30.33	340024	01.2228	15.49
320032	00.9936	16.66	330064	01.3752	28.38	330177	01.0208	12.46	330273	01.2942	21.36	340025	01.1893	14.38
320033	01.1484	19.23	330065	01.1890	17.14	330179	00.8617	14.09	330275	01.2178	18.34	340027	01.1954	15.46
320035	01.0033	14.82	330066	01.2343	17.26	330180	01.1952	16.36	330276	01.1877	16.61	340028	01.5380	17.48
320037	01.2052	15.17	330067	01.3770	19.68	330181	01.3076	28.32	330277	01.1372	16.35	340030	02.0110	19.06
320038	01.1660	15.62	330072	01.3458	26.89	330182	02.5837	26.92	330279	01.2893	17.24	340031	00.9808	12.56
320046	01.1839	18.23	330073	01.1820	14.32	330183	01.4389	18.88	330285	01.8218	21.81	340032	01.3999	17.87
320048	01.3187	13.90	330074	01.1874	17.35	330184	01.3396	25.83	330286	01.3203	22.59	340035	01.1695	14.97
320056	00.9819	.....	330075	01.0879	16.48	330185	01.2256	24.23	330290	01.7578	28.28	340036	01.1713	17.04
320057	01.0573	.....	330078	01.4454	16.90	330186	00.9205	18.79	330293	01.1689	13.72	340037	01.1725	15.50
320058	00.9038	.....	330079	01.3130	16.60	330188	01.1850	17.75	330304	01.2689	25.52	340038	01.1103	14.52
320059	00.9778	.....	330080	01.4167	24.95	330189	01.3177	16.20	330306	01.4522	26.59	340039	01.2748	19.18
320060	00.9187	.....	330082	01.1199	16.29	330191	01.2688	17.18	330307	01.2171	18.33	340040	01.7746	17.75
320061	01.1051	.....	330084	00.9919	15.59	330193	01.3086	27.34	330308	01.1772	28.68	340041	01.2471	15.99
320062	00.9353	.....	330085	01.3266	18.66	330194	01.8119	26.07	330309	01.2334	24.67	340042	01.1864	13.80
320063	01.3272	15.84	330086	01.2540	24.13	330195	01.6272	29.02	330314	01.3526	21.07	340044	01.1056	13.26
320065	01.2822	16.76	330088	01.1094	24.41	330196	01.3367	25.53	330315	01.2558	24.58	340045	01.0365	10.95
320067	00.8203	09.19	330090	01.5534	16.86	330197	01.0945	14.43	330316	01.3037	26.23	340047	01.9028	17.98
320068	00.9119	17.98	330091	01.3842	17.64	330198	01.3399	22.17	330327	00.9253	15.30	340048	00.9055	09.39
320069	01.0454	09.08	330092	01.1025	13.64	330199	01.4635	24.80	330331	01.2220	27.78	340049	00.6394	15.10
320070	01.0243	.....	330094	01.2299	15.78	330201	01.5377	27.83	330332	01.2606	24.30	340050	01.1904	14.69
320074	01.1107	17.15	330095	01.2598	16.49	330202	01.4872	25.07	330333	01.3624	22.00	340051	01.2639	16.23
320079	01.2049	17.41	330096	01.0679	14.88	330203	01.3994	19.16	330336	01.3438	27.39	340052	01.0447	18.62
330001	01.1955	24.84	330097	01.1652	14.63	330204	01.4236	24.90	330338	01.1329	22.52	340053	01.6969	18.96
330002	01.4938	24.26	330100	00.6895	25.95	330205	01.1568	19.46	330339	00.8034	18.09	340054	01.0901	12.68
330003	01.3393	19.29	330101	01.8031	33.09	330208	01.2061	23.16	330340	01.2081	23.91	340055	01.2079	16.69
330004	01.2785	19.10	330102	01.3004	16.32	330209	01.1871	21.17	330350	01.8138	27.96	340060	01.1390	16.38
330005	01.8133	19.53	330103	01.2486	15.94	330211	01.2093	16.31	330353	01.3975	27.49	340061	01.7128	19.20
330006	01.3128	24.11	330104	01.3604	25.44	330212	01.1755	20.25	330354	01.3898	.....	340063	01.0555	13.01
330007	01.3289	17.43	330106	01.5666	33.04	330213	01.1241	16.19	330357	01.3757	32.07	340064	01.2278	17.24
330008	01.1187	15.77	330107	01.2590	24.38	330214	01.7379	28.90	330359	00.9471	23.70	340065	01.3129	12.82
330009	01.3480	28.08	330108	01.2119	15.85	330215	01.2197	15.65	330372	01.2689	22.53	340067	01.1907	12.84
330010	01.1648	15.34	330111	01.0877	14.62	330218	01.1661	17.16	330381	01.1945	27.09	340068	01.2333	14.21
330011	01.2464	17.22	330114	00.8876	15.48	330219	01.6358	18.39	330385	01.1735	29.27	340069	01.7159	18.31
330012	01.6173	27.84	330115	01.2008	14.46	330221	01.3421	26.57	330386	01.1478	20.82	340070	01.3795	16.78
330013	02.0611	16.93	330116	00.9149	13.82	330222	01.2611	15.28	330387	00.8589	23.28	340071	01.0726	14.30
330014	01.3852	27.12	330118	01.6360	18.19	330223	01.0811	15.10	330389	01.8045	29.95	340072	01.1400	13.86
330016	01.0249	14.55	330119	01.7390	29.88	330224	01.2647	18.85	330390	01.2567	28.38	340073	01.4546	20.50
330019	01.1339	23.60	330121	01.0050	14.35	330225	01.1856	23.23	330393	01.7319	25.24	340075	01.1558	15.98
330020	01.0573	14.25	330122	01.2081	20.92	330226	01.2808	16.83	330394	01.5114	17.27	340080	01.1240	13.55
330023	01.2492	22.80	330125	01.8059	19.91	330229	01.3242	14.92	330395	01.3557	30.16	340084	01.0689	14.51

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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
340085	01.2597	15.46	350008	01.0366	15.15	360032	01.0867	16.18	360108	01.0267	15.08	360197	01.2031	16.76
340087	01.1439	16.80	350009	01.1592	15.74	360034	01.1593	13.30	360109	01.0942	17.43	360200	01.0011	13.48
340088	01.1199	16.46	350010	01.1821	12.30	360035	01.5736	19.90	360112	01.7563	21.61	360203	01.1469	15.55
340089	00.9632	12.28	350011	01.9090	17.37	360036	01.3217	17.31	360113	01.3031	18.24	360204	01.2935	16.96
340090	01.1321	16.30	350012	01.1445	12.36	360037	02.1462	20.14	360114	01.1423	16.05	360210	01.2312	19.23
340091	01.6457	18.32	350013	01.0749	14.58	360038	01.5947	18.31	360115	01.3193	18.08	360211	01.2323	17.25
340093	01.0600	11.60	350014	01.0459	14.29	360039	01.2539	15.34	360116	01.1312	16.04	360212	01.3976	20.25
340094	01.3349	16.83	350015	01.7084	15.42	360040	01.3179	17.72	360118	01.3243	17.37	360213	01.1708	15.77
340096	01.2029	17.18	350016	01.0584	10.35	360041	01.3771	18.25	360121	01.2823	16.74	360218	01.2976	16.21
340097	01.1577	16.04	350017	01.4608	14.88	360042	01.1043	16.74	360122	01.3977	17.77	360230	01.3323	20.27
340098	01.6813	19.05	350018	01.1656	10.67	360044	01.1490	15.84	360123	01.2541	17.50	360231	01.1369	12.45
340099	01.1020	13.36	350019	01.6065	18.69	360045	01.4935	19.25	360124	01.2534	17.08	360234	01.3572	17.90
340101	01.0289	11.11	350020	01.4956	18.57	360046	01.1278	18.52	360125	01.1047	16.87	360236	01.1905	18.56
340104	00.9432	10.60	350021	01.0704	10.94	360047	01.2351	13.85	360126	01.2042	18.97	360239	01.2400	18.70
340105	01.3861	17.75	350023	00.8923	15.59	360048	01.7480	21.00	360127	01.1566	16.28	360241	00.5347	17.69
340106	01.1062	17.79	350024	01.1031	13.69	360049	01.2653	17.36	360128	01.1287	13.85	360242	01.7176	.....
340107	01.3146	16.17	350025	01.0558	12.60	360050	01.1666	12.43	360129	01.0400	14.06	360243	00.7473	14.35
340109	01.3269	15.91	350027	00.9712	12.57	360051	01.5445	21.82	360130	01.1366	15.16	360244	00.7208	16.77
340111	01.1675	13.78	350029	01.0062	12.34	360052	01.7086	17.88	360131	01.4162	16.27	360245	00.8023	12.10
340112	01.2839	14.03	350030	01.0917	15.42	360054	01.2621	15.55	360132	01.2311	20.78	360246	00.8798	15.05
340113	02.0160	19.50	350033	00.9596	13.23	360055	01.2391	18.92	360133	01.4596	17.61	360247	00.4357	.....
340114	01.5131	19.16	350034	01.0571	13.58	360056	01.3529	16.92	360134	01.5973	18.25	370001	01.6944	18.41
340115	01.5532	17.23	350035	00.9015	10.11	360057	01.0445	13.04	360135	01.1672	17.12	370002	01.2462	13.60
340116	01.9191	20.30	350038	01.0538	13.26	360058	01.2628	15.35	360136	01.0528	14.73	370004	01.2787	15.30
340119	01.2839	15.21	350039	00.9705	13.53	360059	01.5433	20.00	360137	01.5604	18.98	370005	01.0273	14.12
340120	01.1296	12.33	350041	01.0446	13.05	360062	01.4697	18.40	360140	01.0178	15.47	370006	01.3096	14.88
340121	01.0450	14.52	350042	01.0504	12.39	360063	01.1243	17.19	360141	01.4412	19.84	370007	01.1404	12.80
340122	00.9921	10.30	350043	01.6433	16.58	360064	01.5567	19.65	360142	01.0184	14.99	370008	01.4080	16.02
340123	01.1293	14.07	350044	00.9113	10.01	360065	01.2287	16.97	360143	01.2979	17.74	370011	01.0616	12.47
340124	01.0275	12.27	350047	01.2204	16.64	360066	01.3889	17.16	360144	01.3148	20.19	370012	00.8457	10.05
340125	01.4145	16.94	350049	01.2419	10.38	360067	01.2670	12.11	360145	01.6244	16.84	370013	01.7611	18.61
340126	01.4353	16.23	350050	00.9371	10.24	360068	01.6576	21.91	360147	01.2662	.....	370014	01.3196	17.14
340127	01.3099	16.30	350051	00.9466	14.13	360069	01.1437	16.38	360148	01.0715	16.50	370015	01.2617	13.84
340129	01.3429	18.65	350053	01.0767	09.58	360070	01.6677	16.57	360149	01.1450	20.33	370016	01.3790	14.25
340130	01.3332	16.03	350055	00.9216	11.50	360071	01.2655	15.42	360150	01.2825	17.70	370017	01.1042	12.14
340131	01.4267	16.05	350056	00.9601	12.92	360072	01.1448	16.29	360151	01.3167	16.55	370018	01.2647	14.06
340132	01.3222	12.41	350058	00.9495	12.18	360074	01.3535	19.15	360152	01.4765	17.73	370019	01.3066	11.91
340133	01.0518	13.87	350060	00.7458	08.17	360075	01.4875	20.80	360153	01.1500	13.64	370020	01.2884	12.53
340136	00.7885	24.45	350061	01.0625	13.77	360076	01.3060	18.84	360154	01.0235	12.39	370021	00.9781	10.01
340137	01.2154	12.68	350063	00.8969	.....	360077	01.4820	18.59	360155	01.3290	18.75	370022	01.2741	15.13
340138	01.1811	17.60	350064	00.9840	.....	360078	01.2766	18.97	360156	01.3403	16.47	370023	01.3301	14.95
340141	01.6320	18.27	350066	00.7996	.....	360079	01.7539	19.31	360159	01.1943	18.50	370025	01.4024	15.37
340142	01.1998	14.94	360001	01.3171	17.88	360080	01.1169	14.39	360161	01.2798	18.78	370026	01.4279	16.08
340143	01.3874	18.50	360002	01.2012	15.33	360081	01.3564	17.96	360162	01.2593	17.27	370028	01.8659	17.67
340144	01.4263	14.85	360003	01.7460	20.67	360082	01.3158	19.81	360163	01.8617	19.87	370029	01.2335	12.79
340145	01.3230	16.80	360006	01.7465	19.53	360083	01.2516	15.77	360164	00.8576	13.98	370030	01.2425	12.05
340146	01.0175	15.42	360007	01.0523	15.41	360084	01.6097	18.16	360165	01.2134	14.31	370032	01.5284	14.28
340147	01.2925	17.80	360008	01.2955	16.20	360085	01.8261	19.63	360166	01.1750	15.83	370033	01.0754	11.23
340148	01.4427	18.28	360009	01.3969	17.35	360086	01.4494	16.75	360169	00.9859	16.99	370034	01.2609	12.79
340151	01.1215	14.05	360010	01.2298	15.38	360087	01.4106	17.32	360170	01.2826	15.68	370035	01.6338	15.21
340153	01.9740	21.08	360011	01.2267	17.83	360088	01.2136	15.48	360172	01.3727	16.62	370036	01.0298	09.22
340155	01.3941	20.91	360012	01.2961	17.61	360089	01.1654	16.92	360174	01.2295	19.24	370037	01.7224	16.37
340156	00.8042	.....	360013	01.0861	16.71	360090	01.2325	17.90	360175	01.2416	17.61	370038	00.9103	12.01
340158	01.1785	15.94	360014	01.1236	17.57	360091	01.2653	18.90	360176	01.1811	15.62	370039	01.4595	17.22
340159	01.1571	16.88	360016	01.5986	17.81	360092	01.2754	17.85	360177	01.2619	16.30	370040	01.1036	10.89
340160	01.0888	12.88	360017	01.7484	19.82	360093	01.2219	16.66	360178	01.2206	15.58	370041	01.0290	13.52
340162	01.2211	17.78	360018	01.5417	18.51	360094	01.3012	20.27	360179	01.2895	19.01	370042	00.8626	11.22
340164	01.4594	18.17	360019	01.2939	18.22	360095	01.3299	16.68	360180	02.0595	22.07	370043	00.9753	12.91
340166	01.4192	18.51	360020	01.4334	20.05	360096	01.1102	16.20	360184	00.4913	17.11	370045	01.1501	10.20
340168	00.5028	14.78	360021	01.2759	18.04	360098	01.3988	18.00	360185	01.2472	17.09	370046	00.9820	09.22
340171	01.1220	.....	360024	01.4300	17.76	360099	01.1087	16.91	360186	01.1741	15.04	370047	01.3236	15.40
350001	01.0070	11.08	360025	01.2331	17.66	360100	01.3108	15.63	360187	01.2880	16.00	370048	01.1790	13.46
350002	01.7570	16.04	360026	01.1939	15.59	360101	01.7511	19.71	360188	01.0028	14.77	370049	01.3544	16.07
350003	01.1983	15.67	360027	01.5318	19.06	360102	01.2675	19.68	360189	01.0113	15.40	370051	00.9604	13.31
350004	01.9399	17.94	360028	01.4723	15.28	360103	01.3274	18.70	360192	01.2451	19.28	370054	01.3882	14.79
350005	01.0794	13.14	360029	01.1573	16.41	360104	01.9146	20.28	360193	01.3171	16.77	370056	01.5659	15.41
350006	01.3898	16.16	360030	01.1350	14.82	360106	01.0557	13.89	360194	01.1176	16.14	370057	01.1762	15.05
350007	00.9506	12.20	360031	01.3576	18.42	360107	01.2429	16.98	360195	01.1297	17.72	370059	01.1142	13.53

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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
370060	01.0828	12.88	370190	01.6289	17.49	390002	01.3694	17.03	390078	01.0673	15.98	390164	01.9539	19.14
370063	01.0959	13.12	370192	01.1353	.....	390003	01.2550	15.57	390079	01.7078	16.83	390166	01.1034	17.40
370064	00.9954	10.14	370194	02.0879	.....	390004	01.3802	16.70	390080	01.2568	18.66	390167	01.2653	20.71
370065	01.0424	14.76	370195	02.4526	.....	390005	01.0808	14.82	390081	01.3530	20.23	390168	01.2043	17.54
370071	01.0343	10.18	380001	01.3214	19.27	390006	01.7350	17.39	390083	01.2270	20.87	390169	01.2058	18.63
370072	00.9116	11.67	380002	01.2073	22.74	390007	01.1796	21.33	390084	01.2421	15.29	390170	01.8570	22.43
370076	01.3116	12.42	380003	01.1475	18.75	390008	01.1300	15.08	390086	01.1340	16.87	390173	01.1954	17.08
370077	01.2139	16.30	380004	01.8006	22.89	390009	01.6087	18.07	390088	01.3283	18.42	390174	01.7088	24.17
370078	01.7084	14.58	380005	01.1861	19.47	390010	01.1790	16.58	390090	01.8006	19.41	390176	01.1460	16.79
370079	00.9678	11.98	380006	01.3890	18.29	390011	01.2467	16.49	390091	01.1700	17.09	390178	01.2822	17.74
370080	00.9908	11.12	380007	01.5689	22.66	390012	01.1943	19.15	390093	01.1538	15.20	390179	01.2710	22.80
370082	00.9103	12.48	380008	01.0706	18.69	390013	01.2311	16.77	390095	01.1758	13.95	390180	01.5397	22.83
370083	00.9505	10.95	380009	01.8307	22.17	390014	01.6424	16.42	390096	01.2633	16.88	390181	01.0583	17.80
370084	01.0351	08.88	380010	01.0879	24.15	390015	01.2054	13.06	390097	01.3262	20.91	390183	01.1883	17.16
370085	00.8092	12.94	380011	01.1042	14.95	390016	01.2233	15.58	390098	01.7539	20.06	390184	01.1032	17.69
370086	01.1831	09.89	380013	01.2681	21.54	390017	01.1747	14.20	390100	01.6285	19.30	390185	01.2281	16.12
370089	01.2759	14.01	380014	01.4266	18.89	390018	01.2261	19.47	390101	01.2027	15.70	390189	01.0384	18.41
370091	01.6816	16.13	380017	01.7014	21.77	390019	01.1185	14.53	390102	01.3635	20.34	390191	01.0441	13.91
370092	01.0706	12.73	380018	01.8329	19.21	390022	01.3887	21.81	390103	01.0941	17.17	390192	01.1158	17.15
370093	01.8716	18.67	380019	01.2061	18.88	390023	01.2485	19.71	390104	01.0526	15.15	390193	01.1854	15.39
370094	01.4235	16.67	380020	01.4312	20.06	390024	00.8664	22.60	390106	01.0134	14.85	390194	01.1543	18.97
370095	00.9189	11.62	380021	01.2831	19.10	390025	00.6470	16.64	390107	01.2490	18.66	390195	01.8317	22.08
370097	01.3652	18.99	380022	01.1731	19.92	390026	01.2710	20.58	390108	01.4094	19.97	390196	01.3947	.....
370099	01.1641	12.91	380023	01.2312	17.76	390027	01.9535	23.48	390109	01.1447	14.44	390197	01.3094	18.40
370100	01.0343	13.02	380025	01.2677	21.90	390028	01.7850	18.54	390110	01.6460	17.36	390198	01.1948	15.21
370103	00.9027	11.77	380026	01.1914	16.87	390029	01.9570	18.73	390111	01.8484	26.22	390199	01.2026	14.89
370105	02.0050	17.06	380027	01.2567	20.25	390030	01.2446	16.29	390112	01.1485	12.16	390200	01.0202	14.67
370106	01.5501	16.96	380029	01.1523	17.29	390031	01.1536	16.93	390113	01.2135	16.04	390201	01.2674	18.75
370108	01.0589	10.82	380031	01.0334	15.92	390032	01.2594	17.80	390114	01.1068	21.07	390203	01.3159	20.45
370112	01.0733	12.33	380033	01.7873	22.97	390035	01.2733	17.28	390115	01.3311	21.40	390204	01.2627	20.05
370113	01.1633	12.33	380035	01.3604	18.58	390036	01.3360	17.63	390116	01.2395	19.91	390205	01.3650	22.42
370114	01.6326	14.69	380036	01.1184	17.27	390037	01.3511	18.49	390117	01.1590	15.65	390206	01.3418	19.91
370121	01.1757	15.78	380037	01.2075	18.24	390039	01.0973	15.60	390118	01.1514	16.34	390209	01.0388	15.48
370122	01.1255	09.78	380038	01.3358	21.15	390040	01.0015	12.71	390119	01.3484	17.17	390211	01.1864	17.10
370123	01.2080	14.12	380039	01.3285	18.89	390041	01.2556	16.82	390121	01.3362	18.95	390213	00.9413	14.55
370125	01.0313	11.90	380040	01.2529	19.23	390042	01.4303	21.35	390122	01.0707	16.06	390215	01.1567	20.69
370126	00.9473	10.66	380042	01.1547	18.06	390043	01.1059	15.65	390123	01.3002	20.58	390217	01.2820	17.92
370131	01.0515	12.93	380047	01.6980	19.84	390044	01.6035	18.80	390125	01.2243	15.08	390219	01.3126	18.57
370133	01.1108	09.82	380048	01.0877	13.92	390045	01.7250	17.35	390126	01.3270	20.07	390220	01.2051	19.33
370138	01.1139	14.40	380050	01.3535	16.37	390046	01.5479	18.49	390127	01.2341	20.26	390222	01.3047	20.42
370139	01.0952	10.62	380051	01.5153	19.13	390047	01.6934	23.83	390128	01.2022	17.96	390223	01.6436	23.15
370140	00.9914	11.71	380052	01.1886	16.70	390048	01.1867	16.26	390130	01.1400	16.62	390224	00.9380	13.04
370141	01.3994	19.17	380055	01.2332	23.88	390049	01.5481	19.82	390131	01.2704	16.24	390225	01.2136	15.42
370146	01.0334	12.03	380056	01.0805	15.78	390050	02.1410	21.21	390132	01.2472	20.25	390226	01.7849	23.22
370148	01.5867	19.01	380060	01.5427	21.51	390051	02.1789	24.98	390133	01.7840	20.57	390228	01.2097	18.67
370149	01.2406	15.19	380061	01.5190	21.85	390052	01.1942	16.68	390135	01.2903	19.73	390231	01.3073	21.89
370153	01.0980	13.17	380062	01.1022	15.07	390054	01.2238	14.56	390136	01.2304	15.66	390233	01.3224	16.71
370154	01.0184	12.31	380063	01.3291	19.90	390055	01.7758	21.82	390137	01.3205	17.80	390235	01.5737	23.94
370156	01.0910	13.37	380064	01.4379	18.47	390056	01.1158	15.73	390138	01.3335	17.41	390236	01.1730	15.90
370158	01.0520	12.08	380065	01.0522	19.24	390057	01.3213	18.94	390139	01.5034	23.50	390237	01.6110	20.17
370159	01.3498	13.95	380066	01.3198	17.60	390058	01.3256	17.46	390142	01.6703	22.64	390238	01.3009	16.12
370163	00.8598	10.99	380068	01.0572	19.31	390060	01.1441	16.68	390145	01.3568	18.64	390242	01.2706	18.69
370165	01.0906	11.74	380069	01.1302	17.51	390061	01.4388	20.47	390146	01.3133	16.19	390244	00.9314	13.32
370166	01.0846	15.48	380070	01.3936	21.21	390062	01.1400	15.76	390147	01.2593	19.22	390245	01.3505	23.15
370169	01.1130	10.66	380071	01.2923	18.06	390063	01.7390	19.30	390149	01.2546	19.59	390246	01.2343	15.91
370170	00.9813	.....	380072	00.9776	14.15	390064	01.5536	16.30	390150	01.1045	17.50	390247	01.0532	17.11
370171	01.0235	.....	380075	01.4343	20.90	390065	01.2840	18.85	390151	01.2950	18.26	390249	01.0339	10.81
370172	00.8846	.....	380078	01.1630	16.95	390066	01.2949	17.15	390152	01.0397	17.07	390256	01.7863	23.51
370173	01.2880	.....	380081	01.1420	17.66	390067	01.8124	18.03	390153	01.2439	21.93	390258	01.2630	19.78
370174	00.9656	.....	380082	01.2830	20.35	390068	01.3206	18.13	390154	01.1846	13.93	390260	01.1752	20.02
370176	01.1460	16.48	380083	01.2473	18.93	390069	01.3149	19.23	390155	01.2947	20.56	390262	01.9683	17.25
370177	00.9746	10.10	380084	01.2083	20.61	390070	01.2872	19.49	390156	01.4292	22.61	390263	01.4329	18.66
370178	01.0093	12.17	380087	01.0126	12.30	390071	01.1143	13.36	390157	01.3465	17.97	390265	01.3177	17.72
370179	00.8839	14.28	380088	01.0041	15.71	390072	01.1098	15.76	390158	01.5904	.....	390266	01.2130	16.69
370180	01.0671	.....	380089	01.2966	21.87	390073	01.5899	18.94	390160	01.2106	17.51	390267	01.2925	18.93
370183	01.0923	14.00	380090	01.3003	24.41	390074	01.2338	16.26	390161	01.0926	14.87	390268	01.3885	19.94
370186	01.0180	12.72	380091	01.2100	23.79	390075	01.2463	15.92	390162	01.4285	19.03	390270	01.3067	15.89
370189	00.9704	10.13	390001	01.3711	18.16	390076	01.3156	20.45	390163	01.2240	16.55	390272	00.4528	.....

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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
390277	00.5603	20.34	420002	01.3814	18.80	430011	01.3374	14.33	440024	01.3270	16.22	440146	00.9338	11.08
390278	00.7678	17.52	420004	01.8677	18.35	430012	01.3054	14.99	440025	01.1364	13.01	440147	01.1985	17.06
390279	01.0751	13.63	420005	01.2065	14.35	430013	01.2411	15.06	440029	01.2900	16.30	440148	01.1378	14.37
390281	03.2278	.....	420006	01.2691	18.90	430014	01.2803	16.77	440030	01.2038	13.21	440149	01.2007	15.19
400001	01.2220	08.25	420007	01.5104	16.31	430015	01.1797	14.41	440031	00.9661	12.29	440150	01.2814	19.58
400002	01.4856	10.96	420009	01.2122	15.70	430016	01.8135	17.59	440032	01.0524	12.65	440151	01.3711	15.86
400003	01.2332	08.92	420010	01.1103	14.35	430018	00.9842	14.06	440033	01.0675	14.84	440152	01.5691	16.91
400004	01.1483	07.59	420011	01.0948	14.89	430022	00.9711	10.91	440034	01.5752	16.64	440153	01.2623	15.10
400005	01.1206	06.10	420014	01.1243	14.11	430023	00.9247	09.95	440035	01.3207	15.65	440156	01.5611	18.85
400006	01.2016	08.16	420015	01.3249	15.96	430024	00.9133	12.28	440039	01.6370	16.76	440157	01.0908	13.64
400007	01.2693	07.55	420016	01.0738	14.39	430026	01.0802	11.36	440040	00.9724	17.03	440159	01.2247	14.83
400009	01.0262	07.68	420018	01.7297	18.63	430027	01.8126	16.64	440041	01.0380	12.35	440161	01.6915	20.63
400010	00.9203	07.94	420019	01.2334	14.90	430028	01.0919	13.68	440046	01.3297	13.59	440166	01.4435	17.80
400011	00.9992	08.65	420020	01.3863	15.98	430029	00.9945	13.10	440047	00.9562	15.31	440168	01.0268	13.03
400012	01.2240	07.45	420023	01.4196	18.07	430031	00.9633	11.31	440048	01.7952	16.64	440173	01.5203	16.91
400013	01.3026	07.90	420026	01.9243	18.05	430033	01.0190	11.90	440049	01.6599	15.62	440174	00.9800	13.30
400014	01.3669	07.72	420027	01.3766	15.51	430034	01.0691	11.58	440050	01.2144	16.03	440175	01.2313	18.06
400015	01.2460	10.88	420030	01.3136	15.83	430036	01.0403	10.11	440051	00.9274	13.29	440176	01.2943	18.36
400016	01.3669	10.57	420031	00.9596	12.15	430037	00.9746	12.89	440052	01.2208	14.25	440178	01.1828	20.20
400017	01.2323	06.27	420033	01.2169	19.24	430038	01.0102	10.77	440053	01.3082	15.64	440180	01.1590	16.68
400018	01.3497	09.15	420035	00.8201	12.43	430039	01.0851	11.53	440054	01.2219	12.82	440181	01.0247	11.75
400019	01.6713	09.52	420036	01.2109	15.61	430040	00.9125	12.17	440056	01.0837	13.45	440182	00.9496	15.33
400021	01.4363	07.63	420037	01.2790	19.65	430041	00.9368	11.91	440057	01.0173	10.77	440183	01.5317	15.06
400022	01.3221	09.94	420038	01.3043	14.43	430042	00.9807	10.63	440058	01.3195	14.95	440184	01.3454	18.63
400024	01.0278	08.62	420039	01.1575	14.52	430043	01.1884	12.02	440059	01.3263	15.63	440185	01.1231	14.24
400026	00.9518	05.90	420042	01.2023	12.15	430044	00.9113	13.17	440060	01.1970	14.76	440186	01.1936	16.21
400027	01.1389	08.01	420043	01.1809	18.82	430047	01.1401	12.24	440061	01.2086	15.46	440187	01.2024	14.85
400028	01.0186	07.77	420048	01.1316	14.26	430048	01.2003	15.01	440063	01.6128	17.43	440189	01.4803	18.81
400029	01.1282	06.64	420049	01.1758	14.55	430049	00.9292	12.66	440064	01.1917	15.05	440192	01.1477	14.18
400031	01.1362	08.00	420051	01.5589	17.99	430051	01.0196	13.48	440065	01.2342	16.18	440193	01.2835	17.88
400032	01.1227	07.75	420053	01.1416	14.03	430054	01.0137	13.13	440067	01.1944	15.54	440194	01.4255	16.89
400044	01.2346	09.09	420054	01.3673	16.39	430056	00.8553	08.93	440068	01.2212	16.43	440196	00.9505	13.32
400048	01.1349	07.30	420055	01.0608	12.51	430057	00.9283	10.47	440069	01.1286	14.17	440197	01.4034	19.15
400061	01.6729	11.80	420056	01.1544	13.41	430060	01.1566	08.46	440070	01.1243	12.52	440200	01.1971	15.41
400079	01.2619	08.43	420057	01.1466	14.96	430062	00.8743	10.31	440071	01.3952	14.87	440203	00.9399	13.17
400087	01.3682	07.87	420059	00.9934	13.96	430064	01.1303	11.89	440072	01.5223	13.92	440205	01.0953	14.15
400094	01.0449	07.49	420061	01.1508	16.16	430065	00.9479	09.93	440073	01.3496	16.96	440206	01.0265	13.82
400098	01.2488	07.50	420062	01.4491	15.65	430066	00.9678	10.93	440078	01.0256	13.28	440208	01.8205	.....
400102	01.1685	08.67	420064	01.1139	13.45	430073	01.0704	.....	440081	01.1542	15.31	450002	01.4659	19.35
400103	01.3822	08.80	420065	01.3039	16.72	430076	00.9751	09.41	440082	01.9853	20.54	450004	01.1678	12.38
400104	01.3757	08.97	420066	00.9103	14.40	430077	01.5817	16.53	440083	01.1097	10.96	450005	01.1514	13.79
400105	01.1767	08.37	420067	01.2427	16.24	430079	00.9610	11.47	440084	01.1791	11.41	450007	01.2393	13.73
400106	01.2375	08.39	420068	01.2907	16.08	430080	01.1317	08.89	440087	00.9425	14.44	450008	01.3554	14.96
400109	01.5324	09.13	420069	01.1030	13.71	430081	01.0291	.....	440090	00.9368	13.29	450010	01.3345	15.37
400110	01.1163	07.65	420070	01.2642	15.05	430082	00.8067	.....	440091	01.5497	16.53	450011	01.5020	17.43
400111	01.1523	07.98	420071	01.3101	16.13	430083	00.8649	.....	440100	01.0343	12.82	450014	01.0617	13.84
400112	01.2541	06.01	420072	01.0775	10.64	430084	00.9278	.....	440102	01.0720	12.26	450015	01.5403	15.15
400113	01.2466	08.20	420073	01.3072	18.13	430085	00.9194	.....	440103	01.2317	17.24	450016	01.6194	17.57
400114	01.0452	06.50	420074	00.9037	11.72	430087	00.9027	09.29	440104	01.6500	17.68	450018	01.6073	21.75
400115	01.0096	07.56	420075	00.9694	12.66	440001	01.1291	12.18	440105	01.3509	16.69	450020	01.0239	15.47
400117	01.1759	09.23	420078	01.8104	18.59	440002	01.6019	15.73	440109	01.1368	12.28	450021	01.8149	21.11
400118	01.1868	08.61	420079	01.5628	16.94	440003	01.0727	15.23	440110	00.9697	16.06	450023	01.4758	15.45
400120	01.3057	09.14	420080	01.2627	19.18	440006	01.6333	17.55	440111	01.3691	18.00	450024	01.3739	16.45
400121	01.0090	05.80	420082	01.3944	19.13	440007	01.0099	11.83	440114	01.0453	12.68	450025	01.5088	16.23
400122	00.9993	05.88	420083	01.1937	18.36	440008	00.9877	13.50	440115	01.1184	14.66	450028	01.6360	17.17
400123	01.1685	08.24	420084	00.7413	13.56	440009	01.1773	13.22	440120	01.5405	16.14	450029	01.3996	12.98
400124	02.6681	09.27	420085	01.3941	16.86	440010	00.9181	08.75	440125	01.4435	16.09	450031	01.5825	18.72
410001	01.3237	23.02	420086	01.3585	16.90	440011	01.2884	16.28	440130	01.1725	14.16	450032	01.2733	13.63
410004	01.3672	21.15	420087	01.5958	16.53	440012	01.4781	17.72	440131	01.1390	13.44	450033	01.6352	16.84
410005	01.3477	21.90	420088	01.1487	15.05	440014	01.0633	09.06	440132	01.1117	14.01	450034	01.6414	16.28
410006	01.2581	21.40	420089	01.2296	19.40	440015	01.6236	16.42	440133	01.5475	17.78	450035	01.4498	18.91
410007	01.6598	20.37	420091	01.2145	13.16	440016	01.0124	11.35	440135	01.3052	17.20	450037	01.6198	17.78
410008	01.1681	21.05	430004	01.0941	17.25	440017	01.6214	18.42	440137	00.9781	12.14	450039	01.3536	18.70
410009	01.2979	20.66	430005	01.3166	14.06	440018	01.4781	16.10	440141	01.0780	13.59	450040	01.5551	17.75
410010	01.0163	25.40	430007	01.0466	12.56	440019	01.6255	19.06	440142	01.0334	10.75	450042	01.6664	15.75
410011	01.2082	22.25	430008	01.1342	14.01	440020	01.2332	15.43	440143	01.1007	17.21	450043	01.4465	20.40
410012	01.7245	19.51	430009	01.0881	11.86	440022	01.2045	13.72	440144	01.3344	18.35	450044	01.6233	20.51
410013	01.3149	24.63	430010	01.1233	09.23	440023	01.0084	11.58	440145	01.0427	10.99	450046	01.3659	14.67

