(2) Individuals entitled to institutional services.

(c) Home health services (§ 440.70) to any individual entitled to skilled nursing facility services.

(d) If the State plan includes services in an institution for mental diseases (§§ 440.140 and 440.160) or in an intermediate care facility for the mentally retarded (§ 440.150(c)) for any group of medically needy, either of the following sets of services to each of the medically needy groups:

(1) The services contained in §§ 440.10–440.50 and 440.165; or

(2) The services contained in any seven of the sections in §§ 440.10–440.165.

77. Section 440.230 is revised to read as follows:

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

78. Section 440.240 is revised to read as follows:

§ 440.240 Comparability of services for groups.

Except as limited in § 440.250—

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

(1) The categorically needy.

(2) A covered medically needy group.

79. Section 440.250 is amended by adding new paragraphs (h) through (k) to read as follows:

§ 440.250 Limits on comparability of services.

* * * * *

(h) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

(1) Individuals under age 18; and

(2) Individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

80. The authority citation for Part 441 reads as follows:

Authority. Sec. 1102 of the Social Security Act, (42 U.S.C. 1302), unless otherwise noted.

81. Section 441.10 is amended by revising paragraph (a) to read as follows:

Subpart A—General Provisions

§ 441.10 Basis.

This subpart is based on the following sections of the Act which state requirements and limits on the services specified or provide Secretarial authority to prescribe regulations relating to services.

(a) Sections 1902(a)(10)(D) and 1905(a)(7) for home health services (§ 441.15).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 13.714 Medical Assistance Program)

Dated: September 16, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

[FR Doc. 81-28324 Filed 9-29-81; 8:45 am]

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federal register

Wednesday
September 30, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Reductions in Payments to States

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 433

45 CFR Part 201

Medicaid Program; Reductions in Payments to the States

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

ACTION: Interim Final Rule with Comment Period.

SUMMARY: This rule amends current Medicaid regulations to implement section 2161 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) which imposes reductions in Federal matching payments for fiscal years 1982 through 1984. In the regulations, we describe the conditions and specify minimum criteria under which States may lower the reduction. The conditions are the existence of a qualified hospital cost review program, a specific level of unemployment in a State, and a specific amount of fraud and abuse recoveries by a State or, for fiscal year 1982 only, a combination of fraud and abuse and third party liability recoveries. We intend these regulations to provide guidance as to when the reductions, and offsets against the reductions, will be made and how States can qualify for the offsets.

In addition, we have issued a notice of proposed rulemaking elsewhere in this issue of the **Federal Register** that contains proposed policies concerning recoveries from liable third parties for purposes of implementing section 2161.

DATES: This rule is effective September 30, 1981. It is being issued as a final rule for reasons explained in Waiver of Proposed Rulemaking in the Supplementary Information section below. However, we will consider any comments mailed by November 30, 1981, and revise the regulations, if necessary.

Sections 433.209 and 433.213 of these regulations contain reporting or recordkeeping requirements that have not been approved by the Office of Management and Budget (OMB). The reporting or recordkeeping referenced in these sections is not required until OMB approval has been obtained. HCFA will publish a further notice in the **Federal Register** when OMB approves or disapproves these requirements.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPO–26–FC. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202–245–7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, if as a result of comments, we believe that changes are needed in these regulations, we will publish the changes in the **Federal Register** and respond to the comments in the preamble of that document.

FOR FURTHER INFORMATION CONTACT: Charles Schreibeis, 301–597–1702.

SUPPLEMENTARY INFORMATION:

I. Background

A. Program Description

Medicaid, authorized under title XIX of the Social Security Act, is a program that provides medical assistance to certain categories of individuals and families with low income. The program is funded by both the Federal government and the States, but is administered by the individual States. Each State designs its own program within certain Federal guidelines. Thus, there is substantial variation among the States in the nature of the program itself and in the way in which the program is administered. For example, eligibility requirements, the range of medical services provided to beneficiaries, and the policies governing the ways in which providers of health care services are reimbursed may differ extensively from State to State. Additionally, because of differing levels of administrative resources and the scope of individual programs, the various States emphasize specific administrative aspects of their program, such as fraud and abuse activities, to varying degrees.

Under current law, as noted above, Medicaid is financed jointly with Federal and State funds. Generally, the Federal government shares in the cost of health care services covered under each State's Medicaid program, with the Federal contribution determined under a statutory formula (sections 1903(a) and 1905(b) of the Social Security Act) that is designed to have the Federal government pay a proportionally larger share of the program in States with lower per capita income as compared to the national per capita income. The Federal government also shares in the cost of the administration of each State's Medicaid program (section 1903(a) of the Act).

B. Section 2161 of the Omnibus Budget Reconciliation Act of 1981

On August 13, 1981, the President signed the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35). Section 2161 of that Act added sections 1903(s) and (t) to the Social Security Act and mandated progressive reductions in total Federal Medicaid payments to the States for fiscal years 1982 through 1984. Under the law, Federal matching payments to which a State is entitled are to be reduced by three percent of each quarter's payment in fiscal year (FY) 1982, four percent in FY 83, and four and one half percent in FY 84. However, Congress provided that a State may lower the amount of its reduction by one percentage point for each quarter in the year for each of the following conditions:

- The State has in operation a qualified hospital cost review program.
- The State has an unemployment rate equal to or exceeding 150 percent of the national average.
- The State demonstrates recoveries of Medicaid funds, as a result of fraud and abuse initiatives, equal to one percent of the Federal share of total expenditures. With respect to FY 82 only, States may qualify for this decrease if the combination of recoveries from fraud and abuse and third party liability efforts is equal to one percent of the Federal share of total expenditures.

The legislation further provides that a State will be entitled to a dollar for dollar offset in the reductions if total Federal Medicaid funding of the State's program in a year falls below a specified target amount. However, the amount recovered by a State in this manner may not exceed the total amount of the original reduction for the fiscal year. Congress established the target amount for 1982 as equal to 109 percent of each State's estimate of the amount of Federal funding it needed for FY 81, and stipulated that the State estimates to be used would be those that were submitted to HCFA before April 1, 1981. For FY 83 and FY 84, the target amounts are equal to the FY 82 target amount increased or decreased by the same percentage as the increase or decrease in the index of the medical care

expenditure component of the consumer price index over the same period.

A review of the legislative history of section 2161 and the language of the section itself clearly indicate what Congress intends regarding the existence of a hospital cost review program. Section 2161 states the specific conditions (see section II A of this Preamble) that must be met, including requirements for the effective date of the program, its scope, its treatment of affected groups, and its results in terms of cost containment.

Regarding the offset for States with high unemployment, the statute provides that a State qualifies for the one percent offset in the reduction if the monthly average of unemployment for the quarter immediately preceding the quarter in which the offset is to be applied is equal to or greater than 150 percent of the national average for the same period.

For purposes of the offset gained by fraud and abuse recoveries, and for 1982 only, both fraud and abuse and third party liability recoveries, the statute simply provides that the recoveries for a quarter must equal or exceed one percent of the amount of Federal payments to the State in that quarter.

These provisions, and how we will apply them, are discussed in greater detail below.

Congress specifically applied the reductions, and the offset against the reductions, to the State with Medicaid plans approved as of July 1, 1981. This means that the reductions apply to all States and the District of Columbia, with the exception of Arizona, which does not participate in Medicaid. Other provisions of the Budget Act (section 2162) set limits on Federal funding for Medicaid programs in the other jurisdictions (Guam, Puerto Rico, the Virgin Islands and the Northern Mariana Islands).

Reductions in Medicaid payments to the States under section 2161 were made contingent on approval and publication of regulations by the Secretary implementing several other provisions of law, by the first day of the quarter in which the reductions are applied. First, Congress required that final regulations implementing section 1902(a)(10)(C) of the Social Security Act, as amended by section 2171 of the Omnibus Budget Reconciliation Act of 1981, relating to flexibility in Medicaid eligibility requirements, be published in the **Federal Register**. Second, Congress required that regulations implementing section 1902(a)(13)(A) of the Social Security Act, as amended by section 962 of the Omnibus Reconciliation Act of 1980 and section 2173 of the Omnibus Budget Reconciliation Act of 1981, relating to modifications in requirements for hospital, skilled nursing facility and intermediate care facility reimbursement, be published. The first set of regulations were published elsewhere in this issue, and the second set published elsewhere in this issue.

II. Provisions of the Regulations

A. Location and General Content

We have amended the existing Medicaid regulations in 42 CFR Part 433, State Fiscal Administration, by adding a new Subpart E, Reductions in Total Federal Payments to the States for fiscal years 1982–1984. The new subpart spells out the rules that will govern HCFA's administration of the statutory requirements. Specific provisions are explained below. In addition, we have made conforming changes in 42 CFR Part 433, Subpart A and 45 CFR Part 201. These changes are cross-references to the new subpart.

B. Notice of Proposed Rulemaking on Third Party Liability Recoveries

We issued a notice of proposed rulemaking elsewhere in this issue of the **Federal Register** containing a proposed description of what we mean by recoveries from liable third parties. We are providing the public with a 30 day period in which to comment on the proposal and will issue a final rule as soon as possible after the comment period is over. The final rule will consist of definitions of "third party" and "third party liability" to be included in § 433.203 and a new § 433.215 that will describe the use of recoveries from liable third parties in determining the offset against the FY82 reductions.

C. States with Qualified Hospital Cost Review Programs

Sections 433.207(a) and 433.209 of the new regulations are based on sections 1903 (s)(2)(A) and (s)(3) of the Social Security Act (as enacted by section 2161 of Pub. L. 97–35). Section 1903(s)(2)(A) specifies that the percentage reduction in FFP for a State that is required by the amendment for a quarter is to be decreased by one percentage point if the State has a qualified hospital cost review program for the quarter. Section 1903(s)(3) specifies that a program will be considered to be "qualified" if specific criteria are met. These criteria are as follows:

- The program must have been established by statute, and have been in effect on July 1, 1981, and at the beginning of the quarter in which offset against the reduction is granted;
- The program must be operated directly by the State;
- The program just apply to substantially all non-Federal acute care hospitals;
- Under the program, the State must review all non-Medicare revenues or expenses for inpatient hospital services, or at least 75 percent of all revenues or expenses for inpatient hospital services, including those under Medicare;
- The State must make satisfactory assurances to the Secretary that the program provides substantially equitable treatment to all payors, hospital employees and hospital patients; and
- The State's rate of increase in aggregate inpatient hospital costs per capita or per admission on a calendar year basis must be at least two percentage points lower than the rate of increase in all States without qualifying programs. The period of comparision is the most recent calendar year or, at the State's option, the two or three calendar year period ending at least nine months before the quarter covered by the Federal payment.

These conditions are set forth in § 433.209 of the new regulations as the criteria we will use to determine whether a State is entitled to a decrease in the reduction based on the existence of a qualified hospital cost review program. Since we believe these criteria are largely self-explanatory, we have not included any further description of our interpretation of them in § 433.209. To avoid any confusion as to how we intend to implement § 433.209, however, we are providing an explanation of the meaning of certain key phrases used in that section, as follows:

- *Established by statute.* We will consider a program to be "established by statute" if the statutory laws of the State provide a basis for the operation of the program.
- *In effect.* We will consider a program to have been "in effect" on July 1, 1981 if, on that date, rules or regulations for the conduct of the program had been issued and were in effect.
- *Operated directly by the State.* This means that the State must be directly involved in the operation of the program, or that final decisions under the program must be made by a State employee or by an individual or a commission (or similar body) appointed by the State
- *Substantially all.* We will consider a program to apply to "substantially all" non-Federal acute care hospitals in a State if it applies to all non-Federal acute care hospitals, with possible,

occasional exceptions for the purpose of dealing with extraordinary circumstances.

• *Review.* For purposes of § 433.209, we will consider review of revenue or expenses to mean an examination of:

(1) The reasonableness of a hospital's proposed revenue, expenses, or rate request for a prospective period that results in a determination that is binding on the hospital; or

(2) A hospital's past expenses, rates or revenue for purposes of establishing rates or restricting the revenue to be received by the hospital for services in future periods.

If a State does not review hospitals when their proposed expenses, revenues or rate increases are less than specified target levels, those hospitals would be considered to have been reviewed by the State for purposes of determining whether the program was qualified under this section.

• *Assurances regarding equitable treatment.* To meet this requirement, we are requiring that the State assure HCFA, in a letter signed by the administrator of the Medicaid State agency, that the State's review program provides for equitable treatment of all entities that pay hospitals for inpatient hospital services, all hospital employees, and all hospital patients. In the absence of a significant question about whether all entities are being treated equitably, we will not require the State to specify the basis for its assurances, or to provide further information regarding its manner of ensuring that payers, hospital employees, and patients are treated equitably.

• *Calculation of annual rates of increase in aggregate hospital inpatient costs on a calendar year basis.* In determining whether this requirement is met, we will use the best available national data base. However, no national data bases currently exist with individual or Statewide hospital expense data reported on a calendar year basis. Medicare cost reports, for example, are filed by hospitals based on their own fiscal years which vary throughout the calendar year.

The best available data base currently available is the American Hospital Association's Annual Survey of Hospitals. The expenses reported by AHA are total expense figures (outpatient as well as inpatient expenses). To compute inpatient admission expenses, adjustments are made for outpatient costs by using a ratio of outpatient revenue to total revenue to derive an adjusted admissions figure. HCFA will make a similar adjustment to compute an inpatient expense per capita.

For purposes of this Annual Survey, hospitals are requested by the American Hospital Association (AHA) to report each year's expenses based on their fiscal years ending closest to September 30. AHA then makes the data available from its Annual Survey in September of the year following the reporting date. (Approximately one-half of the hospitals report to AHA on the basis of fiscal years ending on September 30, one quarter on June 30, and the remainder vary throughout the calendar year.) This means that data reported to AHA for hospital reporting periods closest to September 30, 1980 will be available in late September, 1981.

In addition, in order to prepare a national data base for *calendar year* 1980, it is necessary to have available for *all* hospitals both their FY80 and FY81 expenditure data (except those with fiscal years ending on December 31). For example, a hospital whose fiscal year ended on September 30, 1980 would report to AHA its expenditure data for the period October 1, 1979 through September 30, 1980. At the end of its FY81, that hospital would report to AHA its expenditure data for the period October 1, 1980 through September 30, 1981. This latter data would, of course, be included in AHA's Annual Survey available in September, 1982. Therefore, data from both fiscal years would be used to construct a *calendar year* 1980 expenditure file for the hospital because FY81 expenditure reports would be needed to provide the data for the period October through December, 1980.

As a result of this delay in the availability of complete data for calendar year 1980, and in order to avoid an unreasonable delay in the application of the hospital cost review offset against the reduction, we will use the data available by the end of October 1981 in the AHA Annual Survey. We will determine in this manner which States tentatively meet the criterion and apply the offset against the reduction in grants for all quarters of FY81. We anticipate that we will make a supplementary grant award in November to States that qualify for the offset. For subsequent quarters, we will make the adjustment in the initial grant award. We will review the AHA Annual Survey published in September 1982 and make any necessary retroactive adjustments to the grant awards of the States determined to have qualified for the reduction. We will follow these same procedures in FY 83 and FY 84.

D. States with High Unemployment Rates

Section 433.207(b) of the new regulations is based on sections 1903(s)(2)(B) and (4) of the Social Security Act, as enacted by section 2161. Those sections specify that the percentage reduction in FFP required by the amendment for a calendar quarter is to be decreased by one percentage point if the State's average monthly unemployment rate for the immediately preceding calendar quarter, as determined by the Bureau of Labor Statistics (BLS), was at least 50 percent higher than the national average unemployment rate for the same period. To determine whether a State's average monthly unemployment rate is high enough to permit the State to qualify for this decrease, we plan to use the unemployment data in *Employment and Earnings* (table E–1), which is published monthly by the BLS and includes unemployment data for all States. The unemployment data for the 10 largest States are based on the *Current Population Survey*, which is the same survey used to derive estimates of national unemployment rates. Unemployment data for other States are based on State-administered unemployment insurance surveys. The unemployment data for each quarter generally are available by the middle of the following quarter. We will issue a supplementary grant award as soon as the data is available.

