D. Section 404 of the DOE Act

Pursuant to the requirements of section 404(a) of the Department of Energy Organization Act (42 U.S.C. 7101 *et seq.*, Pub. L. 95–91), we have referred this Notice, which contains a "proposal" regarding outstanding exception decisions, concurrently with the issuance hereof, to the Federal Energy Regulatory Commission for a determination as to whether the "proposal" would significantly affect any matter within the Commission's jurisdiction. The Commission will have until the close of the public comment period to make this determination.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) requires the preparation and publication of an initial and final regulatory flexibility analysis at the time of publication of the notice of proposed rule making and final rule, respectively, if the proposal and final rule are likely to have a significant impact on a substantial number of small entities.

This action, if considered a "final rule" and "proposal," removes regulatory requirements and economic distortions caused by the Entitlements Program and related exception decisions. For those Entitlements Program participants that could be classified as "small entities" by reason of being "small governmental jurisdictions" (e.g., governmental entities that were included pursuant to the petroleum substitutes provisions) or "smalls refiners", the "final rule" and the "proposal" regarding outstanding exception orders generally remove a financial burden from them as a class.

DOE's decision not to issue the entitlements notices will adversely affect small entities that would have been net entitlements sellers on the combined lists. Conversely, it will benefit small entities that would have been net entitlements purchasers or subject to exception decisions requiring pay-backs or others restitution. Thus, a number of small entities may be affected, and at least for some, the impact may be significant. The preceding discussion in this Notice, which analyzes the impacts of the "final rule" and the "proposal" and describes the reasons therefor, satisfies the statutory requirements and constitues the initial regulatory flexibility analysis required by section 603(b) of the Act for the "proposal" regarding outstanding exception decisions and the final regulatory flexibility analysis required by section 604 of the Act for DOE's decision not to issue additional entitlements lists.

(Emergency Petroleum Allocation of 1973, 15 U.S.C. 751 *et seq.*, Pub. L. 93–159, as amended, Pub. L. 93–511, Pub. L. 94–99, Pub. L. 94–133, Pub. L. 94–163, and Pub. L. 94–385; Federal Energy Administration Act of 1974, 15 U.S.C. 787 *et seq.*, Pub. L. 93–275, as amended, Pub. L. 94–332, Pub. L. 94–385, Pub. L. 95–70, and Pub. L. 95–91; Energy Policy and Conservation Act, 42 U.S.C. 6201 *et seq.*, Pub. L. 94–163, amended, Pub. L. 94–385, Pub. L. 95–70, Pub. L. 95–619, and Pub. L. 96–30; Department of Energy Organization Act, 42 U.S.C. 7101 *et seq.*, Pub. L. 95–91, Pub. L. 95–509, Pub. L. 95–619, Pub. L. 95–620, and Pub. L. 95–621; E.O. 11790, 39 FR 23185; E.O. 12009, 42 FR 46267; E.O. 12287, 46 FR 9909)

In consideration of the foregoing, this final decision and tentative decision are issued in Washington, D.C. on June 28, 1984.

Rayburn Hanzlik,

Administrator, Economic Regulatory Administration.

[FR Doc. 84–17613 Filed 7–2–84; 8:45 am]

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Federal Register

Tuesday
July 3, 1984

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 405

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System, and Proposed Fiscal Year 1985 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[BERC-279-P]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System; and Proposed Fiscal Year 1985 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to amend the Medicare regulations published as interim final rules on September 1, 1983 (48 FR 39752) and final rules on January 3, 1984 (49 FR 234). Those regulations implement section 1886 of the Social Security Act, which changes the method of payment for inpatient hospital services from a cost-based, retrospective reimbursement system to a prospective payment system based on diagnosis. Generally, our proposed changes would be effective with discharges occurring on or after October 1, 1984, or with hospital cost reporting periods beginning on or after October 1, 1984.

In addition, in the addendum to this proposed rule, we are proposing changes in the methods, amounts, and factors necessary to determine prospective payment rates for medicare inpatient hospital services applicable to discharges occurring on or after October 1, 1984, in the case of the Federal portion of the payment and effective with hospital cost reporting periods beginning on or after October 1, 1984, in the case of the hospital-specific portion. These changes would be applicable in the second year of the three-year transition period for the prospective payment system.

Congress has passed a bill (H.R. 4170, known as the "Deficit Reduction Act of 1984") which, if approved by the President, will affect the proposed rates and rules included in this notice. We will make adjustments as necessary in the final rule to accommodate changes required by this legislation.

DATE: To assure consideration, comments must be received by August 2, 1984.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-279-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code BERC-279-P. Comments will be available for public inspection as they are received, beginning approximately three weeks after today, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m., (202-245-7890).

FOR FURTHER INFORMATION CONTACT:

Marilyn Koch, (301) 594-9344—Transfers; Urban/Rural Areas; Referral Centers; Prospective Payment Rates

Sheridan Gladhill, (301) 594-9440—Rehabilitation Units

Thomas Hoyer, (301) 594-9446—Physician Attestation

George Cray, (301) 597-3874—Base Year Appeals

SUPPLEMENTARY INFORMATION:

I. Background

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 20, 1983, a prospective payment system for Medicare payment of inpatient hospital services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). This list contains 470 specific categories.

Section 1886(d)(1)(A) of the Act provides for a three-year transition period during which a declining portion of the total prospective payment rate is based on a hospital's historical cost in a given base year, and a gradually increasing portion is based on a regional Federal rate per discharge in the first year and a blend of the regional and national Federal rate per discharge in the second and third years. Beginning with the fourth year, and continuing thereafter (that is, for hospital cost reporting periods beginning on or after October 1, 1986), Medicare payment for inpatient hospital services will be determined fully under a national DRG payment methodology.

We published an interim rule in the **Federal Register** (48 FR 39752) on September 1, 1983 to implement the prospective payment system effective with hospital cost reporting periods beginning on or after October 1, 1983. In that rule we established criteria for determining—

—Which hospitals are included in and excluded from the prospective payment system;

—The basis of payment under the prospective payment system;

—The prospective payment rate methodology;

—Additional payment amounts;

—Special treatment of certain hospitals; and

—Other conforming changes.

In particular, we identified the prospective payment rates to be used for the first year of the transition period. We issued a final rule (49 FR 234) on January 3, 1984 to make changes resulting from our consideration of public comments that were received in response to the interim final rule.

In this proposed rule, as a result of our experience with the prospective payment system to date, we are proposing to amend 42 CFR 405 to make further changes in the prospective payment regulations. In addition, in the addendum to this document, we are proposing changes in the methods, amounts, and factors necessary to implement the second year of the transition payment period, applicable to discharges occurring on or after October 1, 1984, in the case of the Federal portion of the payment and effective with hospital cost reporting periods beginning on or after October 1, 1984, in the case of the hospital-specific portion.

II. Current Provisions and Proposed Changes

A. Transfers (§ 405.470)

The term "transfer" is defined, for purposes of the prospective payment system, in § 405.470(c)(2) of the regulations. Generally, for hospital inpatients, we do not count a patient as discharged when the patient is transferred from—

- One inpatient area or unit of the hospital to another area or unit of the hospital;
- The care of a hospital paid under the prospective payment system to the care of another hospital paid under the prospective payment system;
- The care of a hospital paid under the prospective payment system to the care of another hospital that—

—Is excluded from the prospective payment system only because of its participation in an approved statewide reimbursement control program or demonstration, or

—Would be paid under the prospective payment system except that its first cost reporting period under the prospective payment system has not yet begun; or

• The care of a hospital paid under the prospective payment system to the care of another hospital or hospital unit not determined to be excluded from the prospective payment system.

Payment for a transferring hospital, as determined under § 405.470(c)(4), is based on the per diem rate for each day of the patient's stay in that hospital, not to exceed the full DRG payment. The per diem rate is determined by dividing the prospective payment amount for the applicable DRG by the average length of stay for that DRG. As an exception to the per diem computation, for discharges classified into DRG No. 385 (Neonates, died or transferred) or DRG No. 456 (Burns, transferred to another acute care facility), the transferring hospital is paid the full prospective payment amount for the applicable DRG regardless of the length of stay.

As we stated in both the interim final rule (48 FR 39759) and the final rule (49 FR 246), the transfer policy as described in § 405.470(c) is meant as an interim policy, until we are able to restructure the payment method so that we can make one payment to the final discharging hospital for the entire course of treatment.

Under currrent regulations (§ 405.470(c)(4)), the transferring hospital's payment may not exceed the full DRG payment. Consequently, no additional payments for exceptional cases (outlier payments) are payable to transferring hospitals. Only those hospitals in which the patient is considered "discharged" (that is, situations in which a patient is formally released from the hospital, dies in the hospital, or is transferred to another hospital or unit excluded from the prospective payment system) may be entitled to outlier payments.

We have continued to analyze transfer policy data based on our experience thus far with the prospective payment system to determine if any further refinements are necessary. In practice, the per diem rate provides payment commensurate with the transferring hospital's services rendered in the majority of cases. However, in caes in which a patient is transferred to another hospital for specialized care after extensive treatment, it is possible for a transferring hospital to incur costs that would have qualified for cost outlier payment.

In order to recognize these exceptional cases and to provide additional compensation to transferring hospitals for extraordinarily high-cost cases, we are proposing to amend § 405.470(c)(4) to allow a transferring hospital to receive additional payments for discharges occurring on or after October 1, 1984 that meet the cost outlier criteria in § 405.475(d).

We still do not believe that it is appropriate to make day outlier payments to a transferring hospital because—

• We would not expect a patient to be present in the transferring hospital long enough to qualify as a day outlier case; and

• If a patient needed to be transferred, but was kept in the first hospital long enough to qualify as a day outlier case, it would be questionable whether the patient was receiving the most appropriate care.

We will continue to develop a payment method that would make it possible to pay the final discharging hospital one payment, less deductibles and coinsurance, for inpatient services associated with a particular episode of hospitalization.

B. Direction of Rehabilitation Units (§ 405.471)

Section 1886(d)(1)(B) of the Act excludes rehabilitation hospitals and rehabilitation units that are distinct parts of hospitals from the prospective payment system. The regulations implementing this exclusion are set forth in §§ 405.471(c)(2), (c)(4)(i), and (c)(4)(iii).

In particular, the regulations at §§ 405.471(c)(2)(v) and (c)(4)(iii)(F) provide that rehabilitation hospitals and units that wish to be excluded from the prospective payment system must have a director of rehabilitation who—

• Provides services to the hospital/unit or its inpatients on a full-time basis;

• Is a doctor of medicine or osteopathy;

• Is licensed under State law to practice medicine or surgery; and

• Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

These criteria were added to the regulations because we believed that an intensive rehabilitation program requires the full-time direction of a physician with special expertise in the medical management of patients who require rehabilitation services. We also took the view that meeting this requirement is an important indicator of the extent to which the unit is primarily engaged in rehabilitation, and thus deserving of exclusion from the prospective payment system.

Since publication of these regulations as a final rule on January 3, 1984 (49 FR 316), many hospitals and some national organizations have expressed dissatisfaction with our application of the full-time director policy, especially with respect to "small" rehabilitations units. Generally, those opposed to this policy have made the following arguments:

• In a small unit, full-time direction is not needed for medical reasons and is not consistent with actual practice. Adequate direction can be provided by a physician who performs the director's duties on a part-time basis.

• Many units that would otherwise qualify for this exclusion cannot find a physician willing to serve as a full-time medical director, or are unable to afford full-time physician direction. The inability of these units to qualify for an exclusion is a financial burden to the hospital and restricts the access of the hospital's patients to rehabilitation services.

After consideration of these arguments, we have decided that we should relax our full-time director requirement to some degree. We are proposing to amend § 405.471(c)(4)(iii)(F)(*1*) to remove the requirement for full-time service by directors of excluded rehabilitation units, and to specify instead that the director of the unit must provide services to the unit and its inpatients for at least 20 hours per week. We believe that this proposal would avoid the potential problems cited by those who oppose application of the current full-time direction requirement to units, while still allowing us to identify units that are primarily engaged in rehabilitation.

In addition, we are proposing a clarification to §§ 405.471(c)(2)(v)(A) and (c)(4)(iii)(F(*1*) that would specify that time spent by the director of a rehabilitation hospital or unit in providing services to the hospital or unit and to its inpatients is to be counted in meeting the direction requirement. We believe that the revision would help make it clear that directors are not required to perform only administrative functions, and that the time they spend in furnishing care to inpatients of the hospital or unit may be included with their administrative service in determining whether the direction requirement is met.

C. Expansion of Excluded Rehabilitation Units (§405.471)

Section 405.471(c)(4)(iii)(A) states that in order to be excluded, a rehabilitation unit must have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the ten conditions listed in that paragraph.

Since implementation of these regulations, many hospitals with rehabilitation units that are excluded from the prospective payment system have expressed interest in increasing the size of those units. With regard to these expansions, our current policy is the following:

- If a hospital expands its rehabilitation unit by adding beds or rooms, the added beds or rooms will be considered part of the unit for purposes of exclusion only at the start of a cost reporting period. We believe that this policy, which we have also applied to excluded psychiatric and alcohol/drug units, is consistent with our general policy that changes in status from excluded to not excluded, or from not excluded to excluded, will be made only for entire cost reporting periods.
- The "75 percent rule" will be applied to expanded units consistent with the following:

—If the beds or rooms the hospital wishes to add have previously been used for any type of inpatient care (for example, general acute care or skilled nursing facility care), we consider the 75 percent requirement to be met if, during the most recent 12-month cost reporting period, at least 75 percent of all admissions to (or discharges from) the beds or rooms the hospital wished to exclude, including both the previously excluded space and the added space, were for the intensive rehabilitation of patients with one or more of the medical conditions listed in § 405.471(c)(4)(ii)(A). Thus, not all beds or rooms previously used for inpatient care would have to have been used solely for rehabilitation for a full cost reporting period to qualify them for exclusion.

—If the beds or rooms the hospital wishes to add have not previously been used for inpatient care (for example, newly constructed space or space previously used for training rooms), the added beds or rooms must be used for inpatient care for a full cost reporting period before sufficient information is available to determine if they will be eligible for exclusion. The policy is consistent with the position we have taken with regard to new rehabilitation hospitals and units.

Our current policy on the application of the 75 percent rule to rehabilitation units that hospitals wish to expand has been criticized as too restrictive, especially with regard to "new beds" (that is, space not previously used for inpatient care).

In some cases, a more flexible policy might be desirable. For example, if a 30-bed unit with a high occupancy level wishes to add two new beds, it could be considered unreasonable to require that those added beds be included under the prospective payment system for a full cost reporting period. However, the need for more flexibility in certain cases must be weighed against the potential for abuse. For example, if we were to permit a very small unit (for example, one with only ten beds) to double or triple its size and have all the new beds excluded from their first day of operation, this could be used as a way to circumvent our policy on new units. Also, under a very flexible policy, a hospital may be motivated to move all (or as much as possible) of its idle capacity to the cost-reimbursed excluded unit.

In an effort to permit some added flexibility, while not removing all controls on expansion of rehabilitation units, we are proposing a change in our policy concerning the application of the 75 percent rule to those already excluded rehabilitation units that intend to expand. We would permit units with an occupancy level of at least 90 percent to increase their number of beds or square footage by up to ten percent at the start of a cost reporting period without applying the 75 percent rule to the added beds or space. This expansion would be permitted without regard to the previous uses of the added space. Of course, the previously excluded unit would have to have met the 75 percent rule for all admissions to or discharges from excluded beds or rooms during the preceding cost reporting period.

Any increases in unit size beyond those that would be specifically permitted under this rule would be evaluated under the policy on new units set forth in the preamble to the January 3, 1984 final rule (49 FR 241). Thus, the additional beds or rooms would not be eligible for exclusion until they had been used to provide inpatient care for a full 12-month cost reporting period, and all space the hospital wishes to exclude must qualify for exclusion under the 75 percent rule.

We believe this proposed change in policy would permit some expansion and be relatively easy to implement and administer, yet would not allow expansions to become a means of circumventing inclusion in the prospective payment system. The following examples illustrate how our proposals would be applied.

Example: A hospital has a 2,000 square foot rehabilitation unit that includes 20 beds. The unit is excluded from the prospective payment system for the cost reporting period beginning on October 1, 1983 and has an occupancy rate of 90 percent for that period. On July 1, 1984, the hospital begins to furnish inpatient rehabilitation services in a 200 square foot treatment room that it intends to add to the unit. Under our proposal, the added space could be considered part of the excluded rehabilitation unit for the cost reporting period starting on October 1, 1984, even though it had not been used by the unit for inpatient care for a 12-month cost reporting period.

Example: A hospital has a 2,000 square foot rehabilitation unit that includes 20 beds. The unit is excluded from the prospective payment system for the cost reporting period beginning on October 1, 1983, and has an occupancy rate of 90 percent for that period. On July 1, 1984, the hospital moves two aditional beds into the unit and begins to furnish inpatient rehabilitation services to the patients who occupy them. Under our proposal, the two additional beds could be considered part of the excluded rehabilitation unit for the cost reporting period starting on October 1, 1984, even though they had not been used by the unit for inpatient care for a 12-month cost reporting period.

Example: A hospital has a 2,000 square foot rehabilitation unit that includes 20 beds. The unit is excluded from the prospective payment system for the cost reporting period beginning on October 1, 1983, and has an occupancy rate of 90 percent for that period. On July 1, 1984, the hospital begins to furnish inpatient rehabilitation services in a newly constructed addition that occupies 1,000 square feet and contains 10 beds. Under our proposal, only an additional 200 square feet, containing no more than two beds, could be considered part of the excluded unit for the cost reporting period starting on October 1, 1984. The other 800 square feet of space and eight beds in the new addition could not be considered part of the excluded rehabilitation unit until the addition had been used to provide inpatient care for a full 12-month cost reporting period and the expanded unit, comprising 3,000 square feet and 30 beds, had qualified under the 75 percent rule. Thus, the fully expanded 3,000 square foot unit could not be excluded from the prospective payment system before the cost reporting period beginning on October 1, 1985.

We are also proposing to include in the regulations the policy described above under which changes in the square footage or number of beds of any excluded unit would be recognized only at the start of a cost reporting period. Although this provision would not reflect any change from our current policy, we believe codifying the policy would help avoid any potential misunderstanding of it.

D. Physician Attestation (§ 405.472)

Currently, § 405.472(d)(2)(i) requires that, as a part of DRG validation, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest in writing to the principal diagnosis, secondary diagnoses, and names of procedures performed. These regulations require that the following statement immediately precede the physician's signature:

I certify that the identification of the principal and secondary diagnoses and the procedures performed is accurate and complete to the best of my knowledge. (Notice: Intentional misrepresentation, concealment, or falsification of this information may, in the case of a Medicare beneficiary, be punishable by imprisonment, fine, or civil penalty.)

Since publication of this requirement, many physicians and hospitals have questioned the need for such a requirement and other physicians have found its language to be offensive. The physician certification and penalty statement requirement is primarily intended to facilitate the prosecution of those who choose to participate in schemes to defraud the program and to discourage others who are tempted to do so. The statements were not intended to impugn the integrity of physicians in general.

On April 19, 1984, the Inspector General of HHS received the following letter from Stephen S. Trott, Assistant Attorney General, Criminal Division, U.S. Department of Justice:

Our position on penalty statements has been clear for many years. Such warning statements should be required on all forms containing essential information pertaining to monetary transactions with the Federal Government or other matters material to the operation of a Federal program. The existence of certification and penalty statements can be important in our decision whether to prosecute a case and in its successful prosecution. As you know, individuals and corporations are prosecuted for making or assisting in the making of specific false claims, and the forms themselves are a key item of evidence in the government's case. It has proved extremely useful in the context of a criminal jury trial to point to the certification and penalty statements on the forms in issue. Such statements clearly put the individual on notice of his responsibility to provide truthful, accurate, and complete information, and the consequences of not doing so.

The certification and penalty statements were not required of physicians during the first 19 years of the Medicare Part A program because, during that time, Medicare reimbursement was based on hospital cost reports. Under this former system, patient diagnoses and procedures were unimportant for reimbursement purposes. However, with the shift to a prospective payment system, the basis of payment now turns primarily on specification of a DRG for each patient. The patient's record is essential to the process of DRG validation, under which the diagnostic and procedural codes used by the hospital to describe the diagnoses and treatments in connection with its claim for payment are compared with the statements of the attending physician. Because diagnostic and procedural information is now crucial to proper payment, those few physicians who may be tempted to misrepresent this information should be made aware of the obligation to report this information accurately and truthfully.

Penalty statements are virtually universal on forms used in Federal programs that involve the obligation of Federal funds. In addition, these statements have always appeared on cost reports and claim forms used by physicians and other providers in other parts of the Medicare and Medicaid programs. Again, the penalty language is not intended to impugn the integrity of the medical profession; rather, it is a standard cautionary measure routinely used to single out isolated wrongdoers.

Some physicians have complained about the manner in which hospitals have been implementing the physician attestation requirement and have been under the wrong impression that hospitals are required under the regulations to use particular methods for its implementation. The current regulations only require that the certification and penalty statements, as well as the physician's signature, appear somewhere in the permanent record of the patient (for example, on the face sheet, discharge summary, discharge abstract, or on a completely separate form). The statements may be placed on the appropriate documents by rubber stamp, may appear on a preprinted form, or may be placed on the appropriate document by any other legible means.

Many of the concerns expressed by physicians reflected misunderstandings about the certification and penalty requirement and a need for clarification of the requirement. Therefore, we are proposing several modifications to both the language and the positioning of the statements. It is intended that the following proposed changes would help to clarify the scope of the statements and that they would provide additional guidance to the hospitals in their implementation of the attestation requirement.

- Physicians have complained that the word "identification" in the certification statement suggests that they are responsible for certifying to the accuracy of the coding performed by hospital personnel. We do not intend to require physicians to take responsibility for the coding process. In order to clarify that the physician is attesting only to the diagnoses and procedures performed, we are proposing to replace the word "identification" with the phrase "narrative descriptions."
- Some physicians have expressed concern about their having to attest to "procedures performed" since many minor procedures are performed without the physician's personal knowledge. We believe that the current language limiting the physician's attestation to information which is "to the best of [the physician's] knowledge" makes clear that the physician need not attest to procedures of which he or she is unaware. However, we are also proposing that the word "major" immediately precede the word "procedures".
- We are proposing that the certification statement appear on the discharge summary sheet, rather than on another type of hospital form. This change would help to make clear that the physician is attesting only to the diagnoses and procedures performed and not to codings that the hospital staff might include in the face sheet or other documents.
- We are proposing to separate the certification statement from the penalty statement. The certification would continue to appear on each patient's discharge summary sheet, but the penalty statement would be provided only annually to the physician in a notice for which the physician would acknowledge receipt in writing. The annual notice would state the following:

Notice to Physicians

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature on the discharge summary sheet. Anyone who misrepresents, falsifies, or conceals this information may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Acknowledgement of receipt of this notice would be kept on file at the hospital and made available to HCFA upon request. In submitting each claim, the hospital would certify that it had on file an acknowledgement from the attending physician involved.

- We are further proposing that, for a reasonable time, hospitals would be permitted to continue to use the

language and positioning of the certification and penalty statements prescribed in the January 3, 1984 final rule. This is to avoid any inconvenience that may be associated with making the above modifications.

E. Hospitals in Areas Redesignated as Rural (§§ 405.473 and 405.476)

Section 1886(d)(2)(D) of the Act requires that average standardized amounts per discharge be determined for hospitals located in urban areas and rural areas of the nine census divisions and the nation. Under the prospective payment system, a hospital's payment rate is dependent, to some degree, on whether the county in which a hospital is located is designated as an urban area or as a rural area. The term "urban area" is defined in section 1886(d)(2)(D) of the Act, in accordance with the Executive Office of Management and Budget's (EOMB's) designations, as a Metropolitan Statistical Area (MSA), a New England County Metropolitan (NECMA), or certain New England counties deemed to be urban areas under section 601(g) of Pub. L. 98–21 (42 U.S.C. 1395ww (note)). The term "rural area" means any area outside an urban area.

In administering a national payment system, we must have a national classification system built on clear, objective standards. Otherwise, the program becomes increasingly difficult to administer because the distinction between rural and urban hospitals is blurred. We believe that the MSA system is the only one that currently meets the requirements for use as a classification system in a national payment program. The MSA classification is a statistical standard developed for use by Federal agencies in the production, analysis, and publication of data on metropolitan areas. The standards have been developed with the aim of producing definitions that will be as consistent as possible for all MSAs nationwide.

Periodically, EOMB revises the list of MSA/NECMA designations based on a continuing analysis of factors such as changes in population and commuting patterns. Depending on those changes, a hospital may be reclassified as urban and thus receive the higher urban payment rate, or it may lose its urban area status and receive the lower, rural Federal rate. We will recognize these reclassifications, for the purpose of determining payment, beginning with the next Federal fiscal year following EOMB's announcement of the change.

For a hospital that loses its urban area status, the resulting reduction in its Federal payment rate may cause a serious financial burden for the hospital if it suddenly must operate at the lower rate without time for adaptation.

Section 1886(d)(5)(C)(iii) of the Act authorizes adjustments to the payment amounts as the Secretary deems appropriate. Therefore, we are proposing to revise § 405.476 to provide that a hospital that loses its urban status as a result of an EOMB redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased in over a two year period and thus receive, in addition to its rural Federal rate, in the first year, two-thirds of the difference between its present rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status, and, in the second year, one-third of the difference. We note that this adjustment would be granted to a hospital that lost its urban status only if its hospital-specific portion exceeds its Federal rural rate after the Federal rate has been adjusted by the hospital's rural area wage level index and by the doubled indirect teaching adjustment factor (of 11.59 percent for fiscal year (FY) 1985). The proposed adjustment would be applied prospectively for the two successive Federal fiscal years beginning with the Federal fiscal year in which we recognize the reclassification.

A hospital would be required to meet the qualifying conditions only once to receive the additional payment for both years for which this adjustment is being granted. However, if the hospital was subsequently reclassified during this special transition period as urban as a result of a new redesignation by EOMB, the special adjustments would cease to apply.

As a result of EOMB's June 30, 1983 revision of the MSA/NECMA designations, 49 counties that were previously classified as urban lost their urban status. This resulted in the reclassification of 51 hospitals from urban to rural status and the subsequent payment to the hospitals of the lower rural rates for the census divisions in which they are located. Each of these hospitals would also be eligible to receive the two year adjustment effective with discharges beginning in FY 85 provided that the hospital-specific rate exceeded its Federal rural rate for discharges occurring in its first cost reporting period under the prospective payment system.

The following summary and example of the qualifying and adjustment computations assume that a hospital would receive the adjustments beginning in FY 85.

Summary of computation to determine qualifying hospitals.

1. Hospital lost urban area status as a result of an EOMB reclassification occurring after April 20, 1983.

2. Hospital-specific portion (for the hospital's first cost reporting period under the prospective payment system)

$$\frac{\text{Average cost per case}}{\text{case-mix index}} \times \text{Budget neutralized updating factor}$$

Exceeds the: Federal rural rate (for the hospital's first cost reporting period under the prospective payment system). The Federal rural rate = applicable labor-related standardized amount × rural area wage index (+ the nonlabor standardized amount) × doubled teaching adjustment factor (48 FR 39778) where appropriate.

A hospital that meets the two conditions above would receive the following adjustment to its rural Federal payment rate effective with the Federal fiscal year in which we recognize the reclassification:

- For discharges occurring in FY 85, the hospital would have added to its Federal rural rate an amount equal to two-thirds of the difference between the applicable Federal rural rate the hospital receives and the Federal urban rate the hospital would have received had it retained its urban status.
- For discharges occurring in FY 86, the hospital would have added to its Federal rural rate an amount equal to one-third of the difference between the applicable Federal rural rate the hospital receives and the Federal urban rate the hospital would have received had it retained its urban status.

Summary of Adjustment Computation

- Adjust the labor-related portions of the Federal urban and rural standardized amounts by the rural area wage index;
- Determine the difference between the adjusted urban and rural standardized amounts;
- Multiply that difference by the applicable percentage (two-thirds in the first Federal fiscal year for which an adjustment is appropriate and one-third in the second Federal fiscal year);
- Add the amount to the adjusted rural standardized amount, and
- Adjust for indirect teaching costs.