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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
450047	01.1220	13.43	450152	01.2584	16.04	450292	01.2041	20.69	450473	01.0025	17.83	450648	01.0330	11.36
450050	01.0646	16.00	450153	01.5850	17.97	450293	00.9718	13.55	450475	01.1382	14.13	450649	01.0760	14.64
450051	01.5938	18.22	450154	01.1993	12.23	450296	01.3113	16.46	450484	01.4918	18.53	450651	01.8202	21.97
450052	01.0170	13.18	450155	01.0180	12.61	450297	01.0190	12.01	450488	01.2564	15.04	450652	00.9227	13.44
450053	01.1454	13.11	450157	01.0065	12.97	450299	01.3347	17.02	450489	00.9782	11.56	450653	01.2431	18.84
450054	01.7192	21.32	450160	00.9923	17.50	450303	00.9406	09.97	450497	01.1271	12.05	450654	01.0022	11.11
450055	01.1447	12.92	450162	01.1938	16.77	450306	01.0853	12.50	450498	01.2476	13.88	450656	01.4892	16.48
450056	01.6156	18.26	450163	01.0440	15.34	450307	00.8981	13.62	450508	01.5513	16.37	450658	00.9782	14.01
450058	01.5801	14.76	450164	01.0742	12.56	450309	01.0640	12.74	450514	01.2130	18.78	450659	01.5709	21.98
450059	01.2524	13.14	450165	00.9592	14.34	450315	01.1187	19.65	450517	00.9987	10.94	450660	01.5676	21.85
450060	01.3645	22.17	450166	00.9684	10.06	450320	01.3390	18.20	450518	01.5354	16.84	450661	01.1458	19.26
450063	00.9796	11.51	450169	00.9080	13.82	450321	00.9595	12.45	450523	01.5274	21.38	450662	01.6776	16.53
450064	01.5134	15.34	450170	00.9791	11.32	450322	00.7151	15.40	450530	01.4471	21.64	450665	00.9352	11.45
450065	01.1489	14.75	450176	01.2251	15.23	450324	01.6544	15.19	450534	00.9729	20.29	450666	01.2706	19.71
450068	01.7905	20.31	450177	01.0924	13.18	450325	01.2253	11.93	450535	01.2548	14.12	450668	01.5402	18.90
450070	01.2681	15.46	450178	01.0088	14.65	450327	00.9860	12.11	450537	01.3601	17.80	450669	01.2864	19.10
450072	01.2416	18.19	450181	01.0019	15.15	450330	01.2227	16.86	450538	01.3999	21.17	450670	01.3009	19.44
450073	01.1264	12.84	450184	01.5407	23.27	450334	01.0534	11.65	450539	01.2984	13.27	450672	01.6541	19.75
450076	01.5782	.....	450185	01.1327	08.47	450337	01.2371	17.14	450544	01.4369	22.65	450673	01.1436	11.38
450078	00.9932	11.17	450187	01.2814	16.44	450340	01.3187	14.54	450545	01.2718	14.13	450674	01.0111	22.09
450079	01.4322	19.03	450188	01.0119	12.46	450341	01.0248	16.26	450546	01.8222	18.37	450675	01.5087	17.94
450080	01.2955	15.79	450190	01.1860	19.53	450346	01.3451	16.27	450547	01.1713	15.09	450677	01.4313	19.18
450081	01.0995	12.87	450191	01.0888	15.75	450347	01.1474	15.48	450550	00.9808	17.01	450678	01.4822	20.45
450082	00.9666	12.75	450192	01.2364	16.25	450348	01.0026	10.99	450551	01.1921	13.75	450681	03.0551	17.29
450083	01.7113	17.42	450193	02.0587	21.32	450351	01.1755	18.65	450558	01.7741	17.17	450683	01.3220	20.22
450085	01.0883	14.38	450194	01.2395	18.11	450352	01.1091	16.21	450559	00.9492	12.75	450684	01.2741	18.53
450087	01.4225	19.35	450196	01.5055	17.58	450353	01.3200	17.98	450561	01.6456	17.65	450686	01.5540	14.30
450090	01.2033	12.40	450197	01.0524	19.66	450355	01.1377	11.18	450563	01.2363	21.98	450688	01.2881	18.65
450092	01.2143	13.12	450200	01.3821	16.35	450358	02.0797	20.57	450565	01.3067	15.63	450690	01.4332	20.17
450094	01.2606	19.39	450201	01.0166	15.38	450362	01.1880	18.62	450570	01.0343	11.74	450691	01.0990	14.91
450096	01.5374	19.25	450203	01.1911	16.13	450369	01.0899	10.21	450571	01.4975	14.52	450694	01.2392	15.91
450097	01.4459	18.33	450209	01.5470	16.62	450370	01.1322	13.02	450573	01.0043	13.58	450696	01.6532	23.37
450098	01.1700	13.75	450210	01.1942	12.03	450371	01.1439	11.02	450574	00.9401	13.41	450697	01.5296	16.28
450099	01.2845	17.70	450211	01.3875	15.53	450372	01.2685	20.49	450575	01.0588	16.98	450698	00.9741	11.66
450101	01.4874	15.03	450213	01.5135	16.27	450373	01.1458	13.68	450578	00.9188	12.94	450700	00.9361	12.68
450102	01.7024	21.87	450214	01.3724	18.61	450374	00.9606	12.20	450580	01.1043	12.59	450702	01.6116	17.58
450104	01.2215	13.74	450217	01.0493	12.61	450376	01.5130	16.26	450583	01.0101	12.24	450703	01.5347	22.71
450107	01.6114	18.75	450219	01.1376	14.22	450378	01.0872	21.56	450584	01.2252	12.86	450704	01.3685	17.86
450108	00.9951	14.49	450221	01.0919	14.05	450379	01.5119	21.28	450586	00.9990	11.26	450705	01.0325	16.80
450109	00.9937	15.36	450222	01.6583	17.32	450381	01.0501	12.56	450587	01.2284	16.93	450706	01.2203	21.90
450110	01.2581	19.34	450224	01.3804	16.16	450388	01.7618	17.41	450591	01.1443	16.28	450709	01.2258	20.05
450111	01.2467	19.56	450229	01.5720	15.17	450389	01.2091	16.74	450596	01.3111	17.29	450711	01.6445	17.90
450112	01.3458	13.87	450231	01.5952	18.09	450393	01.3286	20.94	450597	01.0558	14.23	450712	00.7326	15.03
450113	01.2354	16.99	450234	00.9894	11.27	450395	01.0373	14.68	450603	00.8313	16.27	450713	01.4795	18.10
450118	01.5684	21.60	450235	01.0641	13.47	450399	00.9972	13.37	450604	01.3843	13.57	450715	01.4608	19.89
450119	01.2883	16.37	450236	01.0680	14.17	450400	01.1529	13.70	450605	01.4572	17.91	450716	01.2763	19.64
450121	01.4394	18.70	450237	01.5497	16.60	450403	01.3695	19.91	450609	00.8873	12.25	450717	01.3876	22.95
450123	01.1501	17.47	450239	01.2041	12.35	450411	00.9528	11.46	450610	01.4525	16.09	450718	01.2410	20.52
450124	01.5911	19.48	450241	01.0376	15.67	450417	01.0520	12.95	450614	01.0500	12.43	450723	01.3595	18.17
450126	01.3790	11.95	450243	00.8397	11.57	450418	01.3231	17.42	450615	01.0751	11.70	450724	01.2949	16.59
450128	01.2417	14.78	450246	00.9745	15.02	450419	01.2764	22.40	450617	01.2951	20.82	450725	01.0238	20.88
450130	01.5026	16.34	450249	00.9682	10.70	450422	00.8069	23.47	450620	01.0721	12.48	450726	00.8634	14.54
450131	01.3704	21.35	450250	00.9525	09.93	450423	01.4345	21.03	450623	01.1422	17.62	450727	00.9554	09.78
450132	01.6500	16.45	450253	01.3238	13.51	450424	01.2052	16.33	450626	01.0899	14.09	450728	00.9742	14.31
450133	01.5434	16.49	450258	01.0987	11.17	450429	01.1218	13.35	450628	00.9432	15.48	450730	01.3596	21.14
450135	01.7232	21.81	450259	01.2053	17.44	450431	01.6621	17.30	450630	01.6460	20.60	450733	01.3642	16.91
450137	01.5052	24.28	450264	00.8888	11.94	450438	01.1814	14.39	450631	01.7443	18.24	450735	00.8814	12.70
450140	00.8514	16.46	450269	01.1527	12.62	450446	00.8552	13.07	450632	01.0135	11.17	450742	01.3392	21.43
450142	01.4322	19.50	450270	01.1746	10.16	450447	01.3578	17.69	450633	01.5955	19.99	450743	01.4512	18.56
450143	01.0933	12.23	450271	01.2705	14.41	450450	01.0892	16.43	450634	01.6915	21.57	450746	01.0348	13.39
450144	01.1100	16.23	450272	01.2918	16.29	450451	01.1189	20.23	450637	01.3801	18.24	450747	01.3596	16.51
450145	00.8715	12.46	450276	01.1012	10.44	450457	01.7888	17.14	450638	01.5960	22.52	450749	01.0066	12.35
450146	01.0002	16.53	450278	00.8518	18.12	450460	01.0391	12.06	450639	01.4075	21.41	450750	01.0207	11.86
450147	01.4238	17.66	450280	01.5267	20.58	450462	01.8388	19.89	450641	01.0270	12.60	450751	01.3180	21.80
450148	01.3128	19.02	450283	01.0534	12.09	450464	00.9829	13.41	450643	01.2616	17.57	450754	00.8914	13.19
450149	01.3535	19.71	450286	01.0404	14.54	450465	01.3156	14.66	450644	01.4772	20.30	450755	01.1576	13.66
450150	00.8833	13.62	450288	01.2198	12.58	450467	00.9614	14.39	450646	01.6091	19.59	450757	00.9791	13.32
450151	01.1042	13.27	450289	01.4806	17.37	450469	01.3754	16.94	450647	02.0177	20.35	450758	01.2161	13.21

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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
450760	01.1995	16.97	460047	01.7910	19.49	490067	01.2066	14.95	500028	01.0863	14.76	500139	01.4752	21.33
450761	01.0624	09.63	460049	01.9373	17.36	490069	01.4041	15.74	500029	00.9240	14.30	500141	01.3369	21.93
450763	01.0137	16.27	460050	01.3229	20.35	490071	01.4437	17.56	500030	01.4741	22.13	500143	00.7548	14.92
450766	02.3026	21.39	460051	01.1889	.....	490073	01.3572	21.49	500031	01.2908	20.19	500146	01.0356	.....
450769	01.0302	13.28	470001	01.2042	17.11	490074	01.3267	16.06	500033	01.2023	18.05	510001	01.7170	17.08
450770	00.9569	13.59	470003	01.8185	20.22	490075	01.3350	16.62	500036	01.3243	19.11	510002	01.2698	16.31
450771	01.9684	19.76	470004	01.1082	14.18	490077	01.1612	16.87	500037	01.1182	17.63	510004	00.9340	12.62
450774	00.9029	23.99	470005	01.2621	18.71	490079	01.3172	14.30	500039	01.3816	21.32	510005	00.9906	13.71
450775	01.2195	19.26	470006	01.1890	17.05	490083	00.6451	14.63	500041	01.2847	22.09	510006	01.2547	17.08
450776	00.9203	.....	470008	01.2515	15.41	490084	01.2474	15.96	500042	01.3841	20.95	510007	01.4719	17.81
450777	01.0133	15.01	470010	01.1785	18.58	490085	01.2069	13.36	500043	01.2790	16.56	510008	01.1392	15.33
450779	01.3433	20.59	470011	01.1576	19.30	490088	01.2040	13.97	500044	01.8929	20.56	510012	01.0689	14.26
450780	01.6395	19.78	470012	01.2641	17.52	490089	01.0777	14.37	500045	01.1206	20.65	510013	01.1401	15.10
450781	01.5121	16.23	470013	01.1730	18.38	490090	01.1910	14.25	500048	00.9121	16.01	510015	00.9645	12.51
450785	01.0081	26.08	470015	01.0821	16.29	490091	01.2048	20.14	500049	01.4662	19.34	510016	00.9894	11.27
450788	01.4240	.....	470018	01.1960	17.37	490092	01.2073	14.32	500050	01.4048	20.41	510018	01.1325	14.40
450793	01.6623	.....	470020	00.9790	14.50	490093	01.2886	15.31	500051	01.6400	22.71	510020	01.0439	10.16
450794	01.4607	.....	470023	01.3025	17.20	490094	01.0703	14.57	500052	01.2844	.....	510022	01.8032	19.52
450795	00.8583	.....	470024	01.1065	17.08	490095	01.4704	16.32	500053	01.2764	20.10	510023	01.1453	15.14
450797	00.6907	.....	490001	01.0855	19.41	490097	01.1309	13.69	500054	01.8765	20.41	510024	01.4123	17.94
450798	00.8914	.....	490002	01.0634	13.61	490098	01.3117	11.69	500055	01.0919	20.32	510026	00.9431	12.19
450799	01.4105	.....	490003	00.6013	17.55	490099	00.9354	15.29	500057	01.3473	16.24	510027	00.9624	13.86
450800	01.3490	.....	490004	01.2275	16.67	490100	01.3718	16.69	500058	01.5008	19.82	510028	01.0722	14.90
450801	01.4785	.....	490005	01.5365	16.10	490101	01.1892	23.64	500059	01.1568	20.02	510029	01.2911	16.69
450802	01.0743	.....	490006	01.1550	13.27	490104	00.8927	14.46	500060	01.4852	20.70	510030	01.1024	14.87
450803	00.8537	.....	490007	02.0173	17.19	490105	00.7368	16.55	500061	00.9874	17.95	510031	01.3462	16.27
450804	01.5317	.....	490009	01.8300	18.08	490106	00.8894	14.86	500062	01.0881	17.16	510033	01.2683	14.42
450805	01.1690	.....	490010	01.0896	17.08	490107	01.3168	22.65	500064	01.5317	21.69	510035	01.1333	16.46
450807	00.9104	.....	490011	01.4141	17.03	490108	00.8692	13.78	500065	01.2988	17.67	510036	01.0124	09.34
450809	01.6695	.....	490012	01.2074	15.55	490109	00.9193	14.09	500068	01.0249	17.17	510038	01.1602	13.71
460001	01.7915	19.82	490013	01.2459	14.82	490110	01.3951	15.90	500069	01.1604	18.62	510039	01.3713	15.02
460003	01.7205	18.38	490014	01.3674	21.04	490111	01.2384	16.79	500071	01.3704	19.46	510043	00.9246	11.33
460004	01.7759	20.68	490015	01.4613	17.30	490112	01.7317	19.07	500072	01.1955	21.19	510046	01.2634	15.26
460005	01.5560	18.80	490017	01.3610	16.58	490113	01.2998	20.96	500073	01.0893	16.85	510047	01.2119	17.26
460006	01.4316	18.71	490018	01.2531	16.88	490114	01.1055	15.00	500074	01.1764	14.80	510048	01.0836	17.39
460007	01.5439	19.27	490019	01.2029	15.60	490115	01.2378	14.25	500075	03.7376	20.25	510050	01.4644	15.34
460008	01.3622	16.02	490020	01.1532	14.16	490116	01.2262	15.61	500077	01.3928	21.63	510053	01.0373	13.50
460009	01.8858	18.11	490021	01.1440	17.12	490117	01.1727	13.62	500079	01.4051	19.87	510055	01.2326	19.41
460010	01.9311	20.15	490022	01.4164	17.59	490118	01.7640	21.32	500080	00.8347	11.56	510058	01.1980	16.23
460011	01.3873	16.16	490023	01.2222	17.03	490119	01.3430	16.41	500084	01.1384	20.05	510059	01.2369	13.65
460013	01.5121	18.54	490024	01.7777	17.06	490120	01.3210	16.90	500085	01.0600	17.19	510060	01.1653	15.36
460014	01.0302	15.38	490027	01.1366	13.11	490122	01.5068	20.86	500086	01.4233	18.48	510061	01.0684	12.59
460015	01.2578	19.75	490028	01.3505	18.42	490123	01.1433	14.80	500088	01.3681	22.86	510062	01.2001	15.38
460016	00.8956	13.54	490030	01.0966	11.16	490124	01.1494	16.99	500089	00.9699	13.99	510063	01.0086	10.63
460017	01.4587	16.52	490031	01.1399	12.61	490126	01.3829	14.72	500090	00.9942	12.60	510065	01.0057	12.04
460018	00.9760	13.59	490032	01.7447	19.08	490127	01.0153	14.44	500092	01.0866	15.65	510066	01.1328	12.02
460019	01.1474	12.90	490033	01.1930	15.58	490129	01.4271	17.98	500094	00.9216	15.53	510067	01.2442	15.91
460020	01.0550	14.21	490035	01.2134	09.64	490130	01.3112	16.58	500096	01.0818	17.13	510068	01.1194	14.01
460021	01.3930	19.20	490037	01.1236	13.27	490131	01.0313	14.06	500097	01.1361	16.12	510070	01.2176	16.05
460022	00.9379	19.41	490038	01.2160	12.54	500001	01.3320	20.92	500098	00.9259	13.66	510071	01.2805	14.49
460023	01.1852	20.75	490040	01.4126	21.19	500002	01.4806	18.75	500101	01.0231	17.84	510072	01.0631	13.50
460024	00.8925	13.88	490041	01.3528	16.82	500003	01.4107	21.28	500102	00.9438	18.43	510077	01.1112	14.36
460025	00.8072	12.63	490042	01.3424	15.18	500005	01.8423	22.52	500104	01.2581	18.71	510080	01.1526	09.35
460026	01.0894	16.98	490043	01.3567	16.74	500007	01.4103	20.14	500106	00.9357	15.53	510081	01.0273	13.19
460027	00.9427	18.71	490044	01.3652	16.65	500008	01.8538	22.88	500107	01.1326	15.58	510082	01.0492	12.08
460029	01.0225	15.71	490045	01.1326	18.60	500009	01.2784	21.07	500108	01.6728	21.40	510084	00.9917	13.25
460030	01.2159	15.78	490046	01.4684	17.24	500011	01.3857	21.44	500110	01.2764	18.75	510085	01.2369	17.99
460032	01.0099	19.00	490047	01.0719	16.34	500012	01.5255	20.94	500118	01.1356	20.88	510086	01.0561	15.65
460033	00.9544	18.22	490048	01.4849	17.53	500014	01.5705	22.36	500119	01.3328	20.48	520002	01.2922	17.24
460035	00.9610	11.43	490050	01.4304	20.06	500015	01.3611	20.92	500122	01.1907	20.27	520003	01.1620	15.19
460036	00.9397	19.41	490052	01.6110	15.34	500016	01.4832	22.76	500123	00.8533	14.78	520004	01.1559	16.53
460037	01.0591	15.92	490053	01.2500	14.14	500019	01.3350	19.82	500124	01.3275	22.39	520006	01.0574	18.05
460039	01.0976	21.08	490054	01.1202	13.91	500021	01.5313	20.77	500125	00.9883	10.72	520007	01.2421	14.14
460041	01.2170	18.29	490057	01.5395	17.05	500023	01.1880	19.09	500129	01.7287	22.41	520008	01.5505	20.54
460042	01.4763	16.14	490059	01.5677	18.24	500024	01.6344	21.06	500132	00.9951	19.79	520009	01.5958	16.88
460043	00.9968	20.44	490060	01.0692	16.72	500025	01.8629	21.69	500134	00.8092	15.75	520010	01.1719	19.34
460044	01.2081	19.41	490063	01.6593	22.34	500026	01.4296	22.42	500137	00.7050	19.99	520011	01.2046	16.46
460046	00.7432	10.23	490066	01.2205	17.58	500027	01.5358	23.68	500138	03.4209	.....	520013	01.2869	17.88

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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
520014	01.2027	15.55	520103	01.3253	17.70	530025	01.3617	17.99						
520015	01.1208	16.65	520107	01.2590	17.46	530026	01.0549	14.63						
520016	01.0905	12.75	520109	00.9991	17.25	530027	00.8298	09.56						
520017	01.1856	16.87	520110	01.1737	16.47	530029	00.9607	13.49						
520018	01.0817	15.88	520111	00.9881	14.44	530031	00.8790	10.95						
520019	01.2831	16.65	520112	01.0774	18.15	530032	01.1497	17.34						
520021	01.3589	19.16	520113	01.1649	17.80									
520024	01.0340	13.33	520114	01.1065	12.61									
520025	01.1366	15.19	520115	01.3241	15.89									
520026	01.0973	17.48	520116	01.2614	17.66									
520027	01.2310	19.22	520117	01.0328	15.40									
520028	01.3213	17.60	520118	00.9426	10.95									
520029	00.9672	16.70	520120	00.8716	11.95									
520030	01.6756	20.19	520121	00.9752	14.18									
520031	01.1149	16.11	520122	00.9991	13.96									
520032	01.1627	14.56	520123	01.1304	16.55									
520033	01.1838	15.91	520124	01.1231	14.34									
520034	01.1326	17.17	520130	01.0848	12.60									
520035	01.2520	14.67	520131	01.0608	15.82									
520037	01.6526	18.23	520132	01.1759	14.31									
520038	01.4892	17.14	520134	01.0288	15.14									
520039	01.0077	16.24	520135	00.9463	13.84									
520040	01.4307	20.05	520136	01.4791	18.87									
520041	01.1426	14.54	520138	01.8806	18.18									
520042	01.0710	16.25	520139	01.2886	18.50									
520044	01.3714	16.09	520140	01.6140	19.31									
520045	01.6919	17.97	520141	01.1169	15.63									
520047	01.0188	14.50	520142	00.9147	12.48									
520048	01.4400	17.67	520144	01.0393	16.10									
520049	01.9950	17.97	520145	00.9143	16.57									
520051	02.0353	19.41	520146	01.0746	13.71									
520053	01.0992	14.78	520148	01.1623	15.34									
520054	01.0858	16.40	520149	00.9555	13.31									
520056	01.3107	17.77	520151	01.0897	14.43									
520057	01.1288	16.08	520152	01.1331	16.38									
520058	01.0509	17.87	520153	00.9798	13.19									
520059	01.3228	18.17	520154	01.1472	16.15									
520060	01.2997	15.15	520156	01.1203	16.37									
520062	01.2655	16.18	520157	00.9424	13.70									
520063	01.2607	17.61	520159	00.9388	16.25									
520064	01.7082	18.60	520160	01.7678	17.77									
520066	01.4098	17.73	520161	01.0250	14.76									
520068	00.8915	15.82	520170	01.2443	18.51									
520069	01.1870	16.75	520171	00.9943	13.69									
520070	01.5908	16.93	520173	01.1567	17.36									
520071	01.1171	17.71	520174	01.4333	20.57									
520074	01.0987	14.96	520177	01.6449	20.33									
520075	01.4698	17.44	520178	01.0559	14.61									
520076	01.1236	14.40	520186	02.5906	.....									
520077	01.0257	14.50	530002	01.1980	18.07									
520078	01.5135	17.89	530003	00.9289	12.59									
520082	01.3440	15.25	530004	01.0252	13.17									
520083	01.5917	21.59	530005	01.1380	13.19									
520084	01.0815	15.73	530006	01.1263	16.83									
520087	01.6157	17.16	530007	01.0519	11.52									
520088	01.2441	17.56	530008	01.2819	17.75									
520089	01.5181	18.76	530009	00.9693	20.60									
520090	01.2798	16.16	530010	01.2110	16.30									
520091	01.3653	17.25	530011	01.0901	15.27									
520092	01.1109	15.11	530012	01.5887	17.25									
520094	01.0028	16.07	530014	01.3344	15.01									
520095	01.3845	18.56	530015	01.1465	19.22									
520096	01.4966	17.78	530016	01.2083	11.87									
520097	01.3301	17.90	530017	00.9927	16.09									
520098	01.7373	19.40	530018	01.0650	14.57									
520100	01.2315	15.91	530019	00.9451	14.32									
520101	01.1002	15.75	530022	01.1165	15.94									
520102	01.2175	19.00	530023	00.8533	17.76									

Note: Case mix indexes do not include discharges from PPS-exempt units. Case mix indexes include cases received in HCFA central office through June 1996.

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	0.8147	0.8691
Taylor, TX		
0060 Aguadilla, PR	0.4237	0.5554
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9853	0.9899
Portage, OH		
Summit, OH		
0120 Albany, GA	0.8597	0.9017
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8624	0.9036
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9350	0.9550
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8194	0.8725
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9992	0.9995
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9510	0.9662
Blair, PA		
0320 Amarillo, TX.		
Potter, TX	0.8730	0.9112
Randall, TX		
0380 Anchorage, AK	1.3255	1.2128
Anchorage, AK		
0440 Ann Arbor, MI	1.1662	1.1110
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8023	0.8600
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8890	0.9226
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4397	0.5697
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9344	0.9546
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9408	0.9591
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 *Atlanta, GA	1.0033	1.0023
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.1077	1.0726
Atlantic, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA–SC	0.8836	0.9187
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 Austin-San Marcos, TX	0.9254	0.9483
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA	1.0189	1.0129
Kern, CA		
0720 *Baltimore, MD	0.9798	0.9861
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9391	0.9579
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3651	1.2375
Barnstable, MA		
0760 Baton Rouge, LA	0.8433	0.8898
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8576	0.9001
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1317	1.0884
Whatcom, WA		
0870 Benton Harbor, MI	0.8550	0.8983
Berrien, MI		
0875 *Bergen-Passaic, NJ	1.1785	1.1190
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9086	0.9365

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8554	0.8986
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8822	0.9178
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9036	0.9329
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8074	0.8637
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8652	0.9056
Monroe, IN		
1040 Bloomington-Normal, IL	0.8990	0.9297
McLean, IL		
1080 Boise City, ID	0.9383	0.9573
Ada, ID		
Canyon, ID		
1123 *Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1613	1.1078
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	0.9522	0.9670
Boulder, CO		
1145 Brazoria, TX	0.8845	0.9194
Brazoria, TX		
1150 Bremerton, WA	1.0901	1.0609
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8542	0.8977
Cameron, TX		
1260 Bryan-College Station, TX	0.8851	0.9198
Brazos, TX		
1280 *Buffalo-Niagara Falls, NY	0.9107	0.9380
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0068	1.0047
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4589	0.5866
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	0.8648	0.9053
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.8821	0.9177
Natrona, WY		
1360 Cedar Rapids, IA	0.8458	0.8916
Linn, IA		
1400 Champaign-Urbana, IL	0.9391	0.9579
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8963	0.9278
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9526	0.9673
Kanawha, WV		
Putnam, WV		
1520 *Charlotte-Gastonia-Rock Hill, NC–SC	0.9620	0.9738
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	0.9155	0.9413
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.8847	0.9195
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 Cheyenne, WY	0.7678	0.8345
Laramie, WY		
1600 *Chicago, IL	1.0760	1.0514
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0417	1.0284
Butte, CA		
1640 *Cincinnati, OH–KY–IN	0.9568	0.9702
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	0.7716	0.8373
Christian, KY		
Montgomery, TN		
1680 *Cleveland-Lorain-Elyria, OH	0.9886	0.9922
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9341	0.9544
El Paso, CO		
1740 Columbia, MO	0.8904	0.9236
Boone, MO		
1760 Columbia, SC	0.9160	0.9417
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL.		
Russell, AL	0.7779	0.8420
Chattanoochee, GA		
Harris, GA		
Muscogee, GA		
1840 *Columbus, OH	0.9681	0.9780
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8881	0.9219
Nueces, TX		
San Patricio, TX		
1900 Cumberland, MD–WV	0.8671	0.9070
Allegany, MD		
Mineral, WV		
1920 *Dallas, TX	0.9729	0.9814
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8497	0.8945
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8388	0.8866
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9559	0.9696
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.8871	0.9212
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8384	0.8863
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.7848	0.8471
Macon, IL		
2080 *Denver, CO	1.0166	1.0113
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8815	0.9173
Dallas, IA		
Polk, IA		
Warren, IA		
2160 *Detroit, MI	1.0724	1.0490
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7740	0.8391
Dale, AL		
Houston, AL		
2190 Dover, DE	0.8997	0.9302
Kent, DE		
2200 Dubuque, IA	0.8112	0.8665
Dubuque, IA		
2240 Duluth-Superior, MN–WI	0.9416	0.9596
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0589	1.0400
Dutchess, NY		
2290 Eau Claire, WI	0.8678	0.9075
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9464	0.9630
El Paso, TX		
2330 Elkhart-Goshen, IN	0.8801	0.9163
Elkhart, IN		
2335 Elmira, NY	0.8417	0.8887
Chemung, NY		
2340 Enid, OK	0.7862	0.8481
Garfield, OK		
2360 Erie, PA	0.9159	0.9416
Erie, PA		
2400 Eugene-Springfield, OR	1.1477	1.0989
Lane, OR		
2440 Evansville-Henderson, IN–KY	0.8983	0.9292
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.9045	0.9336

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.9007	0.9309
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7220	0.8001
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	0.9019	0.9317
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1248	1.0839
Genesee, MI		
2650 Florence, AL	0.8111	0.8664
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8594	0.9014
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0562	1.0382
Larimer, CO		
2680 *Ft. Lauderdale, FL	1.0586	1.0398
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9032	0.9327
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0169	1.0115
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7867	0.8485
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.9192	0.9439
Okaloosa, FL		
2760 Fort Wayne, IN	0.8800	0.9162
Adams, IN		
Allen, IN		
DeKalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 *Forth Worth-Arlington, TX	1.0153	1.0105
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.1177	1.0792
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8881	0.9219
Etowah, AL		
2900 Gainesville, FL	0.9434	0.9609
Alachua, FL		
2920 Galveston-Texas City, TX	1.0997	1.0672
Galveston, TX		
2960 Gary, IN	0.9155	0.9413
Lake, IN		
Porter, IN		
2975 Glens Falls, NY	0.8562	0.8991
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8393	0.8869
Wayne, NC		
2985 Grand Forks, ND–MN	0.9207	0.9450
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.8825	0.9180
Mesa, CO		
3000 Grand Rapids-Muskegon-Holland, MI	1.0119	1.0081
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9015	0.9315
Cascade, MT		
3060 Greeley, CO	0.9690	0.9787
Weld, CO		
3080 Green Bay, WI	0.9366	0.9561
Brown, WI		
3120 *Greensboro-Winston-Salem-High Point, NC	0.9314	0.9525
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9078	0.9359
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.8927	0.9252
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9175	0.9427
Washington, MD		
3200 Hamilton-Middletown, OH	0.9490	0.9648
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	1.0158	1.0108
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 *Hartford, CT	1.2367	1.1566
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS	0.7252	0.8025
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.7953	0.8548
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1461	1.0979
Honolulu, HI		
3350 Houma, LA	0.7853	0.8475
Lafourche, LA		
Terrebonne, LA		
3360 *Houston, TX	1.0000	1.0000
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9174	0.9427
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8206	0.8734
Limestone, AL		
Madison, AL		
3480 *Indianapolis, IN	0.9903	0.9933
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9361	0.9558
Johnson, IA		
3520 Jackson, MI	0.9045	0.9336
Jackson, MI		
3560 Jackson, MS	0.7928	0.8530
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8288	0.8793
Chester, TN		
Madison, TN		
3600 Jacksonville, FL	0.9089	0.9367
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC	0.7055	0.7875
Onslow, NC		
3610 Jamestown, NY	0.7670	0.8339
Chautaqua, NY		
3620 Janesville-Beloit, WI	0.8645	0.9051
Rock, WI		
3640 Jersey City, NJ	1.1382	1.0927
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8901	0.9234
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, 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
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA	0.8398	0.8873
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7220	0.8001
Craighead, AR		
3710 Joplin, MO	0.7659	0.8331
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0542	1.0368
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.9115	0.9385
Kankakee, IL		
3760 *Kansas City, KS–MO	0.9478	0.9640
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	0.9145	0.9406
Kenosha, WI		
3810 Killeen-Temple, TX	1.0392	1.0267
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8502	0.8948
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8590	0.9012
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.8618	0.9032
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8165	0.8704
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8804	0.9165
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.8034	0.8608
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8668	0.9067
Polk, FL		
4000 Lancaster, PA	0.9583	0.9713
Lancaster, PA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
4040 Lansing-East Lansing, MI	1.0010	1.0007
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.7073	0.7889
Webb, TX		
4100 Las Cruces, NM	0.8497	0.8945
Dona Ana, NM		
4120 *Las Vegas, NV–AZ	1.0870	1.0588
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8597	0.9017
Douglas, KS		
4200 Lawton, OK	0.8365	0.8849
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9410	0.9592
Androscoggin, ME		
4280 Lexington, KY	0.8303	0.8804
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.8732	0.9113
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9161	0.9418
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8597	0.9017
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8645	0.9051
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 *Los Angeles-Long Beach, CA	1.2382	1.1576
Los Angeles, CA		
4520 Louisville, KY–IN	0.9447	0.9618
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8510	0.8954
Lubbock, TX		
4640 Lynchburg, VA	0.8052	0.8621
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8824	0.9179
Bibb, GA		
Houston, GA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0021	1.0014
Dane, WI		
4800 Mansfield, OH	0.8524	0.8964
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4215	0.5534
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8485	0.8936
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0082	1.0056
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9068	0.9352
Brevard, FL		
4920 *Memphis, TN–AR–MS	0.8166	0.8705
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0660	1.0447
Merced, CA		
5000 *Miami, FL	0.9938	0.9958
Dade, FL		
5015 *Middlesex-Somerset-Hunterdon, NJ	1.0688	1.0466
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 *Milwaukee-Waukesha, WI	0.9645	0.9756
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 *Minneapolis-St. Paul, MN–WI	1.0777	1.0526
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	0.7981	0.8569
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0112	1.0077
Stanislaus, CA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
5190 *Monmouth-Ocean, NJ	1.0996	1.0672
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8211	0.8737
Ouachita, LA		
5240 Montgomery, AL	0.7876	0.8492
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9714	0.9803
Delaware, IN		
5330 Myrtle Beach, SC	0.7790	0.8428
Horry, SC		
5345 Naples, FL	1.0199	1.0136
Collier, FL		
5360 *Nashville, TN	0.9081	0.9361
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 *Nassau-Suffolk, NY	1.3547	1.2311
Nassau, NY		
Suffolk, NY		
5483 *New Haven-Bridgeport-Stamford-Waterbury-	1.2750	1.1810
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2317	1.1534
New London, CT		
5560 *New Orleans, LA	0.9294	0.9511
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	1.4154	1.2686
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 *Newark, NJ	1.1036	1.0698
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.0803	1.0543
Orange, NY		
Pike, PA		
5720 *Norfolk-Virginia Beach-Newport News, VA–NC	0.8348	0.8837
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	1.5069	1.3242
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9105	0.9378
Marion, FL		
5800 Odessa-Midland, TX	0.8566	0.8994
Ector, TX		
Midland, TX		
5880 *Oklahoma City, OK	0.8371	0.8854
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0689	1.0467
Thurston, WA		
5920 Omaha, NE–IA	0.9480	0.9641
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 *Orange County, CA	1.1902	1.1266
Orange, CA		
5960 *Orlando, FL	0.9470	0.9634
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.7575	0.8268
Daviess, KY		
6015 Panama City, FL	0.8061	0.8628
Bay, FL		
6020 Parkersburg-Marietta, WV–OH	0.7877	0.8492
Washington, OH		
Wood, WV		
6080 Pensacola, FL	0.8202	0.8731
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8905	0.9237
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 *Philadelphia, PA–NJ	1.1237	1.0831
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 *Phoenix-Mesa, AZ	0.9810	0.9870
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7886	0.8499
Jefferson, AR		
6280 *Pittsburgh, PA	0.9701	0.9794
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA	1.0552	1.0375
Berkshire, MA		
6340 Pocatello, ID	0.8784	0.9150
Bannock, ID		
6360 Ponce, PR	0.4685	0.5950
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9619	0.9738
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 *Portland-Vancouver, OR–WA	1.1235	1.0830
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 Providence-Warwick-Pawtucket, RI	1.1092	1.0736
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	1.0116	1.0079
Utah, UT		
6560 Pueblo, CO	0.8284	0.8790
Pueblo, CO		
6580 Punta Gorda, FL	0.8353	0.8841
Charlotte, FL		
6600 Racine, WI	0.8835	0.9187
Racine, WI		
6640 Raleigh-Durham-Chapel Hill, NC	0.9728	0.9813