E. Fraud and Abuse and Third Party Liability Recoveries

Under section 1903(s)(2)(C) of the Act, as enacted by section 2161, the States will be entitled for each quarter to a decrease of one percentage point in the applicable reduction if the total amount of the State's recoveries against expenditures for the previous quarter, that are the result of third party liability or fraud and abuse activities, is equal to or exceeds one percent of the total Federal Medicaid payments due the State for the quarter. The statute goes on to define "recoveries" and further provides that recoveries from liable third parties may be considered for FY 82 only. In addition, the provision specifies that recoveries exceeding one percent of the Federal payment can be carried over for crediting against the succeeding quarter's reduction.

Third party and fraud and abuse recoveries are defined by section 1903(s)(5)(A)(i) as the total amount that the "State demonstrates to the Secretary that it has recovered or diverted * * *" We believe that Congress intended that

the States must be able to document their recoveries and must report them to HCFA before we include them in our determinations concerning the decrease in the reduction of Federal payments. In itself, the phrase "demonstrates to the Secretary" necessarily implies that the recoveries must be auditable and have been reported. Additionally, however, in the Report of the House Committee on the Budget on H.R. 3982 (97th Congress, 1st Sess. 290 (1981)), clear reference is made to the view that the recoveries must be documented. The report goes on to note that claims by the States of reduced expenditures because fraud and abuse has been discouraged are too subjective to establish the right to a smaller reduction through application of the offset. We find nothing in the legislative history of Pub. L. 97-35 to indicate a shift in Congressional intent away from that view. Therefore, in the regulation we do not consider expenditures that may have been reduced because fraud and abuse have been discouraged. We defined recoveries to include funds actually collected or diverted by a Medicaid State agency or Medicaid Fraud Control Unit, and which have been reported to the Federal government.

Furthermore, the statute makes use of the term "diverted" funds. We take the view that Congress intended that diverted funds, as well as recoveries, should be documented by the State before being included in determinations by HCFA concerning decreases in the reduction mandated by Pub. L. 97-35. We included in the definition of diverted funds amounts saved as a result of a State's having applied prepayment screens to all claims submitted by a specifically identified provider, and also savings realized from the application of special prepayment utilization screens in a mechanized or automated claims processing system. With respect to general screens, we distinguish between routine monitoring or screening edits in automated or mechanized claims systems and those put in place by the States as a result of surveillance and utilization review program actions or fraud control unit actions.

We will include savings from the latter source in deteminations about the fraud and abuse effect, and we will designate categories of screens that qualify in our reporting instructions for completion of the quarterly expenditure report (Form HCFA-64). Examples of qualified categories of screens are one time only procedures, inappropriate services for speciality and inappropriate place of service. More generally, diverted funds do not, for example, include amounts—

- Recovered as a result of routine audit activities or review of cost reports;
- Recovered or avoided as a result of detecting duplicate payments or applying normal utilization claims processing screens;
- Saved from claims that are denied as a result of prior authorization or general application of mechanized prepayment screens;
- Recovered as a result of overpayments based on State agency or fiscal agent administrative error;
- Amounts estimated by the States as future savings based on the conviction or suspension of a provider from Medicaid because of fraud or abusive practices;
- Amounts saved as a result of programs that restrict recipients to receive services from certain providers.

Generally, the regulations (§ 433.213) provide that HCFA will grant, on a quarter by quarter basis, the one percent decrease in the applicable reduction based on the total amounts a State can demonstrate as having been recovered or diverted through operation of its fraud control unit or through other fraud or abuse control activities. HCFA will make adjustments based on the decrease after it has received and reviewed the applicable data and determined that a State qualifies for the offset. This normally will occur toward the end of the quarter, or in the next succeeding quarter, depending on the timeliness of receipt and review of the necessary data.

For fiscal year 1982 only, Congress provided that recoveries from liable third parties will be included in determinations regarding the applicability of the one percent decrease in the reduction. This provision is covered in the proposed § 433.215, published in the notice of proposed rulemaking mentioned above.

We also provide in § 433.213 that amounts of third party liability (fiscal year 1982 only) and fraud and abuse recoveries in a quarter that exceed one percent of the total Federal Medicaid payments due a State for that quarter, will be carried forward for one quarter, as provided in section 1903(s)(5)(B).

For the purpose of establishing a tracking system to determine whether a State achieves the requisite level of third party liability and fraud and abuse recoveries, we are requiring that States report the data on existing forms. We will extract the data from these forms. Additionally, it is important to note here that the forms must be properly completed in order to facilitate a timely determination regarding the level of recoveries.

E. Target Amounts

Section 433.217 of the regulations implements section 1903(t) of the Social Security Act, as added by section 2161(b) of Pub. L. 97-35. Section 1903(t) provides for establishment of target amounts of Federal Medicaid expenditures for each State for fiscal years 1982, 1983 and 1984. A State is entitled to a dollar-for-dollar offset of the reductions made under section 2161 if the total Federal Medicaid expenditures fall under its target amount, but the offset applies only up to the total amount of the reductions.

The target amounts are established as follows:

FY 82—109 percent of the State's estimate of the Federal share of expenditures for FY 81, as reflected in the estimate received by the Department before April 1, 1981;

FY 83 and *FY 84*—The FY 82 target amount adjusted by the percentage increase or decrease in the index of the medical care expenditure category of the consumer price index for all urban consumers, between September 1982 and the end of the respective fiscal year (September 1983 or September 1984).

The calculation of the target amounts does not take into account interest paid under section 1903(d)(5) on disallowances of State claims, reductions in payments under section 1903(s) as enacted by section 2161, supplementary payments received by the State for spending less than the target in the previous year, or adjustments for claims relating to expenditures before October 1, 1981.

Under sections 1905(b) and 1101(a)(8) of the Social Security Act, the percentage of the Federal share of each State's medical assistance expenditures is recalculated each two years according to a specified formula. There will be a recalculation of the formula for FY 84. In recognition of this, section 1903(t)(3) provides that any change in this percentage for a State for FY 84 will be disregarded for purposes of computing target amounts. The Conference Report (H.R. Rep. No. 97-208, 97th Cong., 1st Sess. (1981)) points out (p. 960) that this provision was included to avoid rewarding a State simply because of a change in the share of its expenditures paid by the Federal government.

It should be noted that, under section 2165 of Pub. L. 97-35, Congress directed the Comptroller General, in consultation with the Advisory Commission on Intergovernmental Relations, to conduct a study of (1) the statutory formula for

computing the Federal medical assistance percentage (the Federal share of State Medicaid expenditures), and (2) the validity and equity of adjustments that should be made to the States' FY 83 and FY 84 target rates to reflect economic and demographic factors affecting the State but not under the State's ordinary sphere of control. The report is due to Congress by October 1, 1982.

III. Implementation of the Regulations

A. HCFA Grant Awards Process

We will impose the reductions mandated by Congress through our grant awards process. As noted above, the Federal government's share of a State's Medicaid program is determined by a formula based on the State's per capita income, with special provisions for administrative expenditures. Regulations governing the process are located in 45 CFR Part 201. To obtain the Federal government's share (which is called Federal financial participation, or FFP), each State submits to HCFA, 45 days prior to the beginning of each quarter in the fiscal year, an estimate (Form HCFA–25) of the amount of FFP the State will need for that quarter. This estimate includes the amounts the State believes it will need from the Federal government to cover program expenditures (that is, medical services covered under the State plan) and administrative expenditures. After reviewing the estimates, we advance funds by awarding a grant about 15 days before the beginning of the quarter. This grant authorizes States to obtain Federal cash as a payment of estimated expenses. Within 30 days after the end of the quarter, the State submits a quarterly expenditure report (Form HCFA–64) that reflects the actual expenditures incurred by the State. We review the report and determine whether the State has claimed reimbursement for any expenditures that are not allowable. (See **Federal Register** issues of January 15, 1981 (46 FR 3527) and September 17, 1981 (46 FR 46134) for clarification of "expenditures".) If we determine that any adjustments (that is, deferral, disallowance, suspension or other financial actions) are necessary in the amount of FFP advanced to the State before the quarter, the adjustment is made at the same time that the award for the next succeeding quarter is granted or shortly thereafter as a supplemental grant award.

B. Effect of Section 2161 on the Grants Process

The grant award computation form we use (Form HCFA–152) shows the amount of the estimate for the ensuing quarter, and the amounts by which the estimate is reduced or increased because of over- or under-estimates for a prior quarter and for other adjustments. We will use this form to show the applicable reduction to the amount of payments to the State and any of the three offsets against the reduction for which the State qualifies.

Of the three conditions allowing offsets against the reduction, two are not dependent on the budget and awards process followed by HCFA and the States. That is, unemployment offset and the hospital rate review program offset are controlled by factors extrinsic to the grant awards process. On the other hand, we will implement the fraud and abuse and third party liability offset based on information gathered and reported by the States, as explained below, to support their estimates of the amount of FFP needed for a given quarter.

Included in the State's expenditure reports are expenditures for current and prior year activities, as well as collections and adjustment actions. Part of the data reported covers the State's collection efforts in recovering funds through third party payments. In these instances, claims paid under the Medicaid program are collected from insurance companies or others found to have the legal liability to pay for care and services. Also reported are recovered amounts that result from fraud and abuse control actions. State Medicaid fraud control units or other fraud control entities are responsible for collecting payments that were made improperly. Through the efforts of these units, funds are returned to the program.

The following example illustrates how we will reduce Federal payments in accordance with section 2161 of the Pub. L. 97–35. The example contains dates for FY 82, but the process described will apply equally to FY 83 and FY 84. Separate grant awards procedures and forms are used for grants to the States for the Federal share of the costs of State programs for survey and certification of health facilities, and for certified State Medicaid fraud control units authorized under 42 CFR 455.300, but the reductions and offsets apply to FFP for these costs as well. The following illustration also applies generally to our survey and certification grant procedures.

Funding needs for the first quarter of FY 82 were to be submitted by August 15, 1981. For our example, we are using a State funding estimate of $1,000,000. By August 30, 1981 the HCFA Regional Administrator had reviewed the State's estimate and submitted a recommendation of $800,000 as the State's funding need. Both the State estimates and Regional Administrator's recommendation were forwarded to the HCFA central office for use in preparing the first quarter grant award. The initial grant award was issued before the beginning of the quarter and was for the amount that HCFA estimates as the State's need for the quarter, less the three percent reduction. We will apply offsets for unemployment and for third party liability/fraud and abuse recoveries and collections when data is reviewed by HCFA indicating that States qualify for those offsets. In like manner, we will apply the hospital cost review offset when supporting data become available. In the first quarter of FY 82, we expect to apply this offset in November, 1981, and thereafter in the initial grant awards. We will make these adjustments by preparing supplemental grant awards during the quarter, or as soon as possible thereafter.

The States are to submit their expenditure reports 30 days after the end of the quarter, which would be January 30, 1982, for the purpose of our example. The HCFA Regional Administrator reviews the expenditures reported by the State and submits a recommendation on the allowability of the expenditures to the HCFA central office two weeks after the State submits the expenditure report. Based on the State expenditure report and the HCFA Regional Administrator's recommendations, the HCFA central office calculates the final expenditures amount and prepares the final grant award adjustment. This action is to occur together with the initial award for the third quarter; however, due to timing difficulties, the final adjustment will normally occur in the third quarter. As an example, we will assume that the initial HCFA determination of funds required is $800,000 and that $900,000 is the final expenditure amount. In addition, we will assume that the State qualified for the hospital cost review and the third party liability/fraud and abuse offsets. The final award adjustment calculation, including offsets, will be as follows:

HCFA Initial Funding Determination	$800,000
3% reduction—Sec. 2161	−24,000
Initial Grant Award	776,000
Adjusted Expenditures	900,000
3% reduction—Sec. 2161	−27,000
1% TPL/FA offset	9,000
1% Hospital Cost Review Offset	9,000
Final First Quarter Adjusted Expenditure	891,000
Initial Grant Award Funding	−776,000
Final Grant Award Adjustment	115,000

The quarterly cycle continues as described above for the remainder of the fiscal year. At the end of the fiscal year, before the issuance of the initial award for the first quarter of FY 83, the State's total expenditures for the fiscal year are estimated by the HCFA central office based on the available actual expenditure data and the State's budget estimate. To the extent that the State's total estimated expenditures are under the target amount and expenditure reductions have not been offset, the State is entitled to a supplemental adjustment. If, in this case, we use $3,600,000 as the State's estimated FY 82 expenditures, a target amount of $3,650,000 and $36,000 as reductions that have not been offset, we have the following calculation:

Target amount—FY 82	$3,650,000
Estimated Annual Expenditures	−3,600,000
Under Targeted Expenditures	50,000
Reductions not offset	36,000
Less Amount used as supplement award adjustment	36,000

Since $36,000 is the lower of the two amounts that are compared (the amount by which the State's expenditures are under its target amounts, and the amount of reductions not offset), this is the supplemental figure awarded to the State. Upon determination of the final expenditure amount for FY 82, an adjustment will be made as described above in the appropriate grant award.

IV. Impact Analyses

A. Executive Order 12291

The Secretary had determined, in accordance with Executive Order 12291, that this rule does not constitute a major rule. We are required by the Amendment to reduce FFP in Medicaid by more than $100 million per year. However, because the reduction is mandated by law and we are required by the amendment to adopt the specific implementation approach set forth in the regulations, the reduction is not attributable to this regulation.

B. Regulatory Flexibility Analysis

The Secretary certifies, under section 605(b) of the Regulatory Flexibility Act (Pub. L. 96–354), that these regulations will not have a significant economic impact on a substantial number of small businesses, nonprofit entities or small local governments.

One major objective of the revised regulations is to give States financial incentives for more efficient purchasing of health care services under Medicaid. We are aware that, in responding to these incentives, individual States may take actions that have a significant economic impact on some physicians, hospitals, long term care facilities, or other providers of services that meet the definition of "small entities" in Pub. L. 96–345. However, we do not now have any basis for predicting either the specific actions States will take, or the effect these actions will have on small entities. Moreover, apart from the budget reductions involved, which are not attributable to these regulations, State decisions are as likely to have a favorable as adverse impact on small entities, or to affect a less than "substantial" number. Accordingly, these regulations do not meet the thresholds established in the Regulatory Flexibility Act.

V. Waiver of Proposed Rulemaking

As explained earlier in this preamble, the major provisions of the new regulations are based on requirements that are set forth explicitly in section 2161. Because we are required by that amendment to adopt those rules, we believe it is unnecessary to publish a notice of proposed rulemaking. Further, we believe it would be both impractical and contrary to the public interest to delay implementation of section 2161 by the amount of time that would be needed to obtain and analyze public comments. As a practical matter, we would not be able to make any reductions in FFP for the first quarter of fiscal year 1982 if we delayed implementation of these rules by even the minimum amount of time (60 days) usually allowed for public comment and the time (30 days) usually provided for delay in the effective date. Therefore, we find good cause to waive the requirement for publication of a notice of proposed rulemaking and a delayed effective date. However, as stated previously, we will accept any comments mailed within the specified period and will make any changes in the regulations we believe necessary as a result of the comments.

Title 42—Public Health

PART 433—STATE FISCAL ADMINISTRATION

A. 42 CFR Part 433 is amended as set forth below:

1. The table of contents for Part 433 is amended as follows:

a. Subpart A of Part 433 is amended by adding a new § 433.8 as follows:

Subpart A—Federal Matching Provisions

* * * * *

433.8 Application of progressive reductions during fiscal years 1982–1984.

* * * * *

b. A new Subpart E is added to Part 433 as follows:

Subpart E—Reduction in Total Federal Payments to the States for Fiscal Years 1982–1984

Sec.

433.201 Statutory basis and scope.
433.203 Definitions.
433.205 Reductions in total Federal payments.
433.207 Offsets against reductions.
433.209 Qualifications for offset based on hospital cost review programs.
433.213 Offset based on fraud and abuse recoveries.
433.215 Third party liability recoveries [Reserved].
433.217 Use of target amounts to decrease reductions.

2. The authority citation for Part 433 is revised to read as follows:

Authority: Secs. 1102, 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), 1903(s), 1903(t) and 1912 of the Social Security Act (42 U.S.C. 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), 1396b(s), 1396b(t) and 1396(k), unless otherwise noted.

3. Subpart A is amended by adding a new § 433.8 as follows:

§ 433.8 Application of progressive reductions to FFP during fiscal years 1982–1984.

Under sections 1903 (s) and (t) of the Act, HCFA will reduce the FFP described in §§ 433.10 and 433.15 in accordance with the procedures described in Subpart D of this part.