The following is an example of how to determine whether a hospital qualifies for a rural area reclassification

adjustment and how much it would be paid.

Assume a 225 bed hospital, with three full-time employed residents, located in an Indiana county that was designated an urban area as of April 20, 1983 but was redesignated as a rural area on June 30, 1983.

1. The hospital-specific portion standardized for case-mix and adjusted for inflation and budget neutrality is 2349.79.

2. The Federal rural standardized amount for the East North Central census division has a labor-related portion of 2060.28 and a nonlabor-related portion of 480.63.

3. Adjust the labor-related portion by the rural area wage index for Indiana:

2060.28 × .8617 = 1775.34

4. Combine the labor-related and nonlabor-related portions and adjust by the doubled indirect teaching adjustment factor:

3 ÷ 225 = .013333 ÷ .1 = 13333
.13333 × .1159 = .01545

1775.34 + 480.63 = 2255.97
2255.97 × (1 + .01545) = 2290.82

Result—The hospital-specific portion (2349.79) is greater than the comparable Federal amount (2290.82) and, therefore, the hospital would qualify for the special adjustment.

To compute the adjustment amount:

	Labor-related	Nonlabor-related
Urban rate	2461.45	715.43
Rural rate	2060.28	480.63

1. Adjust both the urban and rural labor-related portions by the rural area wage index.

2461.45 × .8617 = 2121.03
2060.28 × .8617 = 1775.34

2. Combine the labor-related and nonlabor-related portions for the urban and rural amounts.

2121.03 + 715.43 = 2836.46
1775.34 + 480.63 = 2255.97

3. Add the rural amount to two-thirds of the difference between the rural and urban amounts.

2255.97 + (.67 times (2836.46 − 2255.97)) = 2644.90

4. Adjust the amount in step 3 by the doubled indirect teaching adjustment factor.

2644.90 × 1.01545 = 2685.76.

5. For discharges occurring in FY 86, the hospital would not have to requalify. Note that the adjustment would be determined based on our adding one-third of the difference between the urban area and the rural area rates.

F. Census Division Boundaries

Section 1886(d)(2)(D) of the Act requires that separate average standardized amounts per discharge be determined for hospitals located in urban areas and rural areas in each of the nine census divisions and the nation. This yields 18 basic regional rates and two national rates. The definition of urban area is generally based on the MSA and NECMA designations issued by EOMB.

Despite the application of a single urban wage index to determine the rate for all hospitals within a given MSA or NECMA, different standardized rates apply to hospitals located in certain MSAs or NECMAs that cross over census divisions. Currently, there are 14 MSAs that overlap census division boundaries resulting in two or more Federal payment rates applying to the same urban area.

Although our current regulations at § 405.473(b)(6) link the payment rate for a hospital to the location within a census division as defined by section 1886(d)(2)(D) of the Act, we believe this policy violates the concept of an MSA. The essential characteristics that define an urban area, and which are embodied in EOMB's definition of an MSA, are a certain population density and economic and social integration of the surrounding counties with the central metropolitan area.

The application of two or more payment rates for hospitals located within the same urban area contradicts this concept of an MSA as being an economically integrated area with relatively uniform prices applicable throughout the area. This inconsistency is most striking when contrasted with the application of a single area wage level index that, according to our hospital market basket, accounts for nearly 80 percent of a hospital's total costs.

Section 1886(d)(5)(C)(iii) of the Act authorizes adjustments to the payment amounts as the Secretary deems appropriate. In the Conference Committee Report accompanying Pub. L. 98–21, it states, in part, that the Secretary is permitted ". . . to provide for such exceptions and adjustments as may be appropriate with respect to hospitals experiencing special problems because of their location within a particular census division". (H.R. Rep. No. 98–47, 98th Congress, 1st Session 22 (1983)). We are, therefore, proposing to amend § 405.473(c) by revising the definition of urban area for the purpose of computing the Federal standardized payment rates by deeming an MSA or NECMA that crosses two or more census divisions, as belonging to the census division in which most of the MSA's or NECMA's hospitals are located. This revised definition will be effective for discharges occurring on or after October 1, 1984.

This change would result in all hospitals within the MSA receiving an identical urban rate based on the census division in which the largest proportion of the hospitals (paid under the prospective payment system) within the MSA are located. Most affected hospitals would receive a relatively higher payment as a result of the change, although a few hospitals would be in a relatively less advantageous position because the majority of hospitals in their respective MSA are in a census division with a lower average standardized amount.

To lessen the impact of the reduction on these hospitals' prospective payment rates, we are proposing to adjust the average standardization amounts these hospitals will receive. We propose to pay them an additional amount equal to 50 percent of the difference between the Federal rate applicable in the census division to which they were previously assigned and the Federal rate applicable in the census division in which they will now be assigned for purposes of the prospective payment system. This adjustment will be in effect *only* for discharges occurring during Federal FY 85. (Note: The difference would be determined based on the Federal rates as recalculated to reflect the census division reassignment.)

Example: Assume a hospital is located in Clark County, Indiana, which is in the Louisville, Kentucky MSA. The hospital was reassigned from the East North Central census division, with a proposed Federal rate of 3,176.88, to the East South Central census division, with a proposed Federal rate of 2,640.49. The wage index for the MSA is 1.0854. The hospital's new Federal rate would be adjusted by subtracting the labor adjusted East South Central urban Federal rate from the labor adjusted East North Central urban Federal rate, and adding 50 percent of the difference to the East South Central urban rate. This amount would be further adjusted by the hospital's applicable adjustment factors, including the indirect teaching adjustment factor.

	Labor	Nonlabor
Old Census Division rate (Table 1)	2,461.45	715.43
New Census Division rate (Table 1)	2,093.46	547.03

1. Multiply the Old Labor rate times the area wage index (plus the old nonlabor rate).

2. Multiply the New Labor rate times the area wage index (plus the new nonlabor rate).

3. Subtract the amount in Step 2 from the amount in Step 1, and multiply by 50 percent.

4. Add the amount in Step 2 to the amount in Step 3.

For all hospitals, we would recalculate the census division urban means (Table 1 in the addendum to this proposed rule) to reflect the revised definition.

In addition, we are proposing to revise the definition of urban area to account for those situations in which the number of hospitals in an MSA or NECMA that crosses census division boundaries is equally split among the census divisions (for example, an MSA with four hospitals that crosses over census divisions one and two, and two hospitals are located in each census division). We are proposing to deem all the hospitals in the MSA or NECMA to be located in the census division with the higher Federal rate.

G. Base Year Appeals (§ 405.474)

Section 405.474(b) states that the intermediary's estimate of a hospital's base-year cost and subsequent modifications, made for purposes of determining the hospital-specific rate under the prospective payment system, are final and may not be changed except as prescribed in the regulations. Under this exception (§ 405.474(b)(3)), a change is allowed to take into account a successful appeal of the hospital's base period notice of amount of program reimbursement, as described in §§ 405.1801 through 405.1883. In our discussion of the regulatory exception in the January 3, 1984 final rule (49 FR 259), we noted that, although it would be generally improper to allow subsequent recalculations, we believe that where information is developed for reasons independent of the prospective payment system (such as the appeal of disallowed base year costs), it is acceptable to consider that information on a prospective basis. We indicated that we revised § 405.474(b) to reflect this policy.

Several parties have pointed out that the regulations state that a recalculation of base year costs would be permitted *only* upon the issuance of a final appeal decision. We agree that § 405.474(b) restricts the recalculation to a final appeal decision. However, we believe that the prospective recalculation of base year costs should be allowed as of the date of other subsequent actions that recognize additional costs as allowable costs for a hospital's base year. These actions that would revise a hospital's base year notice of amount of program reimbursement are—

- The results of a reopening and revision under §§ 405.1885 through 405.1889; or
- A prehearing order of or finding under § 405.1821 or § 405.1853.

We are proposing to clarify § 405.474(b)(3) to specifically include the above administrative actions, in addition to a final administrative or judicial review decision (already in § 405.474(b)(3)), as a basis upon which a recalculation of a hospital's base year costs may be made on a prospective basis.

H. Referral Centers (§ 405.476)

Section 1886(d)(5)(C)(i) of the Act directs the Secretary to provide exceptions or adjustments to the prospective payment system that consider the special needs of regional and national referral centers (specifically including those hospitals of 500 or more beds located in rural areas).

In part, this provision was included because of congressional concern for the large rural hospitals that offer a variety of specialized services, employ many specially-trained personnel, and therefore, have costs comparable to urban acute care facilities.

In the interim final rule (48 FR 39783), we identified certain criteria that we believed would establish a hospital as a referral center as contemplated in the law. Since the statute specifies "regional and national" referral centers, we concluded that Congress intended that these referral centers would be serving a substantial number of patients from a very broad geographic area. Under those interim final regulations (§ 405.476(g)), in order to be considered a referral center, a hospital had to be an acute care hospital with a provider agreement under 42 CFR Part 489 to participate in the Medicare program; and the hospital had to—

- Be located in a rural area (that is, outside of any MSA or NECMA) and have 500 or more beds available for use; or
- Have an inpatient population such that at least 60 percent of all Medicare patients resided out-of-State or more than 100 miles from the hospital (whichever was further), and at least 60 percent of all the services that the hospital furnished to Medicare beneficiaries had to be furnished to beneficiaries who resided out-of-State or 100 or more miles from the hospital (whichever was further).

For rural hospitals with 500 or more beds, we determine prospective payment rates on the basis of the urban, rather than the rural, adjusted standardized amounts as adjusted by the applicable DRG weighting factor and the hospital's area wage index (§ 405.476(g)(2)).

For rural referral centers with less than 500 beds, and for referral centers located in urban areas, there is no adjustment for the first year of the transition period.

The criteria contained in those interim final regulations were constructed based on our best understanding from limited source materials as to what was intended by this statutory provision. The numerical values were chosen as being reasonable in view of what we then perceived as the characteristics of a referral center. While we believe that the criteria we adopted were appropriate, we specifically requested comment on these criteria in the interim final rule, given the scarcity of any material on identification of referral centers, we particularly wanted to obtain public comment and suggestions as to ways in which the criteria could be modified.

The comments we received in response to that interim final rule were uniformly critical of the criteria used to distinguish rural referral centers from other hospitals and emphasized that the policy in the regulations was so restrictive as to assure that hospitals could not qualify. Many commenters were particularly concerned about fairly large rural hospitals (100 to 400 beds) that were sources for specialized care and that therefore should qualify as referral centers. A majority of the comments focused on the inadequacy of a mileage or distance measure as a test for determining whether a hospital was treating referrals.

As a result of the comments received, we revised the criteria for referral centers in the final rule. In that rule (49 FR 174), we outlined several changes to the referral center regulations. As requested by several commenters, we adopted criteria that gave weight to the actual fact of referral. We also eliminated the out-of-State criteria and reduced the mileage limit from 100 to 25 miles. Therefore, as published in the final rule, § 405.467(g)(1) states that a referral center is a hospital, which is an acute care hospital with a Medicare provider agreement, that—

- Is located in a rural area and has 500 or more beds; or
- Has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital

furnishes to Medicare beneficiaries must be furnished to beneficiaries who live more than 25 miles from the hospital.

The payment adjusted provisions were not revised or expanded in the final rule.

While we believe that the criteria published in the final regulations are reasonable for the purpose of defining a referral center, upon further analysis of the special circumstances applicable to rural referral centers of less than 500 beds and based on information we have received, we believe it is necessary to provide a separate set of criteria that would meet these unique circumstances. In keeping with our understanding of congressional intent, and at the same time, seeking a set of qualifying criteria for rural referral centers that characterize the essential features of these facilities, we are proposing to add the following set of criteria (two mandatory and a choice of one out of three other criteria) that could be used to determine whether any hospital located outside of any MSA or NECMA is a referral center:

- The hospital would have to have a 1981 case-mix index of at least 1.03 as published in the September 1, 1983 Federal Register (48 FR 39847).

We selected this criterion as one of the mandatory criteria because, in the case of rural hospitals, the complexity of cases treated in the facility is, in our opinion, one of the principal characteristics that would distinguish between the rural referral centers (hospitals that offer a variety of specialized services and are comparable to urban acute care facilities) and typical rural hospitals. We believe that this level of complexity is the chief characteristic that prompted Congress to include the referral center provision in the prospective payment legislation.

We are proposing to allow hospitals that do not meet the 1.03 case-mix index benchmark an alternative criterion. A hospital whose published case-mix index is below 1.03 could meet this requirement if its case-mix index for the first cost reporting period subject to prospective payment (that is, the first reporting period beginning on or after October 1, 1983) is at least 1.0903. We obtained the 1.0903 figure by multiplying the 1.3 case-mix figure by a factor of 1.0585. This factor represents the estimated increase in a hospital's case-mix index reflecting the increased accuracy and completeness of billing information that would result from making payments to hospitals contingent on this information as occurs under the prospective payment system. Since the hospital case-mix indexes published in the September 1, 1983 Federal Register rely on data from a period in which hospital payments were not dependent on complete and accurate billing data, it is estimated that the indexes were, on average, understated by 5.85 percent.

- The hospital's number of discharges (excluding discharges from subprovider units (as that term is defined in section 2336 of the Provider Reimbursement Manual, HCFA Pub. 15–1)) must have been at least 6,000 for the most recent cost reporting period completed by the hospital before it applies for referral center status.

We would include this criterion as one of the mandatory criteria because we believe that Congress intended that the referral center provision apply to hospitals of above average size and utilization. A suitable measure of the size of a hospital's operation is the number of patients discharged during a given year. We believe that 6,000 discharges is representative of a rural hospital of above average size.

In addition to meeting the two criteria mentioned above (case mix and number of discharges), a hospital would have to meet one of the following three criteria:

- More than 50 percent of the hospital's medical staff are specialists; that is, they have completed minimal training requirements as recognized by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists. We would include this criterion because, frequently, a hospital serves as a referral center for certain specialized areas of treatment.

Also, we would expect that a hospital that provides a secondary or tertiary level of hospital care would have a high percentage of specialists on the staff.

- The hospital's inpatient population is such that 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital. This criterion would be included to assure that the hospital's patients are drawn from a wide geographic area. However, because of the lack of specific information on referral patterns, we are specifically requesting comments on whether it would be more equitable to apply this criterion or an alternative that would require a lower percentage (for instance, 50 percent) but would be measured in terms of the percentage of a hospital's discharges attributable to Medicare beneficiaries who reside more than 25 miles from the facility.
- At least 40 percent of all inpatients treated at the hospital have been referred to the hospital either from physicians not on the hospital's staff or from other hospitals. As mentioned above, we are particularly interested in receiving comments on whether this criterion should be based on all inpatients or only the Medicare inpatients of the hospital.

These criteria (proposed in § 405.476(g)(1)(iii)) would be used in determining whether a hospital qualifies for an adjustment as a referral center that would be effective for discharges occurring on or after October 1, 1984. We are proposing that these referral centers would be paid prospective payment rates on the basis of the urban, rather than the rural, adjusted standardized amounts as adjusted by the applicable DRG weighting factor and the hospital's area wage index. Therefore, these hospitals would be paid on the same basis as those hospitals that meet the criteria in § 405.476(g)(1)(i) (that is, rural hospitals with 500 or more beds). In addition, we are proposing in this document that rural hospitals that meet the criteria in § 405.476(g)(1)(ii) would also be paid, for discharges occurring on or after October 1, 1984, prospective payment rates on the basis of the urban, rather than the rural, adjusted standardized amounts. This change would allow a consistent payment policy for rural hospitals that are eligible for referral center status.

We are not including in this proposal any payment adjustment for urban hospitals that meet the referral center criteria in § 405.476(g)(1)(ii). As we indicated in the January 3, 1984 final rule (49 FR 276), it will not be possible to determine what the appropriate payment adjustments should be until we know how urban hospitals that qualify for referral center status under § 405.476(g)(1)(ii) are atypical when compared to other urban hospitals. We can make this determination only after we have an opportunity to examine and analyze in detail the data pertaining to these hospitals. Since we have received only one application, which is still under review, from an urban hospital under § 405.476(g)(1)(ii), we have been unable to collect the necessary data. Therefore, we are unable to make any proposals in this document concerning payment adjustments for urban hospitals that qualify under § 405.476(g)(1)(ii).

We are considering instituting a periodic review of hospitals that have qualified for a payment adjustment as referral centers. This review would allow us to determine if these hospitals continue to meet the criteria for referral center status. We are specifically requesting comments from the public concerning this procedure.

I. Inpatient Renal Dialysis

In the January 3, 1984 final rule (49 FR 247), we agreed to review the issue of payment for inpatient dialysis. We pointed out that for a patient on dialysis who is admitted to a hospital for an unrelated reason, the DRG payment does not recognize the additional cost of furnishing dialysis. This is of particular concern to end-stage renal disease (ESRD) beneficiaries who will require dialysis whenever they are hospitalized.

We note that the DRG weighting factors were constructed to reflect the relative resource consumption associated with cases falling within the DRG. Therefore, these cases, in which dialysis is required, are included in the relative weight of the DRGs. Since the relative weight reflects the average cost incurred in treating cases, payment for any given discharge may be more or less than the cost incurred in treating a particular case.

A distinction should be made between the dialysis services furnished to non-ESRD beneficiaries and the services furnished to ESRD beneficiaries. Non-ESRD beneficiaries can be expected to require dialysis relatively infrequently, and those cases requiring dialysis will be widely dispersed throughout the inpatient population. ESRD beneficiaries, on the other hand, require routine dialysis and may be concentrated in particular hospitals. When ESRD beneficiaries represent a large share of a hospital's patient population, a disparity may exist between the average cost of dialysis represented within the DRG amount and the expense to the hospital.

To assess the impact of providing inpatient dialysis, we identified the discharges of ESRD patients in the 1981 MEDPAR data file. ESRD patient discharges represent 1.05 percent of the appropriately two million discharges for all hospitals in the MEDPAR data file. These ESRD discharges include those DRGs in which dialysis would be expected to occur as well as those in which dialysis would not be expected to occur except when ESRD beneficiaries are involved. We measured the impact of cases in which inpatient dialysis is not expected to occur by excluding those DRGs in which it would be reasonably assumed that dialysis would occur. While there may be others, for simplicity, we excluded only DRGs 302 (Kidney Transplant), 316 (Renal Failure), and 317 (Admit for Renal Dialysis). After excluding these cases, the remaining ESRD discharges represent less than one percent of total discharges. As we expected, the impact was not spread evenly among all hospitals.

However, even among renal-certified hospitals, the ESRD patient discharges represent only 2.28 percent of total discharges. This is not a significant impact even among hospitals that would be expected to treat the greater number of ESRD patients. We do not believe that the data support special treatment for inpatient dialysis. To the extent thats such cases occur in the data base, they are reflected in the DRG rates.

It is not the purpose of the prospective payment system that a hospital will be able to recover its actual cost of treatment for every case. It was assumed that most hospitals will receive less than their cost in some cases and more than their cost in other cases. Therefore, we are not making any changes in the payment for inpatient renal dialysis at this time.

III. Summary of Regulations Changes

For the convenience of the reader, we are summarizing the changes we are proposing to the regulations. The reader is referred to the detailed discussions above for an explanation of the rationale for these changes.

A. Transfers

We are proposing to make the following change in § 405.470(c)(4) for a hospital transferring an inpatient to another hospital.

- A transferring hospital may be paid an additional payment for extraordinarily high-cost cases that meet the cost outlier criteria in § 405.475(d).

B. Direction of Rehabilitation Units

We are proposing to revise § 405.471 to provide that the director of an excluded rehabilitation unit must serve the unit and its inpatients for at least 20 hours per week, rather than on a full-time basis.

C. Expansion of Excluded Rehabilitation Units

We are proposing to add a new § 405.471(d) to provide that changes in the capacity (that is, number of beds or square footage) of excluded units will be recognized only at the start of a cost reporting period, and that excluded rehabilitation units with an occupancy rate of at least 90 percent in a cost reporting period may increase their capacity by 10 percent per year without applying the 75 percent rule to the added space or considering the previous uses of the added space.

D. Physician Attestation

We are proposing to revise § 405.472(d)(2)(i) to clarify the scope of the physician's certification statement and the accompanying penalty statement and to revise the method for implementation of the attestation requirements.

E. Hospitals in Areas Redesignated as Rural

We are proposing to add new §§ 405.473(c)(2) and 405.476(i) to provide a special adjustment of the rural average standardized amounts to hospitals that are located in counties in MSAs or NECMAs that are redesignated by EOMB to be no longer a part of an MSA or NECMA.

- In § 405.473(c)(2), we define the phrase "hospital reclassified as rural" as a hospital located in a county that is in an MSA or NECMA that is redesignated by EOMB after April 20, 1983 to no longer be in an MSA or NECMA.
- In § 405.476(i), we indicate that we will provide for a two-year phase-in of the rural Federal payment amounts to a hospital, located in an area redesignated as rural, whose hospital-specific portion exceeds its rural rate. For the first year, the additional amount would be an amount equal to two-thirds of the difference between the urban and rural area standardized amounts adjusted for area wage differences for the appropriate region in which the hospital is located. For the second year, the additional amount would be an amount equal to one-third of the difference between the urban and rural area standardized amounts adjusted for area wage differences for the appropriate region in which the hospital is located.

F. Census Division Boundaries

Also, in the proposed new § 405.473(c)(2), we would clarify which census division a hospital belongs to when an MSA/NECMA crosses s census division boundary.

- In § 405.473(c)(2), we define urban area, for the purpose of MSAs or NECMAs that overlap census divisions, by deeming the entire MSA or NECMA as belonging to the census division in which most of the hospitals in that MSA or NECMA are located. We would make a special adjustment for those hospitals that, as a result of the reassigning of hospitals, are in a census division with a lower Federal rate than they would have received. In addition, if there are an equal number of hospitals located in each part of an MSA or NECMA that crosses one or more census divisions, we would deem all the hospitals to belong to the census divisions with the highest Federal rate.

G. Base Year Appeals

We are proposing to revise § 405.474(b)(3)(i)(C) to include, as a basis upon which a prospective recalculation of a hospital's base year cost may be made, administrative actions such as a reopening and a revision, or a prehearing order or finding, in addition to a final administrative or judicial review decision.

H. Referral Centers

We are proposing to add a set of criteria to § 405.476(g) that would expand the definition of referral centers to encompass more rural hospitals. We would pay hospitals that meet these criteria the urban (rather than the rural) adjusted standardized amounts. We are also proposing that rural hospitals that meet the criteria set forth in § 405.476(g)(1)(ii) would also be paid the urban (rather than the rural) adjusted standardized amounts for discharges occurring on or after October 1, 1984.

V. Regulatory Impact Analysis

A. Introduction

Executive Order 12291 (E.O. 12291) requires that a regulatory impact analysis be performed and made available on any major rule. A "major rule" is defined as one that would result in an annual effect on the national economy of $100 million or more, a major increase in costs or prices, or significant adverse effects on competition, employment, investment, productivity or innovation.

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601–612) requires that an initial regulatory flexibility analysis be performed and made available for each proposed rule unless the Secretary certifies that the rule would not have a significant economic impact on a substantial number of small entities.

Under the RFA, small entities include small businesses, nonprofit organizations, and governmental jurisdictions of less than 50,000 population. We treat all hospitals as small entities. Thus, a regulatory flexibility analysis is required if a substantial number of hospitals would be significantly affected by a regulatory document.

If we considered the net effects only, we would not expect the policy changes proposed in this rule to meet the criteria of a major rule. Due to the distributive effects of the prospective payment rate methodology, such as adjustments for budget neutrality, a change that would result in substantially increased payments for one group of hospitals under the prospective payment system would be offset by compensating decreases in payment rates for all other hospitals under the system. (Note that the *aggregate* effect of an increase is offset by a corresponding *aggregate* decrease. Thus, a large increase for a small group is balanced by a small decrease for a large group.) Further, many of the proposed changes that would increase payment for some hospitals, such as the provision affecting the hospitals located in areas redesignated rural by EOMB in june 1983, would not have a substantial effect on total payments, and would have negligible effects on the budget neutrality adjustment factors.

However, some of the provisions proposed in this rule would result in increases in payments to certain groups of hospitals large enough so that the budget neutrality mechanism would result in a redistribution of aggregate payments, due to the offsetting decrease of payments to other hospitals, amounting to over $100 million, even though the *net* effect on aggregate payments to all hospitals might not be significant, due to increases and decreases offsetting each other, we believe that a redistribution of this magnitude constitutes an economic impact meeting the threshold criteria of a major rule.

Further, it is clear that these proposed changes would affect a substantial number of hospitals, and that the effects for certain groups of those hospitals, such as those reclassified as rural by the MSA system, or hospitals that would meet the proposed new referral center criteria, would certainly be significant. Therefore, a regulatory flexibility analysis is required.

In the discussion below, we discuss the expected impacts of these proposed changes and then summarize our expectations of their net effect. This discussion, in combination with the rest of this preamble, constitutes a combined regulatory impact analysis and regulatory flexibility analysis meeting the requirements of E.O. 12291 and the RFA.

B. Objectives

The changes we are proposing do not represent any change in the objectives or basic incentives of the prospective payment system. Rather, we are merely resolving the first and most pressing problems of implementation, in order to ensure that those objectives are achieved and that the incentives created push toward the intended effects. As noted in the final rule published January 3, 1984, we fully expected the prospective payment system to:

- Restructure hospitals' economic incentives, establishing market-like forces;
- Link payment to diagnosis, basing payment on a system that more accurately identifies the product being purchased on behalf of Medicare beneficiaries;
- Establish the Federal government as a prudent buyer of services, adopting an active role in determining payments for inpatient services on behalf of Medicare beneficiaries; and
- Restrain the rate of hospital cost increases, and, therefore, moderate the outflow from the Medicare trust funds.

We expect these proposed changes to further those objectives while avoiding or minimizing unintended adverse consequences and ensuring that outcomes in general are reasonable and equitable. Thus, the intent of these proposals is essentially to fine tune the prospective payment system without undercutting our original objectives. This means giving more to some hospitals, where appropriate, and therefore, if necessary, taking a little from others, to maintain balance.

C. Transfers

Our proposal to pay cost outlier payments to transferring hospitals would benefit those hospitals incurring such costs and would be more equitable than our current payment policy. Although it may appear that this change would result in larger aggregate payments for outlier services, we do not expect the aggregate amount of such payments to be substantial. Generally, transfers occur in less than 1.5 percent of cases. Of this number, a small portion result in high costs to the transferring hospital. Since this is a small portion of a group of cases already known to be relatively small, we believe the increased payments for these cases would be negligible, in view of total payments for inpatient hospital services. We do not believe it is necessary or desirable to reflect this change in either our budget neutrality methodology or in the determination of cost outlier trim points. As a result, we do not expect any hospitals would be disadvantaged by this proposal.

D. Rehabilitation Units

The revision of the "full-time director" requirement for rehabilitation units would result in the approval of a larger number of those units for exclusion from the prospective payment system. Similarly, proposed changes concerning expansion of rehabilitation units would affect the total amount of inpatient hospital costs subject to the prospective

payment system. The greater the cost-based payments made to hospitals and units excluded from the prospective payment system, the smaller the total of payments under that system becomes.

Before October 1, 1983, rehabilitation hospitals and units were not given special recognition by Medicare payment methods, and we did not collect data on them. Since they were excluded by statute from the prospective payment system, we have established criteria and procedures to identify and pay them, and have begun to develop data on them.

As of April 30, 1984, we have recognized 39 rehabilitation hospitals and 181 rehabilitation units for purposes of excluding them from the prospective payment system. By October 1, 1984, we expect to have excluded around 80 hospitals and around 440 units under the current regulations. (Since we do not have historical program data, these are only rough estimates, but they are not inconsistent with the applications for exclusion to date.)

Of the 53 hospitals that had been denied exclusion of a potential rehabilitation unit by April 30, 1984, 19 applicants were denied because they lacked a director who could be considered "full-time" under the current regulations. We expect that some, but not all, of these would be approved under the requirements contained in this proposed rule. Any unit so approved would be excluded from the prospective payment system beginning with its next cost reporting period.