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8458	0.8916
Pennington, SD		
6680 Reading, PA	0.9445	0.9617
Berks, PA		
6690 Redding, CA	1.1605	1.1073
Shasta, CA		
6720 Reno, NV	1.1018	1.0686
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	0.9970	0.9979
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9194	0.9441
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	1.1234	1.0829
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8702	0.9092
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.0428	1.0291
Olmsted, MN		
6840 *Rochester, NY	0.9649	0.9758
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8994	0.9300
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8955	0.9272
Edgecombe, NC		
Nash, NC		
6920 *Sacramento, CA	1.2351	1.1556
El Dorado, CA		
Placer, CA		
Sacramento, CA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
6960 Saginaw-Bay City-Midland, MI	0.9667	0.9771
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9457	0.9625
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8551	0.8983
Andrews, MO		
Buchanan, MO		
7040 *St. Louis, MO–IL	0.9022	0.9319
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	0.9728	0.9813
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.3803	1.2470
Monterey, CA		
7160 *Salt Lake City-Ogden, UT	0.9677	0.9778
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7577	0.8270
Tom Green, TX		
7240 *San Antonio, TX	0.8390	0.8867
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 *San Diego, CA	1.2154	1.1429
San Diego, CA		
7360 *San Francisco, CA	1.4211	1.2721
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 *San Jose, CA	1.4455	1.2870
Santa Clara, CA		
7440 *San Juan-Bayamon, PR	0.4506	0.5793
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		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1561	1.1044
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.1242	1.0835
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3520	1.2294
Santa Cruz, CA		
7490 Santa Fe, NM	1.0823	1.0557
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2487	1.1643
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9789	0.9855
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9649	0.9758
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8752	0.9128
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 *Seattle-Bellevue-Everett, WA	1.1384	1.0928
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA	0.8885	0.9222
Mercer, PA		
7620 Sheboygan, WI	0.7764	0.8409
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8631	0.9041
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9359	0.9556
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8313	0.8812
Woodbury, IA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Dakota, NE		
7760 Sioux Falls, SD	0.8620	0.9033
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9934	0.9955
St. Joseph, IN		
7840 Spokane, WA	1.0524	1.0356
Spokane, WA		
7880 Springfield, IL	0.8671	0.9070
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.7842	0.8466
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA	1.0586	1.0398
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.9538	0.9681
Centre, PA		
8080 Steubenville-Weirton, OH–WV	0.8266	0.8777
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.1391	1.0933
San Joaquin, CA		
8140 Sumter, SC	0.7699	0.8360
Sumter, SC		
8160 Syracuse, NY	0.9396	0.9582
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.0866	1.0585
Pierce, WA		
8240 Tallahassee, FL	0.8313	0.8812
Gadsden, FL		
Leon, FL		
8280 *Tampa-St. Petersburg-Clearwater, FL	0.9302	0.9517
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8591	0.9012
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8509	0.8953
Miller, AR		
Bowie, TX		
8400 Toledo, OH	1.0361	1.0246
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	1.0086	1.0059
Shawnee, KS		
8480 Trenton, NJ	1.0549	1.0373
Mercer, NJ		
8520 Tucson, AZ	0.9075	0.9357
Pima, AZ		
8560 Tulsa, OK	0.8095	0.8653
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.7784	0.8424
Tuscaloosa, AL		
8640 Tyler, TX	0.9996	0.9997
Smith, TX		
8680 Utica-Rome, NY	0.8413	0.8884
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3452	1.2252
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.1052	1.0709
Ventura, CA		
8750 Victoria, TX	0.8393	0.8869
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	0.9993	0.9995
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0151	1.0103
Tulare, CA		
8800 Waco, TX	0.7772	0.8415
McLennan, TX		
8840 *Washington, DC–MD–VA–WV	1.0823	1.0557
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	0.8705	0.9094
Black Hawk, IA		
8940 Wausau, WI	1.0323	1.0220
Marathon, WI		
8960 West Palm Beach-Boca Raton, FL	1.0002	1.0001
Palm Beach, FL		
9000 Wheeling, OH–WV	0.7563	0.8259
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9369	0.9563
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.8041	0.8613
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8467	0.8923
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1315	1.0883
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9046	0.9336
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	1.0026	1.0018
Yakima, WA		
9270 Yolo, CA	1.1444	1.0968
Yolo, CA		
9280 York, PA	0.9104	0.9377
York, PA		
9320 Youngstown-Warren, OH	0.9742	0.9823
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0414	1.0282
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.9497	0.9653
Yuma, AZ		

*Large Urban Area

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7150	0.7947
Alaska	1.2444	1.1615
Arizona	0.7928	0.8530
Arkansas	0.6954	0.7798
California	1.0002	1.0001
Colorado	0.8092	0.8650
Connecticut	1.2759	1.1816
Delaware	0.9447	0.9618
Florida	0.8668	0.9067
Georgia	0.7653	0.8326
Hawaii	1.0245	1.0167
Idaho	0.8277	0.8785
Illinois	0.7553	0.8252
Indiana	0.8124	0.8674
Iowa	0.7366	0.8111
Kansas	0.7107	0.7915
Kentucky	0.7753	0.8401
Louisiana	0.7253	0.8026
Maine	0.8317	0.8814

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Maryland	0.8427	0.8894
Massachusetts	1.0770	1.0521
Michigan	0.8836	0.9187
Minnesota	0.8144	0.8688
Mississippi	0.6793	0.7674
Missouri	0.7261	0.8032
Montana	0.8128	0.8677
Nebraska	0.7214	0.7996
Nevada	0.8775	0.9144
New Hampshire	0.9751	0.9829
New Jersey [1]	.....	.....
New Mexico	0.8000	0.8583
New York	0.8558	0.8989
North Carolina	0.7953	0.8548
North Dakota	0.7358	0.8105
Ohio	0.8332	0.8825
Oklahoma	0.6942	0.7788
Oregon	0.9664	0.9769
Pennsylvania	0.8459	0.8917
Puerto Rico	0.4026	0.5363
Rhode Island [1]	.....	.....
South Carolina	0.7668	0.8337
South Dakota	0.7063	0.7881
Tennessee	0.7341	0.8092
Texas	0.7462	0.8183
Utah	0.8848	0.9196
Vermont	0.8921	0.9248
Virginia	0.7729	0.8383
Washington	0.9933	0.9954
West Virginia	0.7923	0.8526
Wisconsin	0.8430	0.8896
Wyoming	0.8177	0.8713

[1] All counties within the State are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to	Wage index	GAF
Abilene, TX	0.8147	0.8691
Albuquerque, NM	0.9350	0.9550
Alexandria, LA	0.8194	0.8725
Allentown-Bethlehem-Easton, PA	0.9992	0.9995
Amarillo, TX	0.8730	0.9112
Anchorage, AK	1.3255	1.2128
Asheville, NC	0.9344	0.9546
Atlanta, GA	1.0033	1.0023
Bangor, ME	0.9391	0.9579
Baton Rouge, LA	0.8433	0.8898
Benton Harbor, MI	0.8550	0.8983
Benton Harbor, MI (Rural Michigan Hosp.)	0.8836	0.9187
Billings, MT	0.9086	0.9365
Birmingham, AL	0.9036	0.9329
Bismarck, ND	0.8074	0.8637
Boise City, ID	0.9383	0.9573
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1613	1.1078
Caguas, PR	0.4589	0.5866

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Champaign-Urbana, IL	0.8978	0.9288
Charleston-North Charleston, SC	0.8963	0.9278
Charlotte-Gastonia-Rock Hill, NC–SC	0.9620	0.9738
Charlottesville, VA	0.8990	0.9297
Chattanooga, TN–GA	0.8847	0.9195
Chicago, IL	1.0658	1.0446
Cincinnati, OH–KY–IN	0.9568	0.9702
Cleveland-Lorain-Elyria, OH	0.9886	0.9922
Columbia, MO	0.8904	0.9236
Columbus, OH	0.9681	0.9780
Dallas, TX	0.9729	0.9814
Davenport-Moline-Rock Island, IA–IL	0.8388	0.8866
Denver, CO	1.0166	1.0113
Des Moines, IA	0.8714	0.9100
Duluth-Superior, MN–WI	0.9416	0.9596
Dutchess County, NY	1.0291	1.0198
Elkhart-Goshen, IN	0.8801	0.9163
Eugene-Springfield, OR	1.1477	1.0989
Fargo-Moorhead, ND–MN	0.8879	0.9218
Fayetteville, NC	0.8640	0.9047
Flagstaff, AR–UT	0.8828	0.9182
Flint, MI	1.1248	1.0839
Florence, AL	0.8111	0.8664
Florence, SC	0.8594	0.9014
Fort Lauderdale, FL	1.0586	1.0398
Fort Pierce-Port St. Lucie, FL	1.0027	1.0018
Fort Smith, AR–OK	0.7867	0.8485
Fort Walton Beach, FL	0.8980	0.9290
Fort Worth-Arlington, TX	1.0153	1.0105
Gadsden, AL	0.8881	0.9219
Gary, IN	0.9155	0.9413
Grand Forks, ND–MN	0.9207	0.9450
Grand Junction, CO	0.8825	0.9180
Grand Rapids-Muskegon-Holland, MI	1.0119	1.0081
Great Falls, MT	0.9015	0.9315
Greeley, CO	0.9388	0.9577
Green Bay, WI	0.9366	0.9561
Greensboro-Winston-Salem-High Point, NC	0.9314	0.9525
Greenville-Spartanburg-Anderson, SC	0.8927	0.9252
Hartford, CT	1.2191	1.1453
Honolulu, HI	1.1461	1.0979
Houston, TX	1.0000	1.0000
Huntington-Ashland, WV–KY–OH	0.9174	0.9427
Huntsville, AL	0.8081	0.8642
Indianapolis, IN	0.9796	0.9860
Jackson, MS	0.7928	0.8530
Jacksonville, FL	0.9089	0.9367
Johnson City-Kingsport-Bristol, TN–VA	0.8901	0.9234
Joplin, MO	0.7659	0.8331
Kalamazoo-Battlecreek, MI	1.0542	1.0368
Kansas City, KS–MO	0.9478	0.9640
Knoxville, TN	0.8502	0.8948
Lafayette, LA	0.8165	0.8704
Lansing-East Lansing, MI	1.0010	1.0007

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Las Vegas, NV–AZ	1.0870	1.0588
Lexington, KY	0.8303	0.8804
Lima, OH	0.8732	0.9113
Lincoln, NE	0.9030	0.9325
Little Rock-North Little Rock, AR	0.8597	0.9017
Longview-Marshall, TX	0.8504	0.8950
Los Angeles-Long Beach, CA	1.2382	1.1576
Louisville, KY–IN	0.9447	0.9618
Macon, GA	0.8468	0.8924
Madison, WI	1.0021	1.0014
Mansfield, OH	0.8524	0.8964
Medford-Ashland, OR	1.0082	1.0056
Memphis, TN–AR–MS	0.8166	0.8705
Middlesex-Somerset-Hunterdon, NJ	1.0688	1.0466
Milwaukee-Waukesha, WI	0.9645	0.9756
Minneapolis-St. Paul, MN–WI	1.0777	1.0526
Modesto, CA	1.0112	1.0077
Monmouth-Ocean, NJ	1.0764	1.0517
Montgomery, AL	0.7876	0.8492
Nashville, TN	0.9081	0.9361
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2750	1.1810
New London-Norwich, CT	1.2317	1.1534
New Orleans, LA	0.9294	0.9511
New York, NY	1.4010	1.2597
Newark, NJ	1.1036	1.0698
Oakland, CA	1.5069	1.3242
Odessa-Midland, TX	0.8566	0.8994
Oklahoma City, OK	0.8371	0.8854
Omaha, NE–IA	0.9480	0.9641
Orange County, CA	1.1902	1.1266
Peoria-Pekin, IL	0.8905	0.9237
Philadelphia, PA–NJ	1.1237	1.0831
Pittsburgh, PA	0.9539	0.9682
Portland, ME	0.9619	0.9738
Portland-Vancouver, OR–WA	1.1235	1.0830
Provo-Orem, UT	1.0116	1.0079
Raleigh-Durham-Chapel Hill, NC	0.9602	0.9726
Rapid City, SD	0.8458	0.8916
Roanoke, VA	0.8702	0.9092
Rochester, MN	1.0428	1.0291
Rockford, IL	0.8994	0.9300
Sacramento, CA	1.2351	1.1556
Saginaw-Bay City-Midland, MI	0.9667	0.9771
St. Cloud, MN	0.9457	0.9625
St. Louis, MO–IL	0.9022	0.9319
Salt Lake City-Ogden, UT	0.9677	0.9778
San Diego, CA	1.2154	1.1429
San Francisco, CA	1.4211	1.2721
San Jose, CA	1.4455	1.2870
Santa Rosa, CA	1.2363	1.1563
Sarasota-Bradenton, FL	0.9789	0.9855
Seattle-Bellevue-Everett, WA	1.1384	1.0928
Sharon, PA	0.8885	0.9222
Sherman-Denison, TX	0.8631	0.9041

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Sioux Falls, SD	0.8620	0.9033
South Bend, IN	0.9934	0.9955
Springfield, IL	0.8671	0.9070
Springfield, MO	0.7842	0.8466
Stockton-Lodi, CA	1.1391	1.0933
Syracuse, NY	0.9396	0.9582
Tacoma, WA	1.0866	1.0585
Tampa-St. Petersburg-Clearwater, FL	0.9302	0.9517
Texarkana, AR-Texarkana, TX	0.8509	0.8953
Toledo, OH	1.0361	1.0246
Topeka, KS	0.9795	0.9859
Tucson, AZ	0.9075	0.9357
Tulsa, OK	0.8095	0.8653
Tyler, TX	0.9605	0.9728
Victoria, TX	0.8185	0.8718
Washington, DC–MD–VA–WV	1.0823	1.0557
Waterloo-Cedar Falls, IA	0.8591	0.9012
Wausau, WI	0.9698	0.9792
Wichita, KS	0.9211	0.9453
Rural Alabama	0.7150	0.7947
Rural Florida	0.8668	0.9067
Rural Kentucky	0.7753	0.8401
Rural Louisiana	0.7253	0.8026
Rural Michigan	0.8836	0.9187
Rural Minnesota	0.8144	0.8688
Rural New Hampshire	0.9751	0.9829
Rural North Carolina	0.7953	0.8548
Rural Virginia	0.7729	0.8383
Rural Virginia (Rural Kentucky Hosp.)	0.7753	0.8401
Rural Washington	0.9933	0.9954
Rural West Virginia	0.7923	0.8526
Rural Wyoming	0.8177	0.8713

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	15.7361
Aguadilla, PR	8.2856
Akron, OH	19.2662
Albany, GA	16.8101
Albany-Schenectady-Troy, NY	16.8634
Albuquerque, NM	18.2712
Alexandria, LA	15.8746
Allentown-Bethlehem-Easton, PA	19.5376
Altoona, PA	18.5951
Amarillo, TX	17.0704
Anchorage, AK	25.8567
Ann Arbor, MI	22.8035
Anniston, AL	15.6871
Appleton-Oshkosh-Neenah, WI	17.3835
Arecibo, PR	8.5979
Asheville, NC	18.2517
Athens, GA	18.3967
Atlanta, GA	19.6186
Atlantic-Cape May, NJ	21.6594
Augusta-Aiken, GA–SC	17.2764
Austin-San Marcos, TX	18.0941
Bakersfield, CA	19.9230
Baltimore, MD	19.1581

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Bangor, ME	18.3630
Barnstable-Yarmouth, MA	26.6928
Baton Rouge, LA	16.4888
Beaumont-Port Arthur, TX	16.7698
Bellingham, WA	22.1285
Benton Harbor, MI	16.6319
Bergen-Passaic, NJ	23.0426
Billings, MT	17.7662
Biloxi-Gulfport-Pascagoula, MS	16.7252
Binghamton, NY	17.2505
Birmingham, AL	17.6684
Bismarck, ND	15.4928
Bloomington, IN	16.9184
Bloomington-Normal, IL	17.5793
Boise City, ID	18.3461
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	22.7074
Boulder-Longmont, CO	18.6194
Brazoria, TX	17.9908
Bremerton, WA	21.3152
Brownsville-Harlingen-San Benito, TX	16.7030
Bryan-College Station, TX	17.3076
Buffalo-Niagara Falls, NY	17.8073
Burlington, VT	19.6864
Caguas, PR	8.9423
Canton-Massillon, OH	16.9098
Casper, WY	17.2484
Cedar Rapids, IA	16.5386
Champaign-Urbana, IL	18.3634
Charleston-North Charleston, SC	17.5265
Charleston, WV	18.6261
Charlotte-Gastonia-Rock Hill, NC–SC	18.8112
Charlottesville, VA	17.9005
Chattanooga, TN–GA	17.2991
Cheyenne, WY	15.0126
Chicago, IL	21.0400
Chico-Paradise, CA	20.3689
Cincinnati, OH–KY–IN	18.7085
Clarksville-Hopkinsville, TN–KY	15.0873
Cleveland-Lorain-Elyria, OH	19.3308
Colorado Springs, CO	18.2642
Columbia, MO	17.4002
Columbia, SC	17.9118
Columbus, GA–AL	15.2114
Columbus, OH	18.9295
Corpus Christi, TX	17.3648
Cumberland, MD–WV	16.9547
Dallas, TX	19.0236
Danville, VA	16.6152
Davenport-Moline-Rock Island, IA–IL	16.4021
Dayton-Springfield, OH	18.6913
Daytona Beach, FL	17.3459
Decatur, AL	16.3934
Decatur, IL	15.3452
Denver, CO	19.8786
Des Moines, IA	17.2370
Detroit, MI	20.9694
Dothan, AL	15.1351
Dover, DE	17.5916
Dubuque, IA	15.8624
Duluth-Superior, MN–WI	18.4105
Dutchess County, NY	20.7053
Eau Claire, WI	16.9692
El Paso, TX	18.5059
Elkhart-Goshen, IN	17.2083
Elmira, NY	16.4576

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Enid, OK	15.3724
Erie, PA	17.9082
Eugene-Springfield, OR	22.0384
Evansville, Henderson, IN–KY	17.5644
Fargo-Moorhead, ND–MN	17.6861
Fayetteville, NC	17.6113
Fayetteville-Springdale-Rogers, AR	14.1177
Flagstaff, AZ–UT	17.6344
Flint, MI	21.9933
Florence, AL	15.5219
Florence, SC	16.8047
Fort Collins-Loveland, CO	20.6529
Fort Lauderdale, FL	20.6250
Fort Myers-Cape Coral, FL	17.6607
Fort Pierce-Port St. Lucie, FL	19.8836
Fort Smith, AR–OK	15.3772
Fort Walton Beach, FL	17.9727
Fort Wayne, IN	17.2067
Fort Worth-Arlington, TX	19.8533
Fresno, CA	21.8549
Gadsden, AL	17.3656
Gainesville, FL	18.4465
Galveston-Texas City, TX	21.5032
Gary, IN	18.8504
Glens Falls, NY	16.7411
Goldsboro, NC	16.4109
Grand Forks, ND–MN	17.6200
Grand Junction, CO	16.2997
Grand Rapids-Muskegon-Holland, MI	19.7853
Great Falls, MT	16.9748
Greeley, CO	18.9481
Green Bay, WI	17.6730
Greensboro-Winston-Salem-High Point, NC	18.2112
Greenville, NC	17.7503
Greenville-Spartanburg-Anderson, SC	17.4559
Hagerstown, MD	17.9394
Hamilton-Middletown, OH	18.5562
Harrisburg-Lebanon-Carlisle, PA	19.8630
Hartford, CT	24.1823
Hattiesburg, MS	14.1809
Hickory-Morganton-Lenoir, NC	16.8672
Honolulu, HI	22.4099
Houma, LA	15.3561
Houston, TX	19.5534
Huntington-Ashland, WV–KY–OH	17.9378
Huntsville, AL	16.0449
Indianapolis, IN	19.3630
Iowa City, IA	18.3037
Jackson, MI	17.6864
Jackson, MS	15.4167
Jackson, TN	16.2068
Jacksonville, FL	17.7663
Jacksonville, NC	13.7955
Jamestown, NY	14.9979
Janesville-Beloit, WI	16.9030
Jersey City, NJ	22.2562
Johnson City-Kingsport-Bristol, TN–VA	17.3717
Johnstown, PA	16.4213
Jonesboro, AR	14.1168
Joplin, MO	14.9353
Kalamazoo-Battlecreek, MI	20.6127
Kankakee, IL	17.8236
Kansas City, KS–MO	18.5333
Kenosha, WI	17.8819

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Killeen-Temple, TX	20.3189
Knoxville, TN	16.6250
Kokomo, IN	16.7962
La Crosse, WI–MN	16.8513
Lafayette, LA	15.9607
Lafayette, IN	17.1690
Lake Charles, LA	15.7084
Lakeland-Winter Haven, FL	17.1559
Lancaster, PA	18.7384
Lansing-East Lansing, MI	19.5719
Laredo, TX	13.8306
Las Cruces, NM	16.6145
Las Vegas, NV–AZ	21.2545
Lawrence, KS	16.8098
Lawton, OK	16.3566
Lewiston-Auburn, ME	18.3998
Lexington, KY	16.2159
Lima, OH	17.0746
Lincoln, NE	17.9136
Little Rock-North Little Rock, AR	16.8095
Longview-Marshall, TX	16.9037
Los Angeles-Long Beach, CA	24.1347
Louisville, KY–IN	18.4730
Lubbock, TX	16.6400
Lynchburg, VA	15.7441
Macon, GA	17.2534
Madison, WI	19.5953
Mansfield, OH	16.6677
Mayaguez, PR	8.2422
McAllen-Edinburg-Mission, TX	16.5901
Medford-Ashland, OR	19.6857
Melbourne-Titusville-Palm Bay, FL	17.7314
Memphis, TN–AR–MS	15.9681
Merced, CA	20.8439
Miami, FL	19.4323
Middlesex-Somerset-Hunterdon, NJ	21.2792
Milwaukee-Waukesha, WI	18.8591
Minneapolis-St. Paul, MN–WI	21.0727
Mobile, AL	15.6052
Modesto, CA	20.7262
Monmouth-Ocean, NJ	21.1825
Monroe, LA	16.0553
Montgomery, AL	15.4009
Muncie, IN	18.9936
Myrtle Beach, SC	15.2321
Naples, FL	19.9423
Nashville, TN	17.7573
Nassau-Suffolk, NY	26.4893
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	24.8405
New London-Norwich, CT	23.9754
New Orleans, LA	18.1738
New York, NY	27.6763
Newark, NJ	22.9987
Newburgh, NY–PA	21.1229
Norfolk-Virginia Beach-Newport News, VA–NC	16.3222
Oakland, CA	29.3127
Ocala, FL	17.8031
Odessa-Midland, TX	16.5854
Oklahoma City, OK	16.3683
Olympia, WA	20.9003
Omaha, NE–IA	18.5371
Orange County, CA	23.3969
Orlando, FL	18.5164
Owensboro, KY	14.8119
Panama City, FL	15.7629
Parkersburg-Marietta, WV–OH	15.4018

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Pensacola, FL	16.0371
Peoria-Pekin, IL	17.4120
Philadelphia, PA–NJ	21.9722
Phoenix-Mesa, AZ	19.1821
Pine Bluff, AR	15.4205
Pittsburgh, PA	18.9688
Pittsfield, MA	20.6334
Pocatello, ID	17.1752
Ponce, PR	9.1599
Portland, ME	18.8079
Portland-Vancouver, OR–WA	21.9679
Providence-Warwick, RI	21.6876
Provo-Orem, UT	19.7809
Pueblo, CO	16.1970
Punta Gorda, FL	16.3323
Racine, WI	17.2751
Raleigh-Durham-Chapel Hill, NC	19.0221
Rapid City, SD	16.5325
Reading, PA	18.4690
Redding, CA	22.6922
Reno, NV	21.5443
Richland-Kennewick-Pasco, WA	19.4956
Richmond-Petersburg, VA	17.9776
Riverside-San Bernardino, CA	22.2475
Roanoke, VA	17.0151
Rochester, MN	20.3908
Rochester, NY	18.8662
Rockford, IL	17.5872
Rocky Mount, NC	17.5097
Sacramento, CA	24.1510
Saginaw-Bay City-Midland, MI	18.7939
St. Cloud, MN	18.4907
St. Joseph, MO	16.7196
St. Louis, MO–IL	17.6400
Salem, OR	19.0205
Salinas, CA	26.9904
Salt Lake City-Ogden, UT	18.9211
San Angelo, TX	14.8158
San Antonio, TX	16.4044
San Diego, CA	23.7268
San Francisco, CA	27.8836
San Jose, CA	28.3887
San Juan-Bayamon, PR	8.8111
San Luis Obispo-Atascadero-Paso Robles, CA	22.6053
Santa Barbara-Santa Maria-Lompoc, CA	21.9816
Santa Cruz-Watsonville, CA	26.4364
Santa Fe, NM	21.1622
Santa Rosa, CA	24.4155
Sarasota-Bradenton, FL	19.1406
Savannah, GA	18.8663
Scranton-Wilkes Barre-Hazleton, PA	17.1121
Seattle-Bellevue-Everett, WA	22.2595
Sharon, PA	17.3726
Sheboygan, WI	15.1817
Sherman-Denison, TX	16.8423
Shreveport-Bossier City, LA	18.2999
Sioux City, IA–NE	16.2539
Sioux Falls, SD	16.8540
South Bend, IN	19.4248
Spokane, WA	20.5788
Springfield, IL	16.9538
Springfield, MO	15.2957
Springfield, MA	20.6983
State College, PA	18.6507
Steubenville-Weirton, OH–WV	16.1632
Stockton-Lodi, CA	22.1532

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Sumter, SC	15.0540
Syracuse, NY	18.3703
Tacoma, WA	21.2354
Tallahassee, FL	16.2555
Tampa-St. Petersburg-Clearwater, FL	18.0859
Terre Haute, IN	16.7989
Texarkana, AR-Texarkana, TX	16.6266
Toledo, OH	20.2601
Topeka, KS	19.7210
Trenton, NJ	20.6259
Tucson, AZ	17.7311
Tulsa, OK	15.8281
Tuscaloosa, AL	15.2197
Tyler, TX	19.5462
Utica-Rome, NY	16.4509
Vallejo-Fairfield-Napa, CA	27.2708
Ventura, CA	22.3964
Victoria, TX	16.4116
Vineland-Millville-Bridgeton, NJ	19.5394
Visalia-Tulare-Porterville, CA	19.8483
Waco, TX	15.1959
Washington, DC–MD–VA–WV	21.1632
Waterloo-Cedar Falls, IA	17.0208
Wausau, WI	20.1856
West Palm Beach-Boca Raton, FL	19.9482
Wheeling, OH–WV	14.7877
Wichita, KS	18.3188
Wichita Falls, TX	15.7237
Williamsport, PA	16.5567
Wilmington-Newark, DE–MD	22.1249
Wilmington, NC	17.6887
Yakima, WA	19.6049
Yolo, CA	22.3769
York, PA	17.8006
Youngstown-Warren, OH	19.0484
Yuba City, CA	20.3622
Yuma, AZ	18.5693

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	13.9255
Alaska	24.3314
Arizona	15.5012
Arkansas	13.5966
California	19.5577
Colorado	15.8231
Connecticut	24.9480
Delaware	18.4711
Florida	16.9485
Georgia	14.9642
Hawaii	20.0330
Idaho	16.1848
Illinois	14.7683
Indiana	15.8851
Iowa	14.4039
Kansas	13.8962
Kentucky	15.1598
Louisiana	14.1417
Maine	16.2618
Maryland	16.4777
Massachusetts	21.0582
Michigan	17.2651

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Minnesota	15.9249
Mississippi	13.2829
Missouri	14.1978
Montana	15.8928
Nebraska	14.1063
Nevada	17.1588
New Hampshire	19.0549
New Jersey [1]	.....
New Mexico	15.6424
New York	16.7329
North Carolina	15.5456

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
North Dakota	14.3865
Ohio	16.2910
Oklahoma	13.5735
Oregon	18.8958
Pennsylvania	16.5277
Puerto Rico	7.8716
Rhode Island [1]	.....
South Carolina	14.9937
South Dakota	13.8107
Tennessee	14.3532
Texas	14.5903

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Utah	17.3014
Vermont	17.4440
Virginia	15.0809
Washington	19.4229
West Virginia	15.4544
Wisconsin	16.4842
Wyoming	15.9886

[1] All counties within the State are classified as 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	3.0486	7.7	11.1	32
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0134	8.4	11.6	32
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9167	12.7	12.7	37
4	01	SURG	SPINAL PROCEDURES	2.3399	5.9	9.1	30
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5143	3.4	4.4	26
6	01	SURG	CARPAL TUNNEL RELEASE	.7419	2.4	3.4	26
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC.	2.4886	8.1	12.6	32
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.0962	2.6	3.9	27
9	01	MED	SPINAL DISORDERS & INJURIES	1.2677	5.4	7.8	29
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2196	5.7	8.1	30
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8000	3.5	5.0	28
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9457	5.4	7.7	29
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7770	5.0	6.2	29
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA.	1.1999	5.5	7.5	30
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS.	.7231	3.5	4.5	27
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0371	4.9	6.6	29
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.	.6331	3.0	4.0	26
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9319	4.8	6.4	29
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6230	3.4	4.5	27
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS.	2.4854	8.6	11.6	33
21	01	MED	VIRAL MENINGITIS	1.4910	5.8	7.8	30
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.8353	3.8	4.9	28
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8089	3.6	5.1	28
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9694	4.2	5.8	28
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5793	3.0	3.9	24
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.7387	3.3	4.6	27
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3060	3.6	6.3	28
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC.	1.2033	4.8	7.1	29
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	.6371	3.0	4.1	27
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	.3241	2.0	2.0	17
31	01	MED	CONCUSSION AGE >17 W CC	.8412	3.7	5.4	28
32	01	MED	CONCUSSION AGE >17 W/O CC	.4861	2.3	3.1	20
33	01	MED	*CONCUSSION AGE 0–17	.2037	1.6	1.6	9
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0673	4.6	6.5	29
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6149	3.2	4.3	27
36	02	SURG	RETINAL PROCEDURES	.6134	1.3	1.6	6
37	02	SURG	ORBITAL PROCEDURES	.9323	2.7	4.0	27
38	02	SURG	PRIMARY IRIS PROCEDURES	.4282	1.9	2.6	17
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5184	1.5	2.0	10
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	.7072	2.2	3.4	26
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17.	.3299	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.	.5816	1.6	2.2	13
43	02	MED	HYPHEMA	.4520	3.3	4.2	27
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6237	4.7	5.7	29
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6525	3.1	3.8	22
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7656	4.0	5.6	28
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4664	2.8	3.8	27
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2907	2.9	2.9	27
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7245	4.1	5.7	28
50	03	SURG	SIALOADENECTOMY	.7686	1.7	2.1	9
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	.7345	1.9	2.9	20
52	03	SURG	CLEFT LIP & PALATE REPAIR	1.0271	2.1	3.4	24
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.0128	2.2	3.6	26
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4712	3.2	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.7880	2.0	3.0	22
56	03	SURG	RHINOPLASTY	.8283	2.1	2.7	18
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.9325	2.8	4.1	27
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2676	1.5	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.7439	2.3	3.6	26
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2038	1.5	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.1960	2.7	5.1	27
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2885	1.3	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.2168	3.2	4.7	27
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1737	4.8	7.6	29
65	03	MED	DYSEQUILIBRIUM	.5195	2.7	3.4	20
66	03	MED	EPISTAXIS	.5366	2.9	3.6	21
67	03	MED	EPIGLOTTITIS	.8397	3.4	4.2	24
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.7098	3.9	4.8	27
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5239	3.1	3.8	20
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3727	2.4	2.9	15
71	03	MED	LARYNGOTRACHEITIS	.7702	3.1	4.0	27
72	03	MED	NASAL TRAUMA & DEFORMITY	.6532	3.1	4.4	27
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	.7505	3.7	5.0	28
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3278	2.1	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES	3.1951	8.8	11.2	33
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.6036	9.1	12.5	33
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1593	3.8	5.5	28
78	04	MED	PULMONARY EMBOLISM	1.4292	7.0	8.3	31
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.6300	7.2	9.3	31
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9436	5.3	6.6	29
81	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17.	1.4845	6.3	7.8	30
82	04	MED	RESPIRATORY NEOPLASMS	1.3319	5.7	7.9	30
83	04	MED	MAJOR CHEST TRAUMA W CC	.9782	4.9	6.4	29
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5319	2.9	3.7	23
85	04	MED	PLEURAL EFFUSION W CC	1.2200	5.6	7.4	30
86	04	MED	PLEURAL EFFUSION W/O CC	.7117	3.4	4.5	27
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3615	5.1	6.9	29
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9846	4.9	6.1	29
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.1156	5.8	7.1	30
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6978	4.3	5.1	24
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.7524	3.5	4.5	27
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2029	5.6	7.3	30
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7498	4.0	4.9	28
94	04	MED	PNEUMOTHORAX W CC	1.1780	5.3	7.1	29
95	04	MED	PNEUMOTHORAX W/O CC	.5996	3.3	4.1	25
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.8272	4.5	5.5	29
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.6035	3.6	4.3	22
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.7807	2.9	4.3	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	.6869	2.7	3.5	22
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5113	2.0	2.4	12
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8748	3.9	5.2	28
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5335	2.4	3.1	20
103	05	SURG	HEART TRANSPLANT	15.3358	28.4	40.0	52
104	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.3199	12.0	14.6	36
105	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.5998	9.0	11.0	33
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.5564	10.3	11.7	34
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.0685	7.8	8.8	32
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.9135	9.8	12.6	34
109			NO LONGER VALID	.0000	.0	.0	0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1589	8.2	10.9	32
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2875	5.9	6.7	30
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	2.0946	3.5	4.7	27
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.6935	10.6	14.4	35
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5152	6.8	9.5	31
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK.	3.6827	9.1	11.5	33
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GENERATOR PROC.	2.4150	3.9	5.4	28
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.1764	2.7	4.1	27
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5825	2.1	3.2	25
119	05	SURG	VEIN LIGATION & STRIPPING	1.1435	3.3	5.5	27
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9318	5.4	9.2	29
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE.	1.6482	6.4	7.8	30
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE.	1.1617	4.4	5.3	28
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4555	2.7	4.7	27
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.3258	3.8	5.0	28
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	.9246	2.3	3.1	20
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5379	11.0	14.3	35
127	05	MED	HEART FAILURE & SHOCK	1.0265	4.8	6.2	29
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7861	5.9	6.7	27
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1316	2.0	3.5	26
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9352	5.3	6.7	29
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6038	4.3	5.2	28
132	05	MED	ATHEROSCLEROSIS W CC	.6840	2.9	3.6	20
133	05	MED	ATHEROSCLEROSIS W/O CC	.5537	2.3	2.9	16
134	05	MED	HYPERTENSION	.5787	3.0	3.9	23
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.8838	3.7	5.0	28
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5629	2.6	3.3	18
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	.7999	3.3	3.3	27
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC.	.8008	3.5	4.6	27
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	.4971	2.4	2.9	16
140	05	MED	ANGINA PECTORIS	.6205	2.8	3.5	20
141	05	MED	SYNCOPE & COLLAPSE W CC	.7128	3.4	4.5	27
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5288	2.5	3.2	18
143	05	MED	CHEST PAIN	.5223	2.1	2.6	14
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0857	4.1	5.7	28
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6208	2.5	3.2	20
146	06	SURG	RECTAL RESECTION W CC	2.6363	9.8	11.2	34
147	06	SURG	RECTAL RESECTION W/O CC	1.6018	6.7	7.3	27
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3710	11.2	13.5	35
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.5999	7.0	7.7	25
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.6828	9.5	11.7	34
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2910	5.2	6.5	29
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9311	7.6	9.0	32