4. A new Subpart E is added to read as follows:

Subpart E—Reduction in Total Federal Payments to the States for Fiscal Years 1982–1984

§ 433.201 Statutory basis and scope.

(a) *Basis.* Sections 1903 (s) and (t) of the Act (as enacted by section 2161 of Pub. L. 97–35) provide for progressive reductions in Federal payments to the States, in fiscal years 1982 through 1984.

(b) *Scope.* The reductions apply only to the 49 States with Medicaid programs approved by HCFA as of July 1, 1981, and to the District of Columbia. Special funding provisions in § 433.10 apply to Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands.

§ 433.203 Definitions.

For purposes of this subpart—

"Abuse" means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for

services that are not medically necessary or that fail to meet professionally recognized standards for health care.

"Diverted funds" means those amounts saved from claims that are denied or reduced in amount—

(1) As a result of applying prepayment screens to all or a particular portion of the claims submitted by a specifically identified provider; and

(2) By the application of special prepayment utilization screens in a mechanized or automated claims processing system, designed to detect fraud and abuse, to all claims submitted for payment from all providers or from a general category of providers. The term does not include amounts estimated by the States as future savings based on the conviction or suspension of a provider from Medicaid because of fraud or abusive practices.

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or to some other person or entity. It includes any act that constitutes fraud under applicable State law.

"Recoveries" means Medicaid funds a provider of services has been paid in excess of amounts payable under title XIX of the Act, applicable regulations and the State plan that are actually collected or diverted by a State agency or Medicaid Fraud Control Unit, and which have been reported to the Federal Government. Fines, penalties and unexecuted judgments established by, Federal, State, or local courts or administrative bodies are not considered recoveries.

§ 433.205 Reductions in total Federal payments.

(a) *Amount of the reductions.* HCFA will reduce total Federal payments to which a State is otherwise entitled under the Medicaid program by the following percentages:

(1) Three percent in fiscal year 1982.

(2) Four percent in fiscal year 1983.

(3) Four and one half percent in fiscal year 1984.

(b) *Effective date and date reductions end.* HCFA will impose the reductions effective October 1, 1981 for the first quarter in fiscal year 1982. No reductions will be imposed for quarters after the last quarter of fiscal year 1984, which ends on September 30, 1984. However, adjustments relating to the final computations for fiscal years 1982–1984 expenditures will continue to be made until the States have submitted all expenditure reports and all outstanding issues have been resolved.

(c) *Amounts not affected by reductions.* HCFA will not apply the progressive reduction to—

(1) Payments to the State for expenditures made before fiscal year 1981; or

(2) Supplementary payments made to a State resulting from its having incurred fewer expenditures than its target amount, described in § 433.217.

§ 433.207 Offsets against reductions.

HCFA will decrease the reduction specified in § 433.205 by one percentage point for a quarter for a State, for each of the following three conditions that the State meets:

(a) *Hospital cost review program.* Operation by the State of a hospital cost review program that meets the criteria, described in § 433.209, for the quarter covered by the Federal payment.

(b) *Unemployment levels.* An unemployment rate in the State, for the quarter before the quarter covered by the Federal payment, that is equal to or greater than 150 percent of the national unemployment rate for the same period, as determined by the Bureau of Labor Statistics.

(c) *Fraud and abuse and third party liability recoveries.* For the quarter before the quarter covered by the Federal payment, recovery through fraud and abuse initiatives, described in § 433.213, of an amount equal to one percent of the FFP for the quarter covered by the payment. For fiscal year 1982 only, this total may include recoveries from liable third parties (see § 433.215).

§ 433.209 Qualifications for offset based on hospital cost review programs.

(a) A state has a qualified hospital cost review program if the qualifications in the following paragraph (b) of this section are met.

(b) The State must provide HCFA with assurances of equitable treatment, under its cost review program, for hospital employees and patients, and for all payers, including Federal and State programs, that pay hospitals for inpatient hospital services. In addition, in order to qualify, a hospital cost review program must—

(1) Be established by statute;

(2) Have been in effect on July 1, 1981 and at the beginning of the quarter covered by the Federal payment;

(3) Be directly operated by the State;

(4) Apply to substantially all non-Federal acute care hospitals in the State;

(5) Provide for review of all non-Medicare revenues or expenses for inpatient hospital services, or at least 75 percent of all revenues or expenses for inpatient hospital services including those under Medicare; and

(6) Result in an annual rate of increase in aggregate hospital inpatient costs per capita, or per admission, in the State on a calendar year basis that is at least two percentage points less than the rate of increase in all States without qualifying programs. A State may meet this requirement based on performance during the most recent one, two, or three calendar year period ending at least nine months before the quarter covered by the Federal payment.

§ 433.213 Offset based on fraud and abuse recoveries.

(a) *General policy.* HCFA will decrease the reduction under § 433.205 by one percentage point for each quarter in which the State demonstrates that its fraud and abuse recoveries (and third party liability recoveries for fiscal year 1982 only (see § 433.215)), for the quarter before the quarter covered by the Federal payment, are equal to one percent of the total Federal Medicaid payments due to the State in that previous quarter. For purposes of calculating the one percent, HCFA will not include in this total any supplementary payments due to a State resulting from the State's having spent less than its target amount, described in § 433.217.

(b) *Fraud and abuse recoveries.* For purposes of paragraph (a) of this section, fraud and abuse recoveries—

(1) Must be documented by the State; and

(2) May include diverted funds or funds recovered as a result of—

(i) The operation of a State Medicaid fraud control unit, as defined in Part 455, Subpart D, of this chapter;

(ii) Audit activities that are initiated as a result of a suspicion or complaint of fraud or abuse (including any amounts recovered as restitution in civil or criminal litigation resulting from these audit activities, but not including fines, penalties, unexecuted judgments established by Federal, State, or local courts or administrative bodies (and fraud and abuse uncovered through routine audits); and

(iii) State determinations of overutilization or furnishing of unnecessary care.

(c) *Procedures for carrying forward fraud and abuse recoveries.* For purposes of paragraph (a) of this section, HCFA will carry forward, to the next quarter only, the amount by which a State demonstrates that its fraud and abuse recoveries exceed one percent of the total Federal Medicaid expenditures

for the quarter covered by the Federal payment.

§ 433.215 Third party liability recoveries [Reserved].

§ 433.217 Use of target amounts to decrease reductions.

(a) *Purpose of the target amount.* HCFA will issue supplemental grants for fiscal years 1982–1984 based on the amount by which a State's total Federal Medicaid expenditures are under the State's target amount, described in paragraph (b) of this section, for the fiscal year. However, the supplemental grant may not exceed the amount of the reduction, described in § 433.205, for the fiscal year under consideration.

(b) *Method for determining target amounts.*—(1) *Fiscal year 1982.* The target amount for a State for fiscal year 1982 is 109 percent of the State's estimate of the Federal share of all Medicaid expenditures for fiscal year 1981, in the latest estimate received by HCFA central office before April 1, 1981. The estimate may not include Federal expenditures resulting from adjustments made during fiscal year 1981 based on expenditures made before October 1, 1980.

(2) *Fiscal year 1983.* HCFA will derive the target amount for each State for fiscal year 1983 by increasing or decreasing the 1982 target amounts by a percentage equal to the percentage increase or decrease, between September 1982 and September 1983, in the index of the medical care expenditure category of the consumer price index for all urban consumers, as determined by the Bureau of Labor Statistics.

(3) *Fiscal year 1984.* HCFA will derive the target amount for each State for fiscal year 1984 by the same method used for the 1983 targets, except that the 1982 target amounts will be increased or decreased based on medical care expenditure data for the period between September 1982 and September 1984. For purposes of calculating the fiscal year 1984 target amount, HCFA will deem the FMAP for 1984 to be equal to the percentage for 1983.

(c) *Exclusions from target amount determinations.* HCFA will exclude the following from each year's target amount determinations:

(1) Adjustments with respect to prior year claims (see paragraph (b)(1) of this section);

(2) Interest paid on disallowances of disputed claims;

(3) Any offset payments the State receives for spending less than its target amount in the previous year; and

(4) Any reductions in Federal funds under § 433.205.

Title 45—Public Welfare

PART 201—GENERAL ADMINISTRATION—PUBLIC ASSISTANCE PROGRAMS

B. 45 CFR 201.5 is amended by revising the introductory language as set forth below. The authority citation for Part 201 reads as follows:

Authority: Sec. 1102, 49 Stat. 647; 42 U.S.C. 1302.

§ 201.5 Grants.

To States with approved plans, grants are made each quarter for expenditures under the plan for assistance, services, training and administration. The determination as to the amount of a grant to be made to a State is based upon documents submitted by the State agency containing information required under the Act and such other pertinent facts as may be found necessary.

Progressive reductions in Federal Medicaid payments to the States under sections 1903 (s) and (t) of the Act for fiscal years 1982–1984 are described in 42 CFR Part 433, Subpart E.

* * * * *

(Catalog of Federal Domestic Assistance Programs No. 13.714, Medical Assistance Program)

Dated: September 16, 1981.

Carolyne K. Davis

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

[FR Doc. 81-28325 Filed 9-29-81; 8:45 am]

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Wednesday
September 30, 1981

Part VI

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Offset Based on Third Party Liability Recoveries Against Reductions in Medicaid Payments

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 433

Medicaid Program; Offset Based on Third Party Liability Recoveries Against Reductions in Medicaid Payments

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

ACTION: Notice of Proposed Rulemaking.

SUMMARY: Section 2161 of the Omnibus Budget Reconciliation Act (Pub. L. 97–35) imposes reductions in Federal matching payments for fiscal years 1982 through 1984, but also provides for offsets against the reductions if a State meets certain conditions. One of the conditions is a specific level of fraud and abuse recoveries by a State or, for fiscal year 1982 only, a combination of fraud and abuse and third party liability recoveries. Interim final rules, published elsewhere in this issue of the **Federal Register**, amend Medicaid regulations to implement section 2161, except for the provisions relating to third party liability recoveries. We are proposing here that, for purposes of implementing these provisions, recoveries from Medicare would be—

- Excluded in situations in which the State had knowledge of the dual entitlement of individuals to Medicare and Medicaid before a Medicaid claim was paid; and
- Included in situations in which the State had to make a special effort to determine that an individual's claim should be paid by Medicare.

DATE: To assure consideration, comments should be mailed by October 30, 1981.

ADDRESS: Address comments in writing to: Administrator, Department of Health and Human Services, Health Care Financing Administration, P.O. Box 17076, Baltimore, Maryland 21235.

If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave, S.W., Washington, D.C., or to Room 789, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to BPO–27–P. Agencies and organizations are requested to submit comments in duplicate.

Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave., S.W., Washington, D.C., 20201 on Monday through Friday of each from 8:30 a.m. to 5:00 p.m. (202–245–7890).

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments and will respond to them in the preamble to that rule.

FOR FURTHER INFORMATION CONTACT: Charles Schreibeis, 301–597–1702.

SUPPLEMENTARY INFORMATION:

In an interim final rule "Reductions in Payments to the States", published elsewhere in this issue of the **Federal Register**, we issued regulations implementing section 2161 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35). Section 2161 imposes reductions in the total Federal Medicaid payments to the States for fiscal years 1982–1984. However, in enacting section 2161, Congress also provided that States are entitled to an offset against each fiscal year's reduction of one percentage point for each of three conditions involving the existence of a hospital cost review program, the rate of unemployment in a State and the level of recoveries of funds from fraud and abuse activities.

Congress provided that the level of fraud and abuse recoveries must be equal to or more than one percent of the total Federal Medicaid payment, and that, for fiscal year (FY) 1982 only, fraud and abuse recoveries may be combined with recoveries from liable third parties for purposes of determining whether a State is entitled to the offset against the reduction.

The Supplementary Information section of the interim final rule mentioned above contains an extensive discussion of the provisions of section 2161 and of the regulations that implement it. However, the final rule does not include a discussion of the types of recoveries we will use in determinations about a State's third party liability recoveries in FY 82. We refer the reader to the background discussion in the final rule and present here a proposed description of third party liability recoveries.

Proposed Regulations

States reduce costs for Medicaid by predetermining obligations of liable third parties and offsetting the amounts paid on provider invoices (prepayment screens), or by retroactively identifying the obligations and collecting the appropriate amounts from third party payers. In the former system, the reductions are called cost avoidance; in the latter, they are called collections. Both are considered recoveries.

If a Medicaid recipient is also entitled to Medicare, a claim for a provider of health care services is referred, either on a prepayment or post-payment basis, to the Medicare program. In these circumstances, Medicaid is responsible only for any deductible or coinsurance amount payable on behalf of the recipient. Being the payer of last resort, a Medicaid agency routinely transfers claims for services in these situations to the Medicare program.

Generally, we do not believe that transfers of claims to the Medicare program were intended by Congress to be used for purposes of decreasing the reductions in Federal payments. We take this view primarily because the States know beforehand which recipients are entitled to both Medicaid and Medicare and, therefore, which claims will routinely be paid by Medicare. For example, HCFA makes available to all States with buy-in programs (that is, programs in which the States pay Medicare premiums for individuals) certain compilations of information (for example, the Carrier Alphabetic State File (CASF) and the Beneficiary State Tape (BEST) that permit the States to determine whether an individual is dually entitled to Medicare and Medicaid. In addition, if individuals are receiving Supplemental Security Income (SSI) under title XVI of the Social Security Act, they may also be entitled to Medicare. In this case, the Social Security Administration makes SSI and Medicare entitlement information available to the States (Bendex and State Data Exchange (SDX) tapes). In like manner, characteristics of Medicaid applicants such as age, the existence of a long-term disability, or an impairment of a certain nature such as end stage renal disease, help the States to identify individuals entitled to Medicare. On the other hand, situations do arise in which the State pays a Medicaid claim without knowing that the individual is dually entitled. These situations typically involve inaccurate or incomplete information concerning the nature of an individual's disability, or retroactive entitlement to Medicare resulting from successful appeals concerning factors of entitlement to Medicare such as a person's age. For the most part, however, dually entitled individuals are routinely identified and claims are routinely referred to Medicare for payment. The additional effort normally required on the part of the State to detect liable third parties and to seek recoveries is not required in these circumstances. Thus, we believe

that it was the intent of Congress, in providing for the third party liability offset provision, to encourage additional efforts by the States against liable third parties other than the Medicare program.

Therefore, for purposes of implementing section 2161 of Pub. L. 97-35, we are proposing to amend Medicaid regulations (42 CFR Part 433, Subpart E, issued in the **Federal Register** on this date as an interim final rule) by adding a new § 433.215 to prohibit the States from attributing to third party liability recovery efforts, savings realized in Medicaid costs by transferring the claims of dually entitled individuals to Medicare for payment.

However, we would provide an exception for circumstances in which a State has paid a Medicaid claim, subsequently discovers that the individual was also entitled to Medicare, and recovers the payment after referring the claim to Medicare.

We would also state that in order for HCFA to use recoveries from liable third parties in FY 82, the recoveries must be auditable and must have been reported to HCFA. We would also amend § 433.203 to add definitions of "third party" and "third party liability".

Impact Analysis

For information concerning the applicability of Executive Order 12291 and the Regulatory Flexibility Act to these proposed rules, refer to the final rule on "Reductions in Payments to the States", published elsewhere in this issue of the **Federal Register.**

30-Day Comment Period

Normally, when issuing a notice of proposed rulemaking, we provide a 60-day comment period. HCFA and the States need to make determinations about third party liability recoveries as soon as possible. In order to make these determinations, final regulations are necessary. Therefore, we are limiting the comment period to 30 days and will issue final regulations as quickly as possible.

PART 433—STATE FISCAL ADMINISTRATION

42 CFR Part 433, Subpart E is proposed to be amended as follows:

The authority citation for Part 433 reads as follows:

Authority: Secs. 1102, 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), 1903(s), 1903(t) and 1912 of the Social Security Act (42 U.S.C. 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), 1396b(s), 1396b(t) and 1396(k), unless otherwise noted.

1. Section 433.203 is amended by adding two new definitions, in alphabetical order as follows:

§ 433.203 Definitions.

For purposes of this subpart—

* * * * *

"Third party" means any individual, entity or program that is or may be liable to pay all or part of the medical costs of injury, disease or disability of an applicant or recipient.

"Third party liability" means payment resources, available from both private and public health insurance, and other liable third parties, that can be applied toward Medicaid recipients' medical and health benefit expenses.