The proposed changes concerning unit expansion would result in an increased rate of growth of the total number of rehabilitation beds (and associated costs) excluded from the prospective payment system as part of existing units. Unfortunately, presently we have only fragmentary data on the numbers of beds in approved units, and no historical experience in the occupancy rates of units. As a result, we cannot estimate accurately the future effect of these proposed changes. However, based on discussions and review of what data are available, primarily from the hospital industry, we believe that the combination of a 90 percent occupancy threshold and a 10 percent growth cap will tend to permit a reasonable rate of expansion where justified, without allowing over-permissive exclusion of beds and costs from the prospective payment system.

It has been suggested that the use of a threshold occupancy for allowing limited expansion mught create incentives for units to keep their beds filled even if all the patients do not require the services of the unit. We agree that this type of provider behavior, if it did result, would be undesirable. However, for several reasons, we do not believe this to be a substantial threat to the integrity and utility of our proposal.

First, under the rate of increase limits required by section 1886(b) of the Act and implemented by regulations at § 405.463, excluded units already have strong incentives to maximize utilization. We do not believe these incentives would be increased significantly by this proposal. Second, and more important, since these incentives and behaviors are very familiar to us, there are already mechanisms in place that do restrain them. For example, both pre-admission screening and later medical reviews create counter-incentives in the form of potential denial of payment.

E. Physician Attestation

The proposed change concerning physician attestation is insignificant in terms of its economic impact. In essence, it is a revision of language and method of implementation of the attestation requirements that is intended to address criticisms aimed at phrasing and potential misunderstandings. We would still require a signed certification statement for each discharge; however, the penalty statement would be provided to the physician for his acknowledgement on only an annual basis. We do not expect this change to have any effect on payments or costs.

F. MSA Redesignations

As discussed above, we are proposing to make additional payments to hospitals located in counties that lost their urban status as a result of an EOMB MSA/NECMA redesignation after April 20, 1983. There would be additional payments per case for cost reporting periods beginning during the second year of the prospective payment transition period. These payments would be made only to those hospitals that have hospital-specific rates higher than their Federal rural rates.

We estimate that 32 of 51 hospitals affected by the June 1983 EOMB redesignation would receive additional payments under this proposal. These hospitals, located for the most part in the East North Central and West South Central regions, would receive an estimated $4 million for discharges occurring in FY 85. The remaining 19 hospitals would continue to receive their blended Federal rural rate. There may be future redesignations, but we have no way to predict them or estimate their impact.

Increasing payments for a group of hospitals would normally reduce payment to other hospitals through the budget neutrality mechanism. However, these additional payments would affect too few hospitals and be too small in the aggregate to have a substantial effect on the budget neutrality adjustment factors. We estimate that the average payment per case to other hospitals would be reduced by less than 50 cents.

G. Census Division Boundaries

As explained above, we are proposing to deem a hospital that is located in an MSA or NECMA that crosses census division boundaries to belong to the census division in which most of the hospitals within the MSA or NECMA are located. Assuming that all of the hospitals in the affected MSAs continue to participate in the Medicare program, and that no new hospitals emerge in those areas, we estimate that this change would have major impacts on only 23 of the 146 hospitals in the 14 MSAs affected:

- 11 hospitals would be paid at a higher Federal regional rate; and
- 12 hospitals would be paid at a lower adjusted Federal regional rate (receiving, for one year, 50 percent of the difference between the Federal rates of its old and new regions).

One hundred and twenty of the 146 hospitals in affected MSAs would not be reclassified. The remaining three hosptials are located in States that have waivers and are thus excluded from the prospective payment system.

We project that the 11 hospitals reclassified into regions that have higher regional rates would receive about $140 more per case than they could receive if we did not implement this proposal. The 12 hospitals adversely affected would receive about $45 less per case, taking into consideration the payment of half the differential between old and new regions.

Nearly all of the affected hospitals are located in only three regions: South Atlantic, East North Central, and East South Central. The larger proportion of the decrease in payments would be experienced by hospitals in the East North Central region. Hospitals located in the East South Central region would benefit the most from this proposal.

We estimate that the total payment increase for benefited hospitals would amount to about $4 million in the aggregate, and the corresponding decrease to adversely affected hospitals would amount to about $1 million. The net increase of about $3 million, considering payments to all 23 directly affected hospitals, would have the result

of reducing payments to other hospitals through the budget neutrality mechanism, but only by a small amount. The magnitude of this offset would be comparable to that of the additional payments to those hospitals classified rural under the MSA redesignations, reducing the average per case payment by less than 50 cents.

H. Base Year Appeals

We do not expect a significant economic impact to result from the proposed clarification of the provision governing the appeal of base year costs on which transition period prospective payment rates are partially based. We do not view this clarification as a change of policy, since we had not intended to implement the regulation, as published on January 3, 1984, as rigidly as some parties seem to believe. Further, the impact of the base year costs involved diminishes throughout the transition period. Once full national DRG-related payment rates are implemented, revisions or new findings concerning base-year costs would have no effect on prospective payment rates.

We do not have adequate data to estimate how many hospitals will have their base period costs recalculated under this provision. However, we believe the aggregate amounts of additional payments resulting from recalculations would not be substantial enough to affect our overall expectations of program expenditures. This proposal has no effect on the budget neutrality adjustment calculations.

I. Referral Centers

The proposed additional criteria permitting rural hospitals to qualify as referral centers and be paid at urban rates would result in a significant number of new referral centers being recognized. We do not have adequate data to project how many hospitals could meet each of the criteria proposed. However, we can determine how many hospitals had enough discharges and met the case-mix criteria based on the MEDPAR data.

Based on just this data, we project that as many as 113 hospitals may qualify as referral centers under the new criteria. Considering the difference between urban and rural rates, the increased aggregate payments to these hospitals would be substantial. We project that these hospitals could be paid, in the aggregate, about $80 million more than they would be paid without this proposal.

Note.— It appears that some rural hospital with less than 500 beds may qualify as referral centers under the existing criteria at § 405.476(g)(1)(ii). Under this proposed rule, we would pay those hospitals at the urban rate, too. We cannot be sure how many hospitals may so qualify, just as we cannot be certain how many hospitals may be denied referral center status under the proposed criteria. Considering both these problems, we do not believe the total number of potential rural referral centers with less than 500 beds is likely to exceed the projection of 113 based on discharge and case mix.

Based on case mix and volume of discharge, we have identified some potential referral centers in every region, but there are significant regional differences in their distribution. More than half of the potential referral centers identified are in only three regions East North Central, East South Central, and South Atlantic. The New England, Middle Atlantic, and West South Central regions each have less than seven potential referral centers.

Due to the budget neutrality mechanism, the increased payments to new referral centers would result in reduced payments to all other hospitals. We estimate that the average per case payment to other hospitals would be reduced by about $8 as a result of this proposal.

J. Updated Payment Rates

One of the primary functions of this document is to propose updated prospective payment rates in accordance with statutory and regulatory requirements (section 1886(d) of the Act and § 405.470(e) of the regulations). Accordingly, the Addendum to this document, which is printed after the text of the proposed regulations, sets forth tables of proposed new Federal national and regional rates, new DRG relative weights and outlier thresholds, and new factors for calculating hospital-specific rates. In accordance with section 1886(d)(1)(D) of the Act, the Federal rate for FY 85 will be a blend set at 75 percent of the Federal regional rate plus 25 percent of the Federal national rate. This blend will take effect for all Federal rates for all discharges occurring on or after October 1, 1984. Further, as each hospital begins its second year under prospective payment, with its cost reporting period beginning on or after October 1, 1984, the relative proportions of hospital-specific and Federal portions will change from 75 and 25 percent, respectively, to 50 percent hospital-specific and 50 percent Federal.

FY 85, section 1886(e)(1) of the Act requires that Federal and hospital-specific payment rates continue to be adjusted for budget neutrality. (See the technical explanation of the budget neutrality adjustment methodology in section V. of the Addendum.) As a result, aggregate FY 85 prospective payments for inpatient hospital services are projected to be the same as they would have been for those services in FY 85 had the Medicare payment system in effect at the time of enactment of the prospective payment legislation continued in effect. It should be emphasized that we have no discretion in this matter—the FY 85 payment rates must be made budget neutral to what would have been paid under prior law.

In the absence of the budget neutrality requirement, the FY 85 payment rates would increase over the FY 1984 rates, in accordance with section 1886(d)(3) of the Act, by the percentage increase in the hospital market basket index (an input price index) plus one percentage point. For FY 85, we estimate that increase would be about 7.4 percent. However, as a result of the budget neutrality and other adjustments, the proposed payment rates as published would increase by 5.6 percent.

The main factors that contribute to the reduction of the rate of increase below 7.4 percent are:

- Incorporation into the estimate of payments under prior law, on which the budget neutrality adjustment is based, of:
  - —The statutory reduction of the case-mix adjusted limits (from 115 percent of the mean for each group of hospitals) that would have applied under section 1886(a) of the Act; and
  - —The ending of payment for 25 percent of costs in excess of a hospital's rate of increase limit (target amount) under section 1886(b) of the Act;
- The disparity resulting from the difference between the months when lower and higher cost hospitals tend to enter the prospective payment system during FY 84. More of the hospitals that have higher costs, due to higher wage index values and higher indirect teaching adjustments, have cost reporting periods beginning late in the Federal fiscal year. As a result, these hospitals had little effect on the estimated FY 84 average payment levels used in the budget neutrality adjustment methodology. However, all of these hospitals will be paid based on the new Federal rates for all fiscal months of FY 85. Reflection of this situation in the budget neutrality calculations for FY 85, which eliminates the disparity, results in some reduction of the published FY 85 rates;
- Finally, the proposed increases in payments to certain hospitals as discussed elsewhere in this analysis,

which must be offset by decreases in the Federal payment rates.

However, in addition to the factors that would decrease the rates, other factors (other than increasing the rates by the market basket plus one percentage point) result in rate increases. Specifically, the change in outlier policy and the adjustment to reflect the most recent data on the level of transfer payments under the prospective payment system both produce increases in the adjusted Federal rates. (See the addendum for discussion of both of these subjects.)

The following example serves to illustrate in dollar terms the impact of these factors on the increase in the Federal rates published in the Addendum to this rule. The New England region's urban rate is $2,967 in FY 84 (adding labor and non-labor components). This rate, increased by 7.4 percent, would be $3,187 for FY 85, before adjustment for budget neutrality. However, the proposed FY 85 urban Federal regional rate for the New England is $3,134, or $53 less than the rate would have been if we had simply increased the FY 84 rate by 7.4 percent. The example below indicate how the requirement for budget neutrality accounts for the $53 dollar difference. (See Section V of the Addendum, Technical Explanation of Budget Neutrality Adjustment Methodology, for more details.)

Example:

FY 84 Rate: New England urban	$2,967
—Increase by 7.4%	+220
—Additional year of rate of increase limits and elimination of 25% allowance for costs in excess of limits	−54
—Reduce case-mix limits from 115% to 110% of mean	−12
—Phase-in disparity	−13
—Effect of regulatory changes	−22
—Adjust for transfers under prospective payment	+16
—Adjust for change in outlier policy	+32
FY 85 Rate: New England urban	3,134

We expect that the actual average *payment* per case during FY 85 will increase by more than the published Federal payment *rates* as a result of the following.

- Hospitals with higher wage index values entered the prospective payment system later, on average, than hospitals with lower wage index values. Thus, average payments to hospitals in FY 85 will be higher than in FY 84 because a higher proportion of admissions in FY 85 will be associated with hospitals with a higher wage index.
- Hospitals with higher payments for the indirect costs of medical education entered the prospective payment system later, an average, than hospitals with lower payments for those costs. Therefore, average payments to hospitals in FY 85 will be higher than in FY 84 because a higher proportion of admission in FY 85 will be associated with hospitals with higher payments related to indirect medical education cost.
- Hospitals with reporting periods starting later in FY 84 would be expected to have higher base year costs and hospital-specific rates because of the continuing increases in costs. This would further increase FY 85 average prospective payments over FY 84 average prospective payments.
- Several provisions allowing for increased payments would be added for FY 85. These provisions include new criteria for rural referral centers, extra payments to certain hospitals that are in counties redesignated from urban to rural by EOMB, and relief for hospitals in MSAs that overlap more than one region.

K. Summary

E.O. 12291 requires us to assess the benefits, costs, and net benefits of all rules, major or otherwise, and to discuss those costs and benefits in impact analyses for major rules to show that the potential benefits outweigh the cost to society.

In the aggregate, the net effect these proposals would have on the overall level of total payments would be negligible. To the extent that any aggregate change resulted at all, it would be the result of our inability to reflect all these proposals explicity and accurately in the budget neutrality adjustment methodology. Five of the major provisions of this rule (outlier payments to transferring hospitals, director of rehabilitation units expansion of rehabilitation units, physician attestation, and base year appeals) are not reflected in that methodology. However, as discussed above in relation to each provision, although we expect the economic impacts of these provisions to be negligible in the aggregate, each of them has significant benefits.

For the most part, the costs and disadvantages that could result from these proposals would take the form of reductions of payment rates through budget neutrality adjustment. However, as discussed above, the decrease in the budget neutrality factors largely results from considerations outside the scope of these proposals, and, under budget neutrality quantifiable benefits in the form of payment increases for some must be offset by payment decreases for others.

The primary benefit resulting from this proposed rule is the maintenance and effective management of the prospective payment system itself. The incentives of this system are expected to produce substantial benefits in the form of economy and efficiency of operation of participating hospitals, and as improvements in trends of the health care marketplace as a whole. As noted earlier, the objective of these proposals is to fine tune the prospective payment system. Compared to the magnitude and impact of the system as a whole, the effects of these changes would be trivial. For FY 85, Medicare expenditures for inpatient hospital services (including inpatient operating costs, capital costs, medical education, and excluded hospitals and units) are projected to be about $48 billion. This proposed rule would affect the distribution of less than 0.2 percent of those expenditures.

We believe that, from this perspective, the higher payment rates afforded to a little more than 150 hospitals [32 reclassified rural, 11 deemed to be in regions receiving higher payment rates, and perhaps as many as 113 rural referral centers), as well as the nonquantifiable benefits afforded to rehabilitation units and hosptials with affected transfer outlier cases and base year appeals, more than offset the resulting costs. For the above reasons, we believe that this proposal would meet the objectives of E.O. 12291 and the Regulatory Flexibility Act.

V. Other Required Information

A. Responses to Public Comments

Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, in preparing the final rule, which will be published shortly, we will consider all comments that we receive by the close of the comment period and will respond to them in the final rule.

B. Paperwork Reduction Act

These proposed changes do not impose information collection requirements. Consequently, they need not be reviewed by the Executive Office of Managment and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Cost-based reimbursement, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMOs), Health

professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reasonable charges, Reporting requirements, Rural areas, Prospective Payment System, X-rays.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

42 CFR Part 405, Subpart D would be amended as set forth below:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

1. The authority citation for Subpart D reads as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

2. The table of contents for Subpart D is amended by revising the title of § 405.476 to read as follows:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

Sec.

* * * * *

405.476 Special treatment for certain facilities under the prospective payment system.

* * * * *

3. Section 405.470 is amended by reprinting the introductory language of paragraph (b)(5) unchanged, revising paragraph (b)(5)(iv); redesignating paragraph (c)(4) as (c)(4)(i), and adding a new paragraph (c)(4)(ii) to read as follows:

42 CFR Part 405, Subpart D would be amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

1. The authority citation for Subpart D reads as follows:

Authority: Secs. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

2. The table of contents for Subpart D is amended by revising the title of § 405.476 to read as follows:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

Sec.

* * * * *

405.476 Special treatment for certain facilities under the prospective payment system.

* * * * *

3. Section 405.470 is amended by reprinting the introductory language of paragraph (b)(5) unchanged, revising paragraph (b)(5)(iv); redesignating paragraph (c)(4) as (c)(4)(i), and adding a new paragraph (c)(4)(ii) to read as follows:

§ 405.470 Prospective payment: General provisions.

* * * * *

(b) *Basis of payment.*

(1) * * *

(5) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates, hospitals will receive payments for:

(i) * * *

(iv) Bad debts of Medicare beneficaries (see § 405.420 and 405.477 (d)(1).

(c) *Discharges and transfers.*

* * * * *

(4) *Payments to a hospital transferring an inpatient to another hospital.*

(i) * * *

(ii) Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in § 405.475(d).

* * * * *

4. Section 405.471 is amended by reprinting the introductory language unchanged in paragraphs (c)(2) and (c)(2)(v) and revising paragraph (c)(2)(v)(A); by reprinting the introductory language unchanged in paragraphs (c)(4)(iii) and (c)(4)(iii)(F) and revising paragraph (c)(4)(iii)(F)(*1*); and by adding a new paragraph (d) to read as follows:

§ 405.471 Hospitals and hospital services subject to and excluded from the prospective payment system.

* * * * *

(c) *Excluded hospitals and hospital units: classifications.* * * *

(2) *Rehabilitation hospitals.* A rehabilitation hospital must—* * *

(v) Have a director of rehabilitation who—

(A) Provides services to the hospital and its inpatients on a full-time basis;

* * * * *

(4) *Psychiatric, rehabilitation, and alcohol/drug units (distincts parts).*

* * *

(iii) A rehabilitation unit (distinct part) must—* * *

(F) Have a director of rehabilitation who—

(*1*) Provides services to the unit and to its inpatients for at least 20 hours per week;

* * * * *

(d) *Changes in the size of excluded units.*—(1) *All excluded units.* For purposes of exclusion from the prospective payment system under this section, the number of beds and square footage of each excluded unit will remain the same throughout each cost reporting period, and any change in the number of beds or square footage considered to be part of an excluded unit may be made only at the start of a cost reporting period.

(2) *Rehabilitation units.* (i) A hospital that has an excluded rehabilitation unit may increase the number of beds and the square footage of the unit by as much as ten percent for a cost reporting period if during the immediately preceding cost reporting period the number of patient days of care furnished by the unit was at least 90 percent of the total available patient days. However, neither the number of beds nor the square footage of the unit may increase by more than ten percent for any cost reporting period.

(ii) Except as specified in paragraph (d)(2)(i) of this section, the number of beds or the square footage of an excluded rehabilitation unit may be increased only if—

(A) The added beds or rooms were used to provide hospital inpatient care during all of the hospital's most recent 12-month cost reporting period; and

(B) The entire unit the hospital wishes to have excluded, including both previously excluded beds or rooms and added beds or rooms, meets the requirement in paragraph (c)(4)(iii)(A) of this section.

5. In § 405.472, paragraph (d)(2)(i) is revised to read as follows:

§ 405.472 Conditions for payment under the prospective payment system.

* * * * *

(d) *Medical review activities for hospitals paid under the prospective payment system.*

* * * *

(2) *DRG validation.* (i) The attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to in writing on the discharge summary the principal

diagnosis, secondary diagnoses, and names of procedures performed. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's signature:

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge." In addition, when the claim is submitted, the hospital must certify that it has on file a signed acknowledgement from the attending physician that the physician has received the following notice:

Notice To Physicians

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature on the discharge summary sheet. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

* * * * *

6. Section 405.473 is amended by revising paragraph (c)(1), revising and redesignating paragraphs (c)(2) through (c)(6) as (c)(3) through (c)(7) respectively, and adding a new paragraph (c)(2) to read as follows:

§ 405.473 Basic methodology for determining Federal prospective payment rates.

* * * * *

(c) *Federal rates for fiscal years after Federal fiscal year 1984—(1) General rule.* HCFA will determine a national adjusted prospective payment rate, for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under §405.471, and will determine a regional adjusted prospective payment rate for such discharges in each region, for which payment may be made under Medicare Part A. Each such rate will be determined for hospitals located in urban or rual areas within the United States and within each such region respectively, as described in paragraphs (c)(2) through (c)(7) of this section.

(2) *Geographic classifications.* (i) For purposes of this paragraph, the following definitions apply:

(A) The term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(B) The term "urban area" means—

(*1*) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(*2*) The following New England counties, which are deemed to be urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term "rural area" means any area outside an urban area.

(D) The phrase "hospital reclassified as rural" means a hospital located in a county that was part of an MSA or NECMA, as defined by the Executive Office of Management and Budget, but is not part of an MSA or NECMA as a result of an executive Office of Management and Budget redesignation occurring after April 20, 1983.

(ii) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(A) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located. For discharges occurring during fiscal year 1985 only, if a hospital receives a lower Federal rate because the census division in which most of the hospitals are located has a lower Federal rate than the other census division in which the other part of the MSA is located, we will pay an additional amount to the hospital equal to 50 percent of the difference between the fiscal year 1985 Federal rate applicable prior to the reassignment and the fiscal year 1985 Federal rate applicable in the division to which the hospital has been assigned.

(B) The higher Federal rate is payable to all hospitals in the MSA or NECMA if an equal number of hospitals within the MSA or NECMA are located in each census division.

(3) *Updating previous standardized amounts*—(i) *For fiscal year 1985.* HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section (urban areas and rural areas within the United States, and urban areas and rural areas within each region), equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—

(A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and

(D) Adjusted for budget neutrality under paragraph (c)(5) of this section.

(ii) For fiscal year 1986 and thereafter, HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section, equal to the respective adjusted average standardized amounts computed for the previous fiscal year—

(A) Increased by the applicable percentage increase determined under paragraph (c)(4) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(4) *Determining applicable percentage changes for fiscal year 1986 and following.* The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(3)(ii) this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.

(5) *Maintaining budget neutrality for fiscal year 1985.* For fiscal year 1985, HCFA will adjust each of the reduced standardized amounts determined under paragraph (c)(3) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the

Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law as in effect on April 19, 1983. The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control peer review organization, as allowed under section 1866(a)(1)(F) of the Act.

(6) *Computing Federal rates for urban and rural hospitals.* For each discharge classified within a Diagnosis-Related Group, HCFA will establish for the fiscal year a national prospective payment rate and will establish a regional prospective payment rate, for each region, each of which is equal—

(i) For hospitals located in an urban area in the United States or that region respectively, to the product of—

(A) The adjusted average standardized amount (computed under paragraph (c)(3) of this section) for the fiscal year for hospitals located in an urban area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that diagnosis-related group; and

(ii) For hospitals located in a rural area in the United States or that region (respectively), to the product of—

(A) The adjusted average standardized amount (computed under paragraph (c)(3) of this section) for the fiscal year for hospitals located in a rural area in the United States or that region; and

(B) The weighting factor (determined under paragraph (a)(2) of this section) for that diagnosis-related group.

(7) *Adjusting for different area wage levels.* HCFA will adjust the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (c)(6) of this section which are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

7. In § 405.474, the introductory language of paragraph (b)(3)(i) is reprinted unchanged, and paragraph (b)(3)(i)(C) is revised to read as follows:

§ 405.474 Determination of transition period payment rates.

* * * * *

(b) *Determining the hospital-specific rate.*

* * * * *

(3) *Limitations on modifying calculations.* (i) The intermediary will use the best data available at the time in estimating each hosptial's base year costs and the modifications to those costs authorized by paragraph (b)(2) of this section. The intermediary's estimate of base year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as follows: * * *

(C) (*1*) To take into account additional costs recognized as allowable costs for the hospital's base year as the result of—

(*i*) A reopening and revision of the hospital's base year notice of amount of program reimbursement under §§ 405.1885 through 405.1889;

(*ii*) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under §§ 405.1821 or 405.1853 that resolved a matter at issue in the hospital's base year notice of amount of program reimbursement; or

(*iii*) A final administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 that resolved a matter at issue in the hospital's base year notice of amount of program reimbursement.

(*2*) The intermediary will recalculate the hospital's base year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base year costs to take into account these additional costs will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision. The hospital's revised base year costs will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

* * * * *

8. Section 405.476 is amended by: Revising the title; amending paragraph (a) by adding a new paragraph (a)(6); revising paragraph (g); and adding a new paragraph (i) to read as follows:

§ 405.476 Special treatment of certain facilities under the prospective payment system.

(a) *General rules.* * * *

(6) *Hospitals that are located in urban areas and that are reclassified as rural.* HCFA will adjust the rural Federal payment amounts for hospitals reclassified as rural, as defined in § 405.473(c)(2)(i)(D). The criteria for this adjustment are set forth in paragraph (i) of this section.

* * * * *

(g) *Referral centers.*—(1) *Criteria.* HCFA will consider a hospital's request for a referral center adjustment to the hospital's prospective payment rates only if the hospital is an acute care hospital that has a provider agreement under Part 489 of this chapter to participate in Medicare as a hospital; and the hospital meets the criteria specified in either paragraph (g)(1)(i), (g)(1)(ii), or (g)(1)(iii) of this section.

(i) The hospital is located in a rural area (as defined in § 405.473(c)(2)(i)) and has 500 or more beds available for use.

(ii) The hospital has an inpatient population such that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital. In addition, at least 60 percent of the hospital's Medicare patients must live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital.

(iii) For discharges occurring on or after October 1, 1984, the hospital is located in a rural area (as defined in § 405.473(c)(2)(i)) and the hospital meets the criteria specified in paragraphs (g)(1)(iii)(A) and (g)(1)(iii)(B) of this section and at least one of the three criteria specified in paragraphs (g)(1)(iii)(C) through (g)(1)(iii)(E) of this section.

(A) The hospital's 1981 case-mix index is at least 1.03, or, as an alternative, the hospital's case-mix index is at least 1.0903 for its first cost reporting period subject to the prospective payment system.

(B) The hospital's number of discharges (excluding discharges from subprovider units) is at least 6,000 for the hospital's most recently completed cost reporting period.

(C) More than 50 percent of the hospital's medical staff are specialists; that is, they have completed minimal training requirements as recognized by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists.

(D) The hospital's inpatient population is such that at least 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital.

(E) At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

(2) *Payment to referral centers.*—(i) Payment to rural referral centers with 500 or more beds. A hospital that meets the criteria of paragraph (g)(1)(i) of this section will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 405.473(b)(10) or (c)(6), as adjusted by the hospital's area wage index.

(ii) *Payment to all other rural referral centers.* Beginning with discharges occurring on or after October 1, 1984 a hospital that is located in a rural area (as defined in § 405.473(c)(2)(i)) and meets the criteria of paragraph (g)(1)(ii) or (g)(i)(iii) of this section will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 405.473 (b)(10) or (c)(6), as adjusted by the hospital's area wage index.

* * * * *

(i) *Hospitals reclassified as rural.* Effective with discharges occurring on or after October 1, 1984, a hospital reclassified as rural, as defined in § 405.473(c)(2)(i)(D), may receive an adjustment to its rural Federal payment amount for two successive Federal fiscal years provided that its hospital-specific portion for discharges occurring in the hospital's first cost reporting period under the prospective payment system exceeds the Federal rural rate for that same period that is adjusted for the rural area wage index and the indirect teaching adjustment factor.

(1) *First year adjustment.* A hospital that is reclassified as rural, as defined in § 405.473(c)(2)(i)(D), and whose hospital-specific portion exceeds the Federal rural rate, will have its rural average standardized amounts adjusted based on an amount, in addition to its rural average standardized amount, that equals two-thirds of the difference between the urban and rural standardized amounts reflecting the appropriate regional/national blend otherwise applicable to the fiscal year for which an adjustment is made.

(2) *Second year adjustment.* A hospital that continues to meet the definition in § 405.473(c)(2)(i)(D), will have its rural average standardized amounts adjusted based on an amount, in addition to its rural average standardized amount, that equals one-third of the difference between the urban and rural amounts reflecting the appropriate regional/national blend otherwise applicable to the fiscal year for which an adjustment is made.

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare-Hospital Insurance; No. 13.774, Medicare-Supplementary Medical Insurance)

Dated: June 21, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: June 28, 1984.

Margaret M. Heckler,

Secretary.

Editorial Note.—The following addendum will not appear in the Code of Federal Regulations.

ADDENDUM—PROPOSED SCHEDULE OF STANDARIZED AMOUNTS EFFECTIVE WITH DISCHARGES ON OR AFTER OCTOBER 1, 1984, AND UPDATE FACTORS EFFECTIVE WITH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1984

I. Summary and Background

In this addendum, under § 405.470(e)(2)(ii), we are proposing changes in the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services during the second year of the transition period. For hospital cost reporting periods beginning October 1, 1984 through September 30, 1985, each hospital's payment per discharge will be comprised of 50 percent of the Federal rate and 50 percent of the hospital-specific rate (section 1886(d)(1)(C) of the Act). We note that, while the changes to the hospital-specific portion of the prospective payment rate are determined on the basis of cost reporting periods, the changes to the Federal portion are determined on the basis of the Federal fiscal year (FY).