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.	1.1568	5.6	6.2	24
154 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1817	11.6	15.0	36
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.4059	4.5	5.9	29
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8238	6.0	6.0	30
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.1352	4.2	5.8	28
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6077	2.3	2.9	18
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.2268	4.0	5.3	28
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7026	2.4	3.0	16
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	1.0066	3.0	4.4	27
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.5707	1.7	2.2	11
163 ...	06	SURG	*HERNIA PROCEDURES AGE 0–17	.7706	2.1	2.1	11
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	2.3386	8.0	9.4	32
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.2582	5.1	5.8	24
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	1.4497	4.5	5.7	29
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	.8431	2.8	3.2	15
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.0929	3.2	5.0	27
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.6717	2.0	2.5	15
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7453	8.5	12.5	33
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.1202	4.0	5.4	28
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.2920	5.7	8.2	30
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6769	3.0	4.4	27
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9952	4.4	5.6	28
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5485	2.9	3.5	17
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.0856	4.7	6.2	29
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8335	4.0	5.0	28
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6091	3.0	3.6	19
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.1188	5.5	7.2	30
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9194	4.7	6.1	29
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5338	3.3	4.0	22
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7789	3.8	5.0	28
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5553	2.8	3.4	20
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.5414	2.8	3.9	27
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8424	3.7	5.2	28
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3140	2.9	2.9	23
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7104	3.1	4.2	27
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC.	1.0591	4.5	6.1	28
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	.5640	2.7	3.7	27
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.8769	3.9	5.1	28
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.4543	12.1	16.3	36
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7889	6.2	7.9	30
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.2878	11.4	13.9	35
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.7549	6.8	8.5	31
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.6894	8.8	10.5	33
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6127	5.8	6.7	30
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.2679	7.5	9.2	31
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1738	4.3	4.9	23

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.	2.3728	8.4	11.2	32
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.1772	7.9	12.4	32
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.7669	12.1	16.8	36
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3675	5.7	7.8	30
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.2486	5.5	7.7	30
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2004	5.1	6.8	29
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC.	1.2194	5.3	7.3	29
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.7159	3.6	4.7	28
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0508	4.4	5.8	28
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6045	2.6	3.5	21
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.2606	5.9	6.7	23
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8460	7.2	8.6	31
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2740	5.6	6.3	23
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	1.1487	11.1	11.1	35
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7049	7.0	9.7	31
214 ...	08	SURG	BACK & NECK PROCEDURES W CC	1.9255	4.9	6.5	29
215 ...	08	SURG	BACK & NECK PROCEDURES W/O CC	1.1119	3.0	3.7	20
216 ...	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.0784	7.9	11.1	32
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.8812	10.2	15.4	34
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4574	4.8	6.2	29
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	.9553	3.1	3.8	19
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5706	5.3	5.3	29
221 ...	08	SURG	KNEE PROCEDURES W CC	1.8340	5.8	8.1	30
222 ...	08	SURG	KNEE PROCEDURES W/O CC	1.0177	3.1	4.0	27
223 ...	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.8720	2.2	2.9	16
224 ...	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.7417	1.9	2.3	10
225 ...	08	SURG	FOOT PROCEDURES	1.0020	3.3	5.0	27
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.3831	4.4	6.7	28
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.7449	2.3	3.0	18
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	.9349	2.3	3.5	26
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	.6512	1.8	2.4	13
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.0567	3.3	5.2	27
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.2263	3.3	5.1	27
232 ...	08	SURG	ARTHROSCOPY	1.0884	2.6	4.5	27
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	2.0170	6.4	9.1	30
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.0675	3.1	4.1	27
235 ...	08	MED	FRACTURES OF FEMUR	.8395	4.7	6.9	29
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7620	4.7	6.4	29
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	.5637	3.3	4.4	27
238 ...	08	MED	OSTEOMYELITIS	1.3796	7.6	10.1	32
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0115	5.8	7.6	30
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2112	5.5	7.5	30
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6029	3.5	4.6	28
242 ...	08	MED	SEPTIC ARTHRITIS	1.0492	5.8	7.7	30

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				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7241	4.3	5.6	28
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7279	4.3	5.8	28
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	.4954	3.2	4.3	27
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5887	3.6	4.6	28
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5523	2.9	4.0	27
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7325	3.9	5.3	28
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6522	2.9	4.3	27
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6915	3.6	5.1	28
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4640	2.5	3.3	22
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	.2479	1.8	1.8	15
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7438	4.3	5.8	28
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4451	2.9	3.9	25
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2886	2.9	2.9	27
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7651	4.0	5.7	28
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9015	2.8	3.4	17
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7087	2.2	2.5	10
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8640	2.3	3.5	26
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6083	1.6	1.9	8
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.8286	1.9	2.3	12
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	.7695	2.7	3.9	27
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKIN ULCER OR CELLULITIS W CC.	2.1226	9.9	13.9	34
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKIN ULCER OR CELLULITIS W/O CC.	1.1270	6.0	8.3	30
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.4993	4.8	7.7	29
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.7629	2.7	3.7	27
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.8330	2.8	4.3	27
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	.9916	2.5	4.1	27
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6416	6.3	9.3	30
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7003	2.4	3.4	26
271 ...	09	MED	SKIN ULCERS	1.0816	6.6	8.5	31
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	1.0158	5.6	7.5	30
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6346	4.1	5.5	28
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0760	5.3	7.9	29
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5085	2.5	3.7	27
276 ...	09	MED	NON-MALIGNANT BREAST DISORDERS	.6374	3.9	5.0	28
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8526	5.5	6.7	29
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5774	4.3	5.2	25
279 ...	09	MED	*CELLULITIS AGE 0–17	.7190	4.2	4.2	24
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	.6750	3.7	5.1	28
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4560	2.7	3.6	24
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17.	.2509	2.2	2.2	19
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.6990	4.1	5.5	28
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4340	2.9	3.8	26
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.2015	9.5	13.7	34
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.3775	6.6	8.7	31
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.9765	9.4	13.4	33
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0104	5.2	6.9	29
289 ...	10	SURG	PARATHYROID PROCEDURES	1.0198	2.7	4.0	27
290 ...	10	SURG	THYROID PROCEDURES	.8798	2.1	2.8	15

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	.5189	1.4	1.8	8
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.	2.6450	8.4	12.8	32
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.2671	4.6	6.8	29
294 ...	10	MED	DIABETES AGE >35	.7594	4.3	5.7	28
295 ...	10	MED	DIABETES AGE 0 – 35	.7159	3.3	4.3	27
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	.8929	4.7	6.4	29
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5364	3.3	4.3	26
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17.	.5221	2.5	3.4	23
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.8330	3.9	5.4	28
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.0950	5.5	7.3	30
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.6182	3.4	4.4	27
302 ...	11	SURG	KIDNEY TRANSPLANT	3.9047	10.4	12.3	34
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.6409	8.4	10.2	32
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3716	7.5	10.3	31
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1776	3.9	4.9	28
306 ...	11	SURG	PROSTATECTOMY W CC	1.2258	4.3	6.2	28
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6708	2.4	3.0	15
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5252	4.7	7.0	29
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8860	2.3	3.0	18
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0015	3.2	4.6	27
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5670	1.8	2.2	11
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	.9124	3.2	4.8	27
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.5223	1.8	2.3	13
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4836	2.3	2.3	26
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0574	5.3	9.3	29
316 ...	11	MED	RENAL FAILURE	1.3034	5.4	7.6	29
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.4845	1.9	2.9	20
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1296	5.0	7.2	29
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5772	2.3	3.2	24
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC.	.9048	5.1	6.4	29
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC.	.6077	3.9	4.7	24
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5133	3.6	4.4	23
323 ...	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7496	2.7	3.6	24
324 ...	11	MED	URINARY STONES W/O CC	.4159	1.7	2.1	10
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6377	3.4	4.6	27
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4320	2.4	3.4	19
327 ...	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	.2341	3.1	3.1	27
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.6886	3.1	4.3	27
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4567	2.1	2.8	17
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3115	1.6	1.6	9
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	.9914	4.6	6.2	29
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6070	2.8	3.9	27
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17.	.8562	4.3	5.8	28
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.6653	5.3	6.1	23
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.2610	4.2	4.6	17
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8848	3.2	4.1	24
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6147	2.3	2.7	11
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.0499	3.5	5.3	27
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0194	3.1	5.3	27
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2769	2.4	2.4	13
341 ...	12	SURG	PENIS PROCEDURES	1.0745	2.3	3.3	21
342 ...	12	SURG	CIRCUMCISION AGE >17	.7578	2.7	4.0	27
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1504	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.	1.0083	2.3	3.5	25
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8422	2.8	4.0	27
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9559	4.8	6.8	29
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	.5096	2.4	3.3	25
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7107	3.6	4.9	28
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.3974	2.2	3.0	20
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	.6611	3.9	4.8	24
351 ...	12	MED	*STERILIZATION, MALE	.2309	1.3	1.3	5
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5877	2.8	3.9	27
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9174	6.7	8.3	31
354 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.4643	5.2	6.3	28
355 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9056	3.6	3.9	11
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7376	2.6	3.0	12
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3824	8.0	9.8	32
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC.	1.1713	4.1	4.8	19
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC.	.8285	3.0	3.3	10
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8459	2.9	3.5	17
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1148	2.5	3.5	23
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.2951	1.4	1.4	5
363 ...	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	.6911	2.6	3.5	21
364 ...	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.6739	2.6	3.6	27
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	1.7237	5.3	8.1	29
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1941	5.3	7.8	29
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.	.5216	2.3	3.2	24
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.0230	5.3	6.9	29
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5454	2.6	3.7	27
370 ...	14	SURG	CESAREAN SECTION W CC	1.0401	4.3	5.6	26
371 ...	14	SURG	CESAREAN SECTION W/O CC	.6838	3.2	3.6	11
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5439	2.4	3.4	20
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3602	1.7	1.9	7
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6775	2.0	2.6	11
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C.	.6698	4.4	4.4	28
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5638	2.3	3.4	25
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.8188	2.1	3.3	26
378 ...	14	MED	ECTOPIC PREGNANCY	.8054	2.4	2.9	15
379 ...	14	MED	THREATENED ABORTION	.3591	2.0	3.0	21
380 ...	14	MED	ABORTION W/O D&C	.4775	1.7	2.3	12
381 ...	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.5151	1.7	2.3	14
382 ...	14	MED	FALSE LABOR	.2013	1.3	1.6	6
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.4655	2.8	4.1	27
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3921	1.8	3.1	22
385 ...	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3443	1.8	1.8	26
386 ...	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.4329	17.9	17.9	42
387 ...	15		*PREMATURITY W MAJOR PROBLEMS	3.0276	13.3	13.3	37
388 ...	15		*PREMATURITY W/O MAJOR PROBLEMS	1.8268	8.6	8.6	33
389 ...	15		FULL TERM NEONATE W MAJOR PROBLEMS	2.2451	7.9	10.7	32
390 ...	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	1.2845	3.6	4.7	28

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
391 ...	15		*NORMAL NEWBORN	.1490	3.1	3.1	11
392 ...	16	SURG	SPLENECTOMY AGE >17	3.2443	8.9	11.7	33
393 ...	16	SURG	*SPLENECTOMY AGE 0–17	1.3168	9.1	9.1	33
394 ...	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.5994	4.5	8.0	28
395 ...	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8362	3.9	5.4	28
396 ...	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	.6966	2.7	3.8	27
397 ...	16	MED	COAGULATION DISORDERS	1.2612	4.4	6.1	28
398 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC.	1.2106	5.2	6.6	29
399 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	.7030	3.5	4.4	27
400 ...	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.5572	6.7	10.4	31
401 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.4834	8.5	12.4	32
402 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0255	3.1	4.7	27
403 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6925	6.5	9.3	30
404 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8059	3.7	5.1	28
405 ...	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	1.8669	4.9	4.9	29
406 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC.	2.6841	8.1	11.3	32
407 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC.	1.1787	3.8	4.9	28
408 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC.	1.7393	5.0	8.2	29
409 ...	17	MED	RADIOTHERAPY	.9763	4.7	6.7	29
410 ...	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.7514	2.6	3.4	20
411 ...	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3837	2.1	2.7	16
412 ...	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4080	2.1	3.0	23
413 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3257	6.0	8.4	30
414 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7337	3.7	5.2	28
415 ...	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	3.4430	11.4	15.8	35
416 ...	18	MED	SEPTICEMIA AGE >17	1.4838	6.2	8.3	30
417 ...	18	MED	SEPTICEMIA AGE 0–17	.8089	3.7	4.6	28
418 ...	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9697	5.4	6.8	29
419 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8991	4.4	5.7	28
420 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6264	3.5	4.3	24
421 ...	18	MED	VIRAL ILLNESS AGE >17	.7153	3.6	4.7	28
422 ...	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17.	.5347	2.9	3.8	25
423 ...	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.5947	6.3	8.8	30
424 ...	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.3637	10.9	18.0	35
425 ...	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION.	.7051	3.5	4.9	27
426 ...	19	MED	DEPRESSIVE NEUROSES	.5680	3.9	5.5	28
427 ...	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5495	3.7	5.2	28
428 ...	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7303	5.2	8.4	29
429 ...	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.9075	5.9	9.0	30
430 ...	19	MED	PSYCHOSES	.8391	6.9	9.8	31
431 ...	19	MED	CHILDHOOD MENTAL DISORDERS	.6556	4.9	7.2	29
432 ...	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7363	3.9	6.5	28
433 ...	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2986	2.5	3.4	25
434 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7141	4.3	5.8	28
435 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4164	3.8	4.8	28
436 ...	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY.	.8183	12.1	14.8	36
437 ...	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.7657	9.2	10.9	33
438 ...			NO LONGER VALID	.0000	.0	.0	0
439 ...	21	SURG	SKIN GRAFTS FOR INJURIES	1.6144	5.9	8.9	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
440 ...	21	SURG	W/OUND DEBRIDEMENTS FOR INJURIES	1.7725	6.3	9.9	30
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9294	2.4	4.4	26
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.1653	5.6	8.7	30
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.8849	2.5	3.6	26
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7312	4.0	5.3	28
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4845	2.9	3.9	25
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2894	2.4	2.4	22
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.4918	2.1	2.8	17
448 ...	21	MED	ALLERGIC REACTIONS AGE 0–17	.0777	1.0	1.0	1
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.	.7902	3.0	4.5	27
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	.4274	1.8	2.3	13
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2570	2.1	2.1	17
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	.9473	3.8	5.4	28
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4822	2.4	3.2	20
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.	.8575	3.4	5.1	27
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	.4467	2.1	2.8	18
456 ...	22	MED	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.8327	4.1	8.4	28
457 ...	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	1.4657	2.4	4.8	26
458 ...	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.4991	11.9	16.9	36
459 ...	22	SURG	NON-EXTENSIVE BURNS W W/OUND DEBRIDEMENT OR OTHER O.R. PROC.	1.6538	6.7	10.3	31
460 ...	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	.9547	4.6	6.6	29
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	.9963	2.5	4.9	27
462 ...	23	MED	REHABILITATION	1.4298	11.0	13.9	35
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.7101	3.8	5.2	28
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.5028	2.8	3.8	24
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5571	2.3	3.9	26
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5905	2.5	4.8	27
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4588	2.4	4.1	26
468 ...			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6028	10.6	15.3	35
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.	3.5980	6.8	8.1	31
472 ...	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	10.9989	17.0	30.2	41
473 ...	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.5740	8.5	14.7	33
474 ...			NO LONGER VALID	.0000	.0	.0	0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6765	8.6	12.3	33
476 ...		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2479	10.3	13.9	34
477 ...		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.7266	5.9	9.3	30
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2883	5.6	8.3	30
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4080	3.5	4.6	27
480 ...		SURG	LIVER TRANSPLANT	13.9424	26.4	32.6	50
481 ...		SURG	BONE MARROW TRANSPLANT	11.2299	29.7	32.6	54
482 ...		SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES.	3.6578	11.4	14.9	35
483 ...		SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	16.0413	36.0	46.4	60
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.6821	10.6	15.9	35
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	3.2058	9.2	11.7	33
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.7915	9.0	13.6	33
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0305	6.2	9.1	30
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.7905	14.3	20.5	38
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.8141	7.2	10.7	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
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0116	4.4	6.6	28
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6308	3.6	4.3	19
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.0299	11.2	17.4	35
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.	1.7100	4.2	5.9	28
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	.9169	1.8	2.4	15
495 ...		SURG	LUNG TRANSPLANT	9.2870	18.0	22.7	42

*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
079.6	Respiratory syncytial virus (RSV)	N	15	387,[1] 389[1]
			18	421, 422
291.81	Alcohol withdrawal	Y	20	434, 435, 436, 437
291.89	Other specified alcoholic psychosis, not elsewhere classified	Y	20	434, 435, 436, 437
293.84	Organic anxiety syndrome	Y	19	429
300.82	Undifferentiated somatoform disorder	N	19	427
315.32	Receptive language disorder (mixed)	N	19	431
414.04	Coronary atherosclerosis of artery bypass graft	N	5	132, 133
414.05	Coronary atherosclerosis of unspecified type of bypass graft	N	5	132, 133
466.11	Acute bronchiolitis due to respiratory syncytial virus (RSV)	N	4	96, 97, 98
466.19	Acute bronchiolitis due to other infectious organisms	N	4	96, 97, 98
483.1	Pneumonia due to Chlamydia	Y	4	89, 90, 91
			15	387,[1] 389[1]
574.60	Calculus of gallbladder and bile duct with acute cholecystitis without mention of obstruction.	Y	7	207, 208
574.61	Calculus of gallbladder and bile duct with acute cholecystitis with obstruction	Y	7	207, 208
574.70	Calculus of gallbladder and bile duct with other cholecystitis without mention of obstruction.	Y	7	207, 208
574.71	Calculus of gallbladder and bile duct with other cholecystitis with obstruction	Y	7	207, 208
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without mention of obstruction.	Y	7	207, 208
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction	Y	7	207, 208
574.90	Calculus of gallbladder and bile duct without cholecystitis without mention of obstruction	Y	7	207, 208
574.91	Calculus of gallbladder and bile duct without cholecystitis with obstruction	Y	7	207, 208
575.10	Cholecystitis, unspecified	N	7	207, 208
575.11	Chronic cholecystitis	N	7	207, 208
575.12	Acute and chronic cholecystitis	Y	7	207, 208
752.51	Undescended testis	N	12	352
			15	391[1]
752.52	Retractile testis	N	12	352
			15	391[1]
752.61	Hypospadias	N	12	352
752.62	Epispadias	N	12	352
752.63	Congenital chordee	N	12	352
752.64	Micropenis	N	12	352
752.65	Hidden penis	N	12	352
752.69	Other penile anomalies	N	12	352
753.20	Unspecified obstructive defect of renal pelvis and ureter	N	11	331, 332, 333
753.21	Congenital obstruction of ureteropelvic junction	N	11	331, 332, 333
753.22	Congenital obstruction of ureterovesical junction	N	11	331, 332, 333
753.23	Congenital ureterocele	N	11	331, 332, 333
753.29	Obstructive defects of renal pelvis and ureter, not elsewhere classifed	N	11	331, 332, 333
758.81	Other conditions due to sex chromosome anomalies	N	12	352
			13	358, 359, 369
758.89	Other conditions due to chromosome anomalies, not elsewhere classified	N	12	352
			13	358, 359, 369
922.31	Back contusion	N	9	280, 281, 282
			24	484, 485, 486, 487

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
922.32	Buttock contusion	N	9	280, 281, 282
			24	484, 485, 486, 487
922.33	Interscapular region contusion	N	9	280, 281, 282
			24	484, 485, 486, 487
995.50	Child abuse, unspecified	N	21	454, 455
995.51	Child emotional/psychological abuse	N	21	454, 455
995.52	Child neglect (nutritional)	N	21	454, 455
995.53	Child sexual abuse	N	21	454, 455
995.54	Child physical abuse	N	21	454, 455
995.55	Shaken infant syndrome	N	21	454, 455
995.59	Other child abuse and neglect	N	21	454, 455
995.80	Adult maltreatment, unspecified	N	21	454, 455
995.82	Adult emotional/psychological abuse	N	21	454, 455
995.83	Adult sexual abuse	N	21	454, 455
995.84	Adult neglect (nutritional)	N	21	454, 455
995.85	Other adult abuse and neglect	N	21	454, 455
998.11	Hemorrhage complicating a procedure	Y	15	387,[1] 389[1]
			21	452, 453
998.12	Hematoma complicating a procedure	Y	15	387,[1] 389[1]
			21	452, 453
998.13	Seroma complicating a procedure	Y	15	387,[1] 389[1]
			21	452, 453
998.51	Infected postoperative seroma	Y	15	387,[1] 389[1]
			18	418
998.59	Other postoperative infection	Y	15	387,[1] 389[1]
			18	418
998.83	Non-healing surgical wound	Y	21	452, 453
V15.41	History of physical abuse	N	23	467
V15.42	History of emotional abuse	N	23	467
V15.49	Psychological trauma, not elsewhere classified	N	23	467
V61.10	Counseling for marital and partner problems, unspecified	N	23	467
V61.11	Counseling for victim of spousal and partner abuse	N	23	467
V61.12	Counseling for perpetrator of spousal and partner abuse	N	23	467
V61.22	Counseling for perpetrator of parental child abuse	N	23	467
V62.83	Counseling for perpetrator of physical/sexual abuse	N	23	467
V66.7	Encounter for palliative care	N	23	467

[1] Diagnosis code is classified as a ''major problem'' in these DRGs.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
36.17	Abdominal-coronary artery bypass	Y	5	106, 107
39.90	Insertion of non-coronary artery stent or stents	N	.....	
47.01	Laparoscopic appendectomy	Y	6	164, 165, 166, 167
47.09	Other appendectomy	Y	6	164, 165, 166, 167
47.11	Laparoscopic incidental appendectomy	Y	13	365
			21	442, 443
				24
				486
47.19	Other incidental appendectomy	Y	13	365
			21	442, 443
			24	486
51.21	Other partial cholecystectomy	Y	7	195, 196, 197, 198
			17	400, 406,
			17	407
			21	442, 443
			24	486
51.24	Laparoscopic partial cholecystectomy	Y	7	195, 196, 493, 494
			17	400, 406,
			17	407,
			21	442, 443
			24	486
52.84	Autotransplantation of cells of Islets of Langerhans	N	.....	
52.85	Allotransplantation of cells of Islets of Langerhans	N	.....	
52.86	Transplantation of cells of Islets of Langerhans, not otherwise specified	N	.....	
54.51	Laparoscopiclysis of peritoneal adhesions	Y	6	150, 151
			7	201
			13	365

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
			21	442, 443
			24	486
54.59	Otherlys is of peritoneal adhesions	Y	6	150, 151
			7	201
			13	365
			21	442, 443
			24	486
59.03	Laparoscopic lysis of perirenal or periureteral adhesions	Y	11	303, 304, 305
			12	344, 345
			13	365
			17	400
			17	406, 407
			21	442, 443
			24	486
59.12	Laparoscopic lysis of perivesical adhesions	Y	11	308, 309
			12	344, 345
			13	365
			17	400
			17	406, 407
			21	442, 443
			24	486
65.01	Laparoscopic oophorotomy	Y	13	354, 355, 357, 358, 359
65.09	Other oophorotomy	Y	13	354, 355, 357, 358, 359
65.13	Laparoscopic biopsy of ovary	Y	13	354, 355, 357, 358, 359
65.14	Other laparoscopic diagnostic procedures on ovaries	Y	13	354, 355, 357,358, 359
65.23	Laparoscopic marsupialization of ovarian cyst	Y	13	354, 355, 357, 358, 359
65.24	Laparoscopic wedge resection of ovary	Y	10	292, 293
			13	354, 355, 357, 358, 359
65.25	Other laparoscopic local excision or destruction of ovary	Y	13	354, 355, 357, 358, 359
65.31	Laparoscopic unilateral oophorectomy	Y	13	354, 355, 357, 358, 359
65.39	Other unilateral oophorectomy	Y	13	354, 355, 357, 358, 359
65.41	Laparoscopic unilateral salpingo-oophorectomy	Y	13	354, 355, 357, 358, 359
65.49	Other unilateral salpingo-oophorectomy	Y	13	354, 355, 357, 358, 359
65.53	Laparoscopic removal of both ovaries at same operative episode	Y	9	269, 270
			13	354, 355
			13	357, 358, 359
65.54	Laparoscopic removal of remaining ovary	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.63	Laparoscopic removal of both ovaries and tubes at same operative episode	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.64	Laparoscopic removal of remaining ovary and tube	Y	13	354, 355, 357, 358, 359
65.74	Laparoscopic simple suture of ovary	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
65.75	Laparoscopic reimplantation of ovary	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
65.76	Laparoscopic salpingo-oophoroplasty	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
65.81	Laparoscopic lysis of adhesions of ovary and fallopian tube	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
65.89	Other lysis of adhesions of ovary and fallopian tube	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
68.23	Endometrial ablation	Y	13	354, 355, 357, 358, 359
68.51	Laparoscopically assisted vaginal hysterectomy (LAVH)	Y	13	354, 355,
				13
				357, 358,
				13
				359
			14	375
			22	477
68.59	Other vaginal hysterectomy	Y	13	354, 355,
			13	357, 358,
			13	359
			14	375
			22	477

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
291.8	Other specified alcoholic psychosis	Y	20	434, 435, 436, 437
466.1	Acute bronchiolitis	N	4	96, 97, 98
575.1	Other cholecystitis	N	7	207, 208
752.5	Undescended testicle	N	12	352
752.6	Hypospadias and epispadias	N	12	352
753.2	Obstructive defects of renal pelvis and ureter	N	11	331, 332, 333
758.8	Other conditions due to sex chromosome anomalies	N	12	352
			13	358, 359, 369
922.3	Contusion of back	N	9	280, 281,
			9	282
			24	484, 485, 486, 487
995.5	Child maltreatment syndrome	N	21	454, 455
998.1	Hemorrhage or hematoma complicating a procedure	Y	15	387,[1] 389[1]
			21	452, 453
998.5	Postoperative infection	Y	15	387,[1] 389[1]
			18	418
V15.4	Psychological trauma	N	23	467
V61.1	Marital problems	N	23	467

[1] Diagnosis code is classified as a ''major problem'' in these DRGs.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
47.0	Appendectomy	Y	6	164, 165, 166, 167
47.1	Incidental appendectomy	Y	13	365,
			21	442, 443,
			24	486
54.5	Lysis of peritoneal adhesions	Y	6	150, 151,
			7	201
			13	365
			21	442, 443
			24	486
59.01	Ureterolysis with freeing or repositioning of ureter for retroperitoneal fibrosis	Y	11	303, 304,
			11	305
			12	344, 345
			13	365
			17	400, 406,

TABLE 6D.—INVALID PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
			17	407
			21	442, 443
			24	486
65.0	Oophorotomy	Y	13	354, 355 357, 358, 359
65.3	Unilateral oophorectomy	Y	13	354, 355 357, 358, 359
65.4	Unilateral salpingo-oophorectomy	Y	13	354, 355, 357, 358, 359
65.8	Lysis of adhesions of ovary and fallopian tube	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
68.5	Vaginal hysterectomy	Y	13	354, 355,
			13	357, 358,
			13	359
			14	375
			22	477

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft	N	5	132, 133
995.81	Adult physical abuse	N	21	454, 455
997.60	Amputation stump complication, unspecified complication	N	8	256
997.61	Amputation stump complication, neuroma of amputation stump	N	8	256
997.62	Amputation stump complication, infection (chronic)	Y	8	256
997.69	Amputation stump complication, not elsewhere classified	N	8	256
V61.20	Counseling for parent-child problem, unspecified	N	23	467
V61.21	Counseling for victim of child abuse	N	23	467
V67.4	Follow-up examination, following treatment of healed fracture	N	23	465, 466

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
59.11	Other lysis of perivesical adhesions	Y	11	308, 309
			12	344, 345
			13	365
			17	400, 406,
			17	407
			21	442, 443
			24	486
65.51	Other removal of both ovaries at same operative episode	Y	9	269, 270
			13	354, 355
			13	357, 358, 359
65.52	Other removal of remaining ovary	Y	9	269, 270
			13	354, 355
			13	357, 358, 359
65.61	Other removal of both ovaries and tubes at same operative episode	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.62	Other removal of remaining ovary and tube	Y	13	354, 355, 357, 358, 359
65.71	Other simple suture of ovary	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
65.72	Other reimplantation of ovary	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
65.73	Other salpingo-oophoroplasty	Y	11	308, 309,
			12	344, 345
			13	365
			17	400, 406,
			17	407
			21	442, 443
			24	486

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

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CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*0011	00844	*00800	00844	*0085	00844	*01133	*01182
00841	00845	00841	00845	00841	00845	4831	4831
00842	00846	00842	00846	00842	00846	*01134	*01183
00843	00847	00843	00847	00843	00847	4831	4831
00844	*0061	00844	*00841	00844	*0088	*01135	*01184
00845	00841	00845	00841	00845	00841	4831	4831
00846	00842	00846	00842	00846	00842	*01136	*01185
00847	00843	00847	00843	00847	00843	4831	4831
*0020	00844	*00801	00844	*00861	00844	*01140	*01186
00841	00845	00841	00845	00841	00845	4831	4831
00842	00846	00842	00846	00842	00846	*01141	*01190
00843	00847	00843	00847	00843	00847	4831	4831
00844	*0062	00844	*00842	00844	*0090	*01142	*01191
00845	00841	00845	00841	00845	00841	4831	4831
00846	00842	00846	00842	00846	00842	*01143	*01192
00847	00843	00847	00843	00847	00843	4831	4831
*0029	00844	*00802	00844	*00862	00844	*01144	*01193
00841	00845	00841	00845	00841	00845	4831	4831
00842	00846	00842	00846	00842	00846	*01145	*01194
00843	00847	00843	00847	00843	00847	4831	4831
00844	*0069	00844	*00843	00844	*01100	*01146	*01195
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01101	*01150	*01196
00847	00843	00847	00843	00847	4831	4831	4831
*0030	00844	*00803	00844	*00863	*01102	*01151	*01200
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01103	*01152	*01201
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0071	00844	*00844	00844	*01104	*01153	*01202
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01105	*01154	*01203
00847	00843	00847	00843	00847	4831	4831	4831
*0049	00844	*00804	00844	*00864	*01106	*01155	*01204
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01110	*01156	*01205
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0072	00844	*00845	00844	*01111	*01160	*01206
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01112	*01161	*01210
00847	00843	00847	00843	00847	4831	4831	4831
*0050	00844	*00809	00844	*00865	*01113	*01162	*01211
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01114	*01163	*01212
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0073	00844	*00846	00844	*01115	*01164	*01213
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01116	*01165	*01214
00847	00843	00847	00843	00847	4831	4831	4831
*0051	00844	*0081	00844	*00866	*01120	*01166	*01215
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01121	*01170	*01216
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0078	00844	*00847	00844	*01122	*01171	*01280
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01123	*01172	*01281
00847	00843	00847	00843	00847	4831	4831	4831
*0052	00844	*0082	00844	*00867	*01124	*01173	*01282
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TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST

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CCs that are deleted from the list are in Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*2910	30502	2918	2918	2918	9981	57421
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2918	30532	*30390	*30472	*30570	*53300	57440
*2912	30540	2918	2918	2918	9981	57441
2918	30541	*30391	*30473	*30571	*53301	57450
*2913	30542	2918	2918	2918	9981	57451
2918	30550	*30392	*30480	*30572	*53320	5750
*2914	30551	2918	2918	2918	9981	*5780
2918	30552	*30393	*30481	*30573	*53321	9981
*2915	30560	2918	2918	2918	9981	*5781
2918	30561	*30400	*30482	*30580	*53340	9981
*2918	30562	2918	2918	2918	9981	*5789
2910	30570	*30401	*30483	*30581	*53341	9981
2911	30571	2918	2918	2918	9981	*7526
2912	30572	*30402	*30490	*30582	*53360	5970
2913	30590	2918	2918	2918	9981	5981
2914	30591	*30403	*30491	*30583	*53361	5982
2918	30592	2918	2918	2918	9981	5994
2919	*2919	*30410	*30492	*30590	*53400	*7532
2920	2918	2918	2918	2918	9981	5845
29211	*2920	*30411	*30493	*30591	*53401	5846
29212	2918	2918	2918	2918	9981	5847
2922	*29211	*30412	*30500	*30592	*53420	5849
29281	2918	2918	2918	2918	9981	585
29282	*29212	*30413	*30501	*30593	*53421	5996
29283	2918	2918	2918	2918	9981	78820
29284	*2922	*30420	*30502	*4560	*53440	78829
29289	2918	2918	2918	9981	9981	*7724
2929	*29281	*30421	*30503	*45620	*53441	9981
29381	2918	2918	2918	9981	9981	*7903
29382	*29282	*30422	*30520	*53081	*53460	2918
29383	2918	2918	2918	9981	9981	*99791
30300	*29283	*30423	*30521	*53082	*53461	9981
30301	2918	2918	2918	9981	9981	9985
30302	*29284	*30430	*30522	*53083	*53501	*99799
30390	2918	2918	2918	9981	9981	9981
30391	*29289	*30431	*30523	*53089	*53511	9985
30392	2918	2918	2918	9981	9981	*9980
30400	*2929	*30432	*30530	*53100	*53521	9981
30401	2918	2918	2918	9981	9981	*9981
30402	*2930	*30433	*30531	*53101	*53531	9585
30410	2918	2918	2918	9981	9981	9954
30411	*2931	*30440	*30532	*53120	*53541	9980
30412	2918	2918	2918	9981	9981	9981
30420	*29381	*30441	*30533	*53121	*53551	*9985
30421	2918	2918	2918	9981	9981	9985
30422	*29382	*30442	*30540	*53140	*53561	*99881
30440	2918	2918	2918	9981	9981	9981
30441	*29383	*30443	*30541	*53141	*53783	9985
30442	2918	2918	2918	9981	9981	*99889
30450	*29389	*30450	*30542	*53160	*56202	9981
30451	2918	2918	2918	9981	9981	9985
30452	*2939	*30451	*30543	*53161	*56203	*9989
30460	2918	2918	2918	9981	9981	9981
30461	*2940	*30452	*30550	*53200	*56212	9985
30462	2918	2918	2918	9981	9981	
30470	*2941	30453	*30551	*53201	*56213	
30471	2918	2918	2918	9981	9981	
30472	*2948	*30460	*30552	*53220	*5693	
30480	2918	2918	2918	9981	9981	
30481	*2949	*30461	*30553	*53221	*56985	
30482	2918	2918	2918	9981	9981	
30490	*30300	*30462	*30560	*53240	*5751	
30491	2918	2918	2918	9981	57400	
30492	*30301	*30463	*30561	*53241	57401	
30500	2918	2918	2918	9981	57410	
30501	*30302	*30470	*30562	*53260	57411	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	34442	11.0870	3	4	8	14	23
2	6577	11.5545	3	5	8	14	23
3	1	10.0000	10	10	10	10	10
4	6221	9.1249	2	3	6	11	20
5	100697	4.4155	2	2	3	5	9
6	464	3.4030	1	1	2	4	7
7	11182	12.6678	3	5	8	14	25
8	2377	4.1586	1	1	3	5	9
9	1768	7.6697	2	3	5	9	16
10	20201	7.9723	2	3	6	10	16
11	3044	4.9152	1	2	4	6	10
12	24534	7.6319	2	3	5	9	14
13	6348	6.2098	2	4	5	7	11
14	368912	7.4277	2	3	6	9	14
15	145736	4.4476	1	2	3	5	8
16	12479	6.5732	2	3	5	8	12
17	3377	4.0269	1	2	3	5	7
18	22488	6.3283	2	3	5	8	12
19	7265	4.5076	1	2	4	6	8
20	8354	10.1263	2	4	8	13	20
21	1176	7.8180	2	3	6	10	16
22	2753	4.8554	2	2	4	6	9
23	6038	5.0600	1	2	4	6	10
24	56498	5.8137	2	3	4	7	11
25	23104	3.8625	1	2	3	5	7
26	48	4.5625	1	2	3	6	10
27	3729	6.3130	1	1	4	7	14
28	11872	7.0601	1	3	5	8	14
29	3959	4.0354	1	2	3	5	8
31	3381	5.4590	1	2	4	6	10
32	1848	3.1483	1	1	2	4	6
34	17083	6.4969	2	3	5	8	13
35	3832	4.3072	1	2	3	5	8
36	9404	1.6325	1	1	1	2	3
37	1995	4.0551	1	1	3	5	8
38	246	2.6098	1	1	2	3	5
39	3436	1.9744	1	1	1	2	4
40	2958	3.3966	1	1	2	4	7
42	7697	2.2076	1	1	1	2	5
43	105	4.1524	1	2	3	5	8
44	1705	5.7238	2	3	5	7	10
45	2545	3.8310	1	2	3	5	7
46	3116	5.5209	1	2	4	7	10
47	1417	3.7890	1	1	3	5	7
49	2260	5.6518	1	2	4	7	11
50	3511	2.1191	1	1	2	2	3
51	323	2.9195	1	1	1	2	7
52	84	3.5357	1	1	2	3	8
53	3546	3.5491	1	1	2	4	8
54	2	4.0000	1	1	7	7	7
55	2035	2.9666	1	1	2	3	6
56	766	2.7454	1	1	2	3	6
57	677	4.0694	1	1	3	5	8
59	94	3.6064	1	1	2	4	7
60	3	1.0000	1	1	1	1	1
61	226	5.1372	1	1	2	7	14
62	1	2.0000	2	2	2	2	2
63	4238	4.6487	1	2	3	5	10
64	3550	7.5346	1	2	5	9	16
65	30917	3.4293	1	2	3	4	6
66	6878	3.5650	1	2	3	4	6
67	532	4.1992	2	2	3	5	8
68	10392	4.7941	2	3	4	6	9
69	3353	3.7739	1	2	3	5	7
70	32	2.9375	1	2	3	3	5
71	96	4.0313	1	2	3	5	8
72	612	4.4167	1	2	3	5	9
73	6332	4.9588	1	2	4	6	9
75	41590	11.1419	4	6	8	14	22
76	40960	12.4911	3	6	10	15	24

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
77	2446	5.5200	1	2	4	8	12
78	30530	8.2292	4	5	7	10	13
79	220024	9.2606	3	5	7	11	17
80	9456	6.6214	2	4	5	8	12
81	10	7.4000	1	4	6	12	15
82	72211	7.8884	2	3	6	10	16
83	7541	6.3896	2	3	5	8	12
84	1582	3.6846	1	2	3	5	7
85	19391	7.3326	2	3	6	9	14
86	1444	4.5062	1	2	4	6	9
87	62143	6.8199	1	3	6	9	13
88	368008	6.0847	2	3	5	7	11
89	442736	7.0834	3	4	6	9	12
90	43190	5.1359	2	3	4	6	9
91	53	4.4151	1	2	3	6	8
92	12548	7.2620	2	4	6	9	13
93	1332	4.9234	1	3	4	6	9
94	13242	7.0497	2	3	5	9	14
95	1458	4.1221	1	2	3	5	8
96	65710	5.5228	2	3	5	7	10
97	27798	4.2826	2	2	4	5	7
98	20	4.3000	1	1	3	6	10
99	26552	3.4947	1	2	3	4	7
100	10746	2.4205	1	1	2	3	4
101	20899	5.1925	1	2	4	7	10
102	4669	3.1371	1	1	2	4	6
103	487	39.8973	10	15	29	54	82
104	24152	14.5670	6	8	12	18	26
105	20847	10.9617	5	7	9	13	19
106	101038	11.7331	6	8	10	14	19
107	64206	8.8424	5	6	7	10	14
108	6883	12.5720	4	7	10	15	23
110	62140	10.7845	3	6	9	13	20
111	6119	6.6568	3	5	7	8	10
112	201028	4.7049	1	2	4	6	9
113	47381	14.3687	4	6	10	17	28
114	9250	9.4685	2	4	7	12	18
115	11017	11.4341	4	6	9	14	20
116	85879	5.4281	1	2	4	7	11
117	4837	4.1211	1	1	2	5	8
118	7120	3.2142	1	1	2	4	7
119	1791	5.5366	1	1	3	7	13
120	42743	9.1977	1	2	6	12	21
121	167116	7.4255	2	4	6	9	13
122	91508	5.0063	1	3	5	7	9
123	48692	4.6628	1	1	2	6	11
124	145526	4.9010	1	2	4	6	9
125	62240	3.0708	1	1	2	4	6
126	4864	14.0113	4	7	11	17	29
127	705511	6.2183	2	3	5	8	12
128	20583	6.7301	3	4	6	8	11
129	4847	3.5251	1	1	1	4	8
130	96345	6.6835	2	4	6	8	12
131	26865	5.1799	1	3	5	7	8
132	133374	3.5805	1	2	3	4	6
133	6162	2.9761	1	1	2	4	5
134	30025	3.9084	1	2	3	5	7
135	7497	4.9941	1	2	4	6	9
136	1079	3.2586	1	2	3	4	6
138	205732	4.5589	1	2	3	6	9
139	70666	2.9401	1	1	2	4	5
140	184595	3.4847	1	2	3	4	6
141	80056	4.4979	1	2	3	5	8
142	37589	3.2040	1	2	3	4	6
143	138969	2.6105	1	1	2	3	5
144	70455	5.7021	1	2	4	7	11
145	7063	3.2390	1	1	2	4	6
146	9116	11.2399	6	7	9	13	18
147	1716	7.3462	4	6	7	9	11
148	147240	13.4390	6	8	11	16	24

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
149	16479	7.7172	4	6	7	9	11
150	23661	11.7462	4	7	10	14	21
151	4727	6.4637	2	4	6	8	11
152	4681	9.0305	4	6	8	10	15
153	1810	6.1663	3	4	6	8	9
154	37523	14.9701	5	8	12	18	28
155	4800	5.8863	2	3	5	8	10
156	4	15.7500	4	4	10	22	27
157	11976	5.8075	1	2	4	7	11
158	5338	2.9039	1	1	2	4	6
159	18014	5.3347	1	2	4	7	10
160	10461	2.9524	1	1	2	4	5
161	15500	4.3536	1	2	3	5	9
162	8397	2.1870	1	1	2	3	4
163	8	3.0000	1	1	3	4	5
164	5240	9.3945	4	6	8	11	16
165	1757	5.7518	3	4	5	7	9
166	3440	5.7122	2	3	4	7	10
167	2409	3.2333	1	2	3	4	6
168	1870	4.9610	1	2	3	6	10
169	1091	2.5371	1	1	2	3	5
170	13152	12.4993	2	5	9	15	25
171	1205	5.4008	1	2	4	7	11
172	32440	8.1497	2	3	6	10	16
173	2286	4.3994	1	2	3	5	9
174	243520	5.5478	2	3	4	7	10
175	24208	3.5122	1	2	3	4	6
176	16840	6.1428	2	3	5	7	11
177	12619	4.9756	2	3	4	6	9
178	4386	3.6147	1	2	3	5	7
179	11791	7.1640	2	4	6	9	14
180	82971	6.0508	2	3	5	7	11
181	23209	3.9601	1	2	3	5	7
182	237577	4.9658	2	2	4	6	9
183	75774	3.4541	1	2	3	4	6
184	77	3.8831	1	2	2	4	7
185	4037	5.1850	1	2	4	6	10
186	2	1.5000	1	1	2	2	2
187	944	4.2108	1	2	3	6	8
188	64209	6.1263	2	3	5	8	12
189	8146	3.6866	1	1	3	5	7
190	68	5.0882	1	2	4	7	10
191	11098	16.2616	5	8	12	20	32
192	930	7.9161	2	4	7	10	14
193	8975	13.9348	5	8	11	17	25
194	847	8.4652	3	5	7	10	15
195	9686	10.4650	4	6	9	12	18
196	845	6.7136	3	4	6	8	11
197	29491	9.1586	4	5	7	11	16
198	8311	4.9344	2	3	4	6	8
199	2348	11.1661	3	5	9	14	22
200	1655	12.3329	2	4	8	15	26
201	1557	16.7534	4	7	13	21	34
202	26477	7.7437	2	3	6	10	15
203	30205	7.6570	2	3	6	10	15
204	51448	6.7152	2	3	5	8	13
205	22675	7.2389	2	3	5	9	14
206	1783	4.7196	1	2	4	6	10
207	37006	5.7262	2	3	4	7	11
208	10751	3.5105	1	2	3	4	6
209	344259	6.6642	3	4	6	7	10
210	138205	8.5738	4	5	7	10	14
211	26619	6.2716	3	4	6	7	10
212	9	5.0000	2	3	4	5	8
213	7164	9.7067	3	4	7	12	19
214	53836	6.4605	2	3	5	8	12
215	43190	3.6846	1	2	3	5	7
216	6760	11.0719	2	5	8	14	22
217	20436	15.3636	3	6	10	18	31
218	23224	6.2155	2	3	5	7	11

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
219	19076	3.7567	1	2	3	5	6
220	2	5.5000	5	5	6	6	6
221	5227	8.1037	2	4	6	10	16
222	3750	4.0496	1	2	3	5	8
223	19410	2.8704	1	1	2	3	5
224	8378	2.2731	1	1	2	3	4
225	6594	5.0059	1	2	3	6	11
226	5651	6.7383	1	2	4	8	14
227	4846	2.9610	1	1	2	4	6
228	3199	3.5261	1	1	2	4	7
229	1427	2.4043	1	1	2	3	5
230	2578	5.2002	1	2	3	6	11
231	10890	5.0626	1	2	3	6	11
232	602	4.4651	1	1	2	5	10
233	4808	9.0422	2	4	7	11	18
234	2363	4.1727	1	2	3	5	8
235	5827	6.7833	1	3	4	7	13
236	39844	6.2907	2	3	5	7	12
237	1586	4.4067	1	2	3	5	8
238	7925	10.0430	3	5	7	12	19
239	62430	7.6248	2	4	6	9	14
240	12701	7.5282	2	3	5	9	15
241	3183	4.5922	1	2	4	5	9
242	2644	7.6539	2	4	6	9	15
243	84034	5.6150	2	3	4	7	10
244	12036	5.8284	2	3	4	7	11
245	4477	4.3044	1	2	3	5	8
246	1391	4.6161	1	2	4	6	9
247	11132	3.9656	1	2	3	5	8
248	7135	5.2685	1	2	4	6	10
249	10593	4.2878	1	1	3	5	9
250	3359	5.0473	1	2	4	6	9
251	2228	3.3039	1	1	3	4	6
252	1	1.0000	1	1	1	1	1
253	18452	5.8248	2	3	4	7	11
254	9735	3.8817	1	2	3	5	7
255	1	2.0000	2	2	2	2	2
256	4819	5.6921	1	2	4	7	11
257	24829	3.4343	1	2	3	4	6
258	19718	2.4910	1	2	2	3	4
259	4225	3.5089	1	1	2	3	7
260	5083	1.8702	1	1	2	2	3
261	2489	2.3403	1	1	2	3	4
262	749	3.9439	1	1	2	5	8
263	30581	13.9228	4	6	10	16	28
264	3723	8.3503	2	4	6	10	17
265	4517	7.6810	1	3	5	9	16
266	2850	3.7140	1	1	3	5	8
267	238	4.3361	1	1	3	5	9
268	983	4.0651	1	1	2	4	9
269	10745	9.2352	2	4	7	12	19
270	3643	3.4161	1	1	2	4	8
271	22531	8.5207	3	4	7	10	15
272	6142	7.4650	2	3	6	9	14
273	1500	5.4860	2	2	4	7	11
274	2654	7.7939	2	3	5	9	16
275	258	3.6705	1	1	2	4	8
276	928	5.0151	1	2	4	6	9
277	82879	6.7243	3	4	5	8	12
278	27272	5.1610	2	3	4	6	9
279	6	4.1667	1	2	3	4	4
280	13880	5.0710	1	2	4	6	9
281	6277	3.6108	1	2	3	4	7
283	5522	5.4681	2	2	4	7	10
284	1841	3.8403	1	2	3	5	7
285	5132	13.6613	3	6	10	16	26
286	2035	8.6993	3	4	6	9	16
287	6605	13.3889	3	6	9	16	26
288	1020	6.8824	3	4	5	7	11
289	5276	3.9780	1	2	2	4	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
290	8909	2.8289	1	1	2	3	5
291	91	1.7692	1	1	1	2	3
292	5308	12.7491	2	5	9	16	25
293	310	6.7935	1	3	5	8	14
294	90532	5.6749	2	3	4	7	10
295	3894	4.2766	1	2	3	5	8
296	230295	6.3598	2	3	5	8	12
297	33134	4.2911	1	2	3	5	8
298	108	3.3796	1	1	2	4	6
299	927	5.4132	1	2	4	7	10
300	14815	7.2798	2	3	6	9	14
301	2247	4.3796	1	2	3	5	9
302	8314	12.3018	6	7	9	14	21
303	19404	10.2201	4	6	8	12	18
304	13543	10.2916	3	5	7	13	21
305	2681	4.9276	1	3	4	6	9
306	11853	6.2378	2	2	4	8	13
307	2696	2.9841	1	2	2	3	5
308	9573	7.0330	1	2	5	9	15
309	3563	3.0230	1	1	2	4	6
310	30025	4.6157	1	2	3	6	9
311	10221	2.1764	1	1	2	3	4
312	2120	4.8198	1	2	3	6	10
313	788	2.2855	1	1	2	3	5
314	1	5.0000	5	5	5	5	5
315	29516	9.3027	1	2	6	12	20
316	73804	7.4996	2	3	6	9	15
317	838	2.9033	1	1	2	3	6
318	6303	7.1525	2	3	5	9	14
319	522	3.2184	1	1	2	4	7
320	177322	6.4439	2	3	5	8	11
321	26732	4.7118	2	3	4	6	8
322	87	4.3333	2	2	4	5	8
323	18552	3.5564	1	2	3	4	7
324	9159	2.0887	1	1	2	3	4
325	7781	4.5729	1	2	3	5	9
326	2305	3.4265	1	1	2	4	6
327	9	3.3333	1	2	2	4	5
328	853	4.2579	1	2	3	6	8
329	113	2.7965	1	1	2	3	5
330	1	1.0000	1	1	1	1	1
331	40267	6.1796	2	3	5	8	12
332	4973	3.8520	1	2	3	5	8
333	379	5.7968	1	3	4	7	13
334	19978	6.0539	3	4	5	7	9
335	10312	4.6223	2	3	4	6	7
336	63889	4.1249	1	2	3	5	8
337	40544	2.6722	1	2	2	3	4
338	5063	5.2558	1	2	3	6	11
339	2416	5.2562	1	2	3	6	11
340	2	3.0000	1	1	5	5	5
341	6766	3.2573	1	1	2	4	6
342	231	4.0649	1	1	2	5	8
344	4022	3.4510	1	1	2	4	7
345	1428	4.0210	1	2	3	5	9
346	5626	6.7600	1	3	5	8	14
347	443	3.2889	1	1	2	4	7
348	3187	4.8892	1	2	4	6	9
349	734	2.9646	1	1	2	4	6
350	7234	4.7432	2	3	4	6	8
352	603	3.9005	1	1	3	5	8
353	2743	8.3252	3	4	6	9	15
354	10187	6.3342	3	4	5	7	11
355	5884	3.8600	2	3	4	4	6
356	30093	3.0252	1	2	3	4	5
357	6842	9.8297	4	5	8	12	18
358	28152	4.7532	2	3	4	5	8
359	28825	3.2709	2	3	3	4	5
360	17592	3.5444	1	2	3	4	6
361	655	3.4580	1	1	2	4	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
363	4555	3.5139	1	2	2	3	6
364	1879	3.6003	1	1	2	4	8
365	2522	8.1257	2	3	5	10	18
366	4694	7.6877	2	3	5	10	16
367	571	3.3135	1	1	2	4	7
368	2408	6.9049	2	3	5	8	13
369	2531	3.7246	1	1	3	5	7
370	1201	5.5679	3	3	4	5	9
371	1044	3.6236	2	3	3	4	5
372	872	3.3601	1	2	2	3	6
373	3961	1.9258	1	1	2	2	3
374	141	2.5957	1	2	2	3	4
375	5	2.2000	1	1	2	3	4
376	164	3.3537	1	1	2	4	7
377	27	3.2963	1	1	2	3	8
378	172	2.9186	1	2	3	3	5
379	332	3.0361	1	1	2	3	5
380	75	2.2800	1	1	2	2	4
381	209	2.2967	1	1	1	2	5
382	54	1.5741	1	1	1	1	3
383	1557	4.0873	1	2	3	5	8
384	135	3.1481	1	1	1	2	7
385	4	13.5000	1	1	1	3	49
386	1	36.0000	36	36	36	36	36
389	23	10.7391	3	4	8	10	18
390	11	4.7273	1	2	3	5	9
392	2622	11.6484	4	6	8	14	24
394	1734	7.9862	1	2	5	9	16
395	69281	5.3835	1	2	4	7	10
396	19	3.7895	1	1	3	5	8
397	16238	6.0846	2	3	5	7	12
398	17490	6.5883	2	3	5	8	12
399	1505	4.4399	1	2	4	6	8
400	7877	10.4160	2	4	7	13	23
401	6683	12.3822	2	5	9	16	25
402	1621	4.7218	1	1	3	6	10
403	36569	9.2960	2	4	7	12	19
404	4137	5.1047	1	2	4	7	10
406	3407	11.2548	3	5	8	14	23
407	761	4.9304	1	2	4	6	9
408	3100	8.1632	1	2	5	10	18
409	5931	6.7132	2	3	4	6	15
410	89997	3.3583	1	2	3	4	5
411	58	2.6724	1	1	2	3	7
412	37	2.9730	1	1	2	4	5
413	8878	8.3323	2	3	6	10	17
414	845	5.1361	1	2	4	7	11
415	40783	15.7224	4	7	12	19	31
416	201554	8.2165	2	4	7	10	15
417	54	4.5741	1	2	4	7	10
418	19614	6.7661	2	3	5	8	13
419	16484	5.6830	2	3	4	7	10
420	3023	4.3126	2	2	4	5	8
421	12216	4.6523	2	2	4	5	8
422	97	3.8041	1	2	3	4	7
423	9588	8.7110	2	4	6	10	18
424	2102	17.9139	3	6	12	20	35
425	16010	4.8731	1	2	3	6	10
426	4920	5.5150	1	2	4	7	11
427	1856	5.2333	1	2	4	6	11
428	956	8.3347	1	3	5	10	18
429	40733	8.9700	2	3	6	10	17
430	55753	9.7545	2	4	7	12	19
431	200	7.1500	1	3	5	9	13
432	457	6.5252	1	2	4	6	11
433	8283	3.4066	1	1	2	4	7
434	21933	5.8212	2	3	4	7	11
435	16378	4.8060	1	3	4	6	8
436	3128	14.3744	4	8	14	21	28
437	14927	10.8952	4	6	10	14	20

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
439	910	8.9264	2	3	6	11	18
440	5007	9.8354	2	3	6	12	21
441	648	4.4213	1	1	2	4	8
442	14653	8.7421	1	3	6	11	18
443	3469	3.5509	1	1	2	5	7
444	3543	5.2882	1	3	4	6	10
445	1415	3.9046	1	2	3	5	7
446	1	1.0000	1	1	1	1	1
447	3991	2.8013	1	1	2	3	5
448	88	1.0000	1	1	1	1	1
449	30264	4.4273	1	2	3	5	9
450	7178	2.3403	1	1	2	3	5
451	8	6.0000	2	3	4	5	7
452	20326	5.4275	1	2	4	6	11
453	3831	3.1929	1	1	2	4	6
454	5391	5.1330	1	2	3	6	10
455	1181	2.8442	1	1	2	3	5
456	213	8.3803	1	1	4	9	21
457	135	4.8222	1	1	2	5	12
458	1650	16.8358	3	7	13	22	35
459	582	10.2887	2	4	7	13	21
460	2437	6.6422	1	3	5	8	13
461	3230	4.8920	1	1	2	5	12
462	9786	13.7570	4	6	12	18	26
463	12587	5.1722	1	2	4	6	10
464	3225	3.7479	1	2	3	5	7
465	202	3.8762	1	1	2	4	7
466	1943	4.8101	1	1	2	4	10
467	1820	4.1264	1	1	2	4	8
468	62094	15.2184	3	7	12	19	30
471	9604	8.0717	4	5	6	9	14
472	159	30.1635	1	9	28	40	61
473	8650	14.3808	2	4	8	21	36
475	94974	12.1639	2	5	10	16	24
476	7275	13.8367	3	7	11	17	25
477	29790	8.9095	1	3	6	11	18
478	123960	8.3140	1	3	6	10	17
479	18606	4.5577	1	2	4	6	9
480	43	33.5581	12	16	24	39	61
481	122	36.2787	21	25	31	42	60
482	7121	14.8666	5	8	11	17	28
483	38597	45.9566	15	23	37	56	85
484	366	15.8115	2	6	12	22	32
485	3426	11.6985	4	6	9	14	22
486	2316	13.4473	1	6	11	18	28
487	4136	8.9350	1	3	7	11	18
488	1694	17.6251	5	8	13	22	35
489	18721	10.4348	2	4	7	13	22
490	5263	6.5565	1	2	4	8	14
491	9897	4.2698	2	3	3	5	7
492	2139	17.3703	3	5	10	28	37
493	54769	5.8892	1	2	5	8	11
494	28573	2.4247	1	1	2	3	5
495	131	22.7176	10	12	17	26	39
	11135858						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	34442	11.0870	3	4	8	14	23
2	6577	11.5545	3	5	8	14	23
3	1	10.0000	10	10	10	10	10
4	6221	9.1249	2	3	6	11	20
5	100697	4.4155	2	2	3	5	9
6	464	3.4030	1	1	2	4	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
7	11326	12.5507	2	5	8	14	25
8	2651	3.8989	1	1	2	5	9
9	1768	7.6697	2	3	5	9	16
10	20201	7.9723	2	3	6	10	16
11	3044	4.9152	1	2	4	6	10
12	24534	7.6319	2	3	5	9	14
13	6348	6.2098	2	4	5	7	11
14	368912	7.4277	2	3	6	9	14
15	145736	4.4476	1	2	3	5	8
16	12480	6.5737	2	3	5	8	12
17	3376	4.0243	1	2	3	5	7
18	23963	6.3732	2	3	5	8	12
19	7792	4.5249	1	2	4	6	8
20	6352	11.2835	3	5	9	15	22
21	1176	7.8180	2	3	6	10	16
22	2753	4.8554	2	2	4	6	9
23	6038	5.0600	1	2	4	6	10
24	56509	5.8142	2	3	4	7	11
25	23093	3.8603	1	2	3	5	7
26	48	4.5625	1	2	3	6	10
27	3729	6.3130	1	1	4	7	14
28	11873	7.0603	1	3	5	8	14
29	3958	4.0341	1	2	3	5	8
31	3382	5.4595	1	2	4	6	10
32	1847	3.1462	1	1	2	4	6
34	17085	6.4968	2	3	5	8	13
35	3830	4.3065	1	2	3	5	8
36	9404	1.6325	1	1	1	2	3
37	1994	4.0341	1	1	3	5	8
38	246	2.6098	1	1	2	3	5
39	3436	1.9744	1	1	1	2	4
40	2958	3.3966	1	1	2	4	7
42	7697	2.2076	1	1	1	2	5
43	105	4.1524	1	2	3	5	8
44	1705	5.7238	2	3	5	7	10
45	2545	3.8310	1	2	3	5	7
46	3117	5.5201	1	2	4	7	10
47	1416	3.7895	1	1	3	5	7
49	2260	5.6518	1	2	4	7	11
50	3511	2.1191	1	1	2	2	3
51	323	2.9195	1	1	1	2	7
52	100	3.3600	1	1	2	3	7
53	3624	3.5566	1	1	2	4	8
54	2	4.0000	1	1	7	7	7
55	2035	2.9666	1	1	2	3	6
56	766	2.7454	1	1	2	3	6
57	637	4.1334	1	1	3	5	8
59	94	3.6064	1	1	2	4	7
60	3	1.0000	1	1	1	1	1
61	226	5.1372	1	1	2	7	14
62	1	2.0000	2	2	2	2	2
63	4238	4.6487	1	2	3	5	10
64	3550	7.5346	1	2	5	9	16
65	30917	3.4293	1	2	3	4	6
66	6878	3.5650	1	2	3	4	6
67	532	4.1992	2	2	3	5	8
68	10400	4.7953	2	3	4	6	9
69	3345	3.7677	1	2	3	5	7
70	32	2.9375	1	2	3	3	5
71	96	4.0313	1	2	3	5	8
72	612	4.4167	1	2	3	5	9
73	6332	4.9588	1	2	4	6	9
75	41590	11.1419	4	6	8	14	22
76	40962	12.4917	3	6	10	15	24
77	2444	5.5041	1	2	4	8	12
78	30530	8.2292	4	5	7	10	13
79	220099	9.2617	3	5	7	11	17
80	9381	6.5760	2	4	5	8	12
81	10	7.4000	1	4	6	12	15
82	72211	7.8884	2	3	6	10	16

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
83	7541	6.3896	2	3	5	8	12
84	1582	3.6846	1	2	3	5	7
85	19393	7.3333	2	3	6	9	14
86	1442	4.4938	1	2	4	6	9
87	62143	6.8199	1	3	6	9	13
88	368008	6.0847	2	3	5	7	11
89	442908	7.0843	3	4	6	9	12
90	43018	5.1184	2	3	4	6	9
91	53	4.4151	1	2	3	6	8
92	12552	7.2631	2	4	6	9	13
93	1328	4.9059	1	3	4	6	9
94	13243	7.0498	2	3	5	9	14
95	1457	4.1187	1	2	3	5	8
96	65750	5.5233	2	3	5	7	10
97	27758	4.2796	2	2	4	5	7
98	20	4.3000	1	1	3	6	10
99	26556	3.4948	1	2	3	4	7
100	10742	2.4197	1	1	2	3	4
101	20903	5.1927	1	2	4	7	10
102	4665	3.1346	1	1	2	4	6
103	487	39.8973	10	15	29	54	82
104	24152	14.5670	6	8	12	18	26
105	20847	10.9617	5	7	9	13	19
106	101038	11.7331	6	8	10	14	19
107	64206	8.8424	5	6	7	10	14
108	6883	12.5720	4	7	10	15	23
110	62161	10.7839	3	6	9	13	20
111	6098	6.6496	3	5	6	8	10
112	201028	4.7049	1	2	4	6	9
113	47381	14.3687	4	6	10	17	28
114	9250	9.4685	2	4	7	12	18
115	11017	11.4341	4	6	9	14	20
116	85879	5.4281	1	2	4	7	11
117	4837	4.1211	1	1	2	5	8
118	7120	3.2142	1	1	2	4	7
119	1791	5.5366	1	1	3	7	13
120	42743	9.1977	1	2	6	12	21
121	167116	7.4255	2	4	6	9	13
122	91508	5.0063	1	3	5	7	9
123	48692	4.6628	1	1	2	6	11
124	145526	4.9010	1	2	4	6	9
125	62240	3.0708	1	1	2	4	6
126	4864	14.0113	4	7	11	17	29
127	705511	6.2183	2	3	5	8	12
128	20583	6.7301	3	4	6	8	11
129	4847	3.5251	1	1	1	4	8
130	96377	6.6838	2	4	6	8	12
131	26833	5.1772	1	3	5	7	8
132	133378	3.5806	1	2	3	4	6
133	6158	2.9737	1	1	2	4	5
134	30025	3.9084	1	2	3	5	7
135	7497	4.9941	1	2	4	6	9
136	1079	3.2586	1	2	3	4	6
138	205779	4.5592	1	2	3	6	9
139	70619	2.9382	1	1	2	4	5
140	184595	3.4847	1	2	3	4	6
141	80072	4.4984	1	2	3	5	8
142	37573	3.2025	1	2	3	4	6
143	138969	2.6105	1	1	2	3	5
144	70462	5.7020	1	2	4	7	11
145	7056	3.2372	1	1	2	4	6
146	9120	11.2398	6	7	9	13	18
147	1712	7.3376	4	6	7	9	11
148	147283	13.4382	6	8	11	16	24
149	16436	7.7095	4	6	7	9	11
150	23670	11.7463	4	7	10	14	21
151	4718	6.4532	2	4	6	8	11
152	4688	9.0299	4	6	8	10	15
153	1803	6.1570	3	4	6	8	9
154	37530	14.9694	5	8	12	18	28

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
155	4793	5.8782	2	3	5	8	10
156	4	15.7500	4	4	10	22	27
157	11982	5.8109	1	2	4	7	11
158	5332	2.8931	1	1	2	4	6
159	18017	5.3350	1	2	4	7	10
160	10458	2.9512	1	1	2	4	5
161	15509	4.3541	1	2	3	5	9
162	8388	2.1838	1	1	2	3	4
163	8	3.0000	1	1	3	4	5
164	5242	9.3937	4	6	8	11	16
165	1755	5.7499	3	4	5	7	9
166	3444	5.7134	2	3	4	7	10
167	2405	3.2274	1	2	3	4	5
168	1837	4.9559	1	2	3	6	10
169	1070	2.5421	1	1	2	3	5
170	13155	12.5003	2	5	9	15	25
171	1202	5.3719	1	2	4	7	11
172	32447	8.1498	2	3	6	10	16
173	2279	4.3857	1	2	3	5	9
174	243715	5.5466	2	3	4	7	10
175	24013	3.5080	1	2	3	4	6
176	16840	6.1428	2	3	5	7	11
177	12681	4.9738	2	3	4	6	9
178	4324	3.6004	1	2	3	5	7
179	11791	7.1640	2	4	6	9	14
180	83016	6.0517	2	3	5	7	11
181	23164	3.9529	1	2	3	5	7
182	237845	4.9666	2	2	4	6	9
183	75506	3.4460	1	2	3	4	6
184	77	3.8831	1	2	2	4	7
185	4037	5.1850	1	2	4	6	10
186	2	1.5000	1	1	2	2	2
187	944	4.2108	1	2	3	6	8
188	64238	6.1261	2	3	5	8	12
189	8117	3.6789	1	1	3	5	7
190	68	5.0882	1	2	4	7	10
191	11104	16.2586	5	8	12	20	32
192	924	7.8983	2	4	7	9	14
193	8979	13.9328	5	8	11	17	25
194	843	8.4603	3	5	7	10	15
195	9690	10.4638	4	6	9	12	18
196	841	6.7099	3	4	6	8	11
197	29506	9.1575	4	5	7	11	16
198	8296	4.9306	2	3	4	6	8
199	2348	11.1661	3	5	9	14	22
200	1655	12.3329	2	4	8	15	26
201	1557	16.7534	4	7	13	21	34
202	26477	7.7437	2	3	6	10	15
203	30205	7.6570	2	3	6	10	15
204	51448	6.7152	2	3	5	8	13
205	22678	7.2389	2	3	5	9	14
206	1780	4.7163	1	2	4	6	10
207	37033	5.7267	2	3	4	7	11
208	10724	3.5030	1	2	3	4	6
209	344259	6.6642	3	4	6	7	10
210	138220	8.5746	4	5	7	10	14
211	26604	6.2664	3	4	6	7	10
212	9	5.0000	2	3	4	5	8
213	7164	9.7067	3	4	7	12	19
214	53845	6.4613	2	3	5	8	12
215	43181	3.6830	1	2	3	5	7
216	6760	11.0719	2	5	8	14	22
217	20436	15.3636	3	6	10	18	31
218	23230	6.2178	2	3	5	7	11
219	19070	3.7531	1	2	3	5	6
220	2	5.5000	5	5	6	6	6
221	5230	8.1076	2	4	6	10	16
222	3747	4.0408	1	2	3	5	8
223	19412	2.8709	1	1	2	3	5
224	8377	2.2724	1	1	2	3	4