A new § 433.215 is added to read as follows:

§ 433.215 Third party liability recoveries.

(a) *Applicability in fiscal year 1982 only.* For fiscal year 1982 only, for purposes of determining whether a State is entitled to the offset under § 433.213, HCFA will add to the total fraud and abuse recoveries, funds saved as a result of recoveries from liable third parties under procedures described in Subpart D of this Part, except as provided in paragraph (c) of this section.

(b) *Conditions for inclusion of third party liability recoveries.* For purposes of paragraph (a) of this section, HCFA will include recoveries from liable third parties if the recoveries—

(1) Can be validated by audit; and

(2) Have been reported to the Federal government.

(c) *Recoveries from the Medicare program.*—(1) *General policy.* For purposes of paragraph (a) of this section, recoveries from liable third parties may not include recoveries from the Medicare program, except those based on claims paid by Medicaid because the State did not know that the individual was entitled to both Medicare and Medicaid.

(2) *Examples of excluded recoveries.* Recoveries from Medicare that are excluded are based on those cases in which the State knows, prior to the payment of a claim, that the individual is entitled to Medicare. Examples include situations in which—

(i) The State is paying Medicare premiums for the individual under State buy-in agreements (see Subpart B of Part 405 of this chapter);

(ii) The individual is receiving Supplemental Security Income (SSI) benefits under title XVI of the Act; or

(iii) The State has access to or has received information from the Federal government that identifies individuals entitled to Medicare.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: September 16, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: September 24, 1981.

Richard S. Schweiker,

Secretary.

[FR Doc. 81-28328 Filed 9-29-81; 8:45 am]

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Wednesday,
September 30, 1981

Part VII

Department of Health and Human Services

Health Care Financing Administration

Medicare Programs; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Medicare Program; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs

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

ACTION: Final notice.

SUMMARY: This notice sets forth a schedule of limits on hospital per deim inpatient general routine operating costs that may be reimbused under Medicare beginning October 1, 1981. This is a special revision of the schedule, not an annual update, and replaces the current schedule, which was published in the Federal Register on June 30, 1981 (46 FR 33637). It incorporates two changes required by the Omnibus Budget Reconciliation Act of 1981:

- The limits are lowered from 112 percent of mean costs to 108 percent; and
- The limits are revised to reflect a reduction in the nursing salary differential.

As required by statute, this notice also has a special provision for its effective date.

EFFECTIVE DATE: The revised schedule of limits is applicable to cost reporting periods *ending after* September 30, 1981. For any of these cost reporting periods that begin before October 1, 1981, the reductions in payments resulting from application of these limits shall be applied only in proportion to the part of the reporting period that occurs after September 30, 1981.

FOR FURTHER INFORMATION CONTACT: Carl Slutter, 301–594–9344.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) as amended by Section 223 of Pub. L. 92–603, the Social Security Amendments of 1972, authorizes the Secretary to set prospective limits on the costs that are reimbursed under Medicare. These limits may be applied to direct or indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider, and may be based on estimates of the cost necessary in the efficient delivery of needed health services.

Regulations implementing this authority are set forth at 42 CFR 405.460. Under this authority, we published limits on hospital per diem inpatient general routine service costs annually from 1974 through 1978, and limits on hospital per diem inpatient general routine operating costs in 1979 and 1980.

On June 30, 1981, we published in the Federal Register (46 FR 33637) a schedule of limits on hospital per diem inpatient general routine operating costs applicable to cost reporting periods beginning on or after July 1, 1981. In that notice, we described the scope of the limits, and explained our methodology for deriving and applying those limits. That methodology remains essentially unchanged.

II. Changes Required by the Omnibus Budget Reconciliation Act of 1981

A. *Limits cannot exceed 108 percent of mean costs.* Section 2143 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) established a new statutory maximum on cost limits for reimbursement of hospitals under Medicare. The statute states:

> The Secretary, in determining the amount of the payments that may be made under this title with respect to routine operating costs for the provision of general inpatient hospital services, may not recognize as reasonable (in the efficient delivery of health services) routine operating costs for the provision of general inpatient hospital services by a hospital to the extent these costs exceed 108 percent of the mean of such routine operating costs per diem for hospitals, or, in the judgment of the Secretary, such lower percentage or such comparable or lower limit as the Secretary may determine.

As stated in the House Report on H.R. 3850 (House Report No. 97–143, p. 79), the Congress believed that reducing the limits from 112 percent of mean costs to 108 percent is an appropriate method of encouraging efficient operation of hospitals. In accordance with section 2143 of the Omnibus Budget Reconciliation Act of 1981, we have revised the limits to set them at 108 percent of the mean labor-related costs and mean non-labor costs of each comparison group. We continue to have the authority to grant exceptions to and exemptions from the limits. (Exceptions are granted to cover specific types of costs, such as costs of atypical services to meet the special needs of patients treated; exemptions are granted in specific circumstances, such as when a hospital is the sole community source of inpatient hospital care. See 42 CFR 405.460(e) and (f).)

B. *Adjustment required by change in the nursing salary differential.* Under the Medicare regulations (42 CFR 405.430) published in July 1969, we have recognized a per diem rate above the facility's average costs for all patients for inpatient routine nursing care furnished to aged Medicare patients. (The differential is also applied to pediatric and maternity patients, who also are assumed to require a greater amount of routine nursing services than other patients.) This is called the "nursing salary cost differential." The differential is not an add-on to the total routine nursing salary costs incurred by a provider, but rather a reallocation of the actual routine nursing salary costs between aged, pediatric and maternity patients and all other classes of patients. It presumes that, on the average, aged, pediatric and maternity patients receive more routine nursing services than do other patients.

The effect of the nursing differential is that the Medicare program recognizes a higher than average routine per diem cost for aged, pediatric and maternity patients and a lower than average per diem cost for all other classes of patients. (Disabled Medicare beneficiaries are counted in the "all other" category, unless they are also pediatric or maternity patients, and the lower than average per diem is applicable to that class of patient.)

The total impact of the differential on a particular facility's Medicare reimbursement will vary, depending on the provider's patient mix. If all of the provider's patients were aged, pediatric and maternity, no differential would be applicable.

We presently recognize a nursing salary differential equal to 8.5 percent of the provider's average per diem nursing salary costs. However, Section 2141 of Pub. L. 97–35 amended Section 1861(v)(1) of the Social Security Act to state that "an inpatient routine nursing salary cost differential shall be allowable as a reasonable cost of hospitals, at a rate not to exceed 5 percent, to be applied under the same methodology used for the nursing salary cost differential for the month of April 1981." According to its terms, Section 2141 is effective for all cost reporting periods ending after September 30, 1981, and reductions in Medicare payments resulting from the smaller nursing differential shall be made only in proportion to the part of a provider's reporting period that occurs after September 30, 1981.

We will be publishing a separate regulation implementing Section 2141. However, Section 2141 has also necessitated an adjustment of the cost limits. All of our current cost report data incorporates the 8.5 percent differential in the Medicare costs. However, for cost reports that straddle September 30, 1981, we can only recognize a 5 percent nursing differential for that portion of the cost reporting period occurring on or after October 1, 1981. To do this, we have estimated the portion of per diem

costs in each hospital classification group attributable to the 8.5 percent nursing differential, and developed adjustment ratios that reflect the proportionate application of this change to the part of the cost reporting period after September 30, 1981.

Briefly, we derived these ratios in the following way:

- We calculated the total average per diem routine operating costs for each provider grouping (for purposes of these cost limits, hospitals are grouped in seven cells according to SMSA/non-SMSA location and bedsize). We also calculated the Medicare average per diem routine operating costs for the same grouping. (We did this for a cost reporting period ending September 30, 1981, in order to reflect the same period for which we have developed the revised limits.)
- For each grouping, we determined the difference between the overall total average per diem costs and the Medicare average per diem costs. This difference represents the average effect of the 8.5 percent nursing differential on the average per diem cost for that provider grouping.
- For each provider grouping, we multiplied the resulting figure by .588 (the ration of 5 percent to 8.5 percent). The products represent the dollar value, on the average, of a 5 percent nursing differential for each hospital grouping. We subtracted this amount from the average dollar value of the differential at 8.5 percent to obtain the dollar value of the reduction.
- We divided the result from the prior step by the original Medicare average per diem cost for each grouping. This gives us a ratio of the reduction due to the differential to the original mean. (This varies from group to group ranging from approximatley 1 to 2 percent.)
- The ratio obtained from the prior step, for each grouping, is divided into twelve equal parts and applied in proportion to the number of months in the cost year prior to October 1.
- The arithmetic from the prior step yields a set of ratios, set forth in Tables IV A and IV B. An explanation of how to use these tables is also set forth below, in paragraph VII.3.

C. *Special effective date provision.* Section 2143 of the Reconciliation Act also included provisions for its effective date that prescribe how it is to be applied to particular cost reporting periods. Previously, we had always made revised shcedules of cost limits applicable to the cost reporting periods beginning on or after a specified date (usually July 1 of each year). However, Section 2143(b) states that this provision is effective for cost reporting periods *ending* after September 30, 1981.

Thus, these limits apply to current cost reporting years. Section 2143(b) also states, however, that for cost reporting periods that straddle the September 30 date, the limits will be applied in proportion to the part of the cost reporting period that occurs after September 30, 1981. Thus, each hospital cost reporting period beginning before October 1, 1981, and ending after that date, will be governed by two schedules of cost limits: (1) The schedule in effect on the first day of the cost reporting period, which will be applied in proportion to the part of the total period occurring between the first day of the period and ending September 30, 1981; and (2) this schedule, effective October 1, 1981, which will be applied in proportion to the part of the total cost reporting period occurring after September 30, 1981. The method for making these proportional applications is illustrated later in this notice under paragraph VII. 7. For cost reporting periods beginning on or after October 1, 1981, these revised limits will be in effect for the entire cost reporting period.

III. Summary Description of Cost Limit Methodology

The basic methodology previously used has not been changed. A full explanation is set forth in the notices published on April 1, 1980 (45 FR 21582), June 20, 1980 (45 FR 41868) and June 30, 1981 (46 FR 33637). In brief summary, it is as follows:

1. Limits on hospital per diem inpatient general routine operating costs. The limits do not apply to capital-related costs, costs of approved medical or nursing education programs that are properly allocated to interns and residents (in approved programs) and nursing school cost centers on the hospital's Medicare cost report, costs of special care units or ancillary services, or malpractice insurance costs.

2. A classification system based on each hospital's bed size, and whether the hospital is located within a Standard Metropolitan Statistical Area (SMSA), a New England County Metropolitan Area (NECMA) or in a non-SMSA/non-NECMA area. (For a discussion of the exceptions to these rules for certain New England areas, see the notice published June 18, 1980 (45 FR 41218). For a listing of the counties including in each SMSA or NECMA, see the hospital cost limits notice published on June 20, 1980 (45 FR 41868).)

The Executive Office of Management and Budget on June 19, 1981 announced new SMSAs based on the 1980 census. As soon as we have received new wage index values for these areas, we will publish in the **Federal Register** a list of the constituent counties in the SMSAs and their wage index values.

3. Use of actual hospital inpatient general routine per diem operating cost data from Medicare cost reports to derive the limits. We have adjusted the limits to reflect the allowance of an 8.5 percent routine nursing salary cost differential through September 30, 1981, and a 5 percent nursing differential thereafter.

4. A market basket index (see Appendix) that we developed to reflect changes in the prices of goods and services purchased by hospitals.

5. A hospital wage index (see Tables III A and III B) that we developed from hospital wage and employment data obtained from the Bureau of Labor Statistics (BLS). We use this index to adjust for the differing levels of labor-related costs among the areas in which hospitals are located.

6. A cost-of-living adjustment to the nonlabor component of the limits for hospitals in Alaska and Hawaii.

7. Limits set at 108 percent of the mean labor-related costs and of the mean nonlabor costs of each group.

8. An adjustment to the limits for increased costs due to approved internship and residency programs.

9. A formula that permits the limits to be adjusted upward for areas where the number of covered days of care per 1,000 Medicare beneficiaries is less than the national average.

10. An explanation of how these limits will be implemented effective October 1, 1981, in proportion to whatever part of a hospital's cost reporting period occurs after September 30, 1981.

11. A revised schedule of dollar limits, by geographic area and hospital size, that we calculated under the methodology summarized above.

IV. Impact analyses

Executive Order 12291

This notice merely implements statutory amendments made by Pub. L. 97-35 to Section 1861(v)(1) of the Social Security Act, and does not otherwise modify the methodology used to compute the limits in any manner. Therefore, the Secretary has determined that, although this notice will have an annual effect on the economy of $263 million in fiscal year 1982, the development of a Regulatory Impact Analysis is not required. If, in the future, discretionary changes are proposed that would modify the methodology used in computing the limits and would meet the

criteria for conducting a Regulatory Impact Analysis, a Regulatory Impact Analysis will be developed and made available for public comment.

Regulatory Flexibility Act

The Secretary certifies, under Section 605(b) of the Regulatory Flexibility Act (Pub. L. 96-354), that the revised schedule of limits set forth in this notice will not have a significant economic impact on a substantial number of small entities. The reason for the Secretary's certification is that the revised limits merely implement recent statutory changes governing the system of hospital costs limits that is now in effect, and do not otherwise include any changes in our methodology for deriving and applying them.

V. Waiver of Proposed Notice and 30-day Delay in Effective Date

We developed the revised limits set forth below by using the same methodology that we use to develop the current hospital cost limits, which were published on June 30, 1981 (46 FR 33637) and the previous cost limits, published on June 20, 1980 (45 FR 41868). On April 1, 1980, we published a proposed notice that described in detail our methodology for developing and applying those limits, and provided a 60-day period for public comment (45 FR 21582). In developing the current methodology for deriving and applying the schedule of limits, we considered all comments received in response to the April 1, 1980 notice. These comments, and our responses to them, are described in the June 20, 1980 notice.

Because the methodology used for the revised schedule has previously been published for public comment, and because the changes being made in this notice are mandated by statute, we do not believe it is either necessary or useful to request comment agains on that methodology. Therefore, we find good cause to waive publication of a proposed notice, and to publish this notice of revised limits in final form.

In the past, we generally have attempted to allow a 30-day period between the date of publication of each cost limit schedule and the effective date of the schedule. Since the effective date of the statutory changes is October 1, 1981, we find that there is good cause to waive the customary 30-day delay between publication of new limits and their effective date, and apply them to hospitals effective October 1, 1981.

VI. Methodology for Determining per Diem Routine Operating Cost Limit

Development of Published Limits

1. *Data.* We developed the limits by using actual hospital inpatient general routine operating cost data obtained from the latest Medicare cost reports available as of April 15, 1980. In developing the revised limits, we excluded capital-related costs and costs allocated to the interns and residents (in approved programs) and nursing school cost centers. After excluding these costs, we would normally adjust the remaining data for inflation by projecting them from the midpoints of the cost reporting periods used in the data collection through the midpoint of the first cost reporting period to which the limits would apply.

Since the amendments to the statute direct that the revised limits be applied to cost reporting periods *ending* (rather the *beginning*) after September 30, 1981, the limits published in this notice represent what the limits would have been at 108 percent costs for the period October 1, 1980 through September 30, 1981. We derived these limits by deflating (using the market basket index) the means used in deriving the limits published on June 30, 1981, so that the midpoint of the limits became March 31, 1981, rather than December 31, 1981. We then multiplied the new means by 1.08 to arrive at the new limits.

We derived the limits in this manner for ease of administration and application. For every hospital whose cost reporting period ends after September 30, 1981, the intermediary will adjust the limits to account for the change in the nursing differential, as indicaated in item 3 below, and will apply an inflation adjustment as indicated in item 6 under *"Calculation of Individual Hospital Limit"* below. The intermediary will apply both of these adjustments for those months in the cost reporting period that occur after September 30, 1981.

We anticipate that our next schedule of limits will apply for whole cost reporting periods beginning on or after October 1, 1982. The schedule of limits in this notice is applied to periods ending after September 30, 1981. As a result of this, many hospitals will have a second cost reporting period subject to the limits contained in this schedule. For example, a hospital whose cost reporting period ends December 32, 1981 will also be subject to this schedule for the period beginning January 1, 1982. Therefore, we have included additional inflation factors in item 6 which the intermediary will use to determine the limit for the reporting period following the reporting period which ends after September 30, 1981.