During Federal FY 85, the Federal rates will, for the first time, be comprised of a blend of the national rate (25 percent) and the regional rate (75 percent) as required by section 1886(d)(1)(D) of the Act. During the first year of the transition period (that is, Federal FY 1984), the Federal rates are comprised solely of the regional rate.

As discussed in further detail in section II below, we are proposing changes in the determination of the prospective payment rates that were published in the interim final rule on September 1, 1983 (48 FR 39752) and modified in the final rule published on January 3, 1984 (49 FR 234). The changes, to be made prospectively, would affect the calculation of adjusted standardized amounts and the transition period prospective payment rates. As part of these changes, we would incorporate adjustments for the new market basket index and budget neutrality.

II. Proposed Changes to Prospective Payment Rates and DRG Weighting Factors for FY 85

Section 1886(d)(3)(A) of the Act specifies that the FY 84 Federal prospective payment rates be updated for FY 85. In accordance with section 1886(b)(3) of the Act, the FY 84 urban and rural average standardized amounts are to be increased by the applicable market basket index plus one percent.

The basic methodology for determining a hospital's prospective payment rates is set forth in §§ 405.473 and 405.474 of the regulations. For a more detailed discussion of that methodology, we refer the reader to the interim final rule (48 FR 39752) and the final rule (49 FR 234).

Below, we discuss the manner in which we are proposing to change some of the factors or methodology used for determining the prospective payment rates. Note that these proposed changes are supported by new studies and data, and that we may wish to consider further studies and even more recent data, which may change the proposed rates, when publishing the final methodology and rates. These changes would be effective with discharges occurring on or after October 1, 1984, or with hospital cost reporting periods beginning on or after October 1, 1984.

A. Calculation of Adjusted Standardized Amounts

1. Development of a New Hospital Wage Index

Section 1886(d)(2)(C)(ii) of the Act requires that, in computing Federal prospective payment rates for the first year of the prospective payment rates for the first year of the prospective payment system (FY 84), we standardize the average cost per case of each hospital used in the data base for differences in area wage levels. Section 1886(d)(2)(H) of the Act requires that the standardized urban and rural amounts for the nine census regions and national rates (Table 1 of this addendum) be adjusted for a hospital's area wage level as part of the methodology for determining the prospective payment to a hospital. To fulfill both requirements, we constructed a wage index to eliminate variations in the average cost per case.

We used hospital wage and employment data obtained from the Bureau of Labor Statistics' (BLS') ES 202 reporting system to construct the wage index, applied under both of the above provisions of the Act, for computing prospective payments to hospitals during FY 84. The BLS ES 202 system

compiles information on employment and total wages for workers covered by unemployment insurance.

We have used this BLS data since 1979 when we began incorporating an area wage index into the methodology for computing the hospital routine services cost limits (the section "223" cost limits) authorized under section 1861(v) of the Act, and for determining the total inpatient operating cost limits enacted under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248). We were aware, from the outset, of certain limitations in the data, especially in regard to the lack of information on hours of employment or full-time equivalents (FTEs). The BLS data only provide information on the number of workers employed at a hospital. As a result, area wage indexes produced from these data do not distinguish between part-time and full-time employees.

Although we recognize these shortcomings at the time, the disadvantages were outweighed by the advantage of being able to utilize the best data available. In addition, since the wage indexes were used only for computing cost limits rather than the actual payment amounts, we believed the technical deficiencies of the data had less of an inpact on hospitals.

In response to the interim final rule published in the **Federal Register** on September 1, 1983, we received many comments concerning the nature and potential impact of deficiencies in the BLS data used to construct the hospital wage index on the propriety of the prospective payment rates. Rural hospitals in particular expressed their concern regarding the inability of the BLS data to account for regional differences in part-time employment.

Numerous hospitals maintained that they traditionally employed a greater proportion of part-time employees. To the extent that this is true, these providers pointed out that the wage indexes would be understated, which would result in lower prospective payments than would otherwise be warranted.

We concluded from these comments that we needed to critically examine those deficiencies in the wage index that seemed of greatest concern, especially the part-time employment issue, in order to ensure the accuracy of the payment rates, and thereby to maintain confidence in the equity of the prospective payment system. For this reason, we established a joint workgroup with representatives of the hospital industry from across the country to evaluate alternatives to the current wage index. The workgroup's participants included representatives from HCFA, the American Hospital Association, and State hospital associations from Connecticut, Ohio, Louisiana, Nebraska, and California.

The workgroup concluded that addressing all of the deficiencies of the present BLS wage index could only be a long range process due to the need to identify or create a data base specifically designed to overcome all of the techical limitations of the BLS data that may distort the wage index values. These limitations include not only the inability of the data to recognize regional variations in part-time employment, but also the apparent insensitivity of the data to other factors as well, including area differences in hospital occupational mix, overtime utilization, and length of work week.

However, the workgroup's consensus was that we should focus the immediate effort on what was agreed to be the most serious deficiency, the inability of the BLS data to control for area differences in the utilization of part-time employees, by obtaining more accurate data from hospitals subject to the prospective payment system. It was recognized that obtaining the essential data and performing the necessary analysis would have to be accomplished under severe time constraints in order to permit some assessment of the alternative data before the FY 85 update of the prospective payment system. Because of these constraints, the workgroup concluded that the Medicare cost report should be used as the primary source for our obtaining the required salary data. Because of the need to supplement cost report records with additional information on hours of work that would address the part-time employment problem, the workgroup also concluded that the Medicare fiscal intermediaries would be in the best position to collect the additional data from hospitals.

The workgroup reviewed and approved a survey form and instructions for collecting hospital financial data that would permit the analysis of options for the construction of an improved wage index. The survey instrument provided for the extraction of specific hospital salary and fringe benefit data from the Medicare cost report for hospital fiscal years ending in calendar year 1982. This period was selected because calendar year 1982 is the most recent period for which intermediaries could be expected to have a complete set of hospital cost reports. Because the number of reported hospital employees in the BLS data currently used to construct the wage indexes does not distinguish between full-time and part-time employment, the survey was designed to permit the construction of wage indexes based on the average *hourly* hospital wage in each urban/rural area under the prospective payment system. In addition, in order to make the indexes as comparable as possible for all locales despite variation in hospital employment practices, the survey also provided for the exclusion of compensation paid to contracted personnel, interns and residents, personnel employed in non-hospital cost centers, and hospital-based physicians.

Copies of the survey form are available from HCFA on request.

After obtaining the required approval for use of the form from EOMB on March 8, 1984, we initiated the survey through the Medicare fiscal intermediaries on March 16, 1984. As of May 8, 1984, survey forms from 5,538 U.S. non-Federal short term acute care hospitals had been completed and returned to our central office.

Explanation of Survey. For each hospital for which a survey form was submitted, we computed its adjusted gross hospital salaries. The salaries were calculated to exclude wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians. In order to reduce the effects of differences in hospital accounting periods, each hospital's adjusted gross salaries were inflated through the end of calendar year 1982 using the annual rate of increase in the wages and salaries portion of the hospital market basket. The annual rate used was 11.0 percent. The resulting inflated gross hospital salaries were divided by the corresponding total number of paid hours worked to yield an average hourly wage for each hospital.

Initial analysis of the survey forms revealed that of the 5538 hospitals for which we received data, approximately 3300 contained questionable entries. The data were questionable for a variety of reasons. For example, the figures on total paid hours worked that were reported for one particular State did not conform to the survey instructions but represented "productive hours", an alternative definition of worker output, therby distorting the results for this State. Numerous survey forms from hospitals in other locales failed to properly exclude salaries for hospital-based physicians. In many instances where this type of error occurred, the total remuneration for these physicians was inappropriately excluded, resulting in an average hourly hospital wage that we believe grossly understates actual compensation levels in certain locales

compared to other areas. Initially, we also received a significant number of survey records that failed to exclude paid hours for the excluded categories of hospital employees.

We attempted to obtain corrected data for all hospitals in which we detected errors in the survey reports. We contacted each fiscal intermediary serving hospitals for which questionable data had been submitted. In many instances, repeated contacts were made. Despite these efforts, of the 5538 hospitals in the survey data base, we were unable to obtain either an adjusted gross hospital salary figure or the corresponding total paid hours worked for 444 hospitals, thereby making it impossible to compute an average hourly wage for these hospitals. In addition, usable data were not submitted for 10 locales for which wage indexes are required. Also, the data for an additional 237 hospitals yielded an average hourly wage either less than $3.35, the minimum wage in 1982, or greater than $19.58. The latter figure is 2½ times the estimated national average hourly wage of $7.83 for nonsupervisory hospital workers in December 1982 as reported in the February 1984 edition of BLS's *Employment and Earnings*. We believe the survey data from hospitals with an average hourly wage less than the 1982 minimum wage or greater than $19.58 are questionable. Thus, after extensive attempts to correct the survey reports were made, data from 681 hospitals, representing approximately 12 percent of the providers in the survey data base, were, on their face, suspect as to their accuracy. This figure does not reflect survey reports from areas in which the quality of the data are questionable for other reasons, some of which are discussed above.

Although we attempted to obtain corrected data for all hospitals in which we discovered errors in the survey reports, we believe the quality of the survey data, even after including corrected records, is suspect in enough areas so that a reliable index cannot be constructed at this point, even assuming that values for some areas could be estimated by reference to the relationship between the HCFA and BLS data sets. Preliminary analysis reveals that implementation of survey-based wage indexes that conform computationally as closely as possible to the 1981 BLS indexes currently used in the prospective payment system would adversely impact a significant number of hospitals without any assurance that the result represented a true measure of area wage levels. While other hospitals, of course, would benefit, we do not believe it would be equitable to implement a new wage index developed from a survey in which a high proportion of records are either incorrect or otherwise suspect.

Therefore, the prospective payment rates proposed in this rule were developed from the same 1981 BLS wage indexes previously published on September 1, 1983 (see 48 FR 39871). We are publishing in this rule only those revised 1981 BLS wage indexes that reflect all corrections implemented subsequent to their initial publication on September 1, 1983. (See section II.B.1. of this addendum.)

Although we could have calculated new indexes based on 1982 BLS ES 202 data, we have elected not to do this as we would only be updating and not correcting the existing technical deficiencies in the BLS data base.

During the next several weeks, we will be working to overcome the deficiencies in the survey data and evaluating alternatives for correcting the part-time employment distortion that exists in the 1981 indexes. It is our intention to analyze alternatives using data from accurately completed survey forms obtained from the fiscal intermediaries serving hospitals in each urban/rural locale based on the latest available MSA/NECMA definitions announced by EOMB. We shall continue to correct errors in the data reported on the survey forms as we detect them in order to obtain a data base of sufficiently high quality to permit revision of the wage indexes. However, our ability to attain this objective depends in large measure on factors whose timing is difficult to predict or control, such as our ability to thoroughly identify remaining errors in the data base and obtain accurate data from hospitals where the present records are questionable. We wish to note in this regard that the area wage index is a relative measure so that correction of distortions has the effect of both raising the value for some areas and lowering values for other areas. This is a fact inherent in any scale of relativity. Implicit in the notion of relative differences in the premise that where, because of imprecision in the measure, some values are understated, other values must necessarily be overstated.

Therefore, we believe it is important to point out that even if the final survey data are sufficiently accurate to construct more refined wage indexes, there will be, in all likelihood, substantial differences for many areas between any new indexes and the 1981 BLS indexes. We are specifically soliciting comments on resolving all aspects of the part-time employment issue through the use of a new wage index.

It should also be noted that the final wage indexes ultimately adopted for FY 85 may affect the amount of the education adjustment factor (presently 5.795 percent) used in determining the indirect medical education costs in accordance with section 1886(d)(2)(C)(i) of the Act. To the extent wage indexes published in the final rule are revised, we will adjust the education adjustment factor, as appropriate.

2. Grouping of Urban/Rural Averages Within Geographic areas

Under section 1886(d)(2)(D) of the Act, the average standardized amounts per discharge must be determined for hospitals located in urban and rural areas of the nine census divisions and the nation.

For FY 85 the Federal rates will be comprised of the national rate (25 percent) and the regional rate (75 percent) (section 1886(d)(1)(D) of the Act). Therefore, we are proposing to revise Table 1 in this addendum to add a category for national averages so that Table 1 would contain 20 standardized amounts (ten urban amounts and ten rural amounts further divided into labor-related and nonlabor-related portions). The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that the national urban and rural groups include hospitals from all urban or rural geographic areas, respectively. However, certain national adjustment factors, such as those for outliers and budget neutrality, differ slightly from the regional adjustment factors.

EOMB may announce revised listings of MSA/NECMA designations that are used in calculating the standardized amounts. If EOMB makes the announcement before we issue the final rule, we will list the revised MSA/NECMA designations in the addendum to the final rule. As stated in the January 3, 1984 final rule (49 FR 253), these changes in designation will not be recognized in the prospective payment rates until the beginning of each new fiscal year following the announced changes.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the urban and rural average standardized amounts using the applicable target rate percentage specified in section 1886(b)(3)(B) of the

Act. The target rate to be applied is defined under this section of the law as the estimated increase in the hospital market basket of goods and services plus one percent. The market basket identifies the most commonly used categories of hospital inpatient operating expenses and weights each category to reflect the estimated proportion of total hospital operating expenses attributable to that category.

MARKET BASKET PLUS 1 PERCENT

Calendar year	(Percentage)
1984	7.0
1985	7.5
1986	8.1

Because we are required to update the standardized amounts and the hospital-specific portion of the FY 85 prospective payment rates using the market basket rate of increase plus one percent, we are also prosposing to apply these rates in determining the target amounts for those hospitals that are excluded from the prospective payment system but subject to the target rate of increase limits specified in § 405.463. These target rate percentages would be applied in computing hospital target amounts for cost reporting periods beginning on or after October 1, 1984.

4. Adjustments to Average Standardized Amounts

a. Part B Costs. Section 1862(a)(14) of the Act prohibits payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital or by an entity under arrangements made by the hospital. In order to adjust urban and rural regional and national standardized amounts per discharge so that they represent costs previously billed under Part B, we are proposing for FY 85 that the amounts be increased by .13 percent. (We note that this figure (.13 percent) represents the same percentage increase that is used in FY 84.)

This is an estimate made by HCFA's Office of Financial and Actuarial Analysis of the costs of inpatient hospital services previously billed to HCFA.

b. *FICA Taxes.* Section 1886(b)(6) of the Act requires that adjustments be made in the rate of increase base period costs in recognition that certain hospitals were required to enter the Social Security system and being paying FICA taxes as of January 1, 1984. We estimate the amount of the adjustment for FY 85 to the urban and rural regional and national standardized amounts necessary to account for additional costs of payroll taxes for hospitals entering the Social Security system to be .18 percent, which is the same percentage increase as in FY 84. Therefore, we are proposing to increase the standardized amounts by this percentage.

c. *Outliers.* Section 1886(d)(5)(A) of the Act requires that in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion that is estimated to reflect outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act further directs that outlier payments may not be less than five percent or more than six percent of total payments projected to be made based on the prospective payment rates in any year.

In the interim final rule (48 FR 39767), we estimated that outlier payments for FY 84 would be 6.0 percent of total payments (including both standard prospective payment system rates and outlier payments). We made the maximum estimate permitted under the law in order to ensure that we would provide an adequate margin for outlier payments. To achieve this result, we multiplied both the standardized amounts and the hospital-specific portion by .943 (a 5.7 percent reduction factor). For the final rule (49 FR 262), in light of comments received that stated that the uniform 5.7 percent reduction factor benefits facilities with a greater incidence of outliers and penalizes those hospitals with relatively few outliers, we correspondingly requires that the standardized amounts be reduced by a proportion that is estimated to reflect outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act further directs that outlier payments may not be less than five percent or more than six percent of total payments projected to be made based on the prospective payment rates in any year.

In the interim final rule (48 FR 39767), we estimated that outlier payments for FY 84 would be 6.0 percent of total payments (including both standard prospective payments system rates and outlier payments). We made the maximum estimate permitted under the law in order to ensure that we would provide an adequate margin for outlier payments. To achieve this result, we multiplied both the standardized amounts and the hospital-specific portion by .943 (a 5.7 percent reduction factor). For the final rule (49 FR 262), in light of comments received that stated that the uniform 5.7 percent reduction factor benefits facilities with a greater incidence of outliers and penalizes those hospitals with relatively few outliers, we restricted the 5.7 percent reduction only to the Federal standardized amounts.

We think it is desirable to reduce the size of the reserve for outliers from 6.0 percent of total payments, which we had established for FY 84, to 5.0 percent of total payments while providing proportionately greater payment for typical cases and avoiding any great risk of general disadvantages to hospitals. While we could continue to set the prospective payment rates as if outliers would approximate 6.0 percent of total payments, we are mindful that this results in less payment to all hospitals for typical cases. We believe that it is in the greater interest of hospitals and the program to eliminate some of the reserve for outliers and include the corresponding amount in the standardized amounts thereby providing hospitals with somewhat larger Federal rates for typical cases. We note that this has the effect of increasing the predictability of total payments for hospitals in that less of the total is attributable to those cases that meet particular qualifications. As we indicated in the final rule (49 FR 265), we will pay for any outlier that meets the criteria in § 405.475, even if the aggregate outlier payments result in more than five percent (as proposed) of total payments. For those hospitals that experience a higher incidence of outliers, we believe that, in the aggregate, other adjustments (such as the medical education adjustment) are in place to assist these hospitals.

In accordance with these requirements, we have calculated the factors necessary to adjust the national and regional standardized amounts for FY 85 to take into account outlier payments of five percent of total payments on the blended Federal rates. The proposed outlier adjustment factors are as follows:

Regional—.950
National—.950

We are proposing, as well, to revise the day outlier and cost outlier threshold to ensure that total estimated outlier payments for FY 85 would be 5.0 percent of total payments. We are proposing that a discharge in FY 85 will be considered an outlier if the number of days in the stay exceeds the mean length of stay for discharges within the DRG by the lesser of 22 days or 1.94 standard deviations. We refer the reader to Table 5 in this addendum for the proposed DRG outlier thresholds.

For FY 85, we are also proposing that a discharge that does not qualify as a day outlier will be considered a high cost outlier if the cost of covered services exceeds the greater of 2.0 times the Federal rate for the DRG or $13,000.

The methodology for calculating these factors is explained in detail in section V. of this addendum. It should be noted that the regional outlier reduction value (.950) represents an adjustment to the standardized amounts for FY 85 but without regard to reductions for outlier payments in FY 84.

d. *Budget Neutrality.* In accordance with section 1886(e)(1) of the Act, the prospective payment should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 84 and 85, the prospective payment system must be "budget neutral".

The prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Further, effective October 1, 1984, the Federal portion will be a blend of national and regional rates. As a result, we must determine three budget neutrality adjustments—one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we propose to use to make these adjustments is explained in detail in section V. of this addendum.

To summarize, each of these factors is computed based on a comparison of estimated average payment per case (before adjustment for budget neutrality) to estimated average reimbursement under the law in effect before the enactment of section 1886(d) of the Act. We have estimated average payments for both regional and national rates based on early data on payments under the prospective payment system. Further, our estimates take into account the various regulations changes and other matters proposed in this document. We intend to continue to analyze the data emerging from the prospective payment system. Based on the data and analysis available at the time we publish the final rule and rates, we may make further changes that affect the magnitude of the budget neutrality adjustment factors. Such changes would, in turn, affect the regional and national standardized amounts and the hospital-specific rates.

Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:

Regional—.947

National—.950

As with the regional outlier adjustment factor, the regional budget neutrality factor represents estimated payments under the prospective payment system for FY 85 as compared to estimated reimbursement under the law in effect prior to Pub. L. 98–21, for the same period (FY 85), without regard to the reduction for either outlier payments in FY 84 or budget neutrality in FY 84.

B. Adjustments for Area Wage Levels and Cost-of-Living in Alaska and Hawaii

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in section C. below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Table 1, as revised in this addendum, contains the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates.

1. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amount by the appropriate wage index for the area in which the hospital is located. The wage index values that intermediaries would apply in computing the hospital Federal payment rates are those published in Tables 4a and 4b in the interim final rule (48 FR 39871 ff) with the addition of the following revised wage indexes that became effective for the indicated areas after October 1, 1983.

REVISED WAGE INDEX FOR CERTAIN URBAN AREAS

Urban area	Wage index	Effective date
(Constituent Counties or County Equivalents):		
Fort Worth-Arlington, TX; Johnson, TX; Parker, TX; Tarrant, TX.	0.9847	Feb. 9, 1984.
Lincoln, NE; Lancaster, NE	.8709	Do.
Davenport-Rock Island-Moline, IA-IL; Scott, IA; Henry, IL; Rock Island, IL.	.9840	Mar. 23, 1984.
Grand Forks, ND	.9693	Do.

REVISED WAGE INDEX FOR CERTAIN URBAN AREAS—Continued

Urban area	Wage index	Effective date
Richmond-Petersburg, VA; Charles City Co., VA; Chesterfield, VA; Colonial Heights City, VA; Dinwiddie, VA; Goochland, VA; Hanover, VA; Henrico, VA; Hopewell City, VA; New Kent, VA; Petersburg City, VA; Powhatan, VA; Prince George, VA; Richmond City, VA.	.9299	Do.
Sacramento, CA; Eldorado, CA; Placer, CA; Sacramento, CA; Yolo, CA.	1.1454	Do.
West Palm Beach-Boca Raton-Delray Beach, FL; Palm Beach, FL	1.0010	Do.
Rural area: Kentucky	.8162	Do.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(C)(iv) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment for area wages above. For FY 85, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

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

Alaska—All areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.15
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.125

(The above factors are based on data obtained from the U.S. Office of Personnel Management, published in their FPM–591 letter series.)

C. DRG Weighting Factors

In both the interim final rule (48 FR 39889) and the final rule (49 FR 332), we explained that, as a part of applying budget neutrality, we were adjusting the Federal standardized amounts downward to reflect a 3.38 percent expected improvement in hospitals reporting of patient diagnoses and procedures performed on the Medicare hospital bill. This improvement in the accuracy and completeness of reported patient information was anticipated because the prospective payment system makes payments to hospitals based on a patient's diagnosis and procedures performed. Thus, the

prospective payment system offers hospitals an incentive to report complete and accurate medical information on the billing records sent to the fiscal intermediaries, whereas the previous system, based as it was on the reimbursement of incurred costs, without regard to a patient's condition, provided no such incentive.

Increasing the accuracy and completeness of medical data reported on the bills has the effect of raising hospital case-mix index values which in tern results in higher payments to hospitals. The emerging experience under the prospective payment system indicates that the average case mix submitted on the inpatient bills has increased more than the 3.38 percent anticipated for FY 84. To correct for the distortion caused by this higher than expected case mix, we must revise the payment system for FY 85.

The amount of the anticipated increase in hospital payments attributable to the improvement in reporting was based on a study of hospital bills that were coded for the 1981 MEDPAR file and bills coded after medical review. The carefully and completely coded bills were provided from the PSRO Uniform Hospital Discharge Data Set (UHDDS) data base. The study found that reimbursement under the prospective payment system using the PSRO data would be 3.38 percent higher than reimbursement using the MEDPAR data. Since the prospective rates are set using the MEDPAR data, actual payments under the prospective payment system would have been higher than predicted from the MEDPAR data.

The adjustment to the prospective payment rates could have been accomplished in a number of different ways, but because the data used to compute the estimated impact on hospital payments did not reflect actual experience under the prospective payment system, it was considered highly likely that the case mixes of hospitals under prospective payment would vary from the initial estimates based on the PSRO data. Comparing the MEDPAR coding of discharges with the PSRO coding of discharge data could only reveal some measure of the degree to which improvement in the overall reporting of patient data could be expected. This analysis could not reflect changes in case mixes due to other reasons, such as a hospital's decision to specialize in certain DRGs with relatively high relative weights. Therefore, for the first year of the prospective payment system, it was decided to adjust the Federal standardized amounts through the budget neutrality mechanism since the methodology would be reviewed in the second year and could be easily updated based on more current data.

As part of HCFA's prospective payment monitoring system, we have been generating monthly case-mix index values for each hospital under the prospective payment system. Based on hospital bills received through March 1984, which include 896,000 discharges billed under the prospective payment system, we have observed that hospital case-mix index values have increased an average of 5.85 percent over the values published in the interim final rule. This increase reflects the difference between the mix of cases in the 1981 MEDPAR file and the mix of cases actually reported under the prospective payment system.

To determine the degree of difference, we computed a separate case-mix index for each hospital for each month in which we received bills under the system by multiplying the number of discharges for each DRG by the relative weight for that DRG, summing the products, and then dividing that sum by the number of total discharges for that month and hospital. The discharge weighted average prospective payment case-mix index for all hospitals and months in the file was 1.10299.

We then computed a comparable average case mix for the 1981 MEDPAR file. This was done by computing a case-mix index for each hospital on the MEDPAR for each month in 1981 and determining a weighted average of the MEDPAR case-mix indices using the FY 84 prospective payment system discharges already reported to us through March 1984 as weights.

This automatically excludes data for hospital months with no prospective payment bills. This also compensates for any biases that could have been due to seasonal variations, hospital cost reporting period distributions, and the timeliness of submitting bills. The average MEDPAR case-mix index for all hospitals reporting bills under the prospective payment system was 1.04207.

We then computed the ratio of the average MEDPAR case-mix index to the average prospective payment case-mix index. This ratio is 1.0585.

The following example illustrates the methodology for computing the case-mix improvement ratio.

January 1984 PPS Discharges Already Reported to us by March 1984 by DRG

	Hospital A	Hospital B	Hospital C
DRG X (weight .800)	4	0	0
DRG Y (weight 1.000)	20	20	0
DRG Z (weight 1.200)	41	15	0
Total	65	35	0
January 1981 MEDPAR case mix	1.060	1.010	.957
January 1981 MEDPAR discharges	900	750	850

The case mix for January 1984 is the DRG relative weights multiplied by the number of discharges, summed, and then divided by the total number of discharges. For example,

$(.800 \times 4) + (1.000 \times 20) + (1.200 \times 41) + (1.000 \times 20) + (1.200 \times 15) = 110.4$

$110.4 \div 100 + 1.104$

The comparable MEDPAR case mix for January is the January 1981 MEDPAR case mix multiplied by January 1984 discharges, summed, and then divided by the total number of January 1984 discharges.

For example, $(1.060 \times 65) + (1.010 \times 35) + (.957 \times 0) = 104.25$

$104.25 \div 100 + 1.0425$

Since hospital C did not contribute to the January 1984 case mix, it does not contribute to the comparable MEDPAR case mix. It may be that either we had not yet received January 1984 prospective payment system bills by March 1984 from hospital C, or that hospital C was not being reimbursed under the prospective payment system in January 1984.

The increase in case mix is computed by dividing 1.104 by 1.0425 which yields 1.059 for this example.

Since this computed increase in the prospective payment case-mix index values is derived from prospective payment discharge data, we are more confident that it reflects changes not only in improved medical record keeping and reporting of patient diagnoses, but also other changes in hospital behavior. For example, the higher observed case-index values maybe the result of conscious management decisions on the part of hospital staffs to treat some of the less complicated cases without resorting to inpatient services or to specialize more strongly in certain DRGs having relatively high relative weights, and thereby increase the proportion of total admissions currently assigned to high weighted DRGs.

Because the calculated increase in hospital case mix is based on a more comprehensive analysis of changes in

hospital case mix, we expect the difference between a hospital's case-mix index value under the prospective payment system and its published index value to be a fair measure of the increment in coding which is the natural outgrowth of the early stages of adaption to the new system. We would expect that the effect of this process would stabilize over time.

Thus, for discharges occurring on or after October 1, 1984, we are proposing to reduce each DRG relative weight by an amount equal to the observed increase in hospital case-mix value over the increase projected for FY 84. That is, we are proposing to reduce the DRG relative weights. 2.4 percent by dividing each of the relative weights published in table 5 of the interim final rule (48 FR 39876) by 1.024. (We note that the relative weight for DRG 302 was corrected in a Federal Register notice (48 FR 48469).)

The decision to reduce the DRG relative weights to eliminate the distortions resulting from changes in coding practices rather than incorporating the case-mix change into the budget neturality adjustment factors is based on a number of considerations.