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
225	6594	5.0059	1	2	3	6	11
226	5654	6.7386	1	2	4	8	14
227	4843	2.9583	1	1	2	4	6
228	3200	3.5291	1	1	2	4	7
229	1426	2.3969	1	1	2	3	5
230	2578	5.2002	1	2	3	6	11
231	10890	5.0626	1	2	3	6	11
232	601	4.4609	1	1	2	4	10
233	4811	9.0518	2	4	7	11	18
234	2360	4.1470	1	2	3	5	8
235	5827	6.7833	1	3	4	7	13
236	39844	6.2907	2	3	5	7	12
237	1586	4.4067	1	2	3	5	8
238	7925	10.0430	3	5	7	12	19
239	62429	7.6246	2	4	6	9	14
240	12705	7.5277	2	3	5	9	15
241	3179	4.5908	1	2	4	5	9
242	2644	7.6539	2	4	6	9	15
243	84034	5.6150	2	3	4	7	10
244	12041	5.8294	2	3	4	7	11
245	4472	4.3001	1	2	3	5	8
246	1391	4.6161	1	2	4	6	9
247	11132	3.9656	1	2	3	5	8
248	7135	5.2685	1	2	4	6	10
249	10593	4.2878	1	1	3	5	9
250	3360	5.0461	1	2	3	6	9
251	2227	3.3049	1	1	3	4	6
252	1	1.0000	1	1	1	1	1
253	18457	5.8264	2	3	4	7	11
254	9730	3.8776	1	2	3	5	7
255	1	2.0000	2	2	2	2	2
256	4819	5.6921	1	2	4	7	11
257	24832	3.4341	1	2	3	4	6
258	19715	2.4910	1	2	2	3	4
259	4225	3.5089	1	1	2	3	7
260	5083	1.8702	1	1	2	2	3
261	2489	2.3403	1	1	2	3	4
262	749	3.9439	1	1	2	5	8
263	30590	13.9231	4	6	10	16	28
264	3714	8.3341	2	4	6	10	16
265	4518	7.6835	1	3	5	9	16
266	2849	3.7087	1	1	3	5	8
267	238	4.3361	1	1	3	5	9
268	983	4.0651	1	1	2	4	9
269	10750	9.2391	2	4	7	12	19
270	3638	3.3966	1	1	2	4	8
271	22531	8.5207	3	4	7	10	15
272	6144	7.4653	2	3	6	9	14
273	1498	5.4820	2	2	4	7	11
274	2654	7.7939	2	3	5	9	16
275	258	3.6705	1	1	2	4	8
276	928	5.0151	1	2	4	6	9
277	82941	6.7266	3	4	5	8	12
278	27210	5.1505	2	3	4	6	9
279	6	4.1667	1	2	3	4	4
280	13881	5.0709	1	2	4	6	9
281	6276	3.6109	1	2	3	4	7
283	5523	5.4677	2	2	4	7	10
284	1840	3.8408	1	2	3	5	7
285	5132	13.6613	3	6	10	16	26
286	2035	8.6993	3	4	6	9	16
287	6605	13.3889	3	6	9	16	26
288	1020	6.8824	3	4	5	7	11
289	5276	3.9780	1	2	2	4	8
290	8909	2.8289	1	1	2	3	5
291	91	1.7692	1	1	1	2	3
292	5308	12.7491	2	5	9	16	25
293	310	6.7935	1	3	5	8	14
294	90532	5.6749	2	3	4	7	10
295	3894	4.2766	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
296	230483	6.3598	2	3	5	8	12
297	32946	4.2799	1	2	3	5	8
298	108	3.3796	1	1	2	4	6
299	927	5.4132	1	2	4	7	10
300	14816	7.2798	2	3	6	9	14
301	2246	4.3780	1	2	3	5	9
302	8314	12.3018	6	7	9	14	21
303	19404	10.2201	4	6	8	12	18
304	13549	10.2932	3	5	7	13	21
305	2675	4.9073	1	3	4	6	9
306	11854	6.2386	2	2	4	8	13
307	2695	2.9796	1	2	2	3	5
308	9574	7.0326	1	2	5	9	15
309	3562	3.0230	1	1	2	4	6
310	30028	4.6161	1	2	3	6	9
311	10218	2.1747	1	1	2	3	4
312	2120	4.8198	1	2	3	6	10
313	788	2.2855	1	1	2	3	5
314	1	5.0000	5	5	5	5	5
315	29516	9.3027	1	2	6	12	20
316	73804	7.4996	2	3	6	9	15
317	838	2.9033	1	1	2	3	6
318	6305	7.1543	2	3	5	9	14
319	520	3.1808	1	1	2	4	7
320	177433	6.4459	2	3	5	8	11
321	26621	4.6916	2	3	4	6	8
322	87	4.3333	2	2	4	5	8
323	18556	3.5566	1	2	3	4	7
324	9155	2.0877	1	1	2	3	4
325	7785	4.5742	1	2	3	5	9
326	2301	3.4203	1	1	2	4	6
327	9	3.3333	1	2	2	4	5
328	853	4.2579	1	2	3	6	8
329	113	2.7965	1	1	2	3	5
330	1	1.0000	1	1	1	1	1
331	40274	6.1795	2	3	5	8	12
332	4966	3.8494	1	2	3	5	8
333	379	5.7968	1	3	4	7	13
334	19982	6.0546	3	4	5	7	9
335	10308	4.6203	2	3	4	6	7
336	63893	4.1251	1	2	3	5	8
337	40540	2.6719	1	2	2	3	4
338	5063	5.2558	1	2	3	6	11
339	2416	5.2562	1	2	3	6	11
340	2	3.0000	1	1	5	5	5
341	6766	3.2573	1	1	2	4	6
342	231	4.0649	1	1	2	5	8
344	4022	3.4510	1	1	2	4	7
345	1428	4.0210	1	2	3	5	9
346	5626	6.7600	1	3	5	8	14
347	443	3.2889	1	1	2	4	7
348	3188	4.8943	1	2	4	6	9
349	733	2.9400	1	1	2	4	6
350	7234	4.7432	2	3	4	6	8
352	603	3.9005	1	1	3	5	8
353	2743	8.3252	3	4	6	9	15
354	10191	6.3351	3	4	5	7	11
355	5880	3.8566	2	3	4	4	6
356	30093	3.0252	1	2	3	4	5
357	6842	9.8297	4	5	8	12	18
358	28157	4.7538	2	3	4	5	8
359	28820	3.2702	2	3	3	4	5
360	17592	3.5444	1	2	3	4	6
361	655	3.4580	1	1	2	4	7
363	4555	3.5139	1	2	2	3	6
364	1879	3.6003	1	1	2	4	8
365	2522	8.1257	2	3	5	10	18
366	4697	7.6915	2	3	5	10	16
367	568	3.2588	1	1	2	4	7
368	2408	6.9049	2	3	5	8	13

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
369	2531	3.7246	1	1	3	5	7
370	1201	5.5679	3	3	4	5	9
371	1044	3.6236	2	3	3	4	5
372	872	3.3601	1	2	2	3	6
373	3961	1.9258	1	1	2	2	3
374	141	2.5957	1	2	2	3	4
375	5	2.2000	1	1	2	3	4
376	164	3.3537	1	1	2	4	7
377	27	3.2963	1	1	2	3	8
378	172	2.9186	1	2	3	3	5
379	332	3.0361	1	1	2	3	5
380	75	2.2800	1	1	2	2	4
381	209	2.2967	1	1	1	2	5
382	54	1.5741	1	1	1	1	3
383	1557	4.0873	1	2	3	5	8
384	135	3.1481	1	1	1	2	7
385	4	13.5000	1	1	1	3	49
386	1	36.0000	36	36	36	36	36
389	23	10.7391	3	4	8	10	18
390	11	4.7273	1	2	3	5	9
392	2622	11.6484	4	6	8	14	24
394	1734	7.9862	1	2	5	9	16
395	69281	5.3835	1	2	4	7	10
396	19	3.7895	1	1	3	5	8
397	16238	6.0846	2	3	5	7	12
398	17498	6.5878	2	3	5	8	12
399	1496	4.4285	1	2	4	6	8
400	7875	10.4036	2	4	7	13	23
401	6682	12.3664	2	5	9	16	25
402	1619	4.7140	1	1	3	6	10
403	36528	9.2740	2	4	7	12	19
404	4124	5.0902	1	2	4	7	10
406	3407	11.2548	3	5	8	14	23
407	761	4.9304	1	2	4	6	9
408	3100	8.1632	1	2	5	10	18
409	5931	6.7132	2	3	4	6	15
410	89995	3.3580	1	2	3	4	5
411	58	2.6724	1	1	2	3	7
412	37	2.9730	1	1	2	4	5
413	8878	8.3323	2	3	6	10	17
414	845	5.1361	1	2	4	7	11
415	40783	15.7224	4	7	12	19	31
416	201554	8.2165	2	4	7	10	15
417	54	4.5741	1	2	4	7	10
418	19614	6.7661	2	3	5	8	13
419	16497	5.6833	2	3	4	7	10
420	3010	4.3050	2	2	4	5	8
421	12216	4.6523	2	2	4	5	8
422	97	3.8041	1	2	3	4	7
423	9588	8.7110	2	4	6	10	18
424	2102	17.9139	3	6	12	20	35
425	16010	4.8731	1	2	3	6	10
426	4920	5.5150	1	2	4	7	11
427	1856	5.2333	1	2	4	6	11
428	956	8.3347	1	3	5	10	18
429	40733	8.9700	2	3	6	10	17
430	55753	9.7545	2	4	7	12	19
431	200	7.1500	1	3	5	9	13
432	457	6.5252	1	2	4	6	11
433	8283	3.4066	1	1	2	4	7
434	21935	5.8210	2	3	4	7	11
435	16376	4.8062	1	3	4	6	8
436	3128	14.3744	4	8	14	21	28
437	14927	10.8952	4	6	10	14	20
439	910	8.9264	2	3	6	11	18
440	5007	9.8354	2	3	6	12	21
441	648	4.4213	1	1	2	4	8
442	14657	8.7406	1	3	6	11	18
443	3465	3.5512	1	1	2	5	7
444	3543	5.2882	1	3	4	6	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 06/96 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
445	1415	3.9046	1	2	3	5	7
446	1	1.0000	1	1	1	1	1
447	3991	2.8013	1	1	2	3	5
448	88	1.0000	1	1	1	1	1
449	30267	4.4278	1	2	3	5	9
450	7175	2.3376	1	1	2	3	5
451	8	6.0000	2	3	4	5	7
452	20338	5.4282	1	2	4	6	11
453	3819	3.1825	1	1	2	4	6
454	5391	5.1330	1	2	3	6	10
455	1181	2.8442	1	1	2	3	5
456	213	8.3803	1	1	4	9	21
457	135	4.8222	1	1	2	5	12
458	1650	16.8358	3	7	13	22	35
459	582	10.2887	2	4	7	13	21
460	2437	6.6422	1	3	5	8	13
461	3230	4.8920	1	1	2	5	12
462	9786	13.7570	4	6	12	18	26
463	12591	5.1721	1	2	4	6	10
464	3221	3.7464	1	2	3	5	7
465	202	3.8762	1	1	2	4	7
466	1943	4.8101	1	1	2	4	10
467	1820	4.1264	1	1	2	4	8
468	59655	15.3127	3	7	12	19	30
471	9604	8.0717	4	5	6	9	14
472	159	30.1635	1	9	28	40	61
473	8643	14.3722	2	4	8	21	36
475	94974	12.1639	2	5	10	16	24
476	7280	13.8379	3	7	11	17	25
477	31806	9.3027	1	3	7	12	19
478	123973	8.3143	1	3	6	10	17
479	18593	4.5529	1	2	4	6	9
480	40	32.5750	12	16	24	34	55
481	193	32.6166	19	22	28	36	53
482	7121	14.8666	5	8	11	17	28
483	38600	45.9567	15	23	37	56	85
484	366	15.8115	2	6	12	22	32
485	3426	11.6985	4	6	9	14	22
486	2316	13.4473	1	6	11	18	28
487	4136	8.9350	1	3	7	11	18
488	843	20.4152	5	8	14	25	41
489	19523	10.6298	2	4	7	13	22
490	5312	6.5849	1	2	4	8	14
491	9897	4.2698	2	3	3	5	7
492	2139	17.3703	3	5	10	28	37
493	54799	5.8913	1	2	5	8	11
494	28543	2.4171	1	1	2	3	5
495	131	22.7176	10	12	17	26	39
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1996

State	Urban	Rural
ALABAMA	0.420	0.476
ALASKA	0.505	0.796
ARIZONA	0.423	0.568
ARKANSAS	0.540	0.495
CALIFORNIA	0.405	0.540
COLORADO	0.513	0.604
CONNECTICUT	0.553	0.551
DELAWARE	0.503	0.500
DISTRICT OF COLUMBIA	0.525	.....
FLORIDA	0.414	0.418

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1996—Continued

State	Urban	Rural
GEORGIA	0.527	0.532
HAWAII	0.484	0.567
IDAHO	0.580	0.635
ILLINOIS	0.478	0.599
INDIANA	0.564	0.613
IOWA	0.540	0.684
KANSAS	0.449	0.649
KENTUCKY	0.506	0.574

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1996—Continued

State	Urban	Rural
LOUISIANA	0.475	0.540
MAINE	0.593	0.570
MARYLAND	0.765	0.816
MASSACHUSETTS	0.574	0.600
MICHIGAN	0.489	0.594
MINNESOTA	0.563	0.641
MISSISSIPPI	0.525	0.527
MISSOURI	0.459	0.529

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) AUGUST 1996—Continued

State	Urban	Rural
MONTANA	0.513	0.615
NEBRASKA	0.526	0.684
NEVADA	0.321	0.563
NEW HAMPSHIRE	0.591	0.611
NEW JERSEY	0.479	.....
NEW MEXICO	0.484	0.546
NEW YORK	0.584	0.679
NORTH CAROLINA	0.539	0.498
NORTH DAKOTA	0.651	0.694
OHIO	0.557	0.594
OKLAHOMA	0.489	0.558
OREGON	0.577	0.671
PENNSYLVANIA	0.436	0.580
PUERTO RICO	0.495	0.643
RHODE ISLAND	0.587	.....
SOUTH CAROLINA	0.477	0.501
SOUTH DAKOTA	0.559	0.648
TENNESSEE	0.536	0.572
TEXAS	0.462	0.565
UTAH	0.462	0.675
VERMONT	0.576	0.587
VIRGINIA	0.499	0.536
WASHINGTON	0.634	0.688
WEST VIRGINIA	0.578	0.542
WISCONSIN	0.604	0.665
WYOMING	0.495	0.734

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1996

State	Ratio
ALABAMA	0.055
ALASKA	0.077
ARIZONA	0.050
ARKANSAS	0.056
CALIFORNIA	0.040
COLORADO	0.052
CONNECTICUT	0.037
DELAWARE	0.054
DISTRICT OF COLUMBIA	0.042
FLORIDA	0.051
GEORGIA	0.052
HAWAII	0.051
IDAHO	0.064
ILLINOIS	0.044
INDIANA	0.058
IOWA	0.056
KANSAS	0.055
KENTUCKY	0.056
LOUISIANA	0.069
MAINE	0.044
MARYLAND	0.013
MASSACHUSETTS	0.060
MICHIGAN	0.049
MINNESOTA	0.055
MISSISSIPPI	0.056
MISSOURI	0.053

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) AUGUST 1996—Continued

State	Ratio
MONTANA	0.061
NEBRASKA	0.058
NEVADA	0.034
NEW HAMPSHIRE	0.066
NEW JERSEY	0.045
NEW MEXICO	0.055
NEW YORK	0.056
NORTH CAROLINA	0.049
NORTH DAKOTA	0.074
OHIO	0.056
OKLAHOMA	0.056
OREGON	0.052
PENNSYLVANIA	0.045
PUERTO RICO	0.090
RHODE ISLAND	0.039
SOUTH CAROLINA	0.054
SOUTH DAKOTA	0.066
TENNESSEE	0.057
TEXAS	0.055
UTAH	0.055
VERMONT	0.049
VIRGINIA	0.057
WASHINGTON	0.063
WEST VIRGINIA	0.059
WISCONSIN	0.048
WYOMING	0.067

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCLUDED HOSPITALS AND UNITS

Area	1982–1993 difference	1984–1993 difference	1988–1993 difference	1990–1993 difference	1991–1993 difference	1992–1993 difference
Rural Connecticut	22.9642	25.4054	.....	.....	.....	.....
Rural Delaware	8.2430	11.4258	8.2051	9.1337	.....	.....
Rural Hawaii	.....	15.9050	.....	.....	.....	.....
Rural Massachusetts	20.2198	24.1342	.....	.....	.....	.....
Rural New Hampshire	.....	9.8512	.....	.....	.....	.....
Albany, GA	.....	10.3581	.....	.....	.....	.....
Anchorage, AK	.....	.....	.....	8.2863	.....	.....
Andreson, SC	.....	.....	9.1948	17.8927	.....	.....
Arecibo, PR	.....	.....	11.1448	18.6084	15.7978	.....
Athens, GA	15.1448	21.0519	13.7293	13.6463	.....	.....
Atlanta, GA	.....	8.6086	.....	.....	.....	.....
Atlantic City, NJ	.....	12.4784	.....	.....	.....	.....
Bergen-Passaic, NJ	10.5317	12.4189	14.3717	.....	.....	.....
Biloxi-Gulfport, MS	.....	11.1443	10.6209	12.4040	.....	.....
Boise City, ID	.....	.....	.....	8.3390	.....	.....
Boston-Lowell-Brockton-Lawrence-Salem, MA	.....	9.8215	.....	.....	.....	.....
Bremerton, WA	11.9762	13.8828	14.2288	14.3007	12.7288	.....
Bridgeport-Stamford-Norwalk-Danbury, CT	10.0485	14.3994	.....	.....	.....	.....
Burlington, NC	11.2298	14.5664	9.4207	.....	.....	.....
Burlington, VT	.....	8.8170	9.1074	.....	.....	10.3206
Caguas, PR	.....	15.1271	.....	.....	.....	.....
Charleston, WV	.....	.....	8.3229	.....	.....	.....
Charlotte-Gastonia-Rock Hill, NC–SC	.....	14.9051	.....	.....	.....	.....
Clarksville-Hopkinsville, TN–KY	.....	.....	12.9537	.....	.....	.....
Columbia, SC	.....	8.4912	.....	.....	.....	.....
Danville, VA	.....	11.3907	13.1106	.....	.....	.....
Decatur, AL	.....	13.3721	11.9044	.....	.....	.....
El Paso, TX	.....	8.5187	.....	.....	9.8283	.....
Eugene-Springfield, OR	.....	10.5206	10.8031	18.7777	.....	.....
Fayetteville, NC	9.0029	10.4192	8.4909	.....	.....	.....
Flint, MI	.....	.....	.....	.....	9.2030	.....
Florence, AL	.....	11.9746	.....	.....	.....	.....
Florence, SC	12.7213	11.5654	.....	.....	.....	.....

TABLE 10.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982–1993 difference	1984–1993 difference	1988–1993 difference	1990–1993 difference	1991–1993 difference	1992–1993 difference
Fort Walton Beach, FL		12.3564				
Fresno, CA				10.8664	9.4732	8.0939
Gadsden, AL			8.2379	14.6656	9.8985	
Galveston-Texas City, TX			16.5166	11.3722	8.4081	
Greeley, CO				11.0971		
Greensboro-Winston-Salem-High Point, NC	9.2662					
Hamilton-Middleton, OH					8.1472	8.0733
Hartford-Middletown-New Britain, CT	8.7767	12.4966	3.7059	2.2400	−0.1050	−0.1775
Houma-Thibodaux, LA			9.3263			
Jackson, TN		9.6429				
Jersey City, NJ			8.0391			
Killeen-Temple, TX	18.3848					
Lima, OH			8.2156			
Macon-Warner Robins, GA		13.0975				
McAllen-Edinburg-Mission, TX		10.4962	9.8809			
Medford, OR				8.0133		
Merced, CA					8.1676	
Middlesex-Somerset-Hunterdon, NJ		9.6183				
Monmouth-Ocean, NJ	10.0345	15.4149	9.3349			
Munice, IN			20.3096	13.5593		
Nassau-Suffolk, NY		11.9105				
New Bedford-Fall River-Attleboro, MA	13.7683	16.6368	10.4385			
New Haven-West Haven-Waterbury, CT	11.8620	16.2147				
New London-Norwich, CT	11.3300	14.9405				
Newark, NJ		8.8979				
Ocala, FL		11.8261				
Orange County, NY	17.1382	21.4157	11.8518			
Portsmouth-Dover-Rochester, NH	9.0870					
Poughkeepsie, NY		8.8610				
Providence-Pawtucket-Woonsocket, RI		13.9497				
Provo-Orem, UT		9.0782				
Redding, CA		17.2205	9.9157			
Richland-Kennewick, WA				8.1102		
Salinas-Seaside-Monterey, CA	10.6879	9.7202				
Santa Cruz, CA	9.6319	9.7120				
Santa Fe, NM	11.2207	14.0809	18.3339	8.2941		
Sarasota, FL		8.9573				
Savannah, GA	9.0765	14.6762	15.7768	11.1239		
Topeka, KS			8.3342	9.2849		
Tyler, TX				9.5202		
Vallejo-Fairfield-Napa, CA		13.6478		11.7807		
Wilmington, DE–NJ–MD		8.9989				
Wilmington, NC		12.2020				
Worcester-Fitchburg-Leomister, MA	10.9147	17.9463				
Yuma, AZ					9.4870	

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 Social Security Act (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 (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

II. Changes in the Final Rule

Any differences in this final rule impact analysis 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 1995 MedPAR file (June 1996 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.

Our most recent hospital market basket forecasts are: 2.5 percent for prospective payment system hospitals and 2.5 percent for hospitals excluded from the prospective payment system. The respective update factors in the proposed rule were both 2.7 percent. Beyond this change in the hospital market basket forecast, there are no operating or capital prospective payment policy changes from those discussed in the impact analysis in the proposed rule.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our final policy changes, as well as statutory changes effective for FY 1997, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix.

We received no comments on the methodology used for the impact analysis in the proposed rule.

IV. Hospitals Included In and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 46 Indian Health Service hospitals in our data base, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, we have included 5,129 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, childrens', and cancer hospitals. The impacts of our policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of August 1996, there were 1,125 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. In addition, there were 2,315 psychiatric and rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also 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 1997 is 1.5 percent (excluded hospital market basket minus 1.0 percentage points), adjusted to account for the relationship between the hospital's allowable operating cost per case and its target amounts.

The impact on excluded hospitals and units of the final 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 is allowed to 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 can obtain payment adjustments for significant and justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Final Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate analyses of the final changes to each system, beginning here with changes to the operating prospective payment system. Estimated payment impacts of final FY 1997 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The data used in developing the quantitative analyses presented below are taken from the FY 1995 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to 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 each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1995 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.

The following changes are discussed separately below:

- 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 hospitals' wage index values reflecting the wage index update (FY 1993 data).
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 1997.
- 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 1997 policies relative to payments based on FY 1996 policies.

To illustrate the impacts of the FY 1997 final changes, our analysis begins with an FY 1997 baseline simulation model using: the FY 1996 GROUPER (version 13.0); the FY 1996 wage indexes (based on FY 1992 data); no MGCRB reclassifications; and current outlier policy (50 percent phase-out of day outlier payments). Outlier payments 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 1997 model incorporating all of the final rule and statutory changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1996 to FY 1997. Four factors not displayed in the previous five columns have significant impacts here. First is the update to the standardized amounts for FY 1997. 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 1997 using the most recently forecasted hospital market basket increase for FY 1997 of 2.5 percent, minus 0.5 percentage points. Thus, the update to the large urban and other areas standardized amounts is 2.0 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 0.5 percent, or 2.0 percent.

A second significant factor impacting changes in hospitals' payments per case from FY 1996 to FY 1997 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1996 that are no longer reclassified in FY 1997 may have a negative payment impact going from FY 1996 to FY 1997; conversely, hospitals not reclassified in FY 1996 that are reclassified in FY 1997 may have a positive impact. In some cases, these impacts can be quite substantial, so that if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 1996 will be 4.0 percent of actual total DRG payments. When the FY 1996 final rule was published, we projected FY 1996 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 1996 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 1996 payments per case to estimated FY 1997 payments per case.

Finally, the regional floor provision (section 1886(d)(1)(A)(iii)(II) of the Act) expires effective with discharges occurring on or after October 1, 1996. Under this provision (applicable during FY 1996), hospitals within any census division having a regional standardized amount greater than the national standardized amount (large urban or other, depending on which amount was applicable) received a blend of 85 percent of the national amount and 15 percent of the regional amount. Hospitals in census divisions where the regional floor was applicable during FY 1996 will be negatively impacted by its expiration when comparing FY 1996 to FY 1997.

Table I demonstrates the results of our analysis. This 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 5,129 hospitals included in the analysis. This is 78 fewer hospitals than were included in the impact analysis in the FY 1996 final rule (60 FR 45924). Data for 108 hospitals that were included in last year's analysis were not available for analysis this year; however, data were available this year for 30 hospitals for which data were not available last year.

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,881 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,596 hospitals located in large urban areas (populations over 1 million), and 1,285 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,248 hospitals in rural areas. The next two groupings are by bed size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 1997 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 2,981, 1,791, 1,190, and 2,148, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive disproportionate share (DSH) payments, or some combination of these two adjustments. There are 4,044 nonteaching hospitals in our analysis, 850 teaching hospitals with fewer than 100 residents, and 235 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next four rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and EACHs), as well as rural hospitals not receiving a special payment designation. Rural hospitals reclassified for FY 1997 for purposes of the standardized amount are not included here.

The RRCs (90), SCH/EACHs (645), and SCH/EACH and RRCs (38) shown here were not reclassified for purposes of the standardized amount. There are seven EACHs included in our analysis and four EACH/RRCs.

There are two RRCs and three SCHs that will be reclassified for the standardized amount in FY 1997 that, therefore, are not included in these rows. There are significantly fewer reclassifications among these groups than there were in FY 1996, owing to the new criterion under § 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. (See the September 1, 1995 final rule (60 FR 45799).) Before this change (effective with reclassifications for FY 1997), some rural hospitals reclassified to other urban areas in order to qualify for urban DSH payments. For other rural hospitals that already qualified for DSH payments, the urban designation enabled them to qualify for a higher DSH adjustment than they would receive as a rural hospital.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1994 Medicare cost report files, if available (otherwise FY 1993 data are used). Cost report data needed to determine hospital ownership and to calculate Medicare utilization percentages were unavailable for 116 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 reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for either FY 1996 or FY 1997, or for both years, by urban/rural status. The next rows illustrate the overall number of FY 1997 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 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hospitals [1] (0)	DRG recalibration [2] (1)	New wage data [3] (2)	Combined wage and recal [4] (3)	MGCRB reclassification [5] (4)	Day outlier policy changes [6] (5)	All FY 97 changes [7] (6)
(By Geographic Location)							
All hospitals	5,129	0.1	0.1	0.0	0.0	0.0	2.9
Urban hospitals	2,881	0.1	0.1	0.0	−0.4	−0.1	2.9
Large urban	1,596	0.1	0.1	0.0	−0.4	−0.1	2.9
Other urban	1,285	0.1	0.1	0.0	−0.2	0.1	3.0
Rural hospitals	2,248	0.0	0.0	−0.1	2.3	0.1	2.4
Bed size (urban):							
0–99 beds	715	0.0	−0.1	−0.3	−0.5	0.1	2.7
100–199 beds	945	0.0	−0.1	−0.2	−0.4	0.1	2.6
200–299 beds	576	0.1	0.0	0.0	−0.4	0.0	2.9
300–499 beds	478	0.1	0.1	0.1	−0.4	−0.1	3.1
500 or more beds	167	0.1	0.1	0.1	−0.2	−0.2	3.1
Bed size (rural):							
0–49 beds	1,177	−0.1	0.1	−0.1	0.0	0.1	2.4
50–99 beds	657	−0.1	0.1	−0.1	1.0	0.1	2.4
100–149 beds	241	0.0	0.1	−0.1	3.1	0.1	2.6
150–199 beds	98	0.1	0.0	0.0	2.7	0.1	2.7
200 or more beds	75	0.1	−0.1	−0.1	4.9	0.1	1.9
Urban by census division:							
New England	160	0.1	0.0	0.0	−0.2	−0.1	2.0
Middle Atlantic	434	0.0	0.4	0.3	−0.2	−0.7	3.3
South Atlantic	419	0.1	−0.2	−0.2	−0.4	0.1	3.1
East North Central	483	0.1	0.4	0.4	−0.3	0.1	2.5
East South Central	163	0.1	−0.2	−0.2	−0.5	0.2	3.1
West North Central	193	0.1	0.0	0.0	−0.5	0.2	3.3
West South Central	376	0.1	0.1	0.0	−0.5	0.2	3.6
Mountain	127	0.2	−0.3	−0.3	−0.4	0.2	2.9
Pacific	478	0.1	−0.4	−0.4	−0.5	0.1	2.5
Puerto Rico	48	−0.1	−1.2	−1.4	−0.5	0.0	1.9
Rural by census division:							
New England	53	0.1	−0.9	−1.0	2.0	0.2	1.2
Middle Atlantic	85	0.0	−0.5	−0.6	0.9	−0.1	1.7
South Atlantic	297	−0.1	−0.4	−0.5	3.0	0.1	2.3
East North Central	304	0.1	0.3	0.3	2.0	0.1	2.6
East South Central	278	−0.1	0.3	0.1	2.4	0.1	1.9
West North Central	525	0.0	0.1	0.0	2.1	0.1	2.5
West South Central	349	−0.1	0.5	0.2	3.1	0.1	2.8
Mountain	211	0.1	−0.1	−0.1	0.8	0.1	2.6
Pacific	141	0.1	0.6	0.5	2.3	0.1	3.7
Puerto Rico	5	−0.2	−4.2	−4.5	3.3	0.0	1.7
(By Payment Categories)							
Urban hospitals	2,981	0.1	0.1	0.0	−0.3	0.0	2.9

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hospitals [1] (0)	DRG recalibration [2] (1)	New wage data [3] (2)	Combined wage and recal [4] (3)	MGCRB reclassification [5] (4)	Day outlier policy changes [6] (5)	All FY 97 changes [7] (6)
Large urban	1,791	0.1	0.1	0.0	−0.2	−0.1	2.9
Other urban	1,190	0.1	0.0	0.0	−0.4	0.1	3.0
Rural hospitals	2,148	0.0	0.0	−0.1	1.9	0.1	2.2
Teaching status:							
Non-teaching	4,044	0.0	0.0	−0.1	0.3	0.1	2.8
Less than 100 residents	850	0.1	0.1	0.0	−0.3	0.0	3.0
100+ residents	235	0.1	0.2	0.2	−0.2	−0.4	2.8
Disproportionate Share Hospitals (DSH):							
Non-DSH	3,201	0.1	0.0	0.0	0.2	0.1	2.9
Urban DSH:							
100 beds or more	1,410	0.0	0.1	0.0	−0.3	−0.1	2.9
Fewer than 100 beds	101	−0.2	−0.3	−0.6	−0.3	0.2	2.2
Rural DSH:							
Sole community (SCH)	156	−0.1	0.0	−0.3	0.3	0.0	3.6
Referral centers (RRC)	27	0.0	0.1	−0.1	3.7	0.0	3.3
Other rural DSH hospitals:							
100 beds or more	83	0.0	−0.1	−0.2	2.4	0.2	0.3
Fewer than 100 beds	151	−0.2	0.0	−0.3	−0.3	0.1	2.0
Urban teaching and DSH:							
Both teaching and DSH	692	0.0	0.2	0.1	−0.4	−0.2	2.8
Teaching and no DSH	339	0.2	0.0	0.1	−0.1	0.0	3.0
No teaching and DSH	819	0.0	−0.1	−0.2	0.0	0.1	3.0
No teaching and no DSH	1,131	0.1	0.0	−0.1	−0.3	0.2	3.1
Rural hospital types Nonspecial status:							
Hospitals	1,375	0.0	0.0	−0.1	1.7	0.1	1.6
RRC	90	0.1	0.1	0.1	5.0	0.1	3.4
SCH/each	645	−0.1	0.0	−0.2	0.3	0.0	2.6
SCH/each and RRC	38	0.1	0.1	0.0	1.1	−0.1	2.7
Type of ownership:							
Voluntary	2,951	0.1	0.1	0.1	−0.1	−0.1	2.9
Proprietary	696	0.0	−0.2	−0.4	0.3	0.2	2.9
Government	1,366	0.0	0.0	−0.1	0.1	0.0	2.6
Unknown	116	−0.2	0.6	0.3	−0.4	−1.3	2.1
Medicare utilization as a percent of inpatient days:							
0–25	258	−0.1	−0.1	−0.3	−0.4	−0.2	2.0
25–50	1,284	0.1	0.0	0.0	−0.2	−0.1	2.9
50–65	2,097	0.1	0.1	0.0	0.2	0.0	2.9
Over 65	1,374	0.0	0.0	−0.1	0.2	0.1	2.9
Unknown	116	−0.2	0.6	0.3	−0.4	−1.3	2.1
Hospitals Reclassified by the Medicare Geographic Review Board							
Reclassification status during FY96 and FY97:							
Reclassified during both FY96 and FY97	379	0.1	0.2	0.2	5.9	0.0	2.7
Urban	130	0.1	0.4	0.4	3.5	−0.1	3.0
Rural	249	0.0	0.0	−0.1	8.9	0.1	2.5
Reclassified during FY97 only	98	0.2	0.3	0.3	3.8	−0.3	8.3
Urban	29	0.2	0.4	0.5	2.5	−0.5	7.6
Rural	69	0.0	−0.1	−0.1	7.1	0.1	10.2
Reclassified during FY96 only	253	0.1	−0.5	−0.5	−1.2	0.1	−0.5
Urban	91	0.1	−0.8	−0.8	−1.7	0.0	0.6
Rural	162	0.0	0.0	−0.1	−0.4	0.2	−2.2
FY 97 reclassifications:							
All reclassified hospitals	477	0.1	0.2	0.2	5.4	−0.1	3.8
Standard amount only	119	0.1	0.1	0.1	1.7	0.0	2.8
Wage index only	272	0.1	−0.2	−0.2	8.2	−0.1	3.3
Both	86	0.1	0.9	0.9	4.7	−0.2	5.5
Nonreclassified	4,625	0.1	0.0	0.0	−0.6	0.0	2.8
All urban reclassifed	159	0.1	0.4	0.4	3.3	−0.2	4.1
Standard amount only	62	0.1	0.2	0.1	0.9	0.0	2.9
Wage index only	27	0.2	−0.6	−0.5	7.2	−0.4	3.7
Both	70	0.1	1.0	1.0	3.4	−0.2	5.1

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hospitals [1] (0)	DRG recalibration [2] (1)	New wage data [3] (2)	Combined wage and recal [4] (3)	MGCRB reclassification [5] (4)	Day outlier policy changes [6] (5)	All FY 97 changes [7] (6)
Nonreclassified	2,722	0.1	0.0	0.0	−0.6	0.0	2.9
All rural reclassified	318	0.0	0.0	−0.1	8.6	0.1	3.5
Standard amount only	57	0.1	−0.1	−0.1	4.4	0.2	2.5
Wage index only	245	0.0	0.0	−0.1	8.6	0.1	3.2
Both	16	0.1	−0.1	−0.1	18.5	0.2	9.2
Nonreclassified	1,903	0.0	0.1	−0.1	−0.4	0.1	1.9
Other reclassifed:							
Hospitals (section 1886(d)(8)(B))	27	0.1	0.2	0.1	1.2	0.1	2.7

[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 1995, and hospital cost report data are from reporting periods beginning in FY 1993 and FY 1994.