The annual percentage increase over the previous year that we used for our inflation projections are:

	Percent
1978	13.1
1979 (1/1 through 6/30)	10.8
1979 market basket (7/1 through 12/31)	9.1
1980 market basket	11.7
1981 market basket	*10.8
1982 market basket	*9.5
1983 market basket	*9.5

*Forecasted increase.

If the actual rate of the increase in the market basket is at least .3 of 1 percentage point above the estimated rate, we will advise the Medicare intermediaries to use the actual rate to adjust each hospital's cost limit at the time of final settlement.

2. *Adjustment for Education Costs.* We adjusted each hospital's Medicare per diem routine operating costs used in calculating the mean for each group by dividing the per diem costs by 1.0 plus the product of the education adjustment factor (.047) and the individual hospital's adjusted intern-and-resident to bed ratio. We determined that adjusted ratio by dividing the number of full-time equivalent (FTE) interns and residents for the cost reporting period to which each per diem cost applies (see step 5 of the "Calculation of Individual Hospital Limit") by the hospital's bed size determined at the beginning of that period to obtain the hospital's intern-and-resident to bed ratio, and dividing that ratio by .1. Example: The per diem operating cost of a 686-bed hospital in Los Angeles, California, is $200. The hospital employed 77 FTE interns and residents in approved teaching programs.

The per diem cost is adjusted for education costs as follows:

$77 \div 686 = .1122$, which is the intern-and-resident to bed ratio for this hospital.
$.1122 \div .1 = 1.122$ – Adjusted Ratio
$\$200 \div [1 + (.047 \times 1.122)] =$
$\$200 \div 1.0527 = \$189.99$, Education-adjusted per diem cost.

The education-adjusted per diem costs are divided into labor-related and nonlabor portions, adjusted by the wage index and used to calculate the group means (see steps 3 and 4 below).

3. *Use of Wage Index to Adjust Cost Data.* We divided each hospital's adjusted per diem routine operating cost into labor-related and nonlabor portions. We determined the labor-related portion of cost by multiplying each hospital's adjusted per diem

routine operating cost by 79.26 percent, which is the labor-related portion of cost from the market basket. We then divided the labor-related portion of each hospital's per diem cost by the wage index applicable to the hospital's location (see Tables III A and III B) to arrive at an adjusted labor-related portion of routine cost.

If we discover that we, or the Bureau of Labor Statistics, have made any error that results in an incorrect wage index for any area, we will notify the Medicare intermediaries of the corrected index and will direct them to recalculate the limits for affected providers.

4. *Group Limits.* We calculated separate means of routine labor-related and nonlabor operating costs for each group established in accordance with the hospitals' SMSA/NECMA or non-SMSA/non-NECMA location and bed size.

For each group, we multiplied the mean labor-related and mean nonlabor costs by 108 percent. (See Tables I and II as well as the explanation in item 1 above.)

VII. Calculation of Individual Hospital Limit

1. *Cost-of-Living Adjustment (Alaska and Hawaii Hospitals Only).* If a hospital is located in Alaska or Hawaii, the hospital's intermediary will multiply the nonlabor component for the hospital's group (see Tables I and II) by the appropriate cost-of-living adjustment factor from the list included in these tables. The intermediary will use the adjusted nonlabor component in computing the hospital's limit.

Example—Calculation of Cost-of-Living Adjusted Non-Labor Component for a 400-bed Hospital Located in Alaska.

Non-Labor Component—$27.62 (Published in Table I)
Adjustment Factor for Alaska = 1.25
$27.62 × 1.25 = $34.53 Cost-of-Living Adjusted Non-Labor Component.

2. *Adjustment of Labor-Related Component by Wage Index.* To arrive at a labor-adjusted limit for each hospital, the hospital's Medicare intermediary will multiply the labor-related component for the hospital's group by the wage index developed from the wage levels for hospital workers in the area in which the hospital is located (see Tables III. A and III. B). The individual limit that applies to any hospital will be the sum of the nonlabor component, plus the adjusted labor-related component, as adjusted further for the change in the nursing differential under item 3, and for the hospital's actual cost reporting period under item 6, unless the hospital also qualifies for one or more of the adjustments described in steps 4 and 5.

Example—Calculation of Adjusted Limit for a 686-bed Hospital Located in Los Angeles, California, with a cost reporting period ending 11/30/81.

Non-Labor Component—$28.95 (published in Table I).

Labor-related Component—$98.15 (published in Table I).

SMSA Wage Index—1.2899 (published in Table III A).

Computation of Adjusted Limit

$98.15 × 1.2899 (wage index) = $126.60—Adjusted Labor Component
$126.60 + $28.95 = $155.55—Adjusted limit.

The wage indices for each SMSA/NECMA area and for the non-SMSA/non-NECMA areas of each State are published in Tables III A and III B.

3. *Adjustment for change in nursing differential.* To adjust each hospital's limit to take account of the change in the nursing differential from 8.5 percent to 5 percent effective for cost reporting periods ending after September 30, 1981, the Medicare intermediary will multiply the individual limit (after adjusting the labor component under item 2 and combining the adjusted labor component and nonlabor component into an adjusted limit) by the appropriate ratio for that hospital's bed size, urban or rural location, and the beginning date of its reporting period (see Tables IV A and IV B). The resulting limit will reflect application of the 8.5 percent differential from the first day of the reporting period through September 30, 1981, and a 5 percent differential for the remainder of the period.

All cost reporting periods that begin after October 1981 will be subject to the adjustment factor that appears for October 1981.

Example—A 686-bed hospital in Los Angeles, California has an adjusted Medicare limit of $155.55. The adjustment ratio from Table IV A is .99857.

Adjusted limit $155.55 × Adjustment ratio .99857 = $155.33, which is the hospital's limit after applying the nursing salary differential adjustment.

4. *Adjustment for Covered Days of Care.* If a hospital is located in a State that is entitled to a covered days of care adjustment (see Table V) the intermediary will determine the adjusted limit for the hospital, and multiply that limit by the applicable factor from Table IV.

Example—A 686-bed hospital in Los Angeles, California has an adjusted Medicare limit of $155.33. The adjustment factor from Table V is 1.06483.

Adjusted limit $155.33 × Adjustment factor 1.06483 = $165.40, which is the hospital's limit after application of the covered days of care adjustment.

5. *Education Cost Adjustment.* If a hospital has a graduate medical education program approved under 42 CFR 405.421, the intermediary will increase the hospital's limit by 4.7 percent for each .1 increase (above zero) in the hospital's ratio of full-time equivalent (FTE) interns and residents (in approved programs) to its bed size. The hospital will report to its intermediary, 45 days before the start of each cost reporting period, the number of FTE interns and residents it employed on the September 30 immediately preceding the date on which this report is due. The intermediary will calculate the amount of the education cost adjustment based on that report, and will adjust the hospital's limit retroactively at final settlement if, for a cost reporting year, a hospital actually employed more or fewer FTE interns and residents on September 30 of that period than the number it reported.

The number of full-time equivalent interns and residents is the sum of:

a. Interns and residents employed for 35 hours or more per week, and

b. One half of the total number of interns and residents working less than 35 hours per week (regardless of the number of hours worked).

For purposes of this adjustment, a hospital will be allowed to count only interns and residents in teaching programs approved under 42 CFR 405.421 who are employed at the hospital. Interns and residents in unapproved programs and those who are on the hospital's payroll but furnish services at another site will not be taken into account in making this adjustment.

Example—A 686-bed hospital in Los Angeles, California has an adjusted limit of $165.40 for the portion of the cost reporting period occurring after September 30, 1981. The hospital has a cost reporting period of December 1, 1980 through November 30, 1981. The hospital employed 77 FTE interns and residents in approved teaching programs on September 30, 1980.

77 ÷ 686 = .1122 Ratio of FTE Interns and Residents to Beds
Ratio .1122 ÷ .1 = 1.122 Adjusted ratio
The Education Adjustment Factor is .047.
Adjusted Medicare limit
$165.40 × [1 + (education adjustment factor .047 × adjusted ratio 1.122)] = $165.40 × 1.0527 = $174.12 Education-adjusted Medicare limit.

If the number of FTE interns and residents the hospital employs on September 30, 1981, is more or less than

77, the intermediary will adjust the hospital's limit at the time of final settlement of the hospital's cost report.

6. *Market Basket Inflation Adjustment for Cost Reporting Year.* For all hospitals having cost reporting periods ending after September 30, 1981, the intermediary will increase the limit by the factor from Table VI that corresponds to the month and year in which the cost reporting period begins. Each factor represents the monthly increase that we derived by dividing the projected annual increase in the market basket index by twelve. This adjustment is needed to account for price increases that occur after the date on which the limits are effective.

As indicated under item 1 above, the majority of hospitals will experience a second cost reporting period under this schedule of limits. Therefore, Table VI contains additional inflation factors to be applied to the second cost reporting period.

Example—A 686-bed hospital in Los Angeles, California has a cost reporting period that ends November 30, 1981. The otherwise applicable limit for the hospital is $174.12.

Computation of Revised Hospital Limit

Individual Hospital Adjusted Limit—$174.12
Adjustment Factor from Table VI—1.018
Adjusted Limit $174.12 × Adjustment factor 1.018 = Revised Medicare limit $177.25

For the cost reporting period beginning December 1, 1981, the adjustment factor will be 1.12058.

If a hospital uses a cost reporting period that is not 12 months in duration, a special calculation of the adjustment factor must be made. This results from the fact that projections are computed to the midpoint of a cost reporting period and the adjustment factors in Table VI are based on an assumed 12 month reporting period. For cost reporting periods other than 12 months, the calculation must be done specifically for the midpoint of the cost reporting period. The hospital's intermediary will obtain this adjustment factor from HCFA.

7. *Proportional Application of Limits to Cost Reporting Periods Ending After September 30, 1981.* As a result of the new legislation, each hospital reporting period beginning before October 1, 1981, and ending after September 30, 1981, will be governed by two schedules of cost limits: (1) The schedule in effect on the first day of the reporting period, which will be applied in proportion to the part of the total period occurring between the first day of the period and ending September 30, 1981; and (2) the schedule in this notice, which will be applied in proportion to the part of the total period occurring after September 30, 1981.

In determining the proportional application of the new limits, it is not our intention that ongoing systems for reporting and determining reasonable costs be revised or otherwise disrupted or that hospitals be subjected to new reporting requirements. However, we also understand that more than one method can be used to determine the proportional application. We believe some hospitals may find the adjustment easier to calculate as a reduction factor based upon the previous limit, particularly since this application is specific to those cost reporting periods which begin before October 1, 1981 and end after September 30, 1981. Therefore, we have provided two alternatives for calculating the application of the new cost limits. The examples illustrate two alternative methods providers and intermediaries may use to determine the proportional application.

Example 1: A hospital has a cost reporting period which begins December 1, 1980. Assume that the hospital's limit for this period is $177.24, and the limit for that portion of the period ending after September 30, 1981 is $170.24. Assume also that the hospital had 1,000 general routine patient days during the entire cost reporting period.

It is first necessary to determine what total allowable cost would be for the entire period under both the old and new limits (even though neither the old nor the new limit in fact applies to the entire period). This is done as follows:

Total allowable cost for the entire period using old limit:
$177.24 × 1,000 days = $177,240

Total allowable cost for the entire period using new limit:
$170.24 × 1,000 days = 170,240
Difference = $7,000

It is then necessary to determine what proportion of this difference should be applied to the months after September 30, 1981. This is accomplished as follows:

$7,000 × 3/12 (number of months after 9-20-81 in the hospital's cost reporting period) = $1,167

To determine the actual total allowable cost, the amount of the disallowance under the new limits ($1167) is subtracted from the total allowable costs for the entire period (under the old limit) as follows:

Total allowable cost for the period	$177,240
	−1,167
	176,073

Example 2: Assume the same facts as in example 1.

Total allowable costs for the entire period using old limit: $177,240.

Ratio of new limit to old limit $170.24 to $177.24 is .96050.

.96050 represents the proportion which the new limit bears to the old limit. However, since the new limit applies only to months in the reporting period after September 30, 1981, it is necessary to increase this proportion to reflect this fact. This is done by the formula below. .0395 represents the total percentage reduction in the new limit (1.00 − .96050). This figure is then reduced in proportion to the number of months subject to the old limit (10) and the result is added to .96050 to obtain the relationship which total allowable costs using the proportional application of the new limits bears to total allowable costs computed under the old limits for the entire period.

[(.0395 × 10 divided by 12) + .96050] × $177,240 = $176,073 − Total allowable cost for the period.

VIII. Schedule of Limits

Under the authority of section 1861(v) of the Social Security Act, the following per diem limits will apply to hospital inpatient general routine operating costs that may be reimbursed under Medicare effective October 1, 1981. Medicare fiscal intermediaries will compute the adjusted limits for hospitals that participate in Medicare using the methodology set forth in this notice, and will notify each hospital of its applicable limit. These limits, adjusted by the cost reporting year adjustment factors in Table VI, will remain in effect until replaced by a revised schedule of limits published in a final notice in the **Federal Register.**

Table I.—*Hospitals Located in SMSA (NECMA) Areas*

Bed size	Labor-related component	Nonlabor component
Less than 100	$101.28	$28.06
100 to 404	97.78	27.62
405 to 684	94.16	26.58
685 and above	98.15	28.95

Table II.—*Hospitals Located in Non-SMSA (Non-NECMA) Areas*

Bed size	Labor-related component	Nonlabor component
Less than 100	$96.14	$24.02
100 to 169	91.91	23.29
170 and above	87.92	22.64

Nonlabor components for hospitals located in the States of Alaska and Hawaii will be

increased by multiplying them by the following cost-of-living adjustment factors:

Location	Adjustment factor
Alaska	1.25
Hawaii:	
Oahu	1.15
Kauai	1.15
Molokai	1.125
Maui and Lanai	1.15
Hawaii	1.10

Table IIIA.—*Wage Index for Urban Areas*

SMSA area	Wage index
Abilene, TX	0.8485
Akron, OH	1.0417
Albany, GA	.8566
Albany-Schenectady-Troy, NY	.9624
Albuquerque, NM	1.0009
Alexandria, LA	.8954
Allentown-Bethlehem-Easton, PA-NJ	1.0569
Altoona, PA	1.0219
Amarillo, TX	.9233
Anaheim-Santa Ana-Garden Grove, CA	1.2115
Anchorage, AK	1.6461
Anderson, IN	.9812
Ann Arbor, MI	1.2175
Anniston, AL	.8400
Appleton-Oshkosh, WI	1.0124
Asheville, NC	.9678
Atlanta, GA	.9162
Atlantic City, NJ	1.0174
Augusta, GA-SC	.9237
Austin, TX	.9859
Bakersfield, CA	1.1223
Baltimore, MD	1.1698
Baton Rouge, LA	.8813
Battle Creek, MI	1.0229
Bay City, MI	1.1238
Beaumont-Port Arthur-Orange, TX	.8530
Billings, MT	[1].9496
Biloxi-Gulfport, MS	.8143
Binghamton, NY-PA	.9769
Birmingham, AL	.9658
Bismarck, ND	.9032
Bloomington, IN	[1].9481
Bloomington-Normal, IL	.8484
Boise City, ID	.9634
Boston-Lowell-Brockton-Lawrence-Haverhill, MA-NH	1.1214
Bradenton, FL	[1].8631
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1647
Brownsville-Harlingen-San Benito, TX	.9312
Bryan-College Station, TX	.8377
Buffalo, NY	.9926
Burlington, NC	.8899
Canton, OH	.9447
Cedar Rapids, IA	[1].9193
Champaign-Urbana-Rantoul, IL	1.1197
Charleston-North Charleston, SC	.9751
Charleston, WV	1.0628
Charlotte-Gastonia, NC	.9456
Chattanooga, TN-GA	1.0226
Chicago, IL	1.1780
Cincinnati, OH-KY-IN	1.0814
Clarksville-Hopkinsville, TN-KY	.8397
Cleveland, OH	1.1957
Colorado Springs, CO	.9743
Columbia, MO	1.1712
Columbia, SC	.9743
Columbus, GA-AL	.9021
Columbus, OH	1.1184
Corpus Christi, TX	.9337
Dallas-Fort Worth, TX	.9403
Davenport-Rock Island-Moline, IA-IL	.9219
Dayton, OH	1.1064
Daytona Beach, FL	.9423
Decatur, IL	.9096
Denver-Boulder, CO	1.0960
Des Moines, IA	1.0156
Detroit, MI	1.2280
Dubuque, IA	.9426
Duluth-Superior, MN-WI	.9193
Eau Claire, WI	.9806
El Paso, TX	.8714
Elkhart, IN	[1].7997
Elmira, NY	.9642
Enid, OK	.8228