As explained in section V, section 1886(e) of the Act requires us not only to maintain budget neutrality of total prospective payment compared to payment under the previous law, but also that the Federal and hospital-specific payments must be equal to the appropriate blend prescribed for each fiscal year. However, the hospital-specific rate changes only at the beginning of a hospital's cost reporting period. In addition, the hospital-specific blend is reduced from 75 percent to 50 percent at the beginning of a hospital's second year on prospective payment. As a result, to assure compliance with the budget neutrality provisions of the law, the budget neutrality methodology must compensate both for the phase-in of hospitals, and for the difference in the hospital-specific portions.

If we were to propose adjusting the prospective payment amounts for the increase of case mix through the budget neutrality adjustment factors, the resulting impact on the hospital-specific rates would result in an actual decrease in the hospital-specific rates beginning in FY 85 over those rates that went into effect in FY 84. By reducing the weights by 2.4 percent instead of the rates, hospital-specific rates will not be reduced as much as they otherwise would be. This, we believe, will benefit hospitals by maintaining a more even cash flow.

Another benefit of recognizing the observed increase in case mix through an adjustment to the DRG weights rather than the rates is that reducing payment in this manner is more equitable to those hospitals with cost reporting periods beginning early in the Federal fiscal year. This is because the adjustment to compensate for average growth in case mix would take effect on October 1, 1984 rather than being phased in through the budget neutrality adjustment of the hospital-specific portion. By reducing the DRG weights and the resulting payment amounts at the beginning of the Federal fiscal year, rather than with each hospital cost reporting year, hospitals with cost reporting periods beginning earlier in the Federal fiscal year would not have to subsidize those hospitals with cost reporting periods beginning later in the Federal fiscal year. The following example can be used to illustrate this point.

Consider two hospitals, A and B. Hospital A starts its cost reporting period on January 1 and Hospital B starts its cost reporting period on July 1. Both hospitals have hospital-specific rates of $2,500 and 1200 discharges each for FY 85. Suppose that the budget neutrality goal for FY 85 averages $2542, and that the market basket plus 1 percent increase for each hospital is 7.4 percent.

Both hospitals have a reported case-mix 2.4 percent higher than expected. In the absence of an adjustment, each hospital would average, in FY 85, $2,500×1.024 = $2,560 hospital-specific portion payment per discharge before the start of a new cost reporting period, and $2,560×1.074 = $2,749.44 hospital-specific portion reimbursement per discharge after the start of the new cost reporting period.

One option would be to adjust the hospital-specific portion of the rate for new cost reporting periods to compensate for the increment in coding. This can be computed by:

Admissions before new cost reporting period/(Hospital A) $2,560×300×.75 blend + admissions in new cost reporting period/ $2,749.44×900×BN×.5 blend

plus (Hospital B) $2,560×900×.75 blend + $2,749.44×300×BN×.5 blend equals Budget Neutality Goal: $2542×2400×.625 average blend

Solving: $2560×1200×.75 + $2749.44×1200×.5×BN = $2542×2400×.625

Budget Neutrality = .915

This implies that we can only pay $2749.44×.915 = $2516, a 1.7 percent decrease from the payment for discharges occurrring in FY 85 prior to the start of the hospitals' new cost reporting periods.

Another option is to reduce the relative DRG weights by 2.4 percent so that the payment in FY 1985, before a new cost reporting period would be $2,560 divided by 1.024=$2,500 and after a new cost reporting period would be $2,749.44 divided by 1.024=$2,685 before budget neutrality. To compute budget neutrality:

Admissions before new cost reporting period/(Hospital A) $2,500×300×.75 blend + admissions in new cost reporting period/$2,685×900×BN×.5 blend

plus (Hospital B) $2,500×900×.75 blend + $2,685×300×BN×.5 blend equals Budget Neutrality Goal: $2542×2400×.625 average blend

Solving: $2500×1200×.75 + $2685×1200×BN×.5=$2542×2400×.625

Budget Neutrality=.970

which implies we can pay $2,685×.970=$2604 for discharges in the new cost reporting period, a 4.2 percent increase over payment for discharges occurring in FY 85 prior to the start of the hospital's new cost reporting periods.

The difference between the $2,516 average hospital-specific portion rate using budget neutrality to adjust for the expected increase in hospital case-mix indexes and the $2,604 hospital-specific portion rate using a reduction in the DRG relative weights results in a 3.5 percent increase in the average hospital-specific payment rate. It should be noted that even though the difference in the hospital-specific rates between the two options for the new cost reporting years differed by 3.5 percent, the difference in the hospital-specific portion average payments between the two options for the old cost reporting periods differed by 2.4 percent. This example illustrates that cash flow patterns are more managable if the DRG relative weights are adjusted, enabling the adjustment to be spread evenly throughout the fiscal year. Further, if the first option was adopted, questions of equity would arise because hospital A would be subsidizing hospital B due to the fact that hospital A would suffer a reduced hospital-specific rate for nine months in FY 85 so that hospital B could enjoy a higher hospital-specific rate for nine months in FY 85. Therefore, we believe that the adoption of the option to reduce the relative weights is more equitable and manageable.

All inpatient hospital discharges are categorized according to one of 470 DRGs, as discussed in the interim final

rule (48 FR 39760). We believe that the titles of five DRGs, as issued in Table 5 of the interim final rule, are inaccurate or misleading. For example, the title of DRG 316 should have been "Renal Failure" instead of "Renal Failure Without Dialysis". Accordingly, revised titles for DRGs 57, 58, 129, 316 and 317 are included in Table 5 of this addendum.

D. Calculation of Prospective Payment Rates for FY 85

FY 85 represents the second year of the three-year transition period.

General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or After October 1, 1984 and Before October 1, 1985

Prospective Payment Rate = Hospital Specific Portion + Federal Portion

1. Hospital-Specific Portion

The hospital-specific portion of the prospective payment rate is based on a hospital's historical cost experience and is derived from the following formula:

(Base-year Costs) × Updating Factor × 50 percent × DRG Weight (Case-mix Index)

For a more detailed discussion of the hospital-specific portion, we refer the reader to the interim final rule (48 FR 39772).

a. *Budget Neutrality.* The hospital-specific portion of the payment rates will be adjusted for cost reporting periods that begin between October 1, 1983 and October 1, 1985, to maintain budget neutrality in accordance with section 1886(e)(1)(A) of the Act. The hospital-specific portion of the rate is set at 50 percent in the hospital's second transition period.

An adjustment will be made to the otherwise applicable target rate percentage to maintain budget neutrality of the hospital-specific portion of the payment. To determine the necessary adjustment, we estimated what the average payment per case would have been under the reasonable cost methodology under the law in effect before enactment of Pub. L. 98–21. This estimate is compared to a projection of average payment per case based on the hospital-specific portion of the prospective payment amount. The methodology we used in making these estimates and comparisons is explained in further detail in section V. of this addendum. We are proposing that the applicable factor for adjusting the hospital-specific portion to maintain budget neutrality in FY 85 is .987. This factor has been included in the updating factor discussed in section b. below.

b. *Updating Factor.* For cost reporting periods ending on or after September 30, 1984 and before August 31, 1986, we are proposing to apply an update factor to a hospital's previous hospital-specific rate that is equal to the compounded applicable target rate percentage (as applied under the rate of increase limits in § 405.463) as adjusted by a budget neutrality factor of .987. The table below sets forth the updating factors applicable to discharges in FY 85.

If cost reporting period ends	And second cost reporting period under PPS ends	Updating factor
Sept. 30, 1984	Sept. 30, 1985	1.05979
Oct. 31, 1984	Oct. 31, 1985	1.06020
Nov. 30, 1984	Nov. 30, 1985	1.06061
Dec. 31, 1984	Dec. 31, 1985	1.06103
Jan. 31, 1985	Jan. 31, 1986	1.06152
Feb. 28, 1985	Feb. 28, 1986	1.06201
Mar. 31, 1985	Mar. 31, 1986	1.06250
Apr. 30, 1985	Apr. 30, 1986	1.06300
May 31, 1985	May 31, 1986	1.06349
June 30, 1985	June 30, 1986	1.06398
July 31, 1985	July 31, 1986	1.06448
Aug. 31, 1985	Aug. 31, 1986	1.06497

If a hospital's cost reporting period ends on a day other than those listed above, the update factor for the month nearest to (that is, either before or after) the actual ending date is used. However, for those cases in which a hospital's cost reporting year ending date for the first year under the prospective payment system (column 1 in the table shown above) does not match the ending date of the second cost reporting year under the prospective payment system (column 2 in the table shown above), the fiscal intermediary contacts HCFA for the appropriate adjustment factor.

c. *Calculation of Hospital-Specific Portion.* The hospital-specific portion of a hospital's payment rate for a given discharge is calculated by:

Step 1—Multiplying the hospital-specific rate (*Base-year costs*) × (Updating factor) (Case-mix index) by 50 percent, and

Step 2—Multiplying the amount resulting from Step 1 by the specific DRG weighting factor applicable to the discharge.

The result is the hospital-specific portion.

d. *New Providers.* Hospitals that have not completed a 12-month cost reporting period under Medicare (either under current or previous ownership) prior to September 30, 1983 are considered new providers for purposes of the prospective payment system. Their prospective payment rates are computed without regard to the hospital-specific portion. Thus, new providers are paid a blend of 75 percent of the appropriate Federal regional rate and 25 percent of the Federal national rate for discharges occurring on or after October 1, 1984 and before October 1, 1985.

2. Federal Portion

For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, the Federal portion of the hospital's total prospective payment will be 50 percent of the hospital's payment amount. Beginning with discharges occurring on or after October 1, 1984, the Federal portion is comprised of a blend of the Federal regional rate (75 percent) and the Federal national rate, (25 percent).

III. Summary of Prospective Payment Rate Changes

We are proposing to make the following changes in determining of prospective payment rates for FY 85:

A. Calculation of Adjusted Standardized Amounts

- Update the market basket index.
- List the wage indexes revised subsequent to September 1, 1983.
- Update the cost-of-living adjustment factors for hospitals in Alaska and Hawaii.
- Revise the adjusted standardized amounts to contain 20 standardized amounts, that is, nine regional figures and a national figure for labor-related and nonlabor-related amounts (Table 1).
- Adjust the average standardized amounts upward to reflect the estimated costs under Part B and for FICA taxes.
- Adjust the average standardized amounts downward to remove the estimated costs for outliers.
- Adjust the average standardized amounts to reflect budget neutrality.

B. Calculation of Prospective Payment Rates

- Determine a new target rate percentage factor for computing the hospital-specific portion that incorporates an adjustment for budget neutrality.
- Determine total prospective payment based on 50 percent Federal portion and 50 percent hospital-specific portion.
- Determine Federal portion based on 75 percent of the Federal regional rate and 25 percent of the Federal national rate.
- Reduce the DRG relative weights for increases in case mix based on bills submitted under the prospective payment system.

IV. Tables

This section contains the tables referred to throughout the preamble to the proposed rule and in this addendum.

TABLE 1.—ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

Region	Urban		Rural	
	Labor related	Nonlabor related	Labor related	Nonlabor related
1. New England (CT, ME, MA, NH, RI, VT)	2,463.34	671.14	2,106.13	509.17
2. Middle Atlantic (PA, NJ, NY)	2,214.44	663.25	2,096.26	516.39
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,305.84	614.61	1,896.74	429.08
4. East North Central (IL, IN, MI, OH, WI)	2,461.45	715.43	2,060.28	480.63
5. East South Central (AL, KY, MS, TN)	2,093.46	547.03	1,913.31	401.48
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2,401.03	636.44	1,922.71	412.49
7. West South Central (AR, LA, OK, TX)	2,256.85	601.98	1,852.74	400.01
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,217.46	638.98	1,920.58	448.94
9. Pacific (AK, CA, HI, OR, WA)	2,334.09	748.21	2,007.20	523.50
10. National	2,327.14	666.31	1,948.67	439.41

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM (PROPOSED 1985)

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.2762	19.4	41
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.2060	15.8	38
3	1	SURG	* CRANIOTOMY AGE <18	2.8798	12.7	35
4	1	SURG	SPINAL PROCEDURES	2.1926	16.0	38
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6387	9.8	31
6	1	SURG	CARPAL TUNNEL RELEASE	.3899	2.6	8
7	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE >69 +/OR C.C.	1.0038	5.3	27
8	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE <70 W/O C.C.	.7069	4.1	23
9	1	MED	SPINAL DISORDERS + INJURIES	1.3631	9.1	31
10	1	MED	NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR C.C.	1.2780	9.6	32
11	1	MED	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	1.2251	8.5	31
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.0875	9.4	31
13	1	MED	MULTIPLE SCLEROSIS + CEREBELLAR ATAXIA	.9912	8.9	31
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3210	9.9	32
15	1	MED	TRANSIENT ISCHEMIC ATTACKS	.6517	5.6	24
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	.8391	7.4	29
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	.8195	7.2	29
18	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE >69 AND/OR C.C.	.7729	6.6	29
19	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	.6812	5.7	28
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.2833	7.6	30
21	1	MED	* VIRAL MENINGITIS	.6153	4.5	15
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	.7685	6.4	28
23	1	MED	NONTRAUMATIC STUPOR + COMA	1.1297	5.9	28
24	1	MED	SEIZURE + HEADACHE AGE >69 AND/OR C.C.	.7108	5.6	26
25	1	MED	SEIZURE + HEADACHE AGE 18-69 W/O C.C.	.6242	4.9	25
26	1	MED	* SEIZURE + HEADACHE AGE 0-17	.4247	3.3	13
27	1	MED	* TRAUMATIC STUPOR + COMA, COMA >1 HR	1.1102	4.1	26
28	1	MED	TRAUMATIC STUPOR + COMA, COMA <1 HR AGE >69 AND/OR C.C.	1.0450	5.9	28
29	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 18-69 W/O C.C.	.7007	3.8	25
30	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 0-17	.3492	2.0	8
31	1	MED	CONCUSSION AGE >69 AND/OR C.C.	.5909	4.6	27
32	1	MED	CONCUSSION AGE 18-69 W/O C.C.	.4413	3.3	19
33	1	MED	* CONCUSSION AGE 0-17	.2425	1.6	5
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE >69 AND/OR C.C.	.9694	7.1	29
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	.8262	6.2	28
36	2	SURG	RETINAL PROCEDURES	.6927	5.0	15
37	2	SURG	ORBITAL PROCEDURES	.5498	3.4	11
38	2	SURG	PRIMARY IRIS PROCEDURES	.4224	3.0	9
39	2	SURG	LENS PROCEDURES	.4893	2.8	6
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.3884	2.4	7
41	2	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3608	1.6	4
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS + LENS	.5768	3.8	12
43	2	MED	* HYPHEMA	.3738	4.2	12
44	2	MED	ACUTE MAJOR EYE INFECTIONS	.6150	6.5	22
45	2	MED	NEUROLOGICAL EYE DISORDERS	.5509	4.3	18

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 WITH C.C.	.5824	4.1	23
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O C.C.	.4945	3.0	12
48	2	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.3965	2.9	13
49	3	SURG	MAJOR HEAD + NECK PROCEDURES	2.4678	13.6	36
50	3	SURG	SIALOADENECTOMY	.6992	4.6	14
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6545	4.2	15
52	3	SURG	* CLEFT LIP + PALATE REPAIR	.6336	3.8	11
53	3	SURG	SINUS + MASTOID PROCEDURES AGE >17	.5757	3.5	11
54	3	SURG	* SINUS + MASTOID PROCEDURES AGE 0-17	.6798	3.2	11
55	3	SURG	MISCELLANEOUS EAR, NOSE + THROAT PROCEDURES	.4056	2.5	7
56	3	SURG	RHINOPLASTY	.4047	2.8	8
57	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE >17	.5128	2.7	9
58	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE 0-17	.3057	1.5	3
59	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >17	.3073	2.0	4
60	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	.2581	1.5	3
61	3	SURG	* MYRINGOTOMY AGE >17	.4173	2.1	9
62	3	SURG	* MYRINGOTOMY AGE 0-17	.3048	1.3	3
63	3	SURG	OTHER EAR, NOSE + THROAT O.R. PROCEDURES	1.0830	5.8	28
64	3	MED	EAR, NOSE + THROAT MALIGNANCY	1.0559	5.7	28
65	3	MED	DYSEQUILIBRIUM	.4743	4.6	17
66	3	MED	EPISTAXIS	.4020	3.7	15
67	3	MED	* EPIGLOTTITIS	.6604	4.3	17
68	3	MED	OTITIS MEDIA + URI AGE >69 AND/OR C.C.	.6142	6.0	22
69	3	MED	OTITIS MEDIA + URI AGE 18-69 W/O C.C.	.5290	4.8	19
70	3	MED	* OTITIS MEDIA + URI AGE 0-17	.3610	3.1	10
71	3	MED	* LARYNGOTRACHEITIS	.3505	2.9	9
72	3	MED	NASAL TRAUMA + DEFORMITY	.4743	3.8	18
73	3	MED	OTHER EAR, NOSE + THROAT DIAGNOSES AGE >17	.5095	3.5	17
74	3	MED	* OTHER EAR, NOSE + THROAT DIAGNOSES AGE 0-17	.3382	2.1	9
75	4	SURG	MAJOR CHEST PROCEDURES	2.5434	14.4	36
76	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST WITH C.C.	1.8295	10.6	33
77	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST W/O C.C.	1.7752	9.5	32
78	4	MED	PULMONARY EMBOLISM	1.3765	10.4	32
79	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE >69 AND/OR C.C.	1.7561	11.2	33
80	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 18-69 W/O C.C.	1.7036	10.9	33
81	4	MED	* RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 0-17	.8538	6.1	28
82	4	MED	RESPIRATORY NEOPLASMS	1.1133	7.4	29
83	4	MED	MAJOR CHEST TRAUMA AGE >69 AND/OR C.C.	.9579	8.1	30
84	4	MED	* MAJOR CHEST TRAUMA AGE <70 W/O C.C.	.7557	5.3	22
85	4	MED	PLEURAL EFFUSION AGE >69 AND/OR C.C.	1.1192	8.4	30
86	4	MED	PLEURAL EFFUSION AGE <70 W/O C.C.	1.0954	7.6	30
87	4	MED	PULMONARY EDEMA + RESPIRATORY FAILURE	1.5165	7.7	30
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0168	7.5	30
89	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE >69 AND/OR C.C.	1.0771	8.5	31
90	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE 18-69 W/O C.C.	.9618	7.6	29

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM (PROPOSED 1985)

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
91	4	MED	* SIMPLE PNEUMONIA + PLEURISY AGE 0-17	.5011	4.6	14
92	4	MED	INTERSTITIAL LUNG DISEASE AGE >69 AND/OR C.C.	1.0127	7.8	30
93	4	MED	INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	.9496	6.9	29
94	4	MED	PNEUMOTHORAX AGE >69 AND/OR C.C.	1.4037	9.2	31
95	4	MED	PNEUMOTHORAX AGE <70 W/O C.C.	1.0988	7.7	30
96	4	MED	BRONCHITIS + ASTHMA AGE >69 AND/OR C.C.	.7809	6.9	24
97	4	MED	BRONCHITIS + ASTHMA AGE 18-69 W/O C.C.	.7086	6.2	21
98	4	MED	* BRONCHITIS + ASTHMA AGE 0-17	.4175	3.7	11
99	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.7847	5.5	27
100	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE <70 W/O C.C.	.7549	5.1	24
101	4	MED	OTHER RESPIRATORY DIAGNOSES AGE >69 AND/OR C.C.	.8823	6.8	29
102	4	MED	OTHER RESPIRATORY DIAGNOSES AGE <70	.8813	6.1	28
103	5	SURG	* HEART TRANSPLANT	.0000	.0	0
104	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + WITH CARDIAC CATH	6.6921	20.9	43
105	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + W/O CARDIAC CATH	5.1082	16.2	38
106	5	SURG	** CORONARY BYPASS WITH CARDIAC CATH	5.1391	20.4	42
107	5	SURG	** CORONARY BYPASS W/O CARDIAC CATH	3.8956	13.5	35
108	5	SURG	CARDIOTHOR PROC,EXCEPT VALVE + CORONARY BYPASS,WITH PUMP	4.2730	13.3	35
109	5	SURG	CARDIOTHORACIC PROCEDURES W/O PUMP	3.6097	12.1	34
110	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE >69 AND/OR C.C.	2.8641	14.3	36
111	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE <70 W/O C.C.	2.5245	13.2	35
112	5	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION	2.2949	11.2	33
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB + TOE	2.6172	21.6	44
114	5	SURG	UPPER LIMB + TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.0573	16.6	39
115	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT WITH AMI OR CHF	3.8232	15.8	38
116	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	2.7993	9.3	31
117	5	SURG	CARDIAC PACEMAKER REPLACE + REVIS EXC PULSE GEN REPL ONLY	1.7783	6.4	28
118	5	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	1.7392	4.2	18
119	5	SURG	VEIN LIGATION + STRIPPING	1.0361	7.2	29
120	5	SURG	OTHER O.R. PROCEDURES ON THE CIRCULATORY SYSTEM	2.4613	15.0	37
121	5	MED	** CIRCULATORY DISORDERS WITH AMI + C.V. COMP. DISCH. ALIVE	1.8211	11.9	34
122	5	MED	** CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.3331	9.8	32
123	5	MED	CIRCULATORY DISORDERS WITH AMI, EXPIRED	1.1094	3.1	25
124	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH + COMPLEX DIAG	2.1680	8.4	30
125	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG	1.6069	5.0	27
126	5	MED	ACUTE + SUBACUTE ENDOCARDITIS	2.6021	18.4	40
127	5	MED	HEART FAILURE + SHOCK	1.0164	7.8	30
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	.8437	9.6	28
129	5	MED	CARDIAC ARREST, UNEXPLAINED	1.5143	4.6	27
130	5	MED	PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR C.C.	.9419	7.1	29
131	5	MED	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	.9269	6.4	28
132	5	MED	ATHEROSCLEROSIS AGE >69 AND/OR C.C.	.8967	6.7	29
133	5	MED	ATHEROSCLEROSIS AGE <70 W/O C.C.	.8397	5.2	25
134	5	MED	HYPERTENSION	.6884	6.1	26
135	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE >69 AND/OR C.C.	.9689	6.1	28

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM (PROPOSED 1985)

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
136	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 18-69 W/O C.C.	.9447	4.9	27
137	5	MED	* CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 0-17	.6231	3.3	20
138	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE >69 AND/OR C.C.	.9079	5.7	27
139	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE <70 W/O C.C.	.8108	4.8	23
140	5	MED	ANGINA PECTORIS	.7371	5.5	21
141	5	MED	SYNCOPE + COLLAPSE AGE >69 AND/OR C.C.	.6323	5.0	21
142	5	MED	SYNCOPE + COLLAPSE AGE <70 W/O C.C.	.5547	4.3	18
143	5	MED	CHEST PAIN	.6654	4.4	19
144	5	MED	OTHER CIRCULATORY DIAGNOSES WITH C.C.	1.1003	7.0	29
145	5	MED	OTHER CIRCULATORY DIAGNOSES W/O C.C.	.9785	6.4	28
146	6	SURG	RECTAL RESECTION AGE >69 AND/OR C.C.	2.6447	19.1	41
147	6	SURG	RECTAL RESECTION AGE <70 W/O C.C.	2.4499	17.9	40
148	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	2.4896	17.0	39
149	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.1635	15.2	37
150	6	SURG	PERITONEAL ADHESIOLYSIS AGE >69 AND/OR C.C.	2.3189	15.3	37
151	6	SURG	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	1.9799	13.4	35
152	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	1.4503	10.6	33
153	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.2304	9.3	31
154	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE >69 AND/OR C.C.	2.6271	14.8	37
155	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 18-69 W/O C.C.	2.2789	13.0	35
156	6	SURG	* STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 0-17	.8271	6.0	20
157	6	SURG	ANAL PROCEDURES AGE >69 AND/OR C.C.	.7798	6.0	25
158	6	SURG	ANAL PROCEDURES AGE <70 W/O C.C.	.6258	5.2	19
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE >69 AND/OR C.C.	.9079	7.1	23
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE 18-69 W/O C.C.	.7496	6.0	18
161	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE >69 AND/OR C.C.	.6902	5.7	16
162	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	.5717	4.8	12
163	6	SURG	* HERNIA PROCEDURES AGE 0-17	.4256	2.1	6
164	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR C.C.	1.7891	11.9	33
165	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.5775	11.3	29
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR C.C.	1.3992	9.4	29
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.0564	7.4	22
168	6	SURG	PROCEDURES ON THE MOUTH AGE >69 AND/OR C.C.	.8429	4.3	25
169	6	SURG	PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	.8781	4.2	26
170	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE >69 AND/OR C.C.	2.5979	14.6	37
171	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE <70 W/O C.C.	2.3414	13.3	35
172	6	MED	DIGESTIVE MALIGNANCY AGE >69 AND/OR C.C.	1.1980	8.2	30
173	6	MED	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	1.0271	6.7	29
174	6	MED	G.I. HEMORRHAGE AGE >69 AND/OR C.C.	.9063	6.7	29
175	6	MED	G.I. HEMORRHAGE AGE <70 W/O C.C.	.8043	5.8	24
176	6	MED	COMPLICATED PEPTIC ULCER	1.2146	8.1	30
177	6	MED	UNCOMPLICATED PEPTIC ULCER >69 AND/OR C.C.	.7248	6.6	24
178	6	MED	UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	.5997	5.5	20
179	6	MED	INFLAMMATORY BOWEL DISEASE	.9915	8.0	30
180	6	MED	G.I. OBSTRUCTION AGE >69 AND/OR C.C.	.8005	6.2	28

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
181	6	MED	G.I. OBSTRUCTION AGE <70 W/O C.C.	.7661	5.9	28
182	6	MED	ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE >69 +/OR C.C.	.6040	5.4	22
183	6	MED	ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE 18-69 W/O C.C.	.5520	4.8	19
184	6	MED	* ESOPHAGITIS, GASTROENTERITIS + MISC. DIGEST. DISORDERS AGE 0-17	.3732	3.3	11
185	6	MED	DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE >17	.6524	4.2	26
186	6	MED	* DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE 0-17	.4058	2.9	11
187	6	MED	DENTAL EXTRACTIONS + RESTORATIONS	.3896	2.7	8
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR C.C.	.7270	5.1	27
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	.6422	4.5	23
190	6	MED	* OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.3300	2.1	8
191	7	SURG	MAJOR PANCREAS, LIVER + SHUNT PROCEDURES	4.0812	20.8	43
192	7	SURG	* MINOR PANCREAS, LIVER + SHUNT PROCEDURES	3.8278	20.1	42
193	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 +/OR C.C.	2.3938	17.3	39
194	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	1.9415	13.9	36
195	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR C.C.	2.1162	16.0	38
196	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	2.0111	15.8	38
197	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR C.C.	1.4520	11.5	29
198	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.2453	10.1	24
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3998	17.9	40
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.5213	15.1	37
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.6651	16.9	39
202	7	MED	CIRRHOSIS + ALCOHOLIC HEPATITIS	1.1685	9.3	31
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0681	8.0	30
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	.9455	7.5	30
205	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR C.C.	1.0568	7.9	30
206	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C.	.9030	6.8	29
207	7	MED	DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR C.C.	.8293	6.6	28
208	7	MED	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	.7144	5.5	24
209	8	SURG	MAJOR JOINT PROCEDURES	2.2375	17.1	39
210	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR C.C.	2.0345	17.8	40
211	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.9072	15.9	38
212	8	SURG	* HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.6730	11.1	33
213	8	SURG	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM + CONN. TISSUE DISORDERS	2.0815	14.3	36
214	8	SURG	BACK + NECK PROCEDURES AGE >69 AND/OR C.C.	1.7995	15.6	38
215	8	SURG	BACK + NECK PROCEDURES AGE <70 W/O C.C.	1.4570	13.0	35
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.5230	11.3	33
217	8	SURG	WND DEBRID + SKN GRFT EXC HAND,FOR MUSCSKELETAL + CONN.TISS.DIS	2.2289	13.1	35
218	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 +/OR C.C.	1.3916	10.9	33
219	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C.	1.0537	8.3	27
220	8	SURG	* LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	.9120	5.3	25
221	8	SURG	KNEE PROCEDURES AGE >69 AND/OR C.C.	1.2429	8.3	30
222	8	SURG	KNEE PROCEDURES AGE <70 W/O C.C.	.9665	6.4	28
223	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE >69 AND/OR C.C.	1.0472	6.9	29
224	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE <70 W/O C.C.	.8742	5.6	24
225	8	SURG	FOOT PROCEDURES	.6324	4.8	15