[2] This column displays the payment impacts of the recalibration of the DRG weights, based on FY 1995 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 1993 cost reports.

[4] This column displays the combined impacts of the reclassification and recalibration of the DRGs, the updated wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 1 and 2, and the FY 1997 budget neutrality factor of 0.998702.

[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 1997 payment impacts of going from no reclassifications to the reclassifications scheduled to be in effect for FY 1997. Reclassification for prior years has no bearing on the payment impacts shown here.

[6] This column illustrates the payment impacts of phasing out day outlier payments and increasing cost outlier payments, in accordance with section 1886(d)(5) of the Act.

[7] This column shows changes in payments from FY 1996 to FY 1997. It incorporates all of the changes displayed in columns 3 through 5 (the changes displayed in columns 1 and 2 are included in column 3). It also displays the impacts of the updates to the FY 1997 standardized amounts, changes in hospitals' reclassification status in FY 1997 compared to FY 1996, the expiration of the regional floor provision at section 1886(d)(1)(A)(iii)(II) of the Act, and the difference in outlier payments from FY 1996 to FY 1997. The sum of the columns 3 through 5 plus these effects may be different from the percentage changes shown here due to changes in hospitals' geographic reclassification status from FY 1996 to FY 1997, rounding errors and interactive effects.

B. The Impact of the Final Changes to the DRG Classifications and Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us 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.

Consistent with the minor changes we are proposing for the FY 1997 GROUPER, the redistributional impacts across hospital groups are very small (an increase of 0.1 for large and other urban hospitals). Among other hospital categories, the net effects are slightly negative changes for small (up to 99 beds) rural hospitals and slightly positive changes for larger rural (over 150 beds) and urban (over 200 beds) hospitals.

The largest negative effect on any of the hospital categories examined is a 0.2 percent decrease in payments for smaller urban (100 or fewer beds) and rural hospitals that receive DSH payments, as well as rural hospitals in Puerto Rico.

We attribute these negative changes to the increasing gap between the relative weights for medical, diagnostic, and less complicated surgical DRGs and the weights for the more complicated surgical DRGs. Since the cases associated with the former DRGs tend to be treated more often in smaller hospitals with fewer resources available, lowering the relative weights associated with those cases would disproportionately affect these hospitals. In general, small hospitals that serve a disproportionate share of low-income patients and hospitals in rural Puerto Rico fit this definition. We note, however, that these negative impacts are relatively minor and do not result solely from the limited DRG revisions we are making for FY 1997.

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 final wage index for FY 1997 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993. 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 a model using the FY 1996 wage index before geographic reclassifications based on FY 1992 wage data to a model using the FY 1997 prereclassification wage index based on FY 1993 wage data.

The results indicate that the new wage data do not have a significant overall impact on hospital payments. Thus, hospitals with significant changes in their wage indexes are not concentrated within any particular hospital group. Some of the largest changes are found among both urban and rural hospitals grouped by census division. Our review of the wage data (as described below) indicates that these changes were attributable to improved reporting, as well as relative changes in labor costs.

Among urban hospitals in the 50 States and the District of Columbia, the largest increases (0.4 percent) are in the Middle Atlantic and the East North Central census divisions. Significantly, New York City's wage index rises by over 2.4 percent (this also contributes to the 0.2 percent increase among major

teaching hospitals and the 0.6 percent increase in the Unknown category under the Type of Ownership and the Medicare Utilization rows, where a cluster of New York City hospitals that file manual cost reports are grouped). Last year, the Middle Atlantic experienced one of the largest decreases (0.6 percent), which contributed to the 0.4 percent decline among major teaching hospitals—New York City's wage index fell by nearly 2.0 percent in FY 1996 (60 FR 45929). The largest decrease among urban hospitals (outside of Puerto Rico, which is discussed separately below) occurs in the Pacific census division, with a decline of 0.4 percent.

Among the rural hospitals, the largest increases are in the Pacific census division (0.6 percent) and the West South Central census division (0.5 percent); the largest decreases are in the census divisions of New England (0.9 percent), the Middle Atlantic (0.5 percent) and the South Atlantic (0.4 percent). The decrease among rural New England hospitals is primarily due to a 2.7 percent decrease in the wage index for rural Connecticut and rural New Hampshire hospitals. Among rural hospitals last year, the Pacific rural hospitals experienced one of the greatest increases (0.6 percent), while the rural West South Central hospitals experienced one of the greatest decreases (0.4 percent).

In Puerto Rico, payments decline by 4.2 percent for the five rural hospitals and by 1.2 percent for the urban hospitals. The average hourly wages reported in FY 1993 by two rural Puerto Rico hospitals fell from those reported in FY 1992 by 22.4 percent and 18.1 percent, leading to the 4.2 percent overall decline. Also, all six urban areas in Puerto Rico experience decreases in their wage index values. Two of these six experience a decline of more than 5 percent. These MSAs have relatively few hospitals (two and five), thus the decreases appear to be the result of one hospital in each area having a decrease of more than 5 percent in its average hourly wage.

The final FY 1997 wage index represents the fourth annual update to the wage data, and will continue to include salaries, fringe benefits, home office salaries, and certain contract labor costs. In the past, updates to the wage data have resulted in significant payment shifts among hospitals. Since the wage index is now updated annually, we expect these payment fluctuations will continue to decrease.

This expectation is borne out by comparing the FY 1997 wage index (after reclassifications under sections 1886(d)(8)(B) and 1886(d)(10) of the Act) to the FY 1996 wage index. The following chart compares the shifts in wage index values (after reclassifications) for labor markets for FY 1997 with those from FY 1996. The majority of labor market areas (334) experience less than a 5 percent change. Only 19 labor market areas experience a change between 5 and 10 percent; 10 of those experience increases. Still fewer labor markets experience a change of more than 10 percent; one experiences an increase and three experience decreases. For FY 1996, by comparison, 10 labor market areas experienced an increase in their wage index value of more than 10 percent.

Percentage change in area wage index values	Number of labor market areas	
	FY 1997	FY 1996
Increase more than 10 percent	1	6
Increase between 5 and 10 percent, (inclusive)	10	19
Increase/decrease below 5 percent	334	323
Decrease between 5 and 10 percent, (inclusive)	9	6
Decrease more than 10 percent	3	0

Note: There are two new MSAs in FY 1997. Also, there are some MSAs that, after geographic reclassification have no providers remaining and, therefore, are not reflected in this table.

Under the final FY 1997 wage index, 96.6 percent of urban hospitals and 93.9 percent of rural hospitals would experience a change in their wage index of less than 5 percent. Approximately 2.6 percent of urban hospitals and 1.4 percent of rural hospitals would experience a change of between 5 and 10 percent, and 0.9 percent of urban hospitals and 4.6 percent of rural hospitals would 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)	
	Urban	Rural
Increase more than 10 percent	0.3	2.6
Increase between 5 and 10 percent (inclusive)	1.5	0.4
Increase or decrease less than 5 percent	96.6	93.9
Decrease between 5 and 10 percent (inclusive)	1.1	1.0
Decrease more than 10 percent	0.6	2.0

Note: The sum of the columns may not total to 100 due to rounding.

D. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 3)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are budget neutral. As pointed out in the Addendum to this final rule, we compared aggregate payments using the FY 1996 DRG relative weights and wage index to aggregate payments using the FY 1997 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.998509. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 3. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1 and 2, minus the approximately 0.2 percent decrease attributable to the budget neutrality factor. In calculating the total changes shown in column 6, readers should begin with this column and add across, excluding the impacts shown in columns 1 and 2.

E. The Impact of MGCRB Reclassifications (Column 4)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 4 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1997. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural

hospitals reclassified for purposes of receiving the large urban standardized amount also qualify to be treated as urban for purposes of the DSH adjustment. However, effective FY 1997, rural hospitals can no longer be reclassified to an other urban area for purposes of the standardized amount in order to receive a higher DSH adjustment.

By March 30 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may reclassify a hospital for the purpose of using the other area's standardized amount, wage index value, or both. (RRCs and SCHs are exempt from the proximity requirement.)

This impact analysis incorporates all of the MGCRB's reclassification decisions for FY 1997. It also reflects any decisions made by the HCFA Administrator through the appeals and review process. Additional changes that resulted from a request by a hospital to withdraw its application are also reflected in this final rule.

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 0.993511 to ensure that the effects of reclassification are budget neutral. (See section II.A.4 of the Addendum to this final rule).

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.3 percent, while payments to urban hospitals decline 0.4 percent. Large urban hospitals lose 0.4 percent because, as a group, they have the smallest percentage of hospitals that are reclassified (fewer than 3 percent of large urban hospitals are reclassified). There are enough hospitals in other urban areas that are reclassified to limit the decrease in payments to these urban hospitals stemming from the budget neutrality offset to 0.2 percent. Among urban hospital groups generally (that is, bed size, census division, and special payment status), payments fall between 0.1 and 0.5 percent.

A positive impact is evident among all rural hospital groups except rural hospitals with up to 49 beds, which experience a 0.0 percent impact. The smallest effect among all rural census divisions is 0.8 percent for the Mountain division. This division has relatively few MGCRB reclassifications. Among urban census divisions, the New England and the Middle Atlantic display the smallest negative impact, 0.2 percent.

Among the 90 rural hospitals designated as RRCs, 50 hospitals are reclassified for purposes of the wage index only and experience a 9.5 percent increase in payments due to MGCRB reclassification. This group is not shown separately in the table, but this large increase is reflected in several of the rural hospital categories. For example, rural hospitals with 200 or more beds have a 4.9 percent increase in payments in column 4, largely due to this effect.

Rural hospitals reclassified for FY 1996 and FY 1997 experience an 8.9 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 1997 only experience a 7.1 percent increase in payments while rural hospitals reclassified for FY 1996 only experience a 0.4 decrease in payments. This is due to the budget neutrality adjustment, since the changes in this column reflect FY 1997 payments relative to no reclassifications, rather than to FY 1996 reclassifications. Urban hospitals reclassified for FY 1996 but not FY 1997 experience a 1.7 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 1997 but not for FY 1996 experience a 2.5 percent increase in payments.

The FY 1997 Reclassification rows of Table I show the changes in payments per case for all FY 1997 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive an 18.5 percent increase in payments. The number of hospitals in this category has declined from 42 in FY 1996 to 16 in FY 1997. In addition, 245 rural hospitals reclassified for the wage index receive an 8.6 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.4 percent for FY 1997.

Among the 27 rural hospitals deemed to be urban under section 1886(d)(8)(B) of the Act, payments increase 1.2 percent due to MGCRB reclassification. This is because, although these hospitals are treated as being attached to an urban area in our baseline (their redesignation is ongoing, rather than subject to annual review, like the MGCRB reclassifications), they are still eligible for MGCRB reclassification. For FY 1997, one hospital in this category reclassified to a large urban area, resulting in a net increase due to reclassifications of 1.2 percent.

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 0.6 percent, which corresponds closely with the geographic reclassification budget neutrality factor. Rural nonreclassified hospitals decrease slightly less, 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 index values.

The number of reclassifications for purposes of the standardized amount, or for both the standardized amount and the wage index, has declined from 358 in FY 1996 to 205 in FY 1997. This is not surprising because of the elimination of standardized amount reclassifications from rural to other urban areas for individual hospitals. Individual rural (and other urban) hospitals can continue to reclassify to large urban areas for purposes of the standardized amount. The number of wage index only reclassifications increased slightly from 260 in FY 1996 to 272 in FY 1997.

F. Outlier Changes (Column 5)

Medicare provides extra payment in addition to the basic 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 from FY 1994 day outlier levels in 25 percent increments beginning in FY 1995. Day outliers in FY 1997 should account for approximately 8 percent of total outlier payments (25 percent of FY 1994 levels). This reduction in day outlier payments will be offset by an increase in cost outlier payments.

As discussed in the Addendum, for FY 1997, the day outlier threshold will be equal to the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations. The marginal cost factor for day outliers is 33 percent. For FY 1997, a case would receive cost outlier payments if its costs exceed the DRG payment plus $9,700.

We are maintaining the marginal cost factor for cost outliers at 80 percent.

The payment impacts of these changes are minimal. Hospital categories negatively affected by phasing out day outliers are consistent with the categories negatively affected in previous years: urban New England (0.1 percent decline); urban and rural Middle Atlantic census divisions (0.7 percent and 0.1 percent declines, respectively); urban hospitals with 300–499 beds and those with 500 or more beds (0.1 and 0.2 percent declines, respectively); teaching hospitals with 100 or more residents (0.4 percent decline); and hospitals for which data were unavailable to calculate type of ownership or Medicare utilization rates (1.3 percent decline). As noted previously in the wage index discussion, this last category contains a number of New York City hospitals because they file manual cost reports. Because 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 categories have higher percentages of day outliers. The largest positive impact of 0.2 percent affected numerous hospital groups.

G. All Changes (Column 6)

Column 6 compares our estimate of payments per case incorporating all of our changes for FY 1997 to our estimate of payments per case in FY 1996. It also includes the effects of the 2.0 percent update to the standardized amounts and the hospital-specific rates for SCHs and EACHs, and the difference between the percentage of projected outlier payments in FY 1997 (5.1 percent) and the current estimate of the percentage of actual outlier payments in FY 1996 (4.0 percent), as described in the introduction to this Appendix and the Addendum.

Also, column 6 includes the impacts of FY 1997 MGCRB reclassifications compared to the payment impacts of FY 1996 reclassifications. Therefore, when comparing FY 1997 payments to FY 1996, the percent changes due to FY 1997 reclassifications shown in column 4 are offset by the effects of reclassification on hospitals' FY 1996 payments (column 4 of Table I, September 1, 1995 final rule; 60 FR 45926). That is, column 4 of Table I shows the impacts of going from no MGCRB reclassifications to the FY 1997 reclassifications. When comparing FY 1996 and FY 1997 payments, hospitals similarly reclassified during FY 1996 would not experience the full extent of the change shown in column 4. For example, the impact of MGCRB reclassifications on rural hospitals' FY 1996 payments was approximately a 2.3-percent increase, equal to the 2.3-percent increase for FY 1997. Therefore, the net increase in FY 1997 payments due to reclassification for rural hospitals is 0.0 percent.

The FY 1996 standardized amounts were adjusted by a budget neutrality factor of 0.997575, in accordance with section 1886(d)(5)(I) of the Act, so that the change to the transfer payment methodology we implemented last year (doubling the per diem payment for the first day of a transfer) would not affect aggregate payments. As we indicated in last year's final rule (60 FR 45854), this adjustment was applied on a one-time basis to the FY 1996 standardized amounts. In the proposed rule, we indicated that this was interpreted to mean that there was no transfer budget neutrality factor applied after FY 1996, and we estimated the impact of this to be a 0.2 percent increase in FY 1997 payments. As discussed in the Addendum to this final rule, we have corrected this interpretation so that we will continue to apply this budget neutrality factor of 0.997575 in FY 1997, and in the future.

In addition, eliminating the regional floor provision effective for discharges occurring on or after October 1, 1996, results in approximately a 0.2 percent lower average payment in FY 1997 than would occur otherwise. This effect is attributable to particular census divisions, as discussed below.

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 columns 3 through 5 plus the other impacts that we are able to identify. The point should be repeated here, as well, that when comparing the percent changes in column 6 attributable to the isolated changes in the prior columns in this table, columns 1 and 2 are incorporated into column 3. Therefore, just the effect in column 3 should be added into the total change shown in column 6.

The overall payment increase from FY 1997 to FY 1996 for all hospitals is a 2.9 percent increase. This reflects the 0.0 percent net change in total payments due to the final changes for FY 1997 shown in columns 3 through 5, the 2.0 percent update for FY 1997, the 1.1 percent higher outlier payments in FY 1997 compared to FY 1996, and the 0.2 overall negative effect of eliminating the regional floor.

Hospitals in urban areas experience a 2.9 percent rise in payments per case over FY 1996. Similar to all hospitals nationally, this is primarily due to the factors discussed above: the 2.0 percent update; a 1.1 percent impact of the higher level of outlier payments estimated for FY 1997; and the effect of the expiration of the regional floor.

Hospitals in large and other urban areas experience 2.9 percent and 3.0 percent increases, respectively. The lower increase for hospitals in large urban areas appears to be attributable primarily to the 0.1 percent negative impact of the continuing phase-out of day outliers.

Hospitals in rural areas experience a 2.4 percent increase. Their FY 1997 payments are estimated to be 0.4 percent higher than for FY 1996 due to higher outlier payments, in contrast to the national average of 1.1 percent. Like urban hospitals, the impact of geographic reclassification in FY 1997 is offset by an identical 2.3 percent increase in FY 1996.

Among urban bed size groups, column 6 shows changes in payments are higher for the largest urban hospitals compared to smaller urban hospitals. The relatively smaller increases for the smaller urban hospitals appear to be due to the negative impacts of the new wage data, as shown in column 2. Among rural bed size groups, the impacts range from 2.4 percent to 2.7 percent, with the exception of rural hospitals with 200 or more beds. Payments per case for this group of hospitals are estimated to increase 1.9 percent during FY 1997. This below average increase appears to be attributable primarily to a smaller, though still significant, impact of MGCRB reclassifications for FY 1997 compared to FY 1996. In column 4, the FY 1997 impact of reclassification is shown to be 4.9 percent. For FY 1996, however, this impact was 5.4 percent. Thus, the increase is 0.5 percent less for FY 1997 due to a smaller reclassification impact.

As discussed previously, effective for discharges on or after October 1, 1996, the regional floor, which benefitted certain census divisions, expires. The regional floor provided that, in those census divisions where the regional standardized amount exceeded the national standardized amount, hospitals would be paid a blend of 85 percent of the national amount and 15 percent of the regional amount. The census divisions affected by the regional floor during FY 1996 are New England and East North Central. In New England, the impacts of eliminating the regional floor are a 0.7 percent decrease for urban hospitals and a 0.6 percent decrease among rural hospitals. In the East North Central census division, the impacts are a 1.0 percent reduction for urban

hospitals, and a 0.7 percent reduction for rural hospitals. The negative impacts of losing the regional floor for urban hospitals in the East North Central census division are largely offset by higher estimated outlier payments in FY 1997 compared to FY 1996, the 0.4 percent higher payments due to the FY 1993 wage data (column 2), and the 0.1 percent increase due to the phase-out of day outliers (column 5). Urban New England hospitals' higher outlier payments in FY 1997 are also offset by the negative impacts of the expiration of the regional floor. Rural New England hospitals also see a 0.9 percent decrease in payments stemming from the FY 1993 wage data.

Other census divisions below the average payment increase are urban Pacific, urban Puerto Rico, rural Middle Atlantic, rural East South Central, and rural Puerto Rico. With the exception of the rural East South Central, the below average overall payment impacts of these census divisions are related to negative impacts of introducing the FY 1993 wage data. In the rural Middle Atlantic, the negative impact of the new wage data is combined with a smaller impact stemming from MGCRB reclassifications in FY 1997 (0.9 percent compared to 1.5 percent in FY 1996). A smaller FY 1997 reclassification impact (2.4 percent compared to 3.7 percent in FY 1996) is also the reason for the relatively small (1.9 percent) rate of increase in the rural East South Central census division. In rural Puerto Rico, although hospitals experience the greatest negative impact due to the updated wage data, this group benefits from reclassifications by the MGCRB in FY 1997 (of the five rural Puerto Rico hospitals, one is reclassified), with a 3.3 percent increase compared to a 0.5 percent decrease in their FY 1996 payments due to the reclassification budget neutrality factor.

Conversely, the urban Middle Atlantic, urban West North Central, urban West South Central, and rural Pacific census divisions all have overall increases at least 0.4 percent above the national average. The urban West South Central gains from the continued phase-out of day outliers, as well as higher estimated FY 1997 outlier payments compared to FY 1996 (1.5 percent). As noted previously, the urban Middle Atlantic benefits significantly from the updated wage index data. These hospitals also have higher estimated FY 1997 outlier payments, which offset their 0.7 percent decrease due to the phase-out of day outliers. Rural Pacific hospitals benefit from geographic reclassification in FY 1997 (2.3 percent compared to 1.4 percent in FY 1996) and the new wage data (0.5 percent).

The only hospital groups with negative payment impacts from FY 1996 to FY 1997 are hospitals that were reclassified for FY 1996 and are not reclassified for FY 1997. Overall, these hospitals lose 0.5 percent. The urban hospitals in this category actually experience a slight payment increase over FY 1996 (0.6 percent), while the rural hospitals lose 2.2 percent. On the other hand, hospitals reclassified for FY 1997 that were not reclassified for FY 1996 experience the greatest payment increases: 10.2 percent for 69 rural hospitals in this category and 7.8 percent for 29 urban 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 1997 (column 4), all have overall increases above the national average. 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 1997. All nonreclassified hospitals have an average payment increase of 2.8 percent. The average payment increase for all reclassified hospitals is 3.8 percent.

Among SCH/EACHs, the payment increase is 2.6 percent. 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. In addition, nonspecial status rural hospitals experience only a 1.6 percent increase. This below average increase is largely attributable to 123 hospitals in this category that lost their reclassification status from FY 1996 to FY 1997.

Another notably small increase appearing in this column is the 0.3 percent increase for rural DSH hospitals with 100 or more beds. This impact is primarily due to a number of hospitals in this category that lost their MGCRB reclassification from FY 1996 to FY 1997, stemming from the elimination of standardized amount reclassifications solely for higher DSH payments.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 1996 payment per case (2) [1]	Average FY 1997 payment per case (3) [1]	All changes (4)
(By Geographic Location)				
All hospitals	5,129	6,478	6,664	2.9
Urban hospitals	2,881	7,013	7,218	2.9
Large urban areas	1,596	7,544	7,762	2.9
Other urban areas	1,285	6,313	6,502	3.0
Rural areas	2,248	4,297	4,400	2.4
Bed size (urban):				
0–99 beds	715	4,705	4,832	2.7
100–199 beds	945	5,951	6,108	2.6
200–299 beds	576	6,527	6,715	2.9
300–499 beds	478	7,444	7,674	3.1
500 or more beds	167	9,147	9,426	3.1
Bed size (rural):				
0–49 Beds	1,177	3,538	3,622	2.4
50–99 beds	657	3,992	4,090	2.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1996 payment per case (2) [1]	Average FY 1997 payment per case (3) [1]	All changes (4)
100–149 beds	241	4,462	4,579	2.6
150–199 beds	98	4,594	4,716	2.7
200 or more beds	75	5,417	5,518	1.9
Urban by census div.:				
New England	160	7,525	7,672	2.0
Middle Atlantic	434	7,718	7,973	3.3
South Atlantic	419	6,682	6,889	3.1
East North Central	483	6,735	6,905	2.5
East South Central	163	6,181	6,374	3.1
West North Central	193	6,645	6,866	3.3
West South Central	376	6,508	6,743	3.6
Mountain	127	6,766	6,962	2.9
Pacific	478	8,102	8,304	2.5
Puerto Rico	48	2,595	2,644	1.9
Rural by census div.:				
New England	53	5,242	5,304	1.2
Middle Atlantic	85	4,691	4,769	1.7
South Atlantic	297	4,473	4,578	2.3
East North Central	304	4,321	4,434	2.6
East South Central	278	3,969	4,045	1.9
West North Central	525	4,004	4,105	2.5
West South Central	349	3,845	3,952	2.8
Mountain	211	4,569	4,689	2.6
Pacific	141	5,307	5,505	3.7
Puerto Rico	5	2,038	2,073	1.7
(By Payment Categories)				
Urban hospitals	2,981	6,968	7,174	2.9
Large urban areas	1,791	7,370	7,586	2.9
Other urban areas	1,190	6,317	6,504	3.0
Rural areas	2,148	4,263	4,358	2.2
Teaching status:				
Non-teaching	4,044	5,288	5,437	2.8
Fewer than 100 Residents	850	6,895	7,099	3.0
100 or More residents	235	10,565	10,865	2.8
Disproportionate share hospitals (DSH):				
Non-DSH	3,201	5,595	5,755	2.9
Urban DSH:				
100 beds or more	1,410	7,614	7,834	2.9
Fewer than 100 beds	101	4,806	4,911	2.2
Rural DSH:				
Sole community (SCH)	156	4,349	4,507	3.6
Referral centers (RRC)	27	5,179	5,352	3.3
Other Rural DSH hosp.:				
100 beds or more	83	4,198	4,211	0.3
Fewer than 100 beds	151	3,432	3,500	2.0
Urban teaching and DSH:				
Both teaching and DSH	692	8,587	8,832	2.8
Teaching and no DSH	339	7,095	7,310	3.0
No teaching and DSH	819	6,126	6,309	3.0
No teaching and no DSH	1,131	5,438	5,605	3.1
Rural hospital types:				
Nonspecial status hospitals	1,375	3,895	3,958	1.6
RRC	90	5,076	5,246	3.4
SCH/Each	645	4,405	4,519	2.6
SCH/Each and RRC	38	5,213	5,352	2.7
Type of ownership:				
Voluntary	2,951	6,629	6,823	2.9
Proprietary	696	5,948	6,120	2.9
Government	1,366	6,040	6,195	2.6
Unknown	116	7,564	7,724	2.1
Medicare Utilization as a percent of Inpatient days:				
0–25	258	8,741	8,917	2.0
25–50	1,284	7,878	8,103	2.9
50–65	2,097	5,947	6,122	2.9

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1996 payment per case (2) [1]	Average FY 1997 payment per case (3) [1]	All changes (4)
Over 65	1,374	5,055	5,204	2.9
Unknown	116	7,564	7,724	2.1
Hospitals Reclassified by the Medicare Geographic Review Board				
Reclassification status during FY96 and FY97				
Reclassified during both FY96 and FY97	379	5,780	5,939	2.7
Urban	130	6,606	6,802	3.0
Rural	249	5,012	5,136	2.5
Reclassified during FY97 only	98	6,132	6,642	8.3
Urban	29	7,307	7,860	7.6
Rural	69	4,369	4,815	10.2
Reclassified during FY96 only	253	5,893	5,861	−0.5
Urban	91	7,497	7,543	0.6
Rural	162	4,503	4,403	−2.2
FY97 Reclassifications:				
All reclassified hosp.	477	5,845	6,069	3.8
Stand. amt. only	119	5,753	5,914	2.8
Wage index only	272	5,665	5,854	3.3
Both	86	6,254	6,600	5.5
Nonreclass	4,625	6,563	6,744	2.8
All urban reclass	159	6,760	7,035	4.1
Stand. amt. only	62	6,218	6,398	2.9
Wage index only	27	8,949	9,282	3.7
Both	70	6,446	6,777	5.1
Nonreclass	2,722	7,031	7,231	2.9
All Rural Reclass	318	4,916	5,088	3.5
Stand. amt. only	57	4,622	4,737	2.5
Wage index only	245	4,977	5,136	3.2
Both	16	4,904	5,354	9.2
Nonreclass	1,903	4,051	4,127	1.9
Other reclassifed:				
Hospitals (Section 1886(d)(8)(B))	27	4,620	4,743	2.7

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the final changes for FY 1997 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 1997 with the average estimated per case payments for FY 1996, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table I 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 in previous impact analyses for the capital prospective payment system. Specifically, we have cost report data for the third year of the capital prospective payment system (cost reports beginning in FY 1994) available through the June 1996 update of the Hospital Cost Report Information System (HCRIS). We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year.

The lack of such information affects our impact analysis in several ways. Specifically, major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals. Moreover, our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is

put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 1997 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 1997 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 1997. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 1997 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. We continue to be unable to predict accurately FY 1997 capital costs for individual hospitals, but 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 1997 payment policies.

B. Projected Impact Based on the FY 1997 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1996 to FY 1997 using a capital acquisition model. The FY 1997 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 1994 received through the June 1996 update of the Hospital Cost Reporting Information System (HCRIS), interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through July 1, 1996 in the Provider-Specific file. We used this data to determine the FY 1997 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 1994, 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 1994. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 1997 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	−0.53
1996	5.06
1997	5.21

- The Medicare case-mix index will increase by 1.4 percent in FY 1996 and 1.6 percent in FY 1997.
- The Federal capital rate as well as the hospital-specific rate is updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The FY 1997 update factor is .7 percent. (see Addendum, Part III).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1996 to FY 1997. 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 1997 percent of discharges	FY 1997 percent of capital costs	FY 1997 percent of capital payments
Low Cost Hospital	66	62	52	56
High Cost Hospital	34	38	48	44

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 1996 to FY 1997 using the above described actuarial model.

TABLE III.—IMPACT OF FINAL CHANGES FOR FY 1997 ON PAYMENTS PER DISCHARGE

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
Low Cost Hospitals	3,363	6,868,405	$411.84	54.85	$200.68	$15.75	$18.28	$646.55
Fully Prospective	1,548	3,287,821	375.12	50.00	237.10	.....	11.40	623.62
Rebase—Fully Prospective	1,483	2,743,898	371.61	50.00	218.24	.....	27.88	617.74
Rebase—100% Federal Rate	228	643,922	793.64	100.00	.....	.....	0.25	793.89
Rebase—Hold Harmless	104	192,764	335.30	46.49	.....	561.32	59.11	955.72
High Cost Hospitals	1,741	4,288,642	668.50	86.23	.....	145.12	19.59	833.21
100% Federal Rate	1,135	3,010,570	785.30	100.00	.....	.....	2.23	787.53
Hold Harmless	606	1,278,072	393.38	52.33	.....	486.95	60.48	940.81
Total Hospitals	5,104	11,157,046	510.50	67.15	123.54	65.48	18.78	718.30

FY 1997 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	3,363	7,056,653	$471.51	63.97	$157.25	$12.43	$40.25	$681.44	5.40
Fully Prospective	1,548	3,377,933	441.20	60.00	185.78	.....	30.53	657.51	5.43
Rebase—Fully Prospective	1,483	2,819,103	438.15	60.00	171.01	.....	54.23	663.39	7.39
Rebase—100% Federal Rate	238	677,500	778.75	100.00	.....	.....	2.63	781.38	−1.58
Rebase—Hold Harmless	94	182,117	407.13	56.47	.....	481.80	144.04	1,032.97	8.08
High Cost Hospitals	1,741	4,406,184	694.20	89.74	.....	117.32	49.69	861.21	3.36
100% Federal Rate	1,173	3,160,803	779.30	100.00	.....	.....	11.40	790.70	0.40
Hold Harmless	568	1,245,382	478.21	63.00	.....	415.08	146.89	1,040.17	10.56
Total Hospitals	5,104	11,462,838	557.11	74.17	96.80	52.75	43.88	750.54	4.49

Under section 1886(g)(1)(A) of the Act, aggregate payments under the capital prospective payment system for FY 1992 through 1995 respectively, were projected to equal 90 percent of payments that would have been payable on a reasonable cost basis in each year. With the expiration of the capital budget neutrality provision, we now estimate that there was an aggregate 27.50 percent increase in FY 1996 Medicare capital payments over the FY 1995 payments. We estimate aggregate Medicare capital payments will increase by 6.77 percent in FY 1997.

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 4.75 percent, and high capital cost hospitals will experience an average increase of 2.86 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 50 percent to 60 percent and the hospital-specific rate payment percentage will decrease from 50 to 40 percent in FY 1997. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for hospitals receiving a hold-harmless payment for old capital will increase from 52.33 percent to 62.81 percent. (We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 65.8 percent to 67.8 percent.)

We expect that the average hospital-specific rate payment per discharge will decrease from $123.54 in FY 1996 to $96.10 in FY 1997. This is partly due to the 4.32 percent decrease in the FY 1997 hospital-specific rate compared to FY 1996.