Table IIIA.—*Wage Index for Urban Areas*—Continued

SMSA area	Wage index
Erie, PA	.9652
Eugene-Springfield, OR	.9639
Evansville, IN-KY	1.0742
Fargo-Moorhead, ND-MN	.9355
Fayetteville, NC	[1].8353
Fayetteville-Springdale, AR	.7997
Flint, MI	1.1919
Florence, AL	.8056
Fort Collins, CO	.8353
Fort Lauderdale-Hollywood, FL	1.0506
Fort Myers, FL	.9391
Fort Smith, AR-OK	.8899
Fort Wayne, IN	.8881
Fresno, CA	1.1265
Gadsden, AL	.9264
Gainesville, FL	.9019
Galveston-Texas City, TX	1.0607
Gary-Hammond-East Chicago, IN	1.1664
Grand Forks, ND-MN	.8779
Grand Rapids, MI	.9463
Great Falls, MT	[1].9162
Greeley, CO	[1].9312
Green Bay, WI	.9740
Greensboro-Winston-Salem-High Point, NC	.9232
Greenville-Spartanburg, SC	.9371
Hamilton-Middleton, OH	1.0620
Harrisburg, PA	1.0534
Hartford-New Britain-Bristol, CT	1.1535
Honolulu, HI	1.1645
Houston, TX	1.0630
Huntington-Ashland, WV-KY-OH	.9270
Huntsville, AL	.8593
Indianapolis, IN	1.0507
Iowa City, IA	1.0209
Jackson, MI	[1] 1.0173
Jackson, MS	.8699
Jacksonville, FL	.9331
Janesville-Beloit, WI	.8579
Jersey City, NJ	1.1160
Johnson City-Kingsport-Bristol, TN-VA	.8777
Johnstown, PA	1.0445
Kalamazoo-Portage, MI	1.1695
Kankakee, IL	1.0073
Kansas City, MO-KS	.9399
Kenosha, WI	[1] 1.0778
Killeen-Temple, TX	.8868
Knoxville, TN	.9100
Kokomo, IN	.9828
La Crosse, WI	[1].9016
Lafayette, LA	.8622
Lafayette-West Lafayette, IN	.9141
Lake Charles, LA	.8706
Lakeland-Winter Haven, FL	.9749
Lancaster, PA	1.0674
Lansing-East Lansing, MI	1.0811
Laredo, TX	[1].8593
Las Cruces, NM	[1].8129
Las Vegas, NV	1.1884
Lawrence, KS	[1].9193
Lawton, OK	[1].8377
Lewiston,-Auburn, ME	[1].8899
Lexington-Fayette, KY	.9016
Lima, OH	.9932
Lincoln, NE	.9259
Little Rock-North Little Rock, AR	1.0205
Long Branch-Asbury Park, NJ	1.0648
Longview, TX	.8129
Lorain-Elyria, OH	1.0207
Los Angeles-Long Beach, CA	1.2899
Louisville, KY-IN	.9915
Lubbock, TX	.9042
Lynchburg, VA	.8876
Macon, GA	.9637
Madison, WI	1.0257
Manchester-Nashua, NH	.9352
Mansfield, OH	.9196
McAllen-Pharr-Edinburg, TX	.8165
Melbourne-Titusville-Cocoa, FL	.9374
Memphis, TN-AR-MS	1.0371
Miami, FL	1.1050
Midland, TX	[1].9141
Milwaukee, WI	1.0080
Minneapolis-St. Paul, MN-WI	.9802
Mobile, AL	.9416
Modesto, CA	1.0250
Monroe, LA	.9451
Montgomery, AL	.9626
Muncie, IN	[1].9852
Muskegon-Norton Shores-Muskegon Heights, MI	.9658
Nashville-Davidson, TN	1.0187

Table IIIA.—*Wage Index for Urban Areas*—Continued

SMSA area	Wage index
Nassau-Suffolk, NY	1.2758
New Bedford-Fall River, MA	.9687
New Brunswick-Perth Amboy-Sayreville, NJ	1.0409
New Haven-Waterbury-Meridan, CT	1.0900
New London-Norwich, CT	1.0903
New Orleans, LA	.9644
New York, NY-NJ	1.3956
Newark, NJ	1.2099
Newport News-Hampton, VA	.8907
Norfolk-Virginia Beach-Portsmouth, VA-NC	.9496
Northeast Pennsylvania	1.0598
Odessa, TX	[1].9496
Oklahoma City, OK	.9252
Omaha, NE-IA	.9365
Orlando, FL	.9087
Owensboro, KY	[1].8364
Oxnard-Simi Valley-Ventura, CA	1.3788
Panama City, FL	[1].8777
Parkersburg-Marietta, WV-OH	1.0461
Pascagoula-Moss Point, MS	[1] 1.1535
Patterson-Clifton-Passaic, NJ	1.0959
Pensacola, FL	.8841
Peoria, IL	1.0175
Petersburg-Colonial Heights-Hopewell, VA	.9484
Philadelphia, PA-NJ	1.1810
Phoenix, AZ	1.1100
Pine Bluff, AR	[1].7997
Pittsbrugh, PA	1.1275
Pittsfield, MA	1.0275
Portland, ME	.9718
Portland, OR-WA	1.1026
Poughkeepsie, NY	1.0778
Providence-Warwick-Pawtuckett, RI	1.0314
Provo-Orem, UT	.9454
Pueblo, CO	1.0969
Racine, WI	.9240
Raleigh-Durham, NC	1.0173
Rapid City, SD	[1].8680
Reading, PA	1.0101
Reno, NV	[1] 1.2428
Richland-Kennewick, WA	.9763
Richmond, VA	.9252
Riverside-San Bernardino-Ontario, CA	1.1729
Roanoke, VA	.9614
Rochester, MN	.9952
Rochester, NY	1.0653
Rockford, IL	.9696
Sacramento, CA	1.1396
Saginaw, MI	1.1279
St. Cloud, MN	.8680
St. Joseph, MO	.9749
St. Louis, MO-IL	.9977
Salem, OR	1.1063
Salinas-Seaside-Monterey, CA	1.2428
Salt Lake City-Ogden, UT	.8550
San Angelo, TX	.8364
San Antonio, TX	.9509
San Diego, CA	1.1113
San Francisco-Oakland, CA	1.3153
San Jose, CA	1.3055
Santa Barbara-Santa Maria-Lompoc, CA	1.0552
Santa Cruz, CA	1.0811
Santa Rosa, CA	1.4037
Sarasota, FL	.8554
Savannah, GA	.9414
Seattle-Everett, WA	1.0500
Sherman-Denison, TX	.8277
Shreveport, LA	.9292
Sioux City, IA-NE	.9306
Sioux Falls, SD	.8844
South Bend, IN	.9154
Spokane, WA	1.0921
Springfield, IL	.9873
Springfield, MO	.8933
Springfield, OH	.9821
Springfield-Chicopee-Holyoke, MA	1.0184
Steubenville-Weirton, OH-WV	.9689
Stockton, CA	1.3046
Syracuse, NY	1.3209
Tacoma, WA	1.0514
Tallahassee, FL	[1].9219
Tampa-St. Petersburg, FL	.9896
Terre Haute, IN	.8644
Texarkana-TX-Texarkana; AR	1.0929
Toledo, OH-MI	1.1157
Topeka, KS	1.0602
Trenton, NJ	1.1706
Tucson, AZ	.9977
Tulsa, OK	.9626
Tuscaloosa, AL	1.0142

Table IIIA.—*Wage Index for Urban Areas*—Continued

SMSA area	Wage index
Tyler, TX	.9481
Utica-Rome, NY	1.0145
Vallejo-Fairfield-Napa, CA	1.5862
Vineland-Millville-Bridgeton, NJ	1.0083
Waco, TX	.8593
Washington, DC-MD-VA	1.1457
Waterloo-Cedar Falls, IA	.8631
West Palm Beach-Boca Raton, FL	.9632
Wheeling, WV-OH	.9921
Wichita, KS	1.0248
Wichita Falls, TX	.8262
Williamsport, PA	.9749
Wilmington, DE-NJ-MD	1.0898
Wilmington, NC	.8936
Worcester-Fitchburg-Leominster, MA	.9703
Yakima, WA	.8523
York, PA	.9584
Youngstown-Warren, OH	1.1090

[1] Approximate value for area.

Table IIIB.—*Wage Index for Rural Areas*

Non-SMSA area	Wage index
Alabama	0.8960
Alaska	1.5579
Arizona	1.0269
Arkansas	.8686
California	1.2415
Colorado	.8990
Connecticut	1.1552
Delaware	1.0370
Florida	.9917
Georgia	.9463
Hawaii	1.3362
Idaho	.9669
Illinois	.9180
Indiana	.9763
Iowa	.9220
Kansas	.8973
Kentucky	.9207
Louisiana	.9216
Maine	.9926
Maryland	1.1028
Massachusetts	1.1722
Michigan	1.1325
Minnesota	.9052
Mississippi	.8751
Missouri	.9156
Montana	.9561
Nebraska	.8130
Nevada	1.0790
New Hampshire	1.0971
New Jersey	1.0820
New Mexico	1.0073
New York	1.0327
North Carolina	.9917
North Dakota	.9045
Ohio	1.0086
Oklahoma	.9111
Oregon	1.0673
Pennsylvania	1.1358
Rhode Island	(*)
South Carolina	.9180
South Dakota	.7990
Tennessee	.8779
Texas	.8979
Utah	.8499
Vermont	.9993
Virginia	.9792
Washington	1.0465
West Virginia	1.0111
Wisconsin	.9179
Wyoming	1.0402

[*] Not applicable. All of Rhode Island is classified as urban.

Table IVA.—*Nursing Differential Adjustment Ratio for Hospitals Located in Urban Areas*

[Bed size]

Cost reporting period begins	Less than 100	101 to 404	405 to 684	685 and above
October 1980	1.000	1.000	1.000	1.000
November 1980	.99935	.99961	.99963	.99928
December 1980	.99869	.99922	.99925	.99857
January 1981	.99804	.99883	.99888	.99785
February 1981	.99739	.99844	.99850	.99713
March 1981	.99674	.99805	.99813	.99642
April 1981	.99609	.99766	.99776	.99571
May 1981	.99544	.99727	.99738	.99500
June 1981	.99479	.99688	.99701	.99429
July 1981	.99414	.99649	.99664	.99358
August 1981	.99349	.99610	.99626	.99287
September 1981	.99285	.99571	.99589	.99216
October 1981 or after	.99220	.99533	.99552	.99146

Table IVB.—*Nursing Differential Adjustment Ratio for Hospitals Located in Rural Areas*

[Bed size]

Cost reporting periods begins	Less than 100	101 to 169	170 and above
October 1980	1.000	1.000	1.000
November 1980	.99942	.99949	.99974
December 1980	.99885	.99899	.99948
January 1981	.99827	.99848	.99922
February 1981	.99770	.99798	.99896
March 1981	.99712	.99747	.99870
April 1981	.99655	.99697	.99844
May 1981	.99598	.99647	.99818
June 1981	.99541	.99596	.99792
July 1981	.99484	.99546	.99766
August 1981	.99427	.99496	.99740
September 1981	.99370	.99446	.99714
October 1981 or after	.99312	.99396	.99688

Table V.—*Adjustment to Limits Based on Areas With Covered Days of Care Per 1,000 HI Enrollees Less Than the National Average (1979 Data)*

State	Adjustment factor
Alaska	1.06577
Arizona	1.04813
California	1.06483
Colorado	1.00420
Connecticut	1.02302
Florida	1.01248
Georgia	1.01559
Hawaii	1.10006
Idaho	1.08364
Montana	1.04632
Nevada	1.02016
New Hampshire	1.02357
New Mexico	1.05796
Oregon	1.10056
Rhode Island	1.00912
South Carolina	1.02003

Table V.—*Adjustment to Limits Based on Areas With Covered Days of Care Per 1,000 HI Enrollees Less Than the National Average (1979 Data)*—Continued

State	Adjustment factor
Utah	1.13128
Washington	1.10009

The published limit will be increased so that hospitals in States with low utilization per 1,000 HI enrollees would receive higher per diem limits.

Sources of Data: Medicare inpatient covered days of care for short stay hospitals for 1979, by State: HCFA, Office of Research, Demonstrations and Statistics, Current Utilization Tabulations as of June 27, 1980—Table AA4A—Total—Number of Bills, Days of Care, Amount of Covered Charges and Reimbursement by Period Expense Incurred.

Number of Medicare beneficiaries, by State: HCFA, Office of Research, Demonstrations and Statistics, Medicare: 1979, Table 1.1.1., Enrollment (July 1) and reimbursement for hospital and medical insurance by census region, division, and State of residence: All persons, unpublished.

Table VI.—*Cost reporting year adjustment factors*

If the hospital cost reporting period begins—	The adjustment factor is: [1]
Oct. 1, 1980	1.00000
Nov. 1, 1980	1.00900
Dec. 1, 1980	1.01800
Jan. 1, 1981	1.02700
Feb. 1, 1981	1.03600
Mar. 1, 1981	1.04500
Apr. 1, 1981	1.05400
May 1, 1981	1.06300
June 1, 1981	1.07200
July 1, 1981	1.08100
Aug. 1, 1981	1.08892
Sept. 1, 1981	1.09683
Oct. 1, 1981	1.10475
Nov. 1, 1981	1.11267
Dec. 1, 1981	1.12058
Jan. 1, 1982	1.12850
Feb. 1, 1982	1.13642
Mar. 1, 1982	1.14433
Apr. 1, 1982	1.15225
May 1, 1982	1.16017
June 1, 1982	1.16808
July 1, 1982	1.17600
Aug. 1, 1982	1.18392
Sept. 1, 1982	1.19183

Based on projected market basket inflation rates of 10.8 percent for 1981, 9.5 percent for 1982 and 9.5 percent for 1983. These adjustment factors are subject to change based on later estimates of cost increases.

If for any reason, we do not publish a new schedule of limits or do not announce other changes in the current schedule, the current limits would continue in effect. These limits would be increased by .007917 (corresponding to .7917 percent) per month, until a new schedule of limits or other provison is issued.

Appendix.—*Derivation of "Market Basket" index for routine inpatient hospital operating costs*

Category of costs	Relative importance,[1] 1979	Forecaster,[2] percent changes 1980–83	Price variable used
1. Wages and salaries	59.41	DRI–CFS	For the period calendar year 1980 and thereafter: Percentage change in average hourly earnings of hospital industry workers (SIC 806).[3] Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings*, (monthly) Table C–2.
2. Employee benefits	8.13	DRI–MM	Percentage change in supplements to wages and salaries per worker in nonagricultural establishments. Sources: For supplements to wages and salaries—U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (monthly) table 7 (1.12). July issue has detailed components. For total employment—U.S. Dept. of Labor, Bureau of Labor Statistics *Employment and Earnings*, (monthly) table B–4.
3. Professional fees, other (legal, auditing, consulting, etc.) [4]	.49	DRI–MM	Percentage change in hourly earnings index for production or nonsupervisory workers on private nonagricultural payrolls, total private. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, (monthly), table 18.
4. Malpractice insurance premiums	2.09	HHS, HCFA	Percentage change in hospital malpractice insurance premiums per hospital. Data obtained from the American Hospital Association for the period 1967–1978. HHS, Health Care Financing Administration projected these data for 1979–1961
5. Food	5.99	DRI–MM	A. Percentage change in food and beverages component of consumer price index, all urban (relative importance, 3.02). Sources: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 23.
		DRI–MM	B. Percentage change in processed foods and feeds component of producer price index (relative importance, 2.97). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 27
6. Fuel and other utilities	3.33	DRI–MM	A. Percentage change in implicit price deflator—consumption of fuel oil and coal (derived from fuel oil component of consumer price index) (relative importance, 1.43). Source: U.S. Dept. of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, (monthly) table 7.11.
		DRI–MM	B. Percentage change in implicit price deflator—consumption of electricity (derived from electricity component of consumer price index) (relative importance, .83). Source: U.S. Dept. of Commerce, Bureau of Economic Analysis. Unpublished data provided to Data Resources Inc. by the Bureau of Economic Analysis. Historcal time series data are available from the Health Care Financing. Administration or the Bureau of Economic Analysis.
		DRI–MM	C. Percentage change in implicit price deflator for natural gas, derived from utility (piped) gas component of consumer price index (relative importance, .69). Source: Same as electricity above.
		DRI–CFS	D. Percentage change in water and sewerage maintenance component of consumer price index (relative importance, .38). Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 23.
7. Drugs	1.32	DRI–CFS	Percentage change in pharmaceutical preparations, ethical component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Producer Prices and Price Indexes* (monthly), table 6.
8. Chemicals and cleaning products	2.53	DRI–MM	Percentage change in chemicals and allied products component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 27.
9. Surgcal and medical instruments and supplies	1.25	DRI–CFS	Percentage change in special industry machinery and equipment component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 27.
10. Rubber and miscellaneous plastics	1.07	DRI–MM	Percentage change in rubber and plastic products component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 27.
11. Business travel and motor freight	1.44	DRI–CFS	Percentage change in transportation component of consumer price index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 23.
12. Apparel and textiles	1.72	DRI–MM	Percentage change in textile products and apparel component of producer price index. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 27.
13. Business services	3.93	DRI–MM	Percentage change in services component of consumer price index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 23.
14. All other miscellaneous expenses [5]	7.30	DRI–MM	Percentage change of consumer price index for all items, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 23.
Total	100.00		

[1]Routine operating cost weights for 1977 were derived from special studies by the Health Care Financing Administration using primarily data from the American Hospital Association and data from HCFA Medicare cost reports. A Laspeyres price index was constructed using 1977 weights and price variables indicated in this table. In calendar 1977 each price variable has an index value of 100.00. The "relative importance" of the routine operating cost weights changes each period in accordance with price changes for each price variable. Cost categories with relatively higher price increases get relatively higher cost weights and vice versa.