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
226	8	SURG	SOFT TISSUE PROCEDURES AGE >69 AND/OR C.C.	.7797	5.1	27
227	8	SURG	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	.6188	4.2	18
228	8	SURG	GANGLION (HAND) PROCEDURES	.3541	2.2	7
229	8	SURG	HAND PROCEDURES EXCEPT GANGLION	.5857	3.4	14
230	8	SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES OF HIP + FEMUR	1.3275	8.9	31
231	8	SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES EXCEPT HIP + FEMUR	.9296	5.3	27
232	8	SURG	ARTHROSCOPY	.5921	3.6	15
233	8	SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE >69 +/OR C.C.	1.7321	13.1	35
234	8	SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE <70 W/O C.C.	1.2162	8.2	30
235	8	MED	FRACTURES OF FEMUR	1.7174	13.6	36
236	8	MED	FRACTURES OF HIP + PELVIS	1.3530	11.9	34
237	8	MED	SPRAINS, STRAINS, + DISLOCATIONS OF HIP, PELVIS + THIGH	.7743	6.4	28
238	8	MED	OSTEOMYELITIS	1.5147	12.3	34
239	8	MED	PATHOLOGICAL FRACTURES + MUSCULOSKELETAL + CONN.TISS.MALIGNANCY	1.0722	9.2	31
240	8	MED	CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR C.C.	.9481	8.6	31
241	8	MED	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	.8836	8.0	30
242	8	MED	SEPTIC ARTHRITIS	1.5508	11.2	33
243	8	MED	MEDICAL BACK PROBLEMS	.7374	7.5	30
244	8	MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE >69 AND/OR C.C.	.7609	7.5	30
245	8	MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE <70 W/O C.C.	.7009	6.3	28
246	8	MED	NON-SPECIFIC ARTHROPATHIES	.6979	6.8	28
247	8	MED	SIGNS + SYMPTOMS OF MUSCULOSKELETAL SYSTEM + CONN TISSUE	.6405	5.8	27
248	8	MED	TENDONITIS, MYOSITIS + BURSITIS	.5992	5.4	24
249	8	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	.9964	7.6	30
250	8	MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE >69 +/OR C.C.	.7254	6.0	28
251	8	MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C.	.5824	4.2	26
252	8	MED	* FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 0-17	.3450	1.8	7
253	8	MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE >69 +/OR C.C.	.7291	6.6	29
254	8	MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C.	.6111	5.3	27
255	8	MED	* FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4577	2.9	15
256	8	MED	OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	.8502	6.5	29
257	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.0825	9.3	23
258	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	1.0478	8.9	21
259	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	.9903	7.4	29
260	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70	.9106	6.4	27
261	9	SURG	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY + LOC EXC	.7157	4.8	19
262	9	SURG	BREAST BIOPSY + LOCAL EXCISION FOR NON-MALIGNANCY	.4509	3.0	10
263	9	SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE >69 AND/OR C.C.	2.4157	21.3	43
264	9	SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE <70 W/O C.C.	2.1515	18.2	40
265	9	SURG	* SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS WITH C.C.	1.4608	8.6	31
266	9	SURG	SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS W/O C.C.	.9263	5.9	28
267	9	SURG	PERIANAL + PILONIDAL PROCEDURES	.5970	5.0	18
268	9	SURG	SKIN,SUBCUTANEOUS TISSUE + BREAST PLASTIC PROCEDURES	.5262	3.0	15
269	9	SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE >69 +/OR C.C.	.9714	5.7	28
270	9	SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE <70 W/O C.C.	.7933	4.5	27

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM (PROPOSED 1985)

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
271	9	MED	SKIN ULCERS	1.3479	12.1	34
272	9	MED	MAJOR SKIN DISORDERS AGE >69 AND/OR C.C.	.8418	7.8	30
273	9	MED	MAJOR SKIN DISORDERS AGE <70 W/O C.C.	.8092	7.3	29
274	9	MED	MALIGNANT BREAST DISORDERS AGE >69 AND/OR C.C.	.9871	7.5	30
275	9	MED	MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	.8803	6.4	28
276	9	MED	NON-MALIGANT BREAST DISORDERS	.5924	4.2	22
277	9	MED	CELLULITIS AGE >69 AND/OR C.C.	.8655	8.3	30
278	9	MED	CELLULITIS AGE 18-69 W/O C.C.	.7906	7.2	29
279	9	MED	* CELLULITIS AGE 0-17	.4677	4.2	13
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE >69 +/OR C.C.	.6056	5.4	27
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 18-69 W/O C.C.	.5251	4.2	23
282	9	MED	* TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 0-17	.3379	2.2	9
283	9	MED	MINOR SKIN DISORDERS AGE >69 AND/OR C.C.	.6244	5.3	27
284	9	MED	MINOR SKIN DISORDERS AGE <70 W/O C.C.	.5831	4.4	24
285	10	SURG	AMPUTATIONS FOR ENDOCRINE,NUTRITIONAL + METABOLIC DISORDERS	2.7986	24.0	46
286	10	SURG	* ADRENAL + PITUITARY PROCEDURES	2.8273	16.1	38
287	10	SURG	SKIN GRAFTS + WOUND DEBRIDE FOR ENDOC,NUTRIT + METAB DISORDERS	2.7483	22.8	45
288	10	SURG	* O.R. PROCEDURES FOR OBESITY	1.5327	10.0	24
289	10	SURG	PARATHYROID PROCEDURES	1.3414	8.3	29
290	10	SURG	THYROID PROCEDURES	.8349	6.0	17
291	10	SURG	* THYROGLOSSAL PROCEDURES	.4794	2.9	8
292	10	SURG	OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE > 69 +/OR C.C.	1.9831	10.8	33
293	10	SURG	* OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE <70 W/O C.C.	1.4601	8.0	30
294	10	MED	DIABETES AGE =>36	.7897	7.7	30
295	10	MED	DIABETES AGE 0-35	.7282	5.6	26
296	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE >69 AND/OR C.C.	.8769	7.3	29
297	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	.7737	6.0	28
298	10	MED	* NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 0-17	.7361	5.4	26
299	10	MED	INBORN ERRORS OF METABOLISM	.9187	6.8	29
300	10	MED	ENDOCRINE DISORDERS AGE >69 AND/OR C.C.	.9503	7.8	30
301	10	MED	ENDOCRINE DISORDERS AGE <70 W/O C.C.	.7952	6.4	28
302	11	SURG	KIDNEY TRANSPLANT	4.1288	24.1	46
303	11	SURG	KIDNEY,URETER + MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.4802	16.2	38
304	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE >69 +/OR C.C.	1.7531	12.8	35
305	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE <70 W/O C.C.	1.6644	11.9	34
306	11	SURG	PROSTATECTOMY AGE >69 AND/OR C.C.	1.1132	8.6	30
307	11	SURG	PROSTATECTOMY AGE <70 W/O C.C.	.9290	7.2	26
308	11	SURG	MINOR BLADDER PROCEDURES AGE >69 AND/OR C.C.	1.0196	7.1	29
309	11	SURG	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	.9072	5.7	28
310	11	SURG	TRANSURETHRAL PROCEDURES AGE >69 AND/OR C.C.	.6905	4.9	20
311	11	SURG	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	.5733	4.1	15
312	11	SURG	URETHRAL PROCEDURES, AGE >69 AND/OR C.C.	.7250	5.2	22
313	11	SURG	URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	.6735	5.1	21
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4266	2.3	11
315	11	SURG	OTHER KIDNEY + URINARY TRACT O.R. PROCEDURES	2.4301	9.8	32

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED	RENAL FAILURE	1.3002	6.7	29
317	11	MED	* ADMIT FOR RENAL DIALYSIS	.2329	1.2	3
318	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE >69 AND/OR C.C.	.8928	5.5	28
319	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	.7756	4.2	26
320	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE >69 AND/OR C.C.	.7933	7.0	29
321	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	.6644	5.6	23
322	11	MED	* KIDNEY + URINARY TRACT INFECTIONS AGE 0-17	.4446	3.7	13
323	11	MED	URINARY STONES AGE >69 AND/OR C.C.	.6964	4.9	26
324	11	MED	URINARY STONES AGE <70 W/O C.C.	.5344	3.9	19
325	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.7077	5.4	27
326	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 18-69 W/O C.C.	.5737	4.3	21
327	11	MED	* KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 0-17	.4909	3.1	14
328	11	MED	URETHRAL STRICTURE AGE >69 AND/OR C.C.	.6355	4.8	22
329	11	MED	URETHRAL STRICTURE AGE 18-69 W/O C.C.	.5201	3.9	17
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2751	1.6	5
331	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE >69 AND/OR C.C.	.8710	6.3	28
332	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	.7581	5.0	27
333	11	MED	* OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 0-17	.5025	3.2	18
334	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH C.C.	1.5246	12.7	30
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.3271	11.8	29
336	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR C.C.	.9843	8.4	22
337	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	.8292	7.2	17
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.8856	6.3	28
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANT AGE >17	.5950	4.5	15
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	.4278	2.4	7
341	12	SURG	PENIS PROCEDURES	.9749	6.0	23
342	12	SURG	CIRCUMCISION AGE >17	.4129	2.8	10
343	12	SURG	* CIRCUMCISION AGE 0-17	.3738	1.7	4
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0941	7.4	29
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	.8139	5.6	27
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR C.C.	.9175	6.9	29
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O C.C.	.8109	5.7	28
348	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR C.C.	.8656	6.2	28
349	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	.6834	4.9	22
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.5953	5.2	20
351	12	MED	* STERILIZATION, MALE	.2593	1.3	3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6235	4.4	20
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY + VULVECTOMY	1.8922	12.4	34
354	13	SURG	NON-RADICAL HYSTERECTOMY AGE >69 AND/OR C.C.	1.0848	9.6	20
355	13	SURG	NON-RADICAL HYSTERECTOMY AGE <70 W/O C.C.	.9918	8.8	17
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.8262	8.1	18
357	13	SURG	UTERUS + ADENEXA PROCEDURES, FOR MALIGNANCY	1.8738	13.9	36
358	13	SURG	UTERUS + ADENEXA PROC FOR NON-MALIGNANCY EXCEPT TUBAL INTERRUPT	1.0635	8.0	30
359	13	SURG	* TUBAL INTERRUPTION FOR NON-MALIGNANCY	.4179	2.3	7
360	13	SURG	VAGINA, CERVIX + VULVA PROCEDURES	.5845	4.2	19

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
361	13	SURG	* LAPAROSCOPY + ENDOSCOPY (FEMALE) EXCEPT TUBAL INTERRUPTION	.4750	2.6	10
362	13	SURG	* LAPAROSCOPIC TUBAL INTERRUPTION	.3053	1.4	3
363	13	SURG	D+C,CONIZATION + RADIO-IMPLANT, FOR MALIGNANCY	.6363	4.3	18
364	13	SURG	D+C,CONIZATION EXCEPT FOR MALIGNANCY	.3934	2.6	9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7544	12.7	35
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR C.C.	.8246	5.2	27
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	.5650	3.5	24
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.7758	6.7	29
369	13	MED	MENSTRUAL + OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.6796	5.1	27
370	14	SURG	* CESAREAN SECTION WITH C.C.	.9680	7.6	15
371	14	SURG	* CESAREAN SECTION W/O C.C.	.7358	6.1	10
372	14	MED	* VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	.5404	3.8	9
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3968	3.2	9
374	14	SURG	* VAGINAL DELIVERY WITH STERILIZATION AND/OR D+C	.5363	3.6	7
375	14	SURG	* VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D+C	.6728	4.4	15
376	14	MED	* POSTPARTUM DIAGNOSES W/O O.R. PROCEDURE	.4061	2.9	10
377	14	SURG	* POSTPARTUM DIAGNOSES WITH O.R. PROCEDURE	.4649	2.2	8
378	14	MED	* ECTOPIC PREGNANCY	.7904	5.5	11
379	14	MED	* THREATENED ABORTION	.3095	2.2	8
380	14	MED	* ABORTION W/O D+C	.2642	1.5	4
381	14	MED	* ABORTION WITH D+C	.3518	1.4	4
382	14	MED	* FALSE LABOR	.1799	1.2	2
383	14	MED	* OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	.4216	3.4	14
384	14	MED	* OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3169	2.2	9
385	15		* NEONATES, DIED OR TRANSFERRED	.6722	1.8	14
386	15		* EXTREME IMMATURITY, NEONATE	3.5999	17.9	40
387	15		** PREMATURITY WITH MAJOR PROBLEMS	1.8026	13.3	35
388	15		** PREMATURITY W/O MAJOR PROBLEMS	1.1419	8.6	31
389	15		* FULL TERM NEONATE WITH MAJOR PROBLEMS	.5354	4.7	16
390	15		* NEONATES WITH OTHER SIGNIFICANT PROBLEMS	.3440	3.4	9
391	15		* NORMAL NEWBORNS	.2188	3.1	7
392	16	SURG	SPLENECTOMY AGE >17	2.7096	16.4	38
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5006	9.1	31
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD + BLOOD FORMING ORGANS	1.0885	6.1	28
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7655	6.1	28
396	16	MED	* RED BLOOD CELL DISORDERS AGE 0-17	.6147	4.1	18
397	16	MED	COAGULATION DISORDERS	.9632	6.7	29
398	16	MED	RETICULOENDOTHELIAL + IMMUNITY DISORDERS AGE >69 AND/OR C.C.	.8691	6.1	28
399	16	MED	RETICULOENDOTHELIAL + IMMUNITY DISORDERS AGE <70 W/O C.C.	.8261	5.6	28
400	17	SURG	LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	2.7609	16.9	39
401	17	SURG	LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROC AGE >69 AND/OR C.C.	1.2118	8.9	31
402	17	SURG	* LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROCEDURE AGE <70 W/O C.C.	1.1051	7.1	29
403	17	MED	LYMPHOMA OR LEUKEMIA AGE >69 AND/OR C.C.	1.1440	7.1	29
404	17	MED	LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C.	1.1511	6.4	28
405	17	MED	* LYMPHOMA OR LEUKEMIA AGE 0-17	1.0271	4.9	27

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC + C.C.	2.2140	15.0	37
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	2.0865	13.3	35
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH MINOR O.R.PROC	1.1122	7.1	29
409	17	MED	* RADIOTHERAPY	.7943	5.7	28
410	17	MED	CHEMOTHERAPY	.3444	2.6	12
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.7052	4.7	27
412	17	MED	HISTORY OF MALIGNANCY WITH ENDOSCOPY	.3320	2.0	8
413	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE>69 +/OR C.C	1.0718	7.3	29
414	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O C.C.	1.0116	6.4	28
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS + PARASITIC DISEASES	2.9323	15.1	37
416	18	MED	SEPTECEMIA AGE >17	1.5141	9.2	31
417	18	MED	* SEPTECEMIA AGE 0-17	.6984	5.2	20
418	18	MED	POSTOPERATIVE + POST-TRAUMATIC INFECTIONS	.9734	8.4	30
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR C.C.	.8426	6.9	29
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	.7834	6.2	26
421	18	MED	VIRAL ILLNESS AGE >17	.5903	5.4	21
422	18	MED	* VIRAL ILLNESS + FEVER OF UNKNOWN ORIGIN AGE 0-17	.4258	3.2	10
423	18	MED	OTHER INFECTIOUS + PARASITIC DISEASES DIAGNOSES	1.1823	8.8	31
424	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	2.1424	14.2	36
425	19	MED	ACUTE ADJUST REACT + DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6652	5.8	28
426	19	MED	DEPRESSIVE NEUROSES	.9272	9.4	31
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.7498	6.9	29
428	19	MED	DISORDERS OF PERSONALITY + IMPULSE CONTROL	.9513	8.3	30
429	19	MED	ORGANIC DISTURBANCES + MENTAL RETARDATION	.9300	8.8	31
430	19	MED	PSYCHOSES	1.0678	10.8	33
431	19	MED	* CHILDHOOD MENTAL DISORDERS	2.1991	15.4	37
432	19	MED	* OTHER DIAGNOSES OF MENTAL DISORDERS	1.0278	7.2	29
433	20		** SUBSTANCE USE + SUBST INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	.4353	2.5	17
434	20		** DRUG DEPENDENCE	1.0160	9.1	31
435	20		** DRUG USE EXCEPT DEPENDENCE	1.0486	8.0	30
436	20		** ALCOHOL DEPENDENCE	.8646	8.1	30
437	20		** ALCOHOL USE EXCEPT DEPENDENCE	.6038	3.5	26
438	20		** ALCOHOL + SUBSTANCE INDUCED ORGANIC MENTAL SYNDROME	.8223	6.9	29
439	21	SURG	* SKIN GRAFTS FOR INJURIES	1.7792	8.9	31
440	21	SURG	* WOUND DEBRIDEMENTS FOR INJURIES	1.4460	7.2	29
441	21	SURG	* HAND PROCEDURES FOR INJURIES	.7012	3.0	16
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR C.C.	1.8580	9.1	31
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.4854	6.6	29
444	21	MED	MULTIPLE TRAUMA AGE >69 AND/OR C.C.	.8623	6.7	29
445	21	MED	MULTIPLE TRAUMA AGE 18-69 W/O C.C.	.7354	5.2	27
446	21	MED	* MULTIPLE TRAUMA AGE 0-17	.4732	2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4673	3.7	19
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3423	2.9	9
449	21	MED	TOXIC EFFECTS OF DRUGS AGE >69 AND/OR C.C.	.7159	5.6	28
450	21	MED	TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	.5817	3.9	23

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
451	21	MED	* TOXIC EFFECTS OF DRUGS AGE 0-17	.2844	2.1	8
452	21	MED	COMPLICATIONS OF TREATMENT AGE >69 AND/OR C.C.	.8293	5.5	28
453	21	MED	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	.8809	5.1	27
454	21	MED	OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE >69 AND/OR C.C.	.8031	5.3	27
455	21	MED	* OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE <70 W/O C.C.	.6040	3.5	22
456	22		** BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	2.0412	11.6	34
457	22		** EXTENSIVE BURNS	6.7022	12.6	35
458	22	SURG	** NON-EXTENSIVE BURNS WITH SKIN GRAFTS	2.7902	18.3	40
459	22	SURG	** NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT + OTHER O.R. PROC	2.6922	12.7	35
460	22	MED	** NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.3892	9.0	31
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.6120	8.0	30
462	23	MED	* REHABILITATION	1.7840	13.5	36
463	23	MED	SIGNS + SYMPTOMS WITH C.C.	.7521	6.3	28
464	23	MED	SIGNS + SYMPTOMS W/O C.C.	.7150	6.0	28
465	23	MED	** AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	.2022	1.5	4
466	23	MED	** AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	.6228	3.7	26
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.9569	6.1	28
468			UNRELATED OR PROCEDURE	2.0544	11.2	33
469			***PDX INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	0
470			***UNGROUPABLE	.0000	.0	0

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRG CATEGORIES COMBINED (IN PAIRS) IN THE CALCULATION OF THE CASE MIX INDEX.
*** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

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V. Technical Explanation of the Budget Neutrality Adjustment Methodology

A. Overview

Section 1886(e)(1) of the Act requires that, for FYs 84 and 85, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for FYs 84 and 85. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.

In determining the amount of the budget neutrality adjustment factors, we have considered all hospital costs, including pass-through costs such as capital-related and direct medical education costs.

However, it should be noted that the *aggregate payments* that will be adjusted to be budget neutral do not include payment for capital-related costs or direct medical education costs, payments for hospital and distinct part unit services excluded from the prospective payment system, payment of a return on equity capital, or payments on a reasonable cost basis to hospitals under the prospective payment system for outpatient services.

For payments in FY 85, we must take into consideration two situations that did not affect the determination of budget neutrality adjustments for payments in FY 84. First, effective October 1, 1984, the Federal rate will be a blend of national and regional rates. As a result, we must compute separate estimated per discharge payments for Federal national and regional rates, separate outlier adjustments for those rates, and a budget neutrality adjustment factor for each Federal rate. In addition, during FY 85 each hospital will experience a change in the blending ratio of its transition payment rates as it enters the cost reporting period beginning on or after October 1, 1984. For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, the transition payment rate is a blend of 75 percent hospital-specific rates and 25 percent Federal rates.

For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, the blend is 50 percent hospital-specific rates and 50 percent Federal rates. These facts must be reflected at several different points in the methodology, as discussed below.

The budget neutrality adjustments required by the statute are determined by comparing an estimate of FY 85 reimbursement per discharge, as it would have been under the law in effect prior to enactment of Pub. L. 98–21, with estimates of DRG-related payments per discharge under both regional and national Federal rates (including outlier payments, and payments for the indirect costs of medical education, before budget neutrality adjustment) and with an estimate of the hospital-specific payments per discharge (before budget neutrality adjustment). Therefore, payment under each of the four systems (reasonable cost reimbursement, Federal regional rates, Federal national rates, and hospital-specific rates) must be estimated separately.

Based on the estimates of projected payments under all four systems, we must derive three budget neutrality adjustment factors for FY 85. The first such factor will be applied in computing Federal regional rates for FY 85. The second budget neutrality adjustment factor will be applied in computing Federal national rates for FY 85. The third budget neutrality adjustment factor will be applied in computing the updating factors used to determine the hospital-specific portion of transition payment rates for cost reporting periods beginning during FY 85.

Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred had the prior legislation remained in effect. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, if admissions were to increase under prospective payment beyond the level that would have occurred under prior law, that would have to be considered in the adjustment. However, since we have observed no increase in admissions beyond the level that would have occurred under prior law, we are making no adjustment for admission levels.

B. Assumption and Data

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. If TEFRA had remained in effect, the DRG-adjusted limit on per case costs would have been set at 115 percent of the mean for cost reporting periods beginning in FY 84, and at 110 percent of the mean for cost reporting periods beginning in FY 85. Further, although a hospital that had allowable costs in excess of its rate of increase target amount could expect to be paid for 25 percent of those costs for a cost reporting period beginning in FY 83 of 84, it would be paid no more than its target amount per case for its cost reporting period beginning in FY 85.

Due to the TEFRA per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. In developing the budget neutrality adjustment factors for the first year under prospective payment, we assumed that the number of admissions under both prior law and the prospective payment system will be the same. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the four systems, and there is no need to estimate an actual number of hospital admissions.

Most hospitals have cost reporting periods beginning and ending on dates that do not coincide with the beginning and ending of Federal fiscal years. Further, at the beginning of a hospital's second cost reporting peiod under the prospective payment system, the blend between the hospital-specific and Federal portions of the hospital's transition payment rate changes, and the hospital's hospital-specific rate is updated using the most recent updating factor (see section II. D.1.b. in this Addendum). As a result, during FY 85, most hospitals will have two separate hospital-specific rates and two separate blends of Federal and hospital-specific rates. (The Federal rate blend of regional and national portions changes at the beginning of FY 85, not at the beginning of hospital cost-reporting periods, and is therefore constant throughout FY 85.)

To properly allocate the various payment rates, we developed a distribution of discharges that accounts for:

- The proportion of discharges that occur on or after the beginning of FY 85

(October 1, 1984) and on or before the end date of the hospital's cost reporting period; and

• The complementary proportion of discharges that occur on or after the beginning date of the hospital's new cost reporting period and on or before the end of the Federal fiscal year (September 30, 1985).

This distribution, which was developed from the March 1983 update of the 1982 discharge notice file, was applied to the number of discharges in the hospital's 1981 data. This procedure properly weights the relative sizes of hospitals and cost reporting period distributions for computing payments per discharge.

Since the prospective payment system is to be budget neutral for included hospitals, and since the prospective payment system will not change payments to hospitals that are excluded from that system, excluded hospitals were removed from the estimates (for example, long term care, psychiatric, and children's hospitals). Further, four States (Maryland, Massachusetts, New Jersey, and New York) currently operate alternative reimbursement systems under Medicare waivers. Since payment amounts in these States will not change because of the prospective payment system, hospitals in these States were removed from the estimation of payment per discharge under each of the systems for purposes of determining budget neutrality.

We also assumed that the means of affording exceptions or special treatment for sole community hospitals under different systems would provide comparable relief to those relatively few hospitals that qualify for such exceptions and treatment. Since the amounts of special payments to these hospitals are assumed to be the same under all four systems, the budget neutrality determination is not affected by these payments. Therefore, we did not make explicit allowance for additional payments to these hospitals in our estimates and comparisons.

Section 1886(e)(1) of the Act requires that total payments under the Federal systems and under the hospital-specific rate system be the same as total payments that would have been payable under provisions of the prior law (that is the limits that would have been implemented under provisions of TEFRA for FY 85). To achieve this we have equalized the amounts payable under the Federal rates (both regional and national) and hospital-specific rate systems with those that would have been payable on a periodic basis under TEFRA, not with the total end-of-year cash amounts. As a result, changes of cash flow, timing of payments, and retroactive payments will not affect the budget neutrality determination.

Operating costs are defined differently under the different systems. We excluded malpractice costs and kidney acquisition costs from operating costs under the TEFRA limits. However, both Federal rate systems and the hospital-specific rate system exclude the same kidney acquisition costs but include malpractice costs under operating costs. We must use a method of comparing costs that takes into account "the payment amounts which would have been payable for such services for those same hospitals", as required under section 1886(e)(1)(A)(ii) of the Act. The actual amounts paid are comparable only if we include both operating and nonoperating costs. Therefore, if we were to compare only the operating costs of the different payment systems we would not fulfill the statutory requirement. Hence, nonoperating costs (excluding payments to proprietary hospitals for a return on equity capital) must also be included in the calculation of the budget neutrality adjustment factors.

By using total costs, including nonoperating costs, in the comparisons necessary to determine budget neutrality adjustments, we will ensure that the amounts considered under both Federal rate systems and the hospital-specific rate system are comparable to amounts payable under prior law.

These comparisons will yield adjustments reflecting differences between the systems in a way that prevents distortions by differing definitions of operating costs. The nonoperating costs per discharge were computed using data from the same cost reports and the same increase assumptions as for operating costs. hence, any inaccuracies in nonoperating cost assumptions would also affect the operating cost estimates in the same manner, so that the effect on the budget neutral factors would be negligible. Further, only the *difference between prospective payment nonoperating costs and TEFRA nonoperating costs affects the budget neutrality factor. Since the difference is extremely small, the impact of any inaccuracies is minimal.*

The equations below illustrate that comparing total costs in determining budget neutrality adjustments produces results identical to those that would have been produced using only operating costs under the Federal national rate system and comparable costs under the TEFRA system.

Cost Components under Federal rate and TEFRA systems

Federal national rate × budget neutral factor = TEFRA operating costs + Malpractice costs

Federal national rate × budget neutral factor + (kidney acquisition costs capital costs + direct medical education costs) = TEFRA operating costs + (Malpractice costs + capital costs + kidney acquisition costs + direct medical education costs)

Federal national rate × budget neutral factor + Federal system nonoperating costs = TEFRA operating costs + TEFRA nonoperating costs

The analysis is identical for the Federal regional rate system and the hospital-specific rate system. Note that payments for a return on equity (which are not classified as operating costs) are excluded from the equations. Since the amounts for return on equity differ among the systems, adding in return on equity would unbalance the equations. (Under prior law, which must be reflected in the TEFRA estimates, the rate of return was set at 1.5 times the Hospital Insurance Trust Fund interest rates, whereas under Pub. L. 98–21 the rate of return applicable to the costs related to inpatient hospital services was reduced to 1.0 times that rate.)

C. Estimated Payment Per Discharge Under Prior Law (TEFRA Limits)

To estimate payment per discharge under prior law, the TEFRA limits that would have been published must first be determined. These limits are calculated in the same manner as the FY 83 limits, except that more recently available data (that is, 1981 cost report and billing data) are used, and the FY 84 and 85 limits are set at 115 and 110 percent of the mean, respectively, instead of 120 percent of the mean, in accordance with section 1886(a)(1)(A)(ii) of the Act. In addition, for cost reporting periods beginning in FY 85, we would have discontinued payment of 25 percent of the excess costs over a hospital's target amount. The FY 84 limits are computed using the same cost per discharge assumptions and market basket increase published on January 3, 1984. Since the FY 84 limits would have been promulgated by October 1, 1983 under the prior law, they must be computed using data and assumptions comparable to what would have been available at the time of issuance, rather than data or assumptions developed subsequently.