We proposed no changes in our exceptions policies for FY 1997. As a result, the minimum payment levels will be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or,
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 2.61 percent of total capital payments in FY 1996 to 5.97 percent of payments in FY 1997. The number and amount of exceptions payments is expected to increase throughout the transition period. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1997 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	464	57
High Capital Cost	348	43
Total	812	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	5,104	13.0	27.6	59.4
Large urban areas (populations over 1 million)	1,584	15.3	34.8	49.9
Other urban areas (populations of 1 million or fewer)	1,275	15.8	32.9	51.3
Rural areas	2,245	9.7	19.6	70.7
Urban hospitals	2,859	15.5	34.0	50.5
0–99 beds	697	16.4	27.4	56.2
100–199 beds	941	19.2	36.9	43.9
200–299 beds	576	14.4	36.6	49.0
300–499 beds	478	10.3	34.5	55.2
500 or more beds	167	10.2	34.1	55.7
Rural hospitals	2,245	9.7	19.6	70.7
0–49 beds	1,175	7.0	14.6	78.5
50–99 beds	656	12.5	21.6	65.9
100–149 beds	241	13.7	30.7	55.6
150–199 beds	98	15.3	22.4	62.2
200 or more beds	75	8.0	41.3	50.7
By Region:				
Urban by Region	2,859	15.5	34.0	50.5
New England	160	6.9	25.0	68.1
Middle Atlantic	434	10.1	29.7	60.1
South Atlantic	418	20.1	40.2	39.7
East North Central	480	9.6	30.0	60.4
East South Central	162	22.8	34.6	42.6
West North Central	190	18.4	27.4	54.2
West South Central	367	27.8	46.0	26.2
Mountain	126	15.9	42.1	42.1
Pacific	474	12.7	31.2	56.1
Puerto Rico	48	10.4	25.0	64.6
Rural by Region	2,245	9.7	19.6	70.7
New England	53	7.5	15.1	77.4
Middle Atlantic	84	10.7	15.5	73.8
South Atlantic	297	11.8	25.6	62.6
East North Central	304	10.2	11.8	78.0
East South Central	278	9.7	31.3	59.0
West North Central	525	7.0	15.2	77.7
West South Central	347	9.2	24.8	66.0
Mountain	211	12.3	15.2	72.5
Pacific	141	11.3	15.6	73.0
Large urban areas (populations over 1 million)	1,779	15.2	34.5	50.4
Other urban areas (populations over 1 million or fewer)	1,180	15.8	32.2	51.9
Rural areas	2,145	9.6	19.5	71.0
Teaching Status:				
Non-teaching	4,019	13.5	26.6	59.8
Fewer than 100 Residents	850	11.3	32.4	56.4
100 or more Residents	235	9.4	27.7	63.0
Disproportionate share hospitals (DSH):				
Non-DSH	3,178	12.3	24.0	63.7
Urban DSH:				
100 or more beds	1,409	15.4	36.1	48.5
Less than 100 beds	100	17.0	23.0	60.0
Rural DSH:				
Sole Community (SCH/EACH)	156	11.5	18.6	69.9
Referral Center (RRC/EACH)	27	7.4	37.0	55.6
Other Rural:				
100 or more beds	83	8.4	45.8	45.8
Less than 100 beds	151	7.3	25.8	66.9
Urban teaching and DSH:				
Both teaching and DSH	692	11.1	32.2	56.6
Teaching and no DSH	339	11.2	29.8	59.0
No teaching and DSH	817	19.2	37.7	43.1
No teaching and no DSH	1,111	16.7	32.5	50.9
Rural Hospital Types:				
Non special status hospitals	1,372	7.7	19.5	72.8
RRC/EACH	90	10.0	34.4	55.6
SCH/EACH	645	13.3	17.2	69.5

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
SCH, RRC and EACH	38	13.2	21.1	65.8
Type of Ownership:				
Voluntary	2,951	12.3	27.6	60.1
Proprietary	696	23.4	46.7	29.9
Government	1,366	8.7	17.6	73.7
Medicare Utilization as a Percent of Inpatient Days:				
0–25	258	15.1	25.2	59.7
25–50	1,284	14.5	33.4	52.1
50–65	2,097	12.9	28.0	59.1
Over 65	1,374	10.8	21.6	67.5

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 25 of the 5,129 hospitals in our data base. Consequently, the payment methodology distribution is based on 5,104 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 the Federal rate) as hold-harmless hospitals is expected to increase to 27.5 percent in FY 1997.

Table IV indicates that 59.4 percent of hospitals are paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (70.7 percent and 73.7 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 29.9 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 1997 actuarial model to estimate the potential impact of our changes for FY 1997 on total capital payments per case, using a universe of 5,104 hospitals. The individual hospital payment parameters are taken from the best available data, including: the July 1, 1996 update to the Provider-Specific file, cost report data, and audit information supplied by intermediaries. Table V presents estimates of payments per case under our model for FY 1996 and FY 1997 (columns 2 and 3). Column 4 shows the total percentage change in payments from FY 1996 to FY 1997. 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 4.99 percent decrease in the Federal rate, a 1.6 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 reflects the effects of all other changes, including: the change from 50 percent to 60 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 3.9 percent in FY 1997. The results show that the effect of the Federal rate changes alone is to decrease payments by 1.3 percent. The decrease attributable to the Federal rate changes is more than offset by a 5.2 percent increase attributable to the effects of all other changes.

Our comparison by geographic location shows that overall, urban hospitals will gain slightly less than rural hospitals from the final rule changes (increases of 3.8 percent and 4.7 percent, respectively). Payments per case for urban hospitals will decrease at about the same rate as payments per case for rural hospitals (1.2 percent and 1.7 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain slightly less than rural hospitals (5.0 percent compared to 6.4 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 increases in total capital payments per case. Changes by region vary from a low of 2.1 percent increase (rural hospitals of the West South Central region) to a high of 15.2 percent increase (rural hospitals of the New England region).

By type of ownership, government hospitals are projected to have the largest rate of increase (5.1 percent, –1.5 percent due to Federal rate changes and a 6.6 percent positive offset from the effects of all other changes). Payments to voluntary hospitals will increase 3.8 percent (a 1.3 percent decrease due to Federal rate changes and a 5.1 percent

positive offset from the effects of all other changes) and payments to proprietary hospitals will increase 3.4 percent (a 0.9 percent decrease due to Federal rate changes and a 4.3 percent positive offset from 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 standardized amount, wage index, 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 the hospitals being reclassified for FY 1997 compared to the effects of reclassification for FY 1996, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1997 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 1997 as a whole are projected to experience a 4.5 percent increase in payments (a 0.8 percent decrease attributable to Federal rate changes and a 5.3 percent positive offset attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (3.9 percent) than reclassified hospitals (4.5 percent). Payments to nonreclassified hospitals will decrease slightly more than reclassified hospitals from the Federal rate changes (1.3 percent compared to 0.8 percent), but they will gain about the same from the effects of all other changes (5.2 percent compared to 5.3 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1996 Payments Compared to FY 1997 Payments]

	Number of hospitals	Average FY 1996 payments/case	Average FY 1997 payments/case	All changes	Portion attibutable to federal rate change
By Geographic Location:					
All hospitals	5,104	718	746	3.9	−1.3
Large urban areas (populations over 1 million)	1,584	823	852	3.6	−1.2
Other urban areas (populations of 1 million of fewer)	1,275	715	745	4.1	−1.1
Rural areas	2,245	478	501	4.7	−1.7
Urban hospitals	2,859	776	806	3.8	−1.2
0–99 beds	697	566	589	4.0	−1.3
100–199 beds	941	705	732	3.7	−1.3
200–299 beds	576	744	774	4.0	−1.3
300–499 beds	478	801	830	3.7	−1.2
500 or more beds	167	944	980	3.8	−0.9
Rural hospitals	2,245	478	501	4.7	−1.7
0–49 beds	1,175	367	385	5.0	−2.0
50–99 beds	656	447	468	4.8	−1.6
100–149 beds	241	511	532	4.2	−1.7
150–199 beds	98	511	540	5.6	−1.4
200 or more beds	75	612	638	4.3	−2.0
By Region:					
Urban by Region	2,859	776	806	3.8	−1.2
New England	160	784	817	4.3	−1.9
Middle Atlantic	434	813	848	4.2	−1.2
South Atlantic	418	780	814	4.3	−1.1
East North Central	480	727	749	3.1	−1.2
East South Central	162	707	733	3.7	−0.8
West North Central	190	772	809	4.8	−1.0
West South Central	367	796	823	3.4	−0.4
Mountain	126	775	797	2.7	−1.5
Pacific	474	855	883	3.3	−1.7
Puerto Rico	48	305	326	6.8	−0.4
Rural by Region	2,245	478	501	4.7	−1.7
New England	53	606	698	15.2	−2.3
Middle Atlantic	84	497	525	5.6	−2.7
South Atlantic	297	498	511	2.8	−2.0
East North Central	304	482	510	5.9	−1.3
East South Central	278	446	463	3.8	−1.8
West North Central	525	454	477	5.2	−1.7
West South Central	347	440	449	2.1	−1.3
Mountain	211	504	534	6.1	−0.8
Pacific	141	555	587	5.9	−1.3
By Payment Classification:					
All hospitals	5,104	718	746	3.9	−1.3
Large urban areas (populations over 1 million)	1,779	807	836	3.6	−1.2
Other urban areas (populations of 1 million of fewer)	1,180	715	746	4.2	−1.1
Rural areas	2,145	472	494	4.7	−1.8

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1996 Payments Compared to FY 1997 Payments]

	Number of hospitals	Average FY 1996 payments/case	Average FY 1997 payments/case	All changes	Portion attibutable to federal rate change
Teaching Status:					
Non-teaching	4,019	622	645	3.8	−1.3
Fewer than 100 Residents	850	757	787	3.9	−1.2
100 or more Residents	235	1,034	1,079	4.3	−1.2
Urban DSH:					
100 or more beds	1,409	813	843	3.7	−1.2
Less than 100 beds	100	576	607	5.4	−1.2
Rural DSH:					
Sole Community (SCH/EACH)	156	449	486	8.1	−1.5
Referral Center (RRC/EACH)	27	533	541	1.5	−1.0
Other Rural:					
100 or more beds	83	488	504	3.3	−2.5
Less than 100 beds	151	367	379	3.3	−2.2
Urban teaching and DSH:					
Both teaching and DSH	692	879	911	3.6	−1.2
Teaching and no DHS	339	786	821	4.5	−1.1
No teaching and DSH	817	710	737	3.9	−1.2
No teaching and no DSH	1,111	673	697	3.6	−1.1
Rural Hospital Types:					
Non special status hospitals	1,372	439	458	4.2	−2.2
RRC/EACH	90	559	573	2.6	−1.1
SCH/EACH	645	470	502	6.8	−1.6
SCH, RRC and EACH	38	582	6.5	5.7	−1.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY96 and FY97:					
Reclassified During Both FY96 and FY97	379	662	685	3.5	−1.5
Reclassified During FY97 Only	98	673	732	8.7	2.0
Reclassified During FY96 Only	230	652	661	1.4	−3.9
FY 97 Reclassifications:					
All Reclassified Hospitals	477	664	694	4.5	−0.8
All Nonreclassified Hospitals	4,600	726	754	3.9	−1.3
All Urban Reclassified Hospitals	159	756	782	3.5	−1.0
Urban Nonreclassified Hospitals	2,700	778	808	3.8	−1.2
All Reclassified Rural Hospitals	318	570	604	5.9	−0.7
Rural Nonreclassified Hospitals	1,900	442	460	4.1	−2.2
Other Reclassified Hospitals (Section 1886 (D)(8)(B))	27	541	561	3.7	−1.8
Type of Ownership:					
Voluntary	2,951	731	760	3.8	−1.3
Proprietary	696	751	777	3.4	−0.9
Government	1,366	625	657	5.1	−1.5
Medicare Utilization as a Percent of Inpatient Days:					
0–25	258	797	830	4.1	−2.0
25–50	1,284	843	875	3.9	−1.2
50–60	2,097	676	703	4.0	−1.2
Over 65	1,374	603	627	4.0	−1.3

Appendix B: Technical Appendix on the Capital Acquisition Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement 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 for FY 1997: the June 30, 1996 update of the cost reports for PPS-IX (cost reporting periods beginning in FY 1992), PPS-X (cost reporting periods beginning in FY 1993) and PPS-XI (cost reporting periods beginning in FY 1994), the July 1, 1996 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, FY 1995, and FY 1996 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), that the FY 1995 increase in the hospital-specific rate was at least 0.05 percent (the net FY 1995 update), and that the FY 1996 increase in the hospital-specific rate was at least 21.10 percent (the net FY 1996 update). We were able to match hospitals to the files as shown in the following table.

Source	Number of hospitals
Provider-Specific File Only	99
Provider-Specific and Audit File	5029
Other	1
Total	5129

Sixty-six of these hospitals had unusable or missing data. We were able to backfill a hospital-specific rate for 41 of these hospitals from the cost reports as shown in the following table.

Source	Number of hospitals
PPS-VII Cost Reports	1
PPS-VIII Cost Reports	2
PPS-IX Cost Reports	3
PPS-X Cost Reports	7
PPS-XI Cost Reports	28
Total	41

We did not have data for 25 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 5104 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 amounts, 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. For FY 1994 amounts, we used PPS-X and PPS-XI cost reports as the first source of data, weighting each cost report by the number of days in FY 1994. We were able to match 5,049 PPS-IX cost reports, 5,064 PPS-X cost reports, and 4,924 PPS-XI 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 costs 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 0.85 (aging factor). The 0.85 aging factor is the average of changes in capital over its life due to the gradual decrease in interest payments and the retirement of fully depreciated capital. The aged new and old capital is subtracted from the projected capital described in the previous paragraph. The difference represents newly acquired capital. If the hospital has obligated capital, any increase in ''old'' capital up to the total amount of obligated capital in FY 1993 and FY 1994 is assigned to obligated capital. Any remaining obligated capital is assigned to FY 1995 up to the amount of the modeled increase in capital for FY 1995. Even though obligated capital must be put in use for patient care by October 1, 1994, the use of the obligated capital may have started late in FY 1994 with only part of the ''first year'' depreciation and interest realized in FY 1994. The remainder of the ''first year'' depreciation and interest would be realized in 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. Hence, no obligated capital is assigned to years FY 1996 and later. Once obligated capital is assigned, it is included with the ''old'' capital and is capitalized into future years as part of ''old'' capital. 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 1995 MedPAR file using the FY 1997 DRG relative weights published in this final rule. The case-mix index is increased each year after FY 1995 based on analysis of past experiences in case-mix increases.

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 accelerated to around 1.6 percent. Early indications show that FY 1996 case-mix is increasing at FY 1995 level, that is, approximately 1.6 percent. Thus, it appears that the deceleration of case-mix increases in FY 1993 and FY 1994 were anamolous, rather than the beginning of a trend. Therefore, in the model we are using the recent experience and have used a case-mix increase of 1.6 percent in FY 1995 and a projected case-mix increase of 1.6 percent in both FY 1996 and FY 1997. (Since we are using FY 1995 cases for our analysis, the FY 1995 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 adjusted Federal rate starting in FY 1996.

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 1996, the budget neutrality adjustment factor was 1.0025. To determine the factor for FY 1997, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1997 based on its applicable payment methodology. Using our model, we then compared estimated aggregate Federal rate payments based on the FY 1996 DRG relative weights and the FY 1996 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1997 relative weights and the FY 1997 geographic adjustment factor. In making the comparison, we held the FY 1997 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that to achieve budget neutrality for the changes in the geographic adjustment factor and DRG classifications and relative weights, an incremental budget neutrality adjustment of 0.9987 for FY 1997 should be applied to the previous cumulative FY 1996 adjustment of 1.0025 (the product of the FY 1993 incremental adjustment of 0.9980, the FY 1994 incremental adjustment of 1.0053, the FY 1995 incremental adjustment of 0.9998, and the FY 1996 incremental adjustment of 0.9994), yielding a cumulative adjustment of 1.0012 through FY 1997.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor 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 the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FY 1992, FY 1993, FY 1994, FY 1995, FY 1996, the final FY 1997 factor, and the estimated factors that would be applicable through FY 2001. We caution that, except with respect to FY 1992, FY 1993, FY 1994, FY 1995, FY 1996 and FY 1997, 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 1.0012 for FY 1997 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1997.

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	0.70	.9358	N/A	[5] 438.92
1998	1.20	.9121	N/A	432.94
1999	1.20	.9206	N/A	442.22
2000	1.30	9148	N/A	445.15
2001	1.30	[6] N/A	N/A	492.93

[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.

[5] NOTE: Includes the DRG/GAF adjustment factor of 1.0012 and the change in the outlier adjustment from 0.9536 in FY 1996 to 0.9481 in FY 1997. Future adjustments are, for purposes of this projection, assumed to remain at the same level.

[6] NOTE: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

Appendix C: Rebased Market Basket Data Sources

I. Data Sources Used to Determine the Market Basket Relative Weights and Choice of Price Proxy Variables for the Operating Hospital Input Price Indexes

As discussed in section IV of the preamble to this final rule, we are rebasing and revising the hospital market baskets. This appendix describes the technical features of the 1992-based indexes that we are implementing in this rule. For both the prospective payment and excluded hospital market baskets, the differences between the 1992-based market basket and the previous 1987-based market basket are noted. In the September 4, 1990 final rule (55 FR 36170), we discussed in detail the 1987-based hospital market baskets.

We present this description of the hospital operating market baskets in three steps:

- A synopsis of the structural differences between the 1987-based market baskets and the proposed 1992-based market baskets.
- A description of the methodology used to develop the cost category weights in the 1992-based market baskets, making note of the differences from the methodology used to develop the 1987-based market baskets.
- A description of the data sources used to measure price change for each component of the 1992-based market baskets, making note of the differences from the price proxies used in the 1987-based hospital market baskets.

A. Synopsis of Structural Changes Adopted in the Rebased 1992 Operating Hospital Market Baskets.

Three major structural differences exist between the 1987-based and the 1992-based operating hospital market baskets.

- The 1992-based hospital market baskets are based on more recent hospital expenditure data. The 1987-based market baskets contained skeletal cost shares that were derived from the 1987 cost data from the 1988 Annual Survey of the American Hospital Association (AHA). The 1992-based market baskets use data from the hospital cost reports for cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992.
- Some cost categories have been combined, namely Fuel, Oil, Coal, and Other Fuel with Motor Gasoline, and Blood Services with Chemicals. These category mergers reflect the Bureau of Economic Analysis (BEA) reclassification decisions in the 1987 update of the BEA Input-Output Tables.
- In the 1992-based market basket, the sample of excluded hospitals is restricted to more closely reflect the average Medicare length of stay in excluded hospitals. We have used cost report data for excluded hospitals from only those hospitals in which the average length of stay of Medicare patients in the hospital is within 15 percent of the average length of stay of all patients in the hospital to more accurately reflect the structure of costs for Medicare cases. This is a change from the FY 1987-based market basket, for which data from all excluded hospitals were used.

B. Methodology for Developing the Cost Category Weights.

Cost category weights for the 1992-based market baskets were developed in four stages. First, base weights for three (Wages and Salaries, Employee Benefits, Pharmaceuticals) of the six main categories were derived from the 1992 Medicare cost reports for operating costs. Second, the weight for Nonmedical Professional Fees was developed by subtracting Medical Professional Fees reported in the Hospital Cost Report Information System (HCRIS) file from AHA Annual Survey Total Professional Fees to obtain Nonmedical Professional Fees, and the weight for Professional Liability Insurance was developed using 1989 HCRIS data trended forward to 1992, using the relative importance values in the previous market baskets. Third, the sum of Wages and Salaries, Employee Benefits, Pharmaceuticals, Nonmedical Professional Fees, and Professional Liability Insurance was subtracted from total expenses to obtain All Other Expenses. Finally, the weight for All Other Expenses was divided into subcategories using cost shares from the 1987 Input-Output Table for the hospital industry, produced by the U.S. Department of Commerce, Bureau of Economic Analysis, aged to 1992 using price changes. As of this writing the Department of Commerce has not released final 1992 cost data. Therefore we plan to incorporate these data into the FY 1998 proposed rule.

Below, we describe the source of the six main category weights and their subcategories in the 1992-based market

baskets. We make note of the differences between the methodologies used to develop the 1987-based and the 1992-based market baskets.

1. Wages and Salaries

The cost weight for the Wages and Salaries category was derived using the 1992 Medicare cost reports. Contract Labor, which is also derived from the 1992 Medicare cost reports, is split between the Wages and Salaries and Employee Benefits cost categories, using the relationship for employed workers. Examples of Contract Labor are registered nurses and workers in hospital food service or security who are employed and paid by firms that contract for their work with the hospital. The Wages and Salaries cost category was disaggregated into nine occupational subcategories (professional and technical, managers and administration, sales, clerical, craft and kindred, operatives excluding transport, transport equipment operatives, nonfarm laborers and service workers) to reflect the mix of occupational inputs used by hospitals. The Contract Labor wages and salaries component was allocated proportionally to Professional-Technical and Service occupations. The 1987-based weights were developed from the 1987 Current Population Survey, while the 1992-based weights were developed from the 1992 Current Population Survey.

2. Employee Benefits

The cost weight for the employee benefits category was derived from the 1992 cost reports. Like wages and salaries, the employee benefit weight in each 1992-based market basket is a composite of nine labor subcategories. The employee benefits categories in the 1987-based market baskets were developed from the 1987 AHA Annual Survey and used the 1987 Current Population Survey. In 1987 Contract Labor's implied fringe benefits were allocated proportionally to Professional and Technical occupations, while in 1992 they were allocated to Professional-Technical and Service occupations.

3. Nonmedical Professional Fees

The cost weight for the nonmedical professional fees category was derived from the 1992 Medicare Cost Reports and AHA Annual Survey data. Total professional fees were split into the subcategories medical and other (nonmedical) fees using AHA Total Professional Fees minus HCRIS Medical Professional Fees to equal Nonmedical Professional Fees. The 1987-based nonmedical professional fees cost category was derived from the 1987 AHA Annual Survey and American Medical Association (AMA) data. It was split into the subcategories medical and other fees using data derived from the American Medical Association. The medical professional fees category is excluded from the hospital market basket since it is paid under Medicare Part B.

4. Professional Liability Insurance

The 1987-based market baskets have weights for professional liability insurance that were derived from the June 30 and December 31, 1987 HAS/Monitrend surveys. The cost weight for the 1992-based professional liability insurance category was derived from 1989 HCRIS cost shares trended to 1992 using the change in the relative importance factor for professional liability insurance (malpractice) from the previous 1987-based prospective payment hospital and excluded hospital market baskets.

5. Utilities

For the 1987-based market baskets, the cost weight for utilities was derived by extrapolating the 1985 AHA Annual Survey utilities cost weight forward to 1987 using the rate of growth in the HAS/Monitrend cost weight for utilities between 1985 and 1987. The 1987 Utility subcategory weights were aged from their 1982-based index subcategory weights using price changes from 1982 to 1987. The 1992-based market basket cost weights for the subcategories (fuel, oil and gasoline; electricity; natural gas; and water and sewage) were derived from the Bureau of Economic Analysis' 1987 Input-Output table for the hospital industry, aged forward to 1992 by price changes and summed to a weight for utilities.

6. All Other Goods and Services

The all other goods and services category has more subcategories than any other market basket category. Goods found in this category include: direct service food, contract service food, pharmaceuticals, chemicals, medical instruments, photo supplies, rubber and plastics, paper products, apparel, machinery and equipment and miscellaneous products. Services found in this category include: business services, computer services, transportation and shipping, telephone, postage, other labor-intensive services, and other nonlabor-intensive services. The share for pharmaceuticals was derived from the 1992 Medicare cost reports. Relative shares for the other subcategories were derived from the 1987 Bureau of Economic Analysis' Input-Output table for the hospital industry and were aged forward to 1992 using price changes.

C. Price Proxies Used To Measure Cost Category Growth

1. Wages and Salaries

For measuring price growth in the 1992-based market basket, 10 price proxies are applied to the 9 occupational subcategories within the wages and salaries component. As in the 1987-based market basket, the professional and technical subcategory was split in half. An Employee Cost Index (ECI) for hourly wages paid to civilian hospital workers was applied to one half. An ECI of hourly wages and salaries paid to professional and technical workers in private industry was applied to the other half of the professional and technical component. The other eight occupations subcategories of the wages and salaries component were proxied using ECIs for wages and salaries for private industry workers in their respective occupational categories.

2. Employee Benefits

The 1992-based hospital market baskets use occupation-specific ECIs for employee benefits. The distribution of weights and price proxies is the same as for wages and salaries discussed above, but occupation-specific employee benefit ECIs replace occupation-specific wages and salaries ECIs. The components are summed into a composite index, just as was done for the 1987-based market basket.

3. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry is applied to this category. This is a revision from the 1987-based market basket in which the ECI for wages and salaries for professional and technical workers in private industry was used.

4. Fuel, Oil, and Gasoline

The percentage change in the price of refined petroleum products as measured by the Producer Price Index (PPI) (Commodity Code #057) was applied to this component. This is a revision from the 1987-based indexes in which the PPIs for Light Fuel Oil (Commodity Code #0573) and Gasoline (Commodity Code #0571) were used.

5. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) was applied to this component. This is a revision from the 1987-based indexes in

which the PPI for industrial power (Commodity Code #0543) was used.

6. Natural Gas

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) was applied to this component. This is a revision from the 1987-based indexes in which the PPI for Natural Gas (Commodity Code #0531) was used.

7. Water and Sewerage

The percentage change in the price of water and sewerage maintenance as measured by the Consumer Price Index (CPI) for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

8. Professional Liability Insurance

The percentage change in the hospital professional liability insurance price as estimated by hospital industry professional liability insurance premium increase was applied to this component. The same price measure was used in the 1987-based market baskets.

9. Pharmaceuticals

The percentage change in the price of ethical preparations as measured by the PPI (Commodity Code #0635) was applied to this variable. The same price measure was used in the 1987-based market baskets.

10. Food, Direct Purchases

The percentage change in the price of processed foods and feeds as measured by the PPI (Commodity Code #02) was applied to this component. The same price measure was used in the 1987-based market baskets.

11. Food, Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

12. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) was applied to this component. The same price measure was used in the 1987-based market baskets.

13. Surgical and Medical Equipment

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) was applied to this component. The same price measure was used in the 1987-based market baskets.

14. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) was applied to this component. The same price measure was used in the 1987-based market baskets.

15. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) was applied to this component. The same price measure was used in the 1987-based market baskets.

16. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) was used. This is a revision from the 1987-based indexes in which a weighted average of the percentage change in the price of converted paper and paperboard products and the percentage change in the price of paper excluding newsprint and packaging paper (Commodity Code #091301) was used.

17. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) was applied to this component. This is a revision from the 1987-based indexes in which the PPI for textile house furnishings (Commodity Code #0382) was used.

18. Minor Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) was applied to this component. The same price measure was used in the 1987-based market baskets.

19. Miscellaneous Products

The percentage change in the price of all finished goods as measured by the PPI was applied to this component. The same price measure was used in the 1987-based market baskets.

20. Business Services

The ECI for compensation for workers in the business services industry was applied to this component. This is a revision from the 1987-based indexes in which the percentage change in the AHE for wages and salaries for production and nonsupervisory workers in the business services industry as measured by the Bureau of Labor Statistics (SIC Code 73) was used.

21. Computer and Data Processing Services

The percentage change in the AHE of production and nonsupervisory workers engaged in firms furnishing computer data processing services (SIC Code 737) was applied to this component. The same price measure was used in the 1987-based market baskets.

22. Transportation and Shipping

The percentage change in the transportation component of the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

23. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

24. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

25. All Other Services, Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry was applied to this component. This is a revision from the 1987-based indexes in which the ECI for wages and salaries paid to service workers employed in private industry was used.

26. All Other Services, Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

For further discussion of the rationale for choosing specific price proxies, we refer the reader to the September 3, 1986 final rule (51 FR 31582).

II. Data Sources Used to Determine the Cost Category Weights and Vintage Weights, and Choices of Price Proxy Variables for the Hospital Capital Input Price Index

In the preamble to this final rule, we discuss the rebasing of the capital input price index (CIPI). This appendix describes certain technical features of the 1992-based index, as well as differences between the 1992-based CIPI and the 1987-based CIPI. We discussed

the 1987-based CIPI in the September 1, 1995 final rule (60 FR 45817.)

This discussion has the following three parts:

- A synopsis of the differences between the 1987-based CIPI and the 1992-based CIPI.
- A description of the methodology used to develop the cost category weights and vintage weights in the 1992-based CIPI, making note of the differences from the methodology used to develop the 1987-based CIPI.
- A description of the data sources used to measure price change for each component of the 1992-based CIPI, making note of the differences from the price proxies used in the 1987-based CIPI.

A. Synopsis of Changes Adopted in the Rebased 1992 CIPI

We made no structural changes in the 1992-based CIPI. The only major change is the use of more recent hospital capital expenditure data. The 1987-based CIPI contained cost category weights that were derived from 1987 Medicare cost report data and the 1987 Annual Survey of the AHA. The 1992-based CIPI uses data from the hospital Medicare cost reports for cost periods beginning between October 1, 1991 and September 30, 1992. The 1992-based CIPI also uses data from the 1992 Annual Survey of the AHA.

The 1987-based CIPI contained vintage weights that were derived from 1987 Medicare cost report data, the 1963–1987 Panel Survey of the AHA, and the 1980–1989 Securities Data Corporation data on hospital bonds. The 1992-based CIPI uses data from the 1992 Medicare cost reports, the 1963–1992 Panel Survey of the AHA, and 1980–1992 Securities Data Corporation data on hospital bonds.

B. Methodology for Developing Cost Category Weights and Vintage Weights for the 1992-based CIPI

There are five cost categories in the CIPI: Building and fixed equipment depreciation, movable equipment depreciation, capital-related interest expense from government/nonprofit debt instruments, capital-related interest expense from for-profit debt instruments, and other capital-related expenses, such as taxes and insurance. The methodology for developing each of these cost category weights is described below:

1. Building and Fixed Equipment Depreciation

The 1992-based cost weight for building and fixed equipment depreciation was derived using the 1992 Medicare cost reports. The proportion of lease expenses attributable to building and fixed equipment was included in the cost weight based on the proportion of overall capital expenses allocated to building and fixed equipment depreciation. The 1987-based weight was developed from the 1987 Medicare cost reports and the 1987 AHA Annual Survey.

2. Movable Equipment Depreciation

The 1992-based cost weight for movable equipment depreciation was derived using the 1992 Medicare Cost Reports. The proportion of lease expenses attributable to movable equipment was included in the cost weight based on the proportion of overall capital expenses allocated to movable equipment depreciation. The 1987-based weight was developed from the 1987 Medicare cost reports and the 1987 AHA Annual Survey.

3. Government/Nonprofit Interest

The 1992-based cost weight for government/nonprofit interest was derived using the 1992 AHA Annual Survey data. The government/nonprofit interest is 85 percent of total interest, reflecting the relative debts of the government/nonprofit hospital sector and the for-profit hospital sector. The proportion of lease expenses attributable to government/nonprofit interest was included in the cost weight based on the proportion of overall capital expenses allocated to government/non-profit interest expense. The 1987-based weight was developed from the 1987 AHA Annual Survey.

4. For-Profit Interest

The 1992-based cost weight of for-profit interest was derived using the 1992 AHA Annual Survey data. The for-profit interest is 15 percent of total interest, reflecting the relative debts of the government/nonprofit hospital sector and the for-profit hospital sector. The proportion of lease expenses attributable to for-profit interest was included in the cost weight based on the proportion of overall capital expenses allocated to for-profit interest expense. The 1987-based weight was developed from the 1987 AHA Annual Survey.

5. Other Capital-Related Expenses

The 1992-based cost weight for other capital-related expenses was derived using 1992 Medicare cost reports. The proportion of lease expenses attributable to other capital-related expenses was included in the cost weight based on the proportion of overall capital expenses allocated to other capital-related expenses. The 1987-based weight was developed from the 1987 Medicare cost reports and the 1987 Capital Expenditure Survey.

6. There are three sets of vintage weights in the CIPI

Building and fixed equipment depreciation, movable equipment depreciation, and interest expense. The methodology for developing each of these vintage weights is described below.

a. Building and Fixed Equipment: The 1992-based building and fixed equipment vintage weights were derived from the 1992 Medicare cost reports and the 1963–1992 AHA Panel Survey. The 1987-based weights were developed from the 1987 Medicare cost reports and the 1963–1987 AHA Panel Survey.

b. Movable Equipment: The 1992-based movable equipment vintage weights were derived from the 1992 Medicare cost reports and the 1963–1992 AHA Panel Survey. The 1987-based weights were developed from the 1987 Medicare cost reports and the 1963–1987 AHA Panel Survey.

c. Capital-Related Interest: The 1992-based movable equipment vintage weights were derived from the 1980–1992 Securities Data Corporation data on hospital bonds and the 1963–1992 AHA Panel Survey. The 1987-based weights were developed from the 1980–1989 Securities Data Corporation data on hospital bonds and the 1963–1987 AHA Panel Survey.

C. Price Proxies Used to Measure Cost Category Growth in the CIPI

1. Building and Fixed Equipment Depreciation

The percentage change in the vintage-weighted price of building and fixed equipment depreciation as measured by the Boeckh institutional construction index was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

2. Movable Equipment Depreciation

The percentage change in the vintage-weighted price of movable equipment depreciation as measured by the Producer Price Index (PPI) for machinery and equipment was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

3. Government/Nonprofit Interest Expense

The percentage change in the vintage-weighted price of government/nonprofit interest expense as measured by the Average yield on Domestic Municipal Bonds from the Bond Buyer index of 20 bonds was applied to this category in

the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

4. For-Profit Interest Expense

The percentage change in the vintage-weighted price of for-profit interest expense as measured by the Average yield on Moody's Aaa Bonds was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

5. Other Capital-Related Expenses

The percentage change in the price of other capital-related expenses as measured by the CPI for all urban consumers for residential rent was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

We provided more detailed discussion of the rationale for the choice of these price proxies in the June 2, 1995 proposed rule (60 FR 29227) and in the September 1, 1995 final rule (60 FR 45815).

Appendix D: 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 inpatient services furnished in FY 1997 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XII) of the Act sets the FY 1997 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.5 percentage points for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1997 percentage increase in the hospital-specific rates 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 0.5 percentage points. Section 1886(b)(3)(B)(ii) of the Act sets the FY 1997 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 adjustment percentage increase for FY 1997 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 1997 is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for FY 1997.

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 1996 forecast of the FY 1997 rebased market basket increase of 2.5 percent for hospitals subject to the prospective payment system, the updates in the standardized amounts are 2.0 percent for hospitals in both large urban and other areas. The update in the hospital-specific rate applicable to sole community hospitals is 2.0 percent (that is, the market basket rate of increase of 2.5 percent minus 0.5 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 2.5 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 1.5 and 2.5 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 under section 1886(e)(4) of the Act as Appendix E of the May 31, 1996 final rule (61 FR 27591).

II. Secretary's Final Recommendation for Updating the Prospective Payment System Standardized Amounts

We did not receive any public comments concerning our proposed recommendation. Therefore, 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 1.5 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 1.5 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. These figures are consistent with the President's FY 1997 budget recommendation, which continues the reductions imposed by section 13501 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), that is, reductions in the hospital market basket of 2.5 percentage points for FYs 1994 and 1995 and 2.0 percentage points for FY 1996. We believe these recommended changes in the update factor would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund. When the President's budget was submitted, the market basket rate of increase was projected at 3.6 percent. As noted above, our final recommendation is based on the most recent forecast of the rebased market basket. (See section IV of the

preamble to this final rule for a detailed discussion of the market basket.)

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

Our final recommendation is that hospitals and hospital units excluded from the prospective payment system receive an update equal to percentage increase in the rebased market basket that measures input price increases for services furnished by excluded hospitals minus 1.5 percentage points. Thus, given the current estimate of the change in the market basket rate of increase for excluded hospitals of 2.5 percent (compared with the earlier estimate of 2.7 percent used in the proposed rule), our final recommendation is for an update of 1.0 percent. This recommendation is consistent with the President's budget, acknowledging that the market basket rate of increase for these hospitals was forecast at 3.6 percent at the time the budget was submitted.

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