[2]DRI–CFS = Data Resources, Inc., Cost Forecasting Service, 1750 K Street, NW., Washington, D.C. 20006, (Forecast: CFS 811).

DRI–MM = Data Resources, Inc., Macro Model, 29 Hartwell Avenue, Lexington, Massachusetts 02173, (Forecast: Control 032381).

HHS–HCFA = Dept. of Health and Human Services, Health Care Financing Administration, 200 Independence Avenue, SW., Washington, D.C. 20201.

[3]For six months in 1979, the annual percentage change in average hourly earnings of service industry workers was used.

[4]Medical professional fees are included as part of nonroutine costs.

[5]This is a residual category of routine operating costs not included in the 13 specific categories above. It consists primarily of miscelluneous and unallocated items.

(Secs. 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act; 42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a), and 1395hh)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance)

Dated: September 12, 1981.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: September 18, 1981.

Richard S. Schweiker,

Secretary.

[FR Doc. 81–28327 Filed 9–29–81; 8:45 am]

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federal register

Wednesday
September 30, 1981

Part VIII

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Schedule of Limits on Home Health Agency Costs Per Visit Effective October 1, 1981

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Medicare Program; Schedule of Limits on Home Health Agency Costs Per Visit Effective October 1, 1981

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

ACTION: Final Notice.

SUMMARY: This notice sets forth a schedule of limits on home health agency (HHA) costs that may be reimbursed under the Medicare program beginning October 1, 1981. This is a special revision of the schedule, not an annual update, and replaces the current schedule, which was published in the Federal Register on June 30, 1981 (46 FR 33645). It incorporates a change required by the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) which is to lower the level of the limits from the 80th percentile of unweighted per visit costs to the 75th percentile of these costs. As required by statute, this notice also has a special provision for its effective date.

EFFECTIVE DATE: The revised schedule of limits is applicable to all cost reporting periods *ending after* September 30, 1981. For any of these cost reporting periods that begin before October 1, 1981, the reductions of payments resulting from application of these limits shall be applied only in proportion to the part of the reporting period that occurs after September 30, 1981.

FOR FURTHER INFORMATION, CONTACT: Carl Slutter, 301–594–9344

SUPPLEMENTARY INFORMATION:

Background

Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) as amended by section 223 of the Social Security Amendments of 1972 (Pub. L. 92–603) authorizes the Secretary to set prospective limits on allowable costs incurred by a provider of services that will be reimbursed under Medicare. These limits may be based on estimates of the costs necessary in the efficient delivery of needed health services. The limits may be applied to direct or indirect overall costs or to the costs incurred for specific items or services furnished by the provider. This provision of the statute is implemented under regulations at 42 CFR 405.460.

Under this authority, we have published limits on home health agency per visit costs annually since 1979. On June 30, 1981 we published in the Federal Register (46 FR 33645) the current schedule of limits, applicable to cost reporting periods beginning on or after July 1, 1981. These limits contained provisions related to (1) a classification system based on whether a HHA is provider-based or freestanding, and whether the HHA is located within a Standard Metropolitan Statistical Area (SMSA), a New England County Metropolitan Area (NECMA), or on non-SMSA area; (2) a "market basket" index developed from the price of goods and services purchased by HHAs; (3) adjustments to the limits by an area wage index developed from hospital wages; (4) a cost-of-living adjustment for HHAs in Alaska and Hawaii; (5) limits set at the 80th percentile; (6) calculation of per visit limits by type of service; and (7) application of the limits to each HHA in the aggregate.

On August 13, 1981, the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35) became law, including provisions affecting the Medicare program. Section 2144 of that Act amended the Social Security Act, setting new statutory requirements on cost limits for reimbursement of home health agencies under Medicare by adding a new paragraph (L)(ii) to section 1861(v)(1) that read as follows:

"The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) the 75th percentile of such costs per visit for home health agencies, or, in the judgment of the Secretary, such lower percentile or such comparable or lower limit (based on or related to the mean of the costs of such agencies or otherwise) as the Secretary may determine. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate."

Section 2144 also includes provisions on the effective date of the new limits, and the Conference Committee Report accompanying the legislation clarifies the method of application. (H.R. Report No. 97–208, 97th Cong., 1st Sess. p. 949 (1981).) Previously, we applied schedules of cost limits to cost reporting periods beginning after a specified date. Thus, a single schedule applied to each cost reporting period of a home health agency. However, the new provision in 1861(v)(1)(L)(ii) is effective for *all* cost reporting periods *ending* after September 30, 1981, including portions of reporting periods that begin before and continue after that date.

This notice implements these provisions of the Reconciliation Act, but otherwise retains the methodology of the prior cost limits.

Summary of Provisions

This revised schedule of limits on home health agency costs per visit provides for:

1. Identical provisions to those of the June 30, 1981 Notice (see 46 FR 33645) concerning the classification system, market basket and wage index adjustment.

One June 19, 1981, the Executive Office of Management and Budget announced revised Standard Metropolitan Statistical Area (SMSA) definitions based on the 1980 census. As soon as we have received new wage index values for these areas, we will publish in the Federal Register a list of the constituent counties in the revised SMSAs together with the appropriate wage indexes.

2. *Limits set at the 75th percentile.*

In accordance with Pub. L. 97–35, we are setting the basic service limits at the 75th percentile of each comparison group. Each HHA's individual limits will be increased or decreased by the application of the wage index as described in the June 30 notice.

3. *Application of Limits.*

The 75th percentile limits apply to cost reporting periods ending after September 30, 1981 (or beginning on or after 11/1/80), but are applicable only in proportion to that portion of the cost reporting period occurring after September 30, 1981. We explain how this adjustment is made later in this notice.

The limits will continue to be applied in the aggregate. However, the Conference Committee Report accompanying Pub. L. 97–35 "* * * urges the Secretary, as soon as possible, to begin to impose the limits by type of service." (H.R. Report No. 97–208, 97th Cong., 1st Sess. p. 949 (1981).) Therefore, we will continue to examine the possibility of applying the limits to individual services.

Impact Analyses

Executive Order 12291

The Secretary has determined, in accordance with Executive Order 12291, that this final notice does not constitute a "major rule" because it will not: have an annual effect on the economy of $100 million or more; result in a major increase in costs or prices for consumers, any industries, any governmental agencies or any geographic regions; or have significant adverse effects on competition, employment, investment, productivity,

innovation, or on the ability of the United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Regulatory Flexibility Act

The Secretary certifies, under Section 605(b) of the Regulatory Flexibility Act (Pub. L. 96-354), that the revised schedule of limits set forth in this notice will not have a significant economic impact on a substantial number of small entities. The reason for the Secretary's negative certification is that the revised limits merely implement recent statutory changes governing the system of home health agency cost limits that is now in effect, and do not otherwise include any changes in our methodology for deriving and applying them.

Waiver of Proposed Notice and 30-Day Delay in Effective Date

As explained previously, we developed the revised limits using the same methodology that we used to develop the current limits, that were published on June 30, 1981, and the previous cost limits, published on June 5, 1980. On February 15, 1980, we published a proposed notice that described in detail our methodology for developing and applying the limits and provided a 60-day period for public comment (45 FR 10450). In developing the current methodology for deriving and applying the schedule of cost limits, we considered all comments received in response to the February 15, 1980 notice. These comments, and our responses to them, are described in the June 5, 1980 notice (45 FR 38014).

Because the main features of the methodology used in this revised schedule has previously been published for public comment, we believe that it would be impracticable and unnecessary to again request public comment. To do so would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice, and publish this notice of updated limits in final form.

In the past, we generally have attempted to allow a 30-day period between the date of publication of each cost limit schedule and the effective date of the schedule. In this case, it would be impracticable and contrary to the public interest to do so because the effective date of the statutory changes is October 1, 1981. Since prompt publication of the results of these changes in the limits would be in the public interest, we find good cause to waive the customary 30-day delay between publication of new limits and their effective date, and apply them to HHAs effective October 1, 1981.

Methodology For Determining Cost Per Visit Limits

1. *Basic Service Limit.* An explanation of the data used and methodology for calculating the home health agency limits is contained in the June 30, 1981 notice (46 FR 33645). For this schedule, a basic service limit equal to the 75th percentile of the array was calculated for each type of service, according to the provider-based and freestanding classification and the urban or non-urban location of the group.

2. All other aspects of the methodology for determining the cost per visit limits contained in this schedule are identical to those described in the June 30, 1981 notice. For ease of reference, however, we have reprinted the annual percentage increases in the market basket which we use for the June 30, 1981 schedule and these revised limits.

	Percent increase
Calendar year:	
1977	7.1
1978	6.7
1979	7.6
1980 (1/1/80 to 6/30/80)	8.1
1980 (market basket, 7/1/80 to 12/31/80)	11.7
1981 (market basket)	10.8
1982 (market basket)	9.5
1983 (market basket)	9.6

Schedule of Limits

This schedule of limits applies to all cost reporting periods ending after September 30, 1981. However, for cost reporting periods beginning before October 1, 1981, any reduction in payment resulting from this schedule will be applied in proportion to the part of the reporting period occurring after September 30, 1981. The fiscal intermediaries will compute the adjusted limits using the wage index published in Table III A and III B, and adjustment factors published in Table IV and notify each HHA of its applicable limits. These limits will remain in effect until replaced by a revised schedule of limits published in a final notice in the **Federal Register.**

Any HHA that has a cost reporting period that begins prior to October 1, 1981, will be affected by two cost limits: the limit in effect for the period before October 1, 1981 (the cost limits that were published June 5, 1980 *or* June 30, 1981 will apply to this period); and these revised costs limits that apply to the portion of the cost reporting period occurring after September 30, 1981.

The intermediary will determine the proportionate application of the limits in the following manner:

1. Compute the aggregate cost limit using the two schedules which apply:

(a) Limits published June 5, 1980, (45 FR 38014), for cost reporting periods beginning on or after July 1, 1980 *or* limits published June 30, 1981, (46 FR 33645), for cost reporting periods beginning on or after July 1, 1981; and

(b) This schedule of limits.

2. Determine the disallowance under each schedule separately.

3. Multiply the disallowance for each schedule of limits by a factor that represents the portion of the cost reporting period to which each schedule applies. This is divided by the number of months before the effective date (for the period covered by the limits in (a) above) and after the effective date (for the period covered by this schedule) by 12. (See following examples.) These are the reductions in payments which apply to each portion of the cost reporting period.

4. Determine the total disallowance by adding the results from the calculation described in step 3 above. This sum represents the total disallowance for the reporting period.

Examples

A. Cost Reporting Period Beginning on or After October 1, 1981

Example: Home Health Agency X, a freestanding agency located in Pittsburgh, Pennsylvania made 6,000 skilled nursing, 1,000 physical therapy and 2,000 home health aide covered visits to Medicare beneficiaries during the 12-month cost reporting period beginning October 1, 1981. The aggregate cost limit would be determined as follows using the wage index for Pittsburgh, Pennsylvania—1.1275. The provider's actual cost is $500,000.

Portion of Cost Reporting Period after 9/30/81—12÷12=1.0.

Actual Cost: $500,000.

Aggregate Cost Limit (effective 10/01/81):

Type of visit	Visit	Per visit limit [1]	Adjustment limit [2]	Adjustment total
Skilled Nursing (SN)	6,000	45.90	49.95	$299,700
Physical Therapy (PT)	1,000	44.96	48.93	48,930
Home health aide	2,000	33.26	36.20	72,400
Total				421,030
Amount disallowed ($500,000 - $421,030)				78,970

(1) Using adjustment factor of 1.0958 from Table IV
(2) Using wage index = 1.1275.

B. Cost Reporting Periods Beginning Prior to October 1, 1981

1. *Example:* Home Health Agency A, a freestanding agency located in Chattanooga, Tennessee, made 5,000 skilled nursing, 1,000 physical therapy, and 1,000 home health aide covered visits to Medicare beneficiaries during the 12-month cost reporting period beginning July 1, 1981.

The aggregate cost limit (effective 7-1-81) was $322,580 (see 46 FR 33649). The provider's actual cost is $320,000.

Portion of Cost Reporting Period Before 10/1/81—3÷12=.25.

Portion of Cost Reporting Period After 9/30/81—9÷12=.75.

a. Actual Cost: $320,000.

Aggregate Cost Limit (effective 07/01/81)—322,580.

Amount over Limit ($320,000−$322,580)=$0.

Amount Disallowed (07/01/81 to 09/30/81) $0×.25=$0.

Actual Cost: $320,000.

Aggregate Cost Limit (effective 10/01/81).

Type of visit	Visit	Per visit limit [1]	Adjustment limit [2]	Adjustment total
SN	5,000	44.91	45.61	$228,050
PT	1,000	43.98	44.67	44,670
Aide	1,000	32.54	33.05	33,050
Aggregate cost limit (effective 10/01/81) total				305,770

[1] Using adjustment factor of 1.0720 from Table IV.
[2] Wage index=1.0226.

Amount over limit (10/01/81 to 06/30/82) ($320,000−305,770)=$14,230.

Amount Disallowed $14,230×.75=$10,673.

Total Amount Disallowed (07/01/81 to 06/30/82)$0+$10,673.

12. *Example:* Home Health Agency B, a freestanding agency located in Savannah, Georgia made 7,000 skilled nursing, 1,000 physical therapy and 2,500 home health aides covered visits to Medicare beneficiaries during the 12-month cost reporting period beginning January 1, 1981.

The aggregate cost limit (calculated in accordance with the June 5, 1980 Notice) was $412,975. The provider's actual cost is $450,000.

Portion of Cost Reporting Period Before 10/1/81=9÷12=.75.

Portion of Cost Reporting After Before 9/30/81=3÷12=.25.

a. Actual Cost: $450,000.

Aggregate Cost Limit (45 FR 38014) 412,975.

Amount over Limit (01/01/81 to 09/30/81) $450,000−412,975=$37,025.

Amount Disallowed (01/01/81 to 09/30/81) $37,025×.75=$27,769.

b. Actual Cost: $450,000.

Aggregate Cost Limit (effective 10-01-81)

Type of visit	Visit	Per visit limit [1]	Adjustment limit [2]	Adjustment total
SN	7,000	42.64	40.91	$286,370
PI	1,000	41.77	40.07	40,070
Aides	2,500	30.90	29.65	74,125
Aggregate cost limit (effective 10/01/81) total				400,565

[1] Using adjustment factor of 1.0180 from Table IV.
[2] Wage index=.9414.

Amount over Limit=$450,000−400,565=$49,435.

Amount disallowed (10/01/81 to 12/31/81) $49,435×.25=$12,359.