Both FY 1984 and 1985 limits were increased by 0.1326 percent to account for the shift to Part A of the cost of certain services furnished by physicians

to providers as a result of the regulation on payment for those physicians' services published March 2, 1983. (These rules implement section 1887 of the Act, established by section 108 of TEFRA. (48 FR 8902; 42 CFR 405.480 through 405.482, and 405.550 through 405.556.))

To estimate payment per discharge under the TEFRA limits, cost per discharge must be estimated for each hospital and compared to the costs allowable under the TEFRA limits, that is, DRG-adjusted cost per case limits on inpatient operating costs and the separate limit on the rate of increase of those costs. Since the rate of increase target rate percentage is less than the average rate of increase in hospital costs, comparison of the rate of increase target rate percentage to the average rate of increase in hospital costs would lead to the conclusion that all hospitals would be penalized by the rate of increase limit and that no hospital would receive a bonus. To overcome this erroneous conclusion, the rate of increase target must be compared to cost increases that vary by hospital.

Under section 1886(b)(1) of the Act, a hospital that has per case costs less than its target amount would be paid a bonus of 50 percent of the amount by which the target amount exceeds its cost, or five percent of its target amount, whichever is less. Alternatively, a hospital that has costs in excess of its target amount for any cost reporting periods beginning in FY 1983 or 1984 would be paid only 25 percent of its costs in excess of the target amount. However, such a hospital would be paid no more than its target amount per discharge for any cost reporting period beginning on or after October 1, 1984.

Hospital cost per discharge data for cost report years 1978, 1979, 1980, and 1981 were analyzed for patterns in rates of increase in costs per discharge. Since the second year of TEFRA uses a two-year rate of increase target over the hospital's base year, and the third year uses a three-year rate of increase target, we analyzed both two-year and three-year rates of increases.

We developed two empirical distributions covering two-year periods of hospitals' percentage rates of cost increase from the available data for 1978 to 1981, inclusive. The means of the two distributions differed, but, for both distributions, the best-fit normal distribution had a standard deviation of 12 percent. In addition, for both cases the standard error of the fit was less than 0.2 percent. Hence, both empirical distributions showed a close fit to normal distribution. In addition, their standard deviations were equal, even though the means were different. Similarly, we found that a normal distribution with a standard deviation of 17 percent closely approximated the three-year rate of increase distribution.

To compute a hospital's cost per discharge for comparison to the hospital's TEFRA rate-of-increase target amount, the hospital's base year costs were increased by a randomly determined factor. For cost reporting periods beginning in FY 84 this factor was computed by adding the estimated two-year average rate of increase in cost per case to a random number. This random number is generated from a statistical distribution that is normal with a mean of zero, and has a standard deviation of 12 percent. For cost reporting periods beginning in FY 85, the factor was computed by adding the estimnated three-year average rate of increase to a random number generated from the normal distribution with a mean of zero and a standard deviation of 17 percent. In all cases, the random numbers were restricted so that none were further than three standard deviations from the mean. This randomly determined cost per admission for a hospital was compared to the rate of increase limit target amount for determining the reimbursement per discharge under TEFRA. Because of the randomizing process, not all hospitals are shown to be penalized by the target. Hospitals with cost per case over the target amount for reporting periods beginning in FY 84 are shown as receiving one quarter of their excess costs over that limit. Hospitals with costs over the target amount for periods beginning in FY 85 are shown as receiving no more than the limits. For purposes of this estimate, payments to those hospitals assigned rates of increase that would result in bonus payments are affected by cost reporting period beginning dates only in relation to the applicable target rate percentage, since the method for determining the amount of bonus payments does not change. To measure the overall stability, the model was tested with ten different sets of random numbers and found to be stable.

The cost per discharge that is compared to the TEFRA limits was adjusted by 0.1326 percent before comparison to the TEFRA limits to account for the shift of certain types of costs to Part A of Medicare because of the regulations on payment for physician's services to patients and providers, published March 2, 1983 and referred to above. Since this adjustment increases the costs of hospitals below the limits, it will have the effect of raising slightly the estimate of TEFRA payment per discharge.

D. Estimated Payment on a Federal Rate (DRG) Basis

The estimated payments per discharge based on DRG-related payments (that is, Federal rates plus outlier payments) were computed separately for national and regional Federal rates and were estimated by directly using the appropriate national or regional adjusted average standardized amounts, adjusted by the applicable wage index, cost of living adjustment (for hospitals in Alaska and Hawaii), and case mix for each hospital. Additional outlier payments were computd using each hospital's historical experience in the MEDPAR files. The payment amounts were further adjusted to include the indirect costs of medical education.

Before the ratios of estimated DRG-related payments to the estimated payments under prior law are computed, we made adjustments to reflect the provisions of these proposed regulations and certain changes of circumstances. These adjustments take into account:

- The difference in case mix between cases actually reported under the prospective payment system and the 1981 MEDPAR file;
- Payment for transfer cases at less than the full DRG-related payment rate;
- The proposal to pay hospitals located in MSAs that cross census division (regional) boundaries based on the regional rate of the region in which most of the hospitals are located;
- The proposal for payment of hospitals reclassified from urban to rural by the EOMB MSA redesignation; and
- The projected increased number of rural referral centers expected to meet the new criteria.

To adjust for the latest case-mix data, we increased the estimated regional and national payment rates by 5.85 percent. This increase reflects the difference between the mix of cases in the 1981 MEDPAR file and the mix of cases actually reported under the prospective payment system. The derivation of this factor is discussed earlier in the addendum. Since the relative weight for each DRG was reduced by 2.4 percent, as described earlier in the addendum, this 5.85 percent adjustment is actually split between the 2.4 percent adjustment in the DRG relative weights, and the 3.38 percent case mix increase factor we developed for the FY 84 Federal rates.

In order to take the level of payment for transfer cases into account, we computed the transfer savings by month for each hospital using the prospective payment billing data described above. For each transfer case, we subtracted

the actual payment from the standard payment for the DRG assigned to that case, then we summed the savings for all transfers in each month to determine the total transfer savings by month. We then divided each hospital's transfer savings by month by the total of what the standard payments would have been for that month if all discharges, including transfers, had been paid at the full DRG-adjusted rate. We then weighted the savings ratios for each hospital by month by the 1981 MEDPAR discharge data for the corresponding months. By this means, we determined that the average payment per case was 0.5 percent lower than if all transfer cases had been paid at the full rate for the applicable DRG.

To reflect the proposed changes affecting hospitals in MSAs that cross census division (regional) boundaries, we took into account the one-year increase in payments to hospitals whose regional rates declined as a result of reclassification. For discharges occurring in FY 85, we propose to pay these hospitals 50 percent of the difference between their new Federal rate and the rate for the region in which they had previously been classified. The estimated national payment rates are not affected by this provision.

Similarly, we recomputed the estimated national and regional payment rates using the payment rates that would apply for FY 85 for hospitals that were reclassified from urban to rural as a result of the June 1983 EOMB redesignation of MSAs. For those hospitals so affected that have estimated hospital-specific rates higher than their Federal rural rate, we would pay two-thirds of the difference between the applicable Federal urban and rural rates. Hospitals with hospital-specific rates lower than their Federal rural rate would receive the rural rate.

We also recomputed the estimated national and regional payment rates to reflect appropriate payments to existing referral centers with more than 500 beds and to new rural referral centers with less than 500 beds. We identified rural hospitals in the 1981 cost report files and MEDPAR files with total annual admissions greater than 6000 and case-mix indices greater than 1.03. For these hospitals, we substituted urban for rural adjusted average standardized amounts.

For reasons given in the January 3, 1984 final regulations, we did not increase the estimated national or regional payments to reflect the costs of hospital-based physicians' services shifted from Part B to Part A as a result of the regulations published March 2, 1983. The law does not authorize us to adjust the standardized amounts for the effect of those regulations. However, we increased the estimated average per case payments for both hospital-specific rates and payments under prior law to reflect the March 2, 1983 regulations. Our reasons for making this adjustment in only the latter two cases are quite specific. First, the hospital-based physician regulations were primarily intended to implement section 108 of TEFRA. As such, they are clearly related to the Social Security Act as it stood on April 19, 1983, and should be included, with the case-mix limits and rate of increase limit, among provisions affecting payment levels under previous law. Second, the methodology used by intermediaries to determine each hospital's hospital-specific rate permits hospitals to submit data on this shift from Part B to Part A for purposes of adjusting base-year costs. Thus, the hospital-specific estimates would be inaccurate if we failed to take into account the hospital-based physicians regulations.

By increasing the estimated average per case payments under prior law, we increase the amount against which estimated prospective payments are compared to determine the budget neutrality adjustment. This increases the budget neutrality adjustment factor, which in turn results in higher payments under the prospective payment system. Hence, the adjustment for the hospital-based physicians regulations is reflected in both the Federal rate systems and the hospital-specific rate system, even though the standardized amounts from which the Federal rates are determined are not explicitly adjusted. Further, if the Federal rates did reflect explicit adjustment for the hospital-based physicians regulations, the resulting Federal rate budget neutrality adjustment factor would have been lower than it actually is. The net result would be virtually identical.

E. Estimated Hospital-Specific (HSP) Payment Per Discharge

To properly estimate the payments per discharge based on the hospital-specific rates to be used during the transition period, the hospital's base year cost per case must first be estimated, since actual base year data are not available currently. To estimate the base year cost, the 1981 cost report data were adjusted by the change in the nursing differential from 1981 to the base year. These data were updated to the base year and the resulting routine operating costs were compared with the appropriate routine cost limit applicable to base year cost reporting periods, as calculated from the September 30, 1981 **Federal Register** notice, to compute the savings resulting from application of the routine cost limits. Total costs were also reduced by the remainder of the amounts based on the Medicare nursing differential, since section 103 of TEFRA, by amending section 1861(v)(1)(J) of the Act, eliminated this differential effective with services furnished on or after October 1, 1982.

Operating costs were computed by carving direct medical education, capital-related, and certain kidney acquisition costs out of total costs. Operating costs were increased by 0.18 percent and 0.13 percent to adjust, respectively, for the extra estimated costs hospitals will report for their base year because of required coverage of their employees under FICA (as required by section 1886(b)(6) of the Act) and for the requirement that certain services are now required to be paid under Part A of Medicare, which were formerly paid under Part B (as required by section 1886(b)(5)(D) of the Act). Operating costs were further increased by 0.1326 percent to account for the shift of certain types of costs to Part A of Medicare because of the regulations on payment for physicians' services to patients and providers, published March 2, 1983 and referred to above.

For hospital cost reporting periods beginning in FY 84, we inflated the base year operating costs by two years of the market basket index increased by one percentage point for each year, using the market basket index values published January 3, 1984. For hospital cost reporting periods beginning in FY 85, we increased each hospital's estimated hospital-specific rate by the most recently available market basket index values plus one percentage point. We then increased the resulting amount for each hospital by 5.85 per cent to account for increases in reported case mix, divided by 1.024 to account for the revision of the DRG relative weights, and decreased the amount by 0.5 percent to account for payment for transfer cases at less than the full DRG-related amount. These adjustments are discussed above in the section on Federal rates.

F. Adjustment for Outlier Payments

Sections 1886(d)(2)(E) and (d)(3)(B) of the Act require that the average standardized amounts for the Federal rates be reduced so that, when combined with the outlier payments, the resulting payments will be the same as payments under a DRG-related system with no outlier payments but full standard DRG-adjusted rates.

The determination of the outlier payment criteria budget neutrality

adjustment was done only with respect to hospitals that will be reimbursed under the prospective payment system, since outlier payments and standard payments under the prospective payment system will not be on behalf of excluded hospitals and hospitals in waiver States. Reimbursement to excluded hospitals and hospitals in waiver States is not changed by the provisions of the prospective payment system.

The outlier criteria were caliberated using experience in the 1981 MEDPAR file so that outlier payments would be five percent of total Federal rate payments.

Since the outlier criteria were calibrated to yield outlier payments equal to five percent of Federal rate payments, the outlier adjustment for both the national and regional rates is 1−.05=.95.

G. Calculation of Budget Neutrality Adjustment Factors

As noted above, we must compute three budget neutrality adjustment factors—one each for adjusting Federal national and regional rates and the other for adjusting the updating factors used to determine the hospital-specific rates. Further, the Federal rate blend changes effective October 1, 1984, and each hospital's blending ratio of hospital-specific and Federal rates will change during FY 85. To reflect these factors in computations of the budget neutrality adjustment factors, we have weighted estimated payment rates and outlier payments by the discharges that would be paid under each blending ratio.

1. Federal Regional Rate Budget Neutrality Adjustment

Since the standard Federal rate before outlier adjustment, by definition, equals the outlier adjusted Federal rate plus outlier adjusted outlier payments, the former can be substituted for the latter in computing budget neutrality while producing identical results.

For the Federal regional rate system, the following equation must be solved:

Federal regional standard weighted payment per discharge × Federal regional rate budget neutral factor (FRBN) + Federal rate system weighted nonoperating cost per discharge=weighted TEFRA operating reimbursement per discharge=weighted TEFRA nonoperating cost per discharge.

EXAMPLE: COMPUTATION OF FEDERAL REGIONAL RATE BUDGET NEUTRALITY ADJUSTMENT FACTOR (FRBN)

Estimated values:	
TEFRA operating reimbursement per discharge (Federal blend weighted)	$1,362.81
TEFRA nonoperating cost per discharge (Federal blend weighted)	153.38
Weighted Federal regional rate standard payment per discharge	1453.78
Weighted Federal nonoperating cost per discharge	139.71

Solve:

$1,453.78 × FRBN + $139.71=$1,362.81 + $153.38

FRBN = ($1,362.81 + $153.38 − $139.71) divided by $1,453.78 = .947

2. Federal National Rate Budget Neutrality Adjustment

For the Federal national rate system, the following equation must be solved:

Federal national standard weighted payment per discharge × Federal national rate budget neutral factor (FNBN) + Federal rate system weighted nonoperating cost per discharge = weighted TEFRA operating reimbursement per discharge + weighted TEFRA nonoperating cost per discharge.

EXAMPLE: COMPUTATION OF FEDERAL NATIONAL RATE BUDGET NEUTRALITY ADJUSTMENT FACTOR (FNBN)

TEFRA operating reimbursement per discharge	$1,362.81
TEFRA nonoeprating cost per discharge	153.38
Federal national rate standard payment per discharge	1,448.27
Federal nonoperating cost per discharge	139.71

Solve:

$1448.27 × FRBN + $139.71=$1,362.81 + $153.38

FNBN = ($1,362.81 + $153.38 − $139.71) divided by $1,448.27 = .950

3. Hospital-Specific Rate Budget Neutrality Adjustment

The budget neutrality adjustment factor for the hospital-specific rate system is only applied to payments for discharges occurring in cost reporting periods starting in FY85. We cannot readjust a hospital's hospital-specific rate for its first cost reporting period under prospective payment (the period beginning in FY 84). The first year hospital-specific rates have been calculated using an updating factor that is already adjusted for FY 84 budget neutrality. These rates will change only as each hospital begins its second cost reporting period under prospective payment.

As a result, any differences between budget neutrality levels for FYs 84 and 85 can be applied only to each hospital's second year hospital-specific rate. Thus, a change in overall level is allocated over less than the full number of discharges occurring in FY 85.

For the hospital-specific rate system (HSP) the following must be solved:

(HSP payment per discharge for cost reporting periods starting in FY 85 × Fraction of discharges in FY 85 for cost reporting periods starting in FY 85 × 0.50 blending factor X hospital-specific budget neutrality adjustment factor (HSBN)) + (HSP payment per discharge for cost reporting periods starting in FY 84 adjusted for FY 84 budget neutrality adjustment factor × Fraction of discharges occurring in FY 85 for cost reporting periods starting in FY 84 × 0.75 blending factor) + weighted HSP system nonoperating cost per discharge = weighted TEFRA operating reimbursement per discharge + weighted TEFRA nonoperating cost per discharge.

This yields an HSBN that includes the effect of the FY 84 HSBN on discharges occurring in FY 85 for cost reporting periods starting in FY 84. The effect of the FY 84 HSP budget neutrality factor must be removed to avoid double application of two years' HSBNs when updating the hospital-specific rates for cost reporting periods starting in FY 85. This is done by dividing the result of the calculation described above by the FY 84 HSBN, which was .983.

EXAMPLE: COMPUTATION OF HOSPITAL-SPECIFIC RATE BUDGET NEUTRALITY ADJUSTMENT FACTOR (HSBN)

Estimated values	
TEFRA operating reimbursement per discharge (HSP blend weighted)	$2,113.10
TEFRA nonoperating cost per discharge (HSP blend weighted)	239.16
HSP payment per discharge for cost reporting periods beginning in FY 85 × fraction of FY 85 discharges × 0.50 blending factor	1,034.05
HSP payment per discharge for cost reporting periods × fraction of FY 85 discharges beginning in FY 84×0.75 blending factor × FY 84 HSBN of 0.983	1,131.11
Weighted HSP nonoperating cost per discharge	218.08

Solve:

($1034.05×HSBN)+$1131.11+ 218.08=$2113.10+$239.16

HSBN=($2113.10+ $239.16−$1113.11−$218.08) divided by $1034.05=.970

Then, to remove the effect of the FY 84 HSBN: .970 divided by .983=.987

Note that the HSP budget neutral factor is not applied to the outlier

payments. Outliner payments are paid based only on applicable Federal rates, which already incorporate an adjustment for budget neutrality.

H. SUMMARY—TABLE OF INFLATION ASSUMPTIONS USED IN BUDGET NEUTRALITY DETERMINATION

Calendar year	Cost per admission (percent)	Hospital input price index (percent)
1982	15.0	9.4
1983	10.9	6.2
1984	9.8	6.0
1985	9.8	6.5

I. SUMMARY—TABLE OF OUTLIER AND BUDGET NEUTRALITY ADJUSTMENT FACTORS—FEDERAL FISCAL YEAR 1985

Adjustment factors	Federal national rates	Federal regional rates	Hospital-specific rates
Outlier	0.950	0.950	—
Budget neutrality	0.947	0.950	0.987

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Part IV

Department of Agriculture

Agricultural Marketing Service

7 CFR Part 29

Tobacco Inspection; Final Rule

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 29

Tobacco Inspection

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: The Tobacco Adjustment Act of 1983 (Title II of Pub. L. 98–180) ("the Act") approved November 29, 1983, requires the inspection for grade and quality of all tobacco offered for importation into the United States except cigar and oriental tobacco which must be certified by the importer as to kind and type and, in the case of cigar tobacco, that such tobacco will be used solely in the manufacture of cigars. The Act also requires that the Secretary establish grade and quality standards for the inspection of imported tobacco and fix and collect fees from the importers to cover, as nearly as practicable, the costs of such services. The Department issued a notice of proposed rulemaking in the **Federal Register** on May 16, 1984, allowing interested parties a 15-day comment period for views and comments on the inspection for grade and quality of all tobacco offered for importation into the United States except cigar and oriental tobacco. Based on comments received from a cross section of the industry, the Department has determined that effective 10 days from the date of this publication, official grading and inspection will be provided to all tobacco offered for importation into the United States except cigar and oriental tobacco. The Department will also fix and collect fees from the importers to cover as nearly as practicable, the costs of such services. Regulations governing the certification of imported cigar and oriental tobacco will be proposed at a later date.

EFFECTIVE DATE: July 13, 1984.

FOR FURTHER INFORMATION CONTACT: Lioniel Edwards, Director, Tobacco Division, Agricultural Marketing Service (AMS), Room 502, Annex Building, United States Department of Agriculture, Washington, DC 20250, (202) 447–2567.

SUPPLEMENTARY INFORMATION: The authority for these regulations is contained in the Tobacco Inspection Act (48 Stat. 731; 7 U.S.C. 511 *et seq.*) and the Tobacco Adjustment Act of 1983 (Title II of Pub. L. 98–180), which requires the inspection for grade and quality of all tobacco offered for importation into the United States except cigar and oriental tobacco which must be certified by the importer as to kind and type and, in the case of cigar tobacco, that such tobacco will be used solely in the manufacture of cigars. The Act also requires the Department to fix and collect fees from the importer for the inspection services. These fees and charges would, as nearly as practicable, cover the cost of such services, including the administrative and supervisory costs customarily included by the Secretary in user fee calculations. The Act also requires the Secretary to establish grade and quality standards for the inspection of imported tobacco. These standards were published in the **Federal Register** on April 20, 1984 (49 FR 16755).

These regulations are designed to accomplish the statutory requirements of inspection of imported tobacco in a manner, insofar as practicable, that does not place an undue burden on the Federal inspection service or impede the expeditious movement of the commodity in commerce. The data collected on volume, grade, and quality of the tobacco inspected will be compiled, summarized, and published on a quarterly basis. This information will be periodically compared with statistics released by other government agencies to insure that all imported tobacco is inspected as required by the Act. Official standards for the inspection and grading of imported tobacco were approved in a separate rulemaking procedure (49 FR 16755).

The Department investigated the importation of tobacco into the United States prior to publishing proposed rules. Most imported tobacco arrives in this country by vessel, typically in 40-foot containers which carry 90–99 packages weighing approximately 500 pounds each. Generally, these containers are transferred to a rail or truck carrier and transported to an inland port of entry where the tobacco is unloaded for warehousing, manipulation, or manufacturing. Most imported tobacco is initially stored in bonded warehouses. Shipments are identified by invoices and packing lists which give detailed accountings of the tobacco, including country of origin, weight, and company grade.

USDA will inspect all tobacco offered for importation into the United States, including tobacco entering foreign trade zones, but excluding transshipped tobacco, oriental and cigar tobacco. Tobacco shall be inspected at the point of entry as it is unpacked from a container, or otherwise unloaded from a carrier, for warehousing, manipulation, or manufacturing using a selective sampling technique. The importer shall be issued an inspection certificate showing, among other things, the type, U.S. standard grade, date of inspection, country of origin, and net weight in pounds.

The fee for inspection of imported tobacco shall initially be set at $.0035 per pound. This fee was determined after a thorough review of the procedures to be used, the anticipated volume of inspection, and the number of staff hours necessary to provide the inspection service. Since this is a new program, the costs actually incurred would be closely monitored during the startup phase. Based on this review, adjustments would be made in the fee as necessary.

Regulations pertaining to the inspection of imported tobacco pursuant to section 213(a)(1) are being adopted at this time in order to expedite the information collection purposes of the statute as it pertains to the vast majority of imported tobacco. Regulations pertaining to the certification of cigar and oriental tobacco pursuant to section 213(a)(2) will be proposed at a later date.

The notice of proposed rulemaking published in the May 16, 1984, **Federal Register** (49 FR 20711) generated nine comments.

Three tobacco dealers criticized the requirement that importers retain the import inspection certificate until the inspected lot has been manufactured or exported, at which time they must send the original certificate to the Director.

AMS has decided to revise § 29.407 to require that the importer retain the certificate until the entire lot covered by it has been sold, manufactured or exported. When the importer no longer has ownership of any tobacco covered by the inspection certificate, the importer may dispose of the certificate. This minor revision places a lesser burden on importers while still accomplishing the Department's purpose.

An exporter-importer suggested that the needed information could be collected just as easily on the basis of samples submitted by the importer, subject to spot-checking. One producer organization, on the other hand, believes that submitted sampling should not be considered a satisfactory substitute for onsite sampling and grading by an inspector and urges that its use be kept to a minimum.

The Department believes that it is the intent of Congress, as illustrated in the legislative history of the Dairy and Tobacco Adjustment Act of 1983, that submitted sampling by importers should not be the primary means of inspecting imported tobacco. Congress has

indicated that all imported tobacco be inspected except where time, geographical distance or availability of inspectors prevent a timely onsite inspection.

Several commenters asked that TIB (temporary importation under bond) tobacco be treated the same as transshipped tobacco—i.e., excluded from inspection requirements.

The Department interprets the legislation to require that all tobacco offered for importation, except cigar, oriental, and transshipped tobacco, be inspected. Transshipped tobacco is defined as that which is not unloaded for warehousing, manipulation, manufacturing or exporting. Since TIB tobacco is unloaded, it does not meet the definition for exclusion. Moreover, TIB tobacco may be blended with domestic tobacco and manufactured, and, thus has an impact on the domestic tobacco price support program. Further, TIB tobacco may be imported, subject to penalty.

A manufacturer of smokeless products and smoking tobacco commented on the certification of imported cigar and oriental tobacco. Certification, however, is not the subject of this final rule. Regulations covering the certification of imported cigar and oriental tobacco will be proposed at a later date.

A manufacturer stated that the proposed $.0035-per-pound fee is excessive and should be based on an hourly rate rather than a price per pound. The Department has made a thorough analysis of importation and the inspection procedures, and has determined that a fee based on poundage inspected would be the most appropriate means for recovering its costs. The Department points out that inspectors must be continuously available for import inspection, and fees charged must cover this expense. The Department will closely monitor the cost of service and make appropriate adjustments as it determines to be necessary.

A dealer proposed that the term "lot" be redefined to include only that tobacco on a single invoice that is encompassed by a single grademark.

The inspection certificate will provide for itemization of different grades within the same lot. This should allow sufficient detail to describe mixed lots. Therefore, the Department will be able to record the required information on each shipment on a single certificate.

A dealer proposed that § 29.402 requiring five days' notice of the date and location of unloading be amended to allow for notice of the approximate date, maintaining that this information often cannot be obtained accurately.

The Department believes that five days is a reasonable period of time to provide for the orderly scheduling of inspectors. This will also be closely monitored for possible adjustment by the Department.

One dealer expressed concern that the Department would be collecting sensitive data about a company's operation that could be of interest to competitors.

The Tobacco Division, Agricultural Marketing Service, has been collecting individual company data on tobacco stocks since the implementation of the Tobacco Stocks Reporting Act of 1929. The Division is fully familiar with the need for confidentiality of data, and intends to provide safeguards against the inadvertent release of such data.

Some of the respondents questioned the need for inspection of imported tobacco.

The Department must carry out the mandate of Congress. The Dairy and Tobacco Adjustment Act of 1983 requires the inspection and certification of imported tobacco.

This final rule has been reviewed under USDA procedures established to implement Executive Order 12291 and Departmental Regulation 1512–1 and has been determined to be "nonmajor" because it does not meet any of the criteria established for major rules under the Executive Order. Initial review of the regulations contained in 7 CFR Part 29, for need, currentness, clarity, and effectiveness has been completed. During the startup phase of this operation, the Department will closely monitor the procedures established in this final rule to ensure that any problems which may arise are promptly addressed.

In compliance with Office of Management and Budget (OMB) regulations, 5 CFR Part 1320 Controlling Paperwork Burdens on the Public, which implements the Paperwork Reduction Act of 1980, Pub. L. 96–511, the information collection requirements contained in the proposed rule were submitted to OMB for review as prescribed in § 1320.13 Clearance of Collection of Information Requirements in Proposed Rules under section 3504(h) of the Paperwork Reduction Act. OMB has approved the information collection requirements under the control number 0581–0056.

Additionally, in conformance with the provisions of Pub. L. 96–354, the Regulatory Flexibility Act, full consideration has been given to the potential economic impact upon small business of this final rule. A number of firms which are affected by these adopted regulations do not meet the definition of small business either because of their individual size or because of their dominant position in one or more marketing areas. William T. Manley, Deputy Administrator, Agricultural Marketing Service, has certified that these actions will have no significant economic impact upon all entities, small or large, and will not substantially affect the normal movement of the commodity in the market place.

William T. Manley, Deputy Administrator, Agricultural Marketing Service, has determined that an emergency situation exists which warrants an effective date less than 30 days following publication. There is a need to implement and test procedures prior to the opening of the flue-cured marketing season when inspectors and supervisors will be occupied in the inspection and grading of domestically produced tobacco. Therefore, this final rule will become effective (insert a date 10 days following date of publication).

List of Subjects in 7 CFR Part 29

Administrative practices and procedure, Tobacco.

For the reasons set out in the preamble, the regulations contained in 7 CFR Part 29, are amended as follows:

1. The authority citation for Part 29 reads as follows:

Authority: Title II of Pub. L. 98–180; (49 Stat. 731; 7 U.S.C. *et seq.*).

2. After § 29.133 the following sections are added:

§ 29.400 Inspection of Imported Tobacco.

All Tobacco offered for importation into the United States, including tobacco entering foreign trade zones, but excluding transshipped tobacco, oriental and cigar tobacco, shall be inspected for grade and quality. Tobacco subject to inspection shall be inspected at the point of entry.

§ 29.401 Definitions.

As used in §§ 29.400–29.500, the words and phrases hereinafter defined shall have the following meanings:

(a) *Importation.* Arriving within the territorial limits of the United States with the intent to unload.

(b) *Importer.* The owner of the tobacco at the time of importation or the owner's successor in interest if the tobacco is sold prior to the completion of the requirements of §§ 29.400–29.500.

(c) *Inspection Certificate.* An official written representation of a lot of tobacco made by an inspector and issued to an importer.

(d) *Invoice.* A writing on behalf of the importer that is used in commercial

transactions of tobacco for selling, purchasing, shipping, or consigning.

(e) *Lot.* A unit of shipment of tobacco encompassed by a single invoice.

(f) *Package.* A hogshead, carton, case, bale, or other securely enclosed parcel or bundle.

(g) *Packing List.* A document itemizing each package covered by a single invoice listing, among other things, the kind of tobacco in each package, the net weight, and the marks and numbers identifying each package.

(h) *Point of Entry.* The place at the port of entry or foreign trade zone where tobacco is unloaded from a carrier or unpacked from a container for the purpose of warehousing, manipulation, or manufacturing.

(i) *Port of Entry.* Any place designated by Executive Order of the President, by order of the Secretary of the Treasury, or by Act of Congress, at which a customs officer is authorized to accept entries of merchandise, to collect duties, and to enforce the various provisions of the Customs and Navigation Laws. The term "port of entry" incorporates the geographical area under the jurisdiction of the port director when such port is one other than a district headquarters port.

(j) *Tobacco.* Tobacco between the time it is cured and stripped from the stalk or primed and cured, in whole leaf or unmanufactured form, and the time it is utilized in product manufacturing. Conditioning, sweating, stemming, and threshing are not considered manufacturing.

(k) *Transshipped Tobacco.* Tobacco that arrives within the territorial limits of the United States for the purpose of continuous transportation without being unloaded for warehousing, manipulation, or manufacturing, to a destination outside the territorial limits of the United States.

(l) *Unload.* To remove from a carrier at the port of entry or at a foreign trade zone.

§ 29.402 Advance notice.

The importer shall notify, orally or in writing, the Raleigh Regional Office, USDA, AMS, Tobacco Division, P.O. Box 27846, Raleigh, North Carolina, 27611, or the Lexington Regional Office, USDA, AMS, Tobacco Division, 333 Waller Avenue, Lexington, Kentucky, 40504, of the date and location that tobacco subject to inspection under § 29.400 will be unloaded for warehousing, manipulation, or manufacturing. This notice shall be received at the Regional Office at least five working days prior to unloading the tobacco for warehousing, manipulation, or manufacturing.

§ 29.403 Accessibility of Tobacco.

All tobacco subject to inspection under § 29.400 shall be made accessible by the importer for examination in a manner prescribed by the inspector. This includes providing proper lighting, removal of package coverings, and such other provisions as the inspector may deem necessary for inspection.

§ 29.405 Inspection.

The inspector shall review each lot of tobacco through a process of selective sampling in sufficient detail to allow an accurate determination of the types and grades contained in each lot.

§ 29.405 Inspection by submitted samples.

The Director, in lieu of onsite inspection, may approve submission by the importer of samples where time, geographical distance, or availability of inspectors prevent a timely onsite inspection, or where tobacco is classified as a "temporary importation under bond" as defined in 19 CFR 10.31 *et seq.* The importer shall certify that sampling was conducted in accordance with procedures approved by the Director. All tobacco inspected by submitted sample is subject to spot-checking at the discretion of the Director. Submitted samples shall be disposed of in a manner approved by the Director unless return of the sample is requested by the importer at the time of submission. Samples will only be returned at the importer's expense.

§ 29.406 Import inspection certificate.

An import inspection certificate shall consist of a certificate issued by the Tobacco Division in a form approved by the Director. A certificate shall be issued to the importer as soon as practicable following the completion of inspection. A separate certificate shall be issued for each lot of tobacco. In case of a lost or destroyed certificate, a duplicate may be issued under the same number, date, and name by an authorized official. Duplicate certificates shall be plainly marked "Duplicate" above the signature of the supervising official who issued it.

§ 29.407 Disposition of import inspection certificate.

The inspector shall provide the importer with the original portion of the certificate and forward the first copy to the Director and the second copy to the appropriate Regional Office. The importer shall retain the original inspection certificate until the lot inspected has been sold, manufactured into products or exported from the United States.

§ 29.500 Fees and charges for inspection of imported tobacco.

The fee for inspection of imported tobacco is $.0035 per pound, and shall be paid by the importer. This inspection fee applies to all tobacco imported into the United States except as provided in § 29.400. Fees for services rendered shall be remitted by check or draft in accordance with a statement issued by the Director, and shall be made payable to "Agricultural Marketing Service".

Dated: June 29, 1984.

William T. Manley,

Deputy Administrator, Marketing Program Operations.

[FR Doc. 84-17814 Filed 7-2-84: 8:45 am]

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Federal Register

Tuesday
June 3, 1984

Part V

Office of Personnel Management

5 CFR Part 550
Pay Administration (General); Final Rule

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 550

Pay Administration (General)

AGENCY: Office of Personnel Management.

ACTION: Final regulations.

SUMMARY: The Office of Personnel Management is publishing final regulations to implement the salary offset provisions of the Debt Collection Act of 1982 (Pub. L. 97–365, enacted on October 25, 1982). Proposed regulations were published in the **Federal Register** on September 26, 1983 (48 FR 43687).

Based on the comments received on the proposed regulations and the publication of the final amendments to the Federal Claims Collection Standards (FCCS) (49 FR 8889, dated March 9, 1984), we are making changes which will clarify the required contents of agency salary offset regulations. The final regulations also simplify the procedures for processing salary offset requests when the creditor agency and the employee's paying agency are not the same.

EFFECTIVE DATE: These regulations are effective August 2, 1984.

FOR FURTHER INFORMATION CONTACT: Patricia A. Rochester, (202) 632–4634.

SUPPLEMENTARY INFORMATION: In the September 26, 1983 **Federal Register**, the Office of Personnel Management (OPM) proposed to add a new Subpart K to Part 550 of Title 5 of the Code of Federal Regulations to deal with salary offset under 5 U.S.C. 5514. Interested parties were initially given until October 26, 1983, to submit written comments concerning this proposal; however, the comment period was later extended through December 5, 1983 (see 48 FR 53121, dated November 25, 1983).

There were 20 respondents to OPM's proposed salary offset regulations. The respondents included 18 Federal agencies and two labor organizations. A summary of the comments, OPM's responses to them and the changes in the final regulations follow:

Section 550.1101 Purpose

Part 550.1101 contains a general statement of OPM's purpose in preparing these regulations. We added a statement to clarify that the procedures described in § 550.1106 for processing salary offset requests apply only when the employee's creditor and paying agencies are not the same.

Section 550.1102 Scope.

Part 550.1102, explaining the scope of the regulations, was changed as follows: (1) In § 550.1102(b)(1), we added examples of debts which are separately authorized by other statutes. These debts may be recovered under the statute specifically authorizing their recovery (e.g., travel advances and employee training expenses). (2) Section 550.1102(b)(2) was reworded for clarity. (3) Section 550.1102(b)(3) was eliminated and its contents were moved to the introductory paragraph of § 550.1102(b). Based on a commenter's request, we clarified the relationship between salary offset under 5 U.S.C. 5514 and administrative offset under 31 U.S.C. 3716. Administrative offset is defined in 31 U.S.C. 3701(a)(1) as "withholding money payable by the United States Government to, or held by the Government for, a person to satisfy a debt the person owes the Government." So, even though it is separately authorized and governed by 5 U.S.C. 5514, salary offset is still an administrative offset. Therefore, any matters not addressed in these regulations should be consistent with the provisions of the FCCS.

Section 550.1103 Definitions.

Part 550.1103 contains definitions of terms as they are used in the regulations. Changes were made in the definitions discussed below.

(1) "Creditor agency" was amended by deleting the word "Federal" as unnecessary.

(2) The definition of "debt" was amended. Four commenters requested that additional categories of pay adjustments be excluded from § 5514; another requested that the current excluded pay adjustments be dropped. Upon further consideration, we determined that exclusion (b), relating to certain ministerial adjustments to pay, should be eliminated from the final regulations. While we determined that the matters listed as exclusion (a), relating to certain claims arising from an election or change of election in coverage under a Federal benefits program, was warranted, treating the adjustment as an exclusion from the term "debt" did not adequately express the reasons underlying OPM's position that the procedures of 5 U.S.C. 5514 need not be extended to such matters. Individuals who elect coverage or a change in coverage under a Federal benefits program either know, or should know, that they are consenting to deductions from their pay. The employee, in electing such coverage has, in the authorizing form, consented to deductions from his or her salary and, accordingly, such deductions are not in fact involuntary salary offsets under § 5514.

Limiting this exception from the procedures provided under § 5514 to deductions for four pay periods or less will insure that the terms of the employee's consent are honored.

For these reasons, the reference to exclusions from the definition of the term "debt" has been deleted from the final regulations. Section (c) of 5 CFR 550.1104 has been rewritten to reflect these changes.

(3) "Delinquent debt" was deleted as unnecessary since it is defined in the FCCS.

(4) "Disposable pay" was amended in response to several comments. One comment requested clarification of the relationship between the 15 percent limitation on salary offset in § 5514 and the garnishment limitation under 15 U.S.C. 673 (which provides for garnishment of salaries for alimony and child support). Two commenters requested specific enumeration of the deductions "required by law."

The amended section requires an agency to exclude the deductions listed by OPM's garnishment regulations at 5 CFR 581.105 (b) through (f) to determine disposable pay for salary offset purposes. For garnishment purposes, agencies must exclude the deductions at § 581.105 (b) through (f) plus any amount deducted for a debt(s) due the United States (§ 581.105(a)).

(5) The definition of "employee" was amended to delete the word "former." Former employees are not entitled to the same procedures as current employees, so their inclusion in the definition of employee is misleading.

(6) "FCCS" has been added to the list of definitions.

(7) "Paying agency" was revised slightly to improve clarity.

(8) "Salary offset" now explains that it means an administrative offset from current pay not requiring the employee's consent.

(9) "Waiver" now includes "non-recovery" as a term more descriptive of the waiver action taken based on a comment by one of our commenters. A number of comments and questions were received on this definition and the subsequent provisions in the proposed regulation Most commenters were confused about the relationship of the hearing requirements on the waiver decision and the hearing requirements of the salary offset procedure. Because of the confusion, we decided that OPM regulations would be limited to the salary offset process and most of the

material on waiver has been deleted. Debt collection efforts which should be undertaken before making a salary offset are explained in the FCCS.

Section 550.1104 Agency regulations.

Section 550.1104 lists the minimum provisions OPM will expect to see in agency regulations. The list of required provisions is substantially the same as in the proposed regulation; however, we made editorial changes where it was possible to clarify or simplify the language and changed the order of presentation for former parts (8) through (12). An explanation of the substantive changes and discussion of the comments is provided for each affected paragraph.

(1) Several commenters requested OPM to prepare a model regulation that can be adopted by any agency whose needs are satisfied by its provisions. However, because of the number and variety of programs that are involved in salary offset, a model regulation will be of limited use. We prefer simply to expand on the regulatory instructions in material to be included in a Federal Personnel Manual System letter.

(2) Paragraph 550.1104(b) requires a description of the employee's rights under § 5514. Several changes were made to this provision as a result of the comments received. (a) The references to waiver in the proposed regulation were deleted. (b) We added a requirement that the creditor agency tell the employee about other rights and remedies available in addition to those provided by § 5514. This requirement was previously included in the discussion of the hearing decision (former § 550.1105(h)). One commenter suggested, and we agree, that the hearing decision should be limited to a report on the hearing. So, the requirement is more appropriately included here. (c) Another commenter requested that we specify who has responsibility for providing a hearing officer. The regulations now state that the creditor agency must make arrangements for a qualified official. (d) One commenter believed it was not clear that there is an alternative to using an administrative law judge (ALJ) to hold the hearing. We amended the language to make this choice more apparent.

(3) Former paragraph 550.1104(d), "exceptions to when hearing must be offered" was deleted, so subsequent paragraphs were renumbered.

(4) Current paragraph 550.1104(d) requires an agency to prescribe regulations to notify the employee a minimum of 30 days prior to the proposed date of the collection, and includes a list of items which must be covered in the notice. A majority of the items to be included in the notice are identical to those in the proposed regulation. The changes are discussed below.

(a) The proposed regulation stated that "deductions shall not be made, *nor may payments be required*, unless * * *." A commenter suggested that the language "nor may payments be required" might be misinterpreted to mean that the creditor agency cannot require payments under other collection methods until the § 5514 offset is effective. We agree that the language could be misinterpreted, so it has been deleted.

(b) Another commenter pointed out that some employees might not be able to physically inspect agency records on the debt and suggested that we add language to permit the employee to request and receive a copy of the applicable records from the creditor agency. This suggestion was adopted.

(c) The language in part 550.1104(d)(6) was reworded at the suggestion of another commenter. The proposed regulation suggested that the employee be given an opportunity to arrange a repayment schedule differing from that proposed by the creditor agency. The commenter noted that, in some cases, the employee will already have had such an opportunity. We amended this provision to note that only one opportunity need be given. We also amended the language so it is clear that agencies must allow the employee one opportunity to make voluntary payment of the debt as required by 4 CFR 102.2(e). Agencies generally should attempt to secure an employee's consent to repayment of a debt prior to instituting salary offset. The personal interview referenced in 4 CFR 102.7 should normally be used for this purpose.

(d) Part 550.1104(d)(7) was amended for the reasons noted at (c) in our discussion of § 550.1104(b).

(e) A new paragraph (11) has been added to § 550.1104(d). This paragraph makes no substantive change in procedures under 5 U.S.C. 5514 as explained by these regulations. Its purpose is solely to provide for specific notice to debtors that they may be subject to civil or criminal penalties, or to administrative disciplinary action, if they submit any knowingly false or frivolous representations, statements or evidence in a petition for hearing. The new § 550.1104(d)(11) references existing provisions of statute and regulation.

(f) Current part 550.1104(d)(12) was added for the reasons noted at (b) in our discussion of § 550.1104(b).

(g) Paragraph 550.1104(e) concerns petitions for a hearing. Except for several editorial changes and the deletion of the provisions on waiver, the paragraph is the same as in the proposed regulation. A commenter suggested that the regulation be amended to require notice via "certified" or "registered" mail with "return receipt requested" to provide agencies information on when notice is received. We did not adopt this suggestion; however, we recommend that notices be sent this way.

(h) Paragraph 550.1104(g) requires agencies to prescribe the form and content of hearings, responses and decisions. Here again, the waiver material was deleted. One commenter requested that we discuss the employee's right to representation. As mentioned earlier, most commenters were confused about the relationship of the hearing requirements on waiver decisions and the hearing requirements of the salary offset procedure. Because of the confusion, we have deleted the information concerning the content of the hearing and have simply referenced the applicable portion of the FCCS, 4 CFR 102.3(c) which provides a full explanation of the type of hearing an agency should provide.

Salary offset procedures are, under 5 U.S.C. 5514(a)(3), to be effected in accordance with the standards established in the FCCS. Accordingly, we have deleted the language that could be viewed as requiring an oral hearing in each instance. The provisions of 4 CFR 102.3(c) set out those circumstances under which an oral hearing is required and those situations when a hearing on the written record will suffice. The discussion, formerly located at the end of this section, of the employee's rights and remedies if the decision is unfavorable was moved to paragraph 550.1104(b).

(i) Paragraph 550.1104(h) is a combination of paragraphs (i) and (j) from the proposed regulation. The discussion of the method and source of deductions was simplified and shortened, and the material on the repayment schedule was moved to paragraph (d).

(j) Paragraph (i) requires a description of agency policy on establishing reasonable deductions. A number of comments requested changes to the minimum installment amount and to the time limit for repayment of the debt. Since this material is included in the FCCS, we have deleted it from this subpart. Agencies are reminded that their regulations must also be consistent with the FCCS.

(k) Paragraph 550.1104(k) requires agencies to prescribe when deductions will be scheduled to begin in their internal collections. We also added language to 5 CFR 550.1106(d)(2)(i) requiring deductions to begin at the next officially established pay interval, when the creditor and paying agencies are different. The remaining provisions from the proposed regulation were deleted as unnecessary.

(l) Paragraph 550.1104(l) requires paying agencies to provide for collecting an employee's debt from any final payments due from their agency. Paragraph 550.1104(m) requires agencies to provide for collecting an employee's debt from any subsequent payments due from other government agencies. Two commenters requested guidance on the application of § 5514 to collections from a former employee. We amended the language in both of the paragraphs to show such collections will come under 31 U.S.C. 3716. Collections under § 3716 are not subject to the 15 percent limitation.

(m) Paragraph 550.1104(n) requires provisions on interest, penalties and administrative costs. Several commenters requested further guidance; however, we retained the language from the proposed regulation, since specific information is given in the FCCS.

(n) Paragraph 550.1104(p) discusses provisions for refunding money received in payment of debts later found not to be due. Two commenters suggested that some statement should be made about the employee's entitlement to interest on the monies refunded. We added language to show that such refunds do not bear interest unless required or permitted by law or contract.

Section 550.1105 Approval of agency regulations.

Part 550.1105 concerning OPM review and approval of agency regulations is substantially the same as in the proposed regulations.

Section 550.1106 Requesting recovery when the current paying agency is not the creditor agency.

(1) Paragraph 550.1106(a) concerns the statute of limitations on commencing collection under § 5514. A number of comments were received on the statute of limitations in § 550.1106(a). Several commenters noted that some of the programs that will be using the salary offset have specific statutory provisions governing the period for collection of debts. Other commenters felt that the limitation period should be consistent with that established for administrative offsets under 31 U.S.C. 3716. Another commenter suggested the provision was unnecessary since the limitation period is specified by statute. We have amended this provision to require that the statute of limitations applied for salary offset be consistent with 4 CFR 102.3(b)(3) as required by 5 U.S.C. 5514(a)(3).

(2) Four comments were received on § 550.1106(d). Most commenters expressed concern over the additional burden placed upon the paying agency and the additional delay in commencing the actual offset from the employee's salary. One commenter suggested that the employee be requested to sign a statement acknowledging that certain facts dealing with the provision of the required procedures under § 5514(b) were established.

We amended § 550.1106 (b) and (d), to permit the employee's paying agency to furnish him or her with a copy of the creditor agency's debt claim form and immediately establish the deduction effective in the next officially established pay interval. We believe this is permissable because the debt claim form to be completed by the creditor agency (§ 550.1106(b)) calls for specific details on certain actions taken by the employee and the creditor agency and will show that the required due process was given. As an alternative to providing the detailed information, the creditor agency may have the employee sign a statement acknowledging receipt of the required procedures and submit it as an attachment to the debt claim form.

E.O. 12291, Federal Regulation

OPM has determined that this is not a major rule as defined under Section 1(b) of E.O. 12291, Federal Regulation.

Regulatory Flexibility Act

I certify that these regulations will not have a significant economic impact on a substantial number of small entities because these regulations concern administrative practices and will affect only the Federal Government.

List of Subjects in 5 CFR Part 550

Administrative Practice and Procedures, Government employees, Personnel Management Office, Wages.

U.S. Office of Personnel Management.

Donald J. Devine,

Director.

Accordingly, OPM adds a new Subpart K of Part 550 of Title 5 of the Code of Federal Regulations to read as follows:

PART 550—PAY ADMINISTRATION (GENERAL)

* * * * *

Subpart K—Collection by Offset From Indebted Government Employees

Sec.

Authority: 5 U.S.C. 5514; sec. 8(1), E.O. 11609, 3 CFR, 1971–1975 Comp., 586; redesignated in sec. 2–1, E.O. 12107, 3 CFR, 1978 Comp., 264.

§ 550.1101 Purpose.

This subpart provides the standards to be used by Federal agencies to prepare regulations implementing 5 U.S.C. 5514 and by OPM to review and approve such agency regulations, and establishes procedural guidelines to recover debts from the current pay account of an employee when the employee's creditor and paying agencies are not the same.

§ 550.1102 Scope.

(a) *Coverage.* This subpart applies to agencies and employees defined by § 550.1103.

(b) *Applicability.* This subpart and 5 U.S.C. 5514 apply in recovering certain debts by administrative offset, except where the employee consents to the recovery, from the current pay account of an employee. Because it is an administrative offset, debt collection procedures for salary offset which are not specified in 5 U.S.C. 5514 and these regulations should be consistent with the provisions of FCCS.

(1) *Excluded debts or claims.* The procedures contained in this subpart do not apply to debts or claims arising under the Internal Revenue Code of 1954 as amended (26 U.S.C. 1 *et seq.*), the Social Security Act (42 U.S.C. 301 *et seq.*), or the tariff laws of the United States; or to any case where collection of a debt by salary offset is explicity provided for or prohibited by another statute (e.g., travel advances in 5 U.S.C. 5705 and employee training expenses in 5 U.S.C. 4108).

(2) *Waiver requests and claims to the General Accounting Office.* This subpart does not preclude an employee from requesting waiver of a salary overpayment under 5 U.S.C. 5584, 10 U.S.C. 2774, or 32 U.S.C. 716, or in any way questioning the amount or validity of a debt by submitting a subsequent claim to the General Accounting Office in accordance with procedures prescribed by the General Accounting Office. Similarly, in the case of other

types of debts, it does not preclude an employee from requesting waiver, if waiver is available under any statutory provision pertaining to the particular debt being collected.

§ 550.1103 Definitions.

For purposes of this subpart—

"Agency" means (a) an Executive Agency as defined by § 105 of title 5 of the United States Code, the U.S. Postal Service, the U.S. Postal Rate Commission, and (b) a Military Department as defined by § 102 of title 5, United States Code.

"Creditor agency" means the agency to which the debt is owed.

"Debt" means an amount owed to the United States from sources which include loans insured or guaranteed by the United States and all other amounts due the United States from fees, leases, rents, royalties, services, sales of real or personal property, overpayments, penalties, damages, interest, fines and forfeitures (except those arising under the Uniform Code of Military Justice), and all other similar sources.

"Disposable pay" means that part of current basic pay, special pay, incentive pay, retired pay, retainer pay, or in the case of an employee not entitled to basic pay, other authorized pay remaining after the deduction of any amount required by law to be withheld. Agencies must exclude deductions described in 5 CFR 581.105 (b) through (f) to determine disposable pay subject to salary offset.

"Employee" means a current employee of an agency, including a current member of the Armed Forces or a Reserve of the Armed Forces (Reserves).

"FCCS" means the Federal Claims Collection Standards jointly published by the Justice Department and the General Accounting Office at 4 CFR 101.1 *et seq.*

"Paying agency" means the agency employing the individual and authorizing the payment of his or her current pay.

"Salary offset" means an administrative offset to collect a debt under 5 U.S.C. 5514 by deduction(s) at one or more officially established pay intervals from the current pay account of an employee without his or her consent.

"Waiver" means the cancellation, remission, forgiveness, or non-recovery of a debt allegedly owed by an employee to an agency as permitted or required by 5 U.S.C. 5584, 10 U.S.C. 2774, or 32 U.S.C. 716, 5 U.S.C. 8346(b), or any other law.

§ 550.1104 Agency regulations.

Under this subpart and 5 U.S.C. 5514, each creditor agency must issue regulations, subject to approval by the Office of Personnel Management (OPM), governing the collection of a debt by salary offset. Each agency is responsible for assuring that the regulations governing collection of internal debts are uniformly and consistently applied to all its employees. Agency regulations issued under authority of 5 U.S.C. 5514 must contain the following minimum provisions:

(a) *Applicability or scope.* Indicate whether regulations cover internal or Government-wide collections under 5 U.S.C. 5514, or both.

(b) *Entitlement to notice, hearing, written responses and decisions.* Identify when the employee is entitled to notice, when hearings will be offered, when the employee is entitled to a response or decision after exercising his or her rights under § 5514 and this subpart, and if the hearing official's decision is not in the employee's favor or the employee chooses not to request a hearing, what other rights and remedies are available under the statutes or regulations governing the program that requires the collection to be made. Except as provided in paragraph (c) of this section, each employee from whom the creditor agency proposes to collect a debt under this subpart is entitled to receive from the creditor agency—

(1) A written notice as described in paragraph (d) of this section;

(2) The opportunity to petition for a hearing and, if a hearing is given, to receive a written decision from the official holding the hearing on the following issues:

(i) The determination of the creditor agency concerning the existence or amount of the debt; and

(ii) The repayment schedule, if it was not established by written agreement between the employee and the creditor agency.

(c) *Exception to entitlement to notice, hearing, written responses, and final decisions.*

In regulations covering internal collections, an agency shall except from the provisions of paragraph (b) of this section any adjustment to pay arising out of an employee's election of coverage or a change in coverage under a Federal benefits program requiring periodic deductions from pay, if the amount to be recovered was accumulated over four pay periods or less.

(d) *Notification before deductions begin.* Provide for notification before deductions begin. Except as provided in paragraph (c) of this section, deductions under the authority of 5 U.S.C. 5514 must not be made unless the head of the creditor agency or his designee provides the employee at least 30 days before any deduction, written notice stating at a minimum:

(1) The creditor agency's determination that a debt is owed, including the origin, nature, and amount of that debt;

(2) The creditor agency's intention to collect the debt by means of deduction from the employee's current disposable pay accont;

(3) The amount, frequency, proposed beginning date, and duration of the intended deductions;

(4) An explanation of the creditor agency's policy concerning interest, penalties, and administrative costs, including a statement that such assessments must be made unless excused in accordance with the FCCS;

(5) The employee's right to inspect and copy Government records relating to the debt or, if employee or his or her representative cannot personally inspect the records, to request and receive a copy of such records;

(6) If not previously provided, the opportunity (under terms agreeable to the creditor agency) to establish a schedule for the voluntary repayment of the debt or to enter into a written agreement to establish a schedule for repayment of the debt in lieu of offset. The agreement must be in writing, signed by both the employee and the creditor agency; and documented in the creditor agency's files (4 CFR 102.2(e));

(7) The employee's right to a hearing conducted by an official arranged by the creditor agency (an administrative law judge, or alternatively, a hearing official not under the control of the head of the agency) if a petition is filed as prescribed by the creditor agency;

(8) The method and time period for petitioning for a hearing;

(9) That the timely filing of a petition for hearing will stay the commencement of collection proceedings;

(10) That a final decision on the hearing (if one is requested) will be issued at the earliest practical date, but not later than 60 days after the filing of the petition requesting the hearing unless the employee requests and the hearing official grants a delay in the proceedings;

(11) That any knowingly false or frivolous statements, representations, or evidence may subject the employee to:

(i) Disciplinary procedures appropriate under chapter 75 of title 5, United States Code, Part 752 of title 5, Code of Federal Regulations, or any other applicable statutes or regulations;

(ii) Penalties under the False Claims Act, §§ 3729–3731 of title 31, United States Code, or any other applicable statutory authority; or

(iii) Criminal penalties under §§ 286, 287, 1001, and 1002 of title 18, United States Code or any other applicable statutory authority.

(12) Any other rights and remedies available to the employee under statutes or regulations governing the program for which the collection is being made; and

(13) Unless there are applicable contractual or statutory provisions to the contrary, that amounts paid on or deducted for the debt which are later waived or found not owed to the United States will be promptly refunded to the employee.

(e) *Petitions for hearing.* (1) Prescribe the method and time period for petitioning for a hearing. Ordinarily, a hearing may be requested by filing a written petition addressed to the appropriate creditor agency official stating why the employee believes the determination of the agency concerning the existence or amount of the debt is in error.

(2) The employee's petition or statement must be signed by the employee and fully identify and explain with reasonable specificity all the facts, evidence and witnesses, if any, which the employee believes support his or her position.

(f) *Petitions for hearing made after time expires.* Prescribe the action to be taken on a petition for hearing made after the expiration of the period provided in the notice described in paragraph (d) of this section. Ordinarily a