Total amount disallowed (01/01/81 to 12/31/81) $27,769+12,359=$40,128.

Before the limits are applied at cost settlement, the provider's actual costs will be reduced by the amount of individual items of cost (e.g., administrative compensation, contract services) that are found to be excessive under Medicare principles of provider reimbursement. The fiscal intermediaries will review the various reported costs against such screens as the cost guidelines for physical therapy under arrangements (see 42 CFR 405.432) and against the limitation on costs that are substantially out of line with those of comparable agencies (see 42 CFR 405.451). The provider's cost will also be reduced by the amount of reimbursable costs that are not included in the limitation amount (e.g., medical appliances).

Table I.—*Per Visit Limits for Provider-Based Home Health Agencies*

Type of visit	Limit	Wage portion 69.28 percent	Non-wage portion 30.72 percent
SMSA (NECMA) Location:			
Skilled nursing care	54.66	37.87	16.79
Physical therapy	49.30	34.16	15.14
Speech pathology	51.49	35.67	15.82
Occupational therapy	48.46	33.57	14.89
Medical social services	50.58	35.04	15.54
Home health aide	48.36	33.50	14.86
NON-SMSA Location:			
Skilled nursing care	51.43	35.63	15.80
Physical therapy	48.72	33.75	14.97
Speech pathology	[1]	[1]	[1]
Occupational therapy	[1]	[1]	[1]
Medical social services	[1]	[1]	[1]
Home health aide	41.94	29.06	12.88

[1] Insufficient data—Use basic service limits for freestanding non-SMSA agencies.

Table II.—*Per visit limits for freestanding home health agencies* [1]

Type of visit	Limit	Wage portion 69.28 percent	Non-wage portion 30.72 percent
SMSA (NECMA) location:			
Skilled nursing care	41.89	29.02	12.87
Physical therapy	41.03	28.43	12.60
Speech pathology	42.33	29.33	13.00
Occupational therapy	41.82	28.97	12.85
Medical social services	48.46	33.57	14.89

Table II.—*Per visit limits for freestanding home health agencies* [1]—Continued

Type of visit	Limit	Wage portion 69.28 percent	Non-wage portion 30.72 percent
Home health aide	30.35	21.03	9.32
Non-SMSA location:			
Skilled nursing care	43.44	30.10	13.34
Physical therapy	43.65	30.24	13.41
Speech pathology	45.65	31.63	14.02
Occupational therapy	40.07	27.76	12.31
Medical social services	45.78	31.72	14.06
Home health aide	27.90	19.33	8.57

[1] Nonwage portion of limits for HHAs located in States of Alaska and Hawaii will be increased by the following cost-of-living adjustment:

Alaska	25
Hawaii (island):	
Oahu	15
Kauai	15
Molokai	12.5
Maui and Lanai	15
Hawaii	10

Table III A.—*Wage Index for Urban Areas*

SMSA area	Wage index
Abilene, TX	.8485
Akron, OH	1.0417
Albany, GA	.8566
Albany-Schenectady-Troy, NY	.9624
Albuquerque, NM	1.0009
Alexandria, LA	.8954
Allentown-Bathlehem-Easton, PA-NJ	1.0589
Altoona, PA	1.0219
Amarillo, TX	.9233
Anaheim-Santa Ana-Garden Grove, CA	1.2115
Anchorage, AK	1.6461
Anderson, IN	.9812
Ann Arbor, MI	1.2175
Anniston, AL	.8400
Appleton-Oshkosh, WI	1.0124
Asheville, NC	.9678
Atlanta, GA	.9162
Atlantic City, NJ	1.0174
Augusta, GA-SC	.9237
Austin, TX	.9859
Bakersfield, CA	1.1223
Baltimore, MD	1.1698
Baton Rouge, LA	.8813
Battle Creek, MI	1.0229
Bay City, MI	1.1238
Beaumont-Port Arthur-Orange, TX	.8530
Billings, MT	[1].9496
Biloxi-Gulfport, MS	.8143
Binghamton, NY-PA	.9769
Birmingham, AL	.9658
Bismarck, ND	.9032
Bloomington, IN	[1].9481
Bloomington-Normal, IL	.8484
Boise City, ID	.9834
Boston-Lowell-Brockton-Lawrence-Haverhill, MA-NH	1.1214
Bradenton, FL	[1].8631
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1647
Brownsville-Harlingen-San Benito, TX	.9312
Bryan-College Station, TX	.8377
Buffalo, NY	.9926
Burlington, NC	.8899
Canton, OH	.9447
Cedar Rapids, IA	[1].9193
Champaign-Urbana-Rantoul, IL	1.1197
Charleston-North Charleston, SC	.9751
Charleston, WV	1.0628
Charlotte-Gastonia, NC	.9456
Chattanooga, TN-GA	1.0226
Chicago, IL	1.1780
Cincinnati, OH-KY-IN	1.0814
Clarksville-Hopkinsville, TN-KY	.8397
Cleveland, OH	1.1957
Colorado Springs, CO	.9743
Columbia, MO	1.1712
Columbia, SC	.9743
Columbus, GA-AL	.9021
Columbus, OH	1.1184
Corpus Christi, TX	.9337
Dallas-Fort Worth, TX	.9403
Davenport-Rock Island-Moline, IA-IL	.9219
Dayton, OH	1.1064

Table III A.—*Wage Index for Urban Areas*—Continued

SMSA area	Wage index
Daytona Beach, FL	.9423
Decatur, IL	.9096
Denver-Boulder, CO	1.0960
Des Moines, IA	1.0156
Detroit, MI	1.2280
Dubuque, IA	.9426
Duluth-Superior, MN-WI	.9193
Eau Claire, WI	.9606
El Paso, TX	.8714
Elkhart, IN	[1].7997
Elmira, NY	.9642
Enid, OK	.8228
Erie, PA	.9652
Eugene-Springfield, OR	.9639
Evansville, IN-KY	1.0742
Fargo-Moorhead, ND-MN	.9355
Fayetteville, NC	[1].8353
Fayetteville-Springdale, AR	.7997
Flint, MI	1.1919
Florence, AL	.8056
Fort Collins, CO	.8353
Fort Lauderdale-Hollywood, FL	1.0506
Fort Myers, FL	.9391
Fort Smith, AR-OK	.8899
Fort Wayne, IN	.8881
Fresno, CA	1.1265
Gadsden, AL	.9264
Gainesville, FL	.9019
Galveston-Texas City, TX	1.0607
Gary-Hammond-East Chicago, IN	1.1664
Grand Forks, ND-MN	.8779
Grand Rapids, MI	.9463
Great Falls, MT	[1].9162
Greeley, CO	[1].9312
Green Bay, WI	.9740
Greensboro-Winston-Salem-High Point, NC	.9232
Greenville-Spartanburg, SC	.9371
Hamilton-Middleton, OH	1.0620
Harrisburg, PA	1.0534
Hartford-New Britain-Bristol, CT	1.1535
Honolulu, HI	1.1645
Houston, TX	1.0630
Huntington-Ashland, WV-KY-OH	.9270
Huntsville, AL	.8593
Indianapolis, IN	1.0507
Iowa City, IA	1.0209
Jackson, MI	[1]1.0173
Jackson, MS	.8699
Jacksonville, FL	.9331
Janesville-Beloit, WI	.8579
Jersey City, NJ	1.1180
Johnson City-Kingsport-Bristol, TN-VA	.8777
Johnstown, PA	1.0445
Kalamazoo-Portage, MI	1.1695
Kankakee, IL	1.0073
Kansas City, MO-KS	.9399
Kenosha, WI	[1]1.0778
Killeen-Temple, TX	.8868
Knoxville, TN	.9100
Kokomo, IN	.9828
La Crosse, WI	[1].9016
Lafayette, LA	.8622
Lafayette-West Lafayette, IN	.9141
Lake Charles, LA	.8706
Lakeland-Winter Haven, FL	.9749
Lancaster, PA	1.0674
Lansing-East Lansing, MI	1.0811
Laredo, TX	[1].8593
Las Cruces, NM	[1].8129
Las Vegas, NV	1.1884
Lawrence, KS	[1].9193
Lawton, OK	[1].8377
Lewiston-Auburn, ME	[1].8899
Lexington-Fayette, KY	.9016
Lima, OH	.9932
Lincoln, NE	.9259
Little Rock-North Little Rock, AR	1.0205
Long Branch-Asbury Park, NJ	1.0648
Longview, TX	.8129
Lorain-Elyria, OH	1.0207
Los Angeles-Long Beach, CA	1.2899
Louisville, KY-IN	.9915
Lubbock, TX	.9042
Lynchburg, VA	.8876
Macon, GA	.9637
Madison, WI	1.0257
Manchester-Nashua, NH	.9352
Mansfield, OH	.9196
McAllen-Pharr-Edinburg, TX	.8165
Melbourne-Titusville-Cocoa, FL	.9374
Memphis, TN-AR-MS	1.0371
Miami, FL	1.1050
Midland, TX	[1].9141
Milwaukee, WI	1.0080
Minneapolis-St. Paul, MN-WI	.9802
Mobile, AL	.9416
Modesto, CA	1.0508
Monroe, LA	.9451
Montgomery, AL	.9626
Muncie, IN	[1].9852
Muskegon-Norton Shores-Muskegon Heights, MI	.9658
Nashville-Davidson, TN	1.0187
Nassau-Suffolk, NY	1.2758
New Bedford-Fall River, MA	.9687
New Brunswick-Perth Amboy-Sayreville, NJ	1.0409
New Haven-Waterbury-Meriden, CT	1.0990
New London-Norwich, CT	1.0903
New Orleans, LA	.9644
New York, NY-NJ	1.3956
Newark, NJ	1.2099
Newport News-Hampton, VA	.8907
Norlolk-Virginia Beach-Portsmouth, VA-NC	.9496
Northeast Pennsylvania	1.0598
Odessa, TX	[1].9496
Oklahoma City, OK	.9252
Omaha, NE-IA	.9365
Orlando, FL	.9087
Owensboro, KY	[1].8364
Oxnard-Simi Valley-Ventura, CA	1.3788
Panama City, FL	[1].8777
Parkersburg-Marietta, WV-OH	1.0461
Pascagoula-Moss Point, MS	[1]1.1535
Paterson-Clifton-Passaic, NJ	1.0959
Pensacola, FL	.8841
Peoria, IL	1.0175
Petersburg-Colonial Heights-Hopewell, VA	.9484
Philadelphia, PA-NJ	1.1810
Phoenix, AZ	1.1100
Pine Bluff, AR	[1].7997
Pittsburgh, PA	1.1275
Pittsfield, MA	1.0275
Portland, ME	.9718
Portland, OR-WA	1.1026
Poughkeepsie, NY	1.0778
Providence-Warwick-Pawtucket, RI	1.0314
Provo-Orem, UT	.9454
Pueblo, CO	1.0969
Racine, WI	.9240
Raleigh-Durham, NC	1.0173
Rapid City, SD	[1].8680
Reading, PA	1.0101
Reno, NV	[1]1.2428
Richland-Kennewick, WA	.9763
Richmond, VA	.9252
Riverside-San Bernardino-Ontario, CA	1.1729
Roanoke, VA	.9614
Rochester, MN	.9852
Rochester, NY	1.0653
Rockford, IL	.9696
Sacramento, CA	1.1396
Saginaw, MI	1.1279
St. Cloud, MN	.8680
St. Joseph, MO	.9749
St. Louis, MO-IL	.9977
Salem, OR	1.1083
Salinas-Seaside-Monterey, CA	1.2428
Salt Lake City-Ogden, UT	.8550
San Angelo, TX	.8364
San Antonio, TX	.9509
San Diego, CA	1.1113
San Francisco-Oakland, CA	1.3153
San Jose, CA	1.3055
Santa Barbara-Santa Maria-Lompoc, CA	1.0552
Santa Cruz, CA	1.0811
Santa Rosa, CA	1.4037
Sarasota, FL	.8554
Savannah, GA	.9414
Seattle-Everett, WA	1.0500
Sherman-Denison, TX	.8277
Shreveport, LA	.9292
Sioux City, IA-NE	.9306
Sioux Falls, SD	.8844
South Bend, IN	.9154
Spokane, WA	1.0921
Springfield, IL	.9873
Springfield, MO	.8933
Springfield, OH	.9821
Springfield-Chicopee-Holyoke, MA	1.0184
Steubenville-Weirton, OH-WV	.9689
Stockton, CA	1.3046
Syracuse, NY	1.3209
Tacoma, WA	1.0514
Tallahassee, FL	[1].9219
Tampa-St. Petersburg, FL	.9698
Terre Haute, IN	.8644
Texarkana-TX-Texarkana, AR	1.0929
Toledo, OH-MI	1.1157
Topeka, KS	1.0602
Trenton, NJ	1.1706
Tucson, AZ	.9977
Tulsa, OK	.9626
Tuscaloosa, AL	1.0142
Tyler, TX	.9461
Utica-Rome, NY	1.0145
Vallejo-Fairfield-Napa, CA	1.5862
Vineland-Millville-Bridgeton, NJ	1.0083
Waco, TX	.8593
Washington, DC-MD-VA	1.1457
Waterloo-Cedar Falls, IA	.8631
West Palm Beach-Boca Raton, FL	.9632
Wheeling, WV-OH	.9921
Wichita, KS	1.0248
Wichita Falls, TX	.8282
Williamsport, PA	.9749
Wilmington, DE-NJ-MD	1.0898
Wilmington, NC	.8936
Worcester-Fitchburg-Leominster, MA	.9703
Yakima, WA	.9523
York, PA	.9884
Youngstown-Warren, OH	1.1090

[1] Approximate value for area.

Table III B.—*Wage Index for Rural Areas*

Non-SMSA area	Wage index
Alabama	.8960
Alaska	1.5579
Arizona	1.0289
Arkansas	.8686
California	1.2415
Colorado	.8990
Connecticut	1.1552
Delaware	1.0370
Florida	.9917
Georgia	.9463
Hawaii	1.3362
Idaho	.9669
Illinois	.9180
Indiana	.9763
Iowa	.9220
Kansas	.8973
Kentucky	.9207
Louisiana	.9216
Maine	.9926
Maryland	1.1028
Massachusetts	1.1722
Michigan	1.1325
Minnesota	.9052
Mississippi	.8751
Missouri	.9156
Montana	.9561
Nebraska	.8130
Nevada	1.0790
New Hampshire	1.0971
New Jersey	1.0620
New Mexico	1.0073
New York	1.0327
North Carolina	.9917
North Dakota	.9045
Ohio	1.0086
Oklahoma	.9111
Oregon	1.0673
Pennsylvania	1.1358
Rhode Island	[1]
South Carolina	.9180
South Dakota	.7990
Tennessee	.8779
Texas	.8979
Utah	.8499
Vermont	.9993
Virginia	.9792
Washington	1.0465
West Virginia	1.0111
Wisconsin	.9179
Wyoming	1.0402

[1] Not applicable. All of Rhode Island is classified as urban.

Table IV.—*Cost Reporting Year Adjustment Factors* [1]

If the HHA cost reporting period begins	The adjustment factor is
December 1, 1980	1.0090
January 1, 1981	1.0180
February 1, 1981	1.0270
March 1, 1981	1.0360
April 1, 1981	1.0450
May 1, 1981	1.0540
June 1, 1981	1.0630
July 1, 1981	1.0720
August 1, 1981	1.0799
September 1, 1981	1.0878
October 1, 1981	1.0958
November 1, 1981	1.1037
December 1, 1981	1.1116
January 1, 1982	1.1195
February 1, 1982	1.1274
March 1, 1982	1.1353
April 1, 1982	1.1433
May 1, 1982	1.1512
June 1, 1982	1.1591
July 1, 1982	1.1670

[1] Based on a projected market basket inflation rate of 9.5 percent for 1982. These adjustment factors are subject to change based on later estimates of costs increases.

If, for any reason, we do not publish a new schedule of limits or do not announce other changes in the current schedule, the current limits would continue in effect. These limits would be increased by .008 (corresponding to .8 percent) per month, until a new schedule of limits or other provision is issued. The adjustment factor of .008 is based on a projected market basket inflation rate of 9.6 percent for 1983.

(Sections 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act; 42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a) and 1395hh)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance)

Dated: September 12, 1981.

Carolyne K. Davis, Ph.D.,

Administrator, Health Care Financing Administration.

Approved: September 18, 1981.

Richard S. Schweiker,

Secretary.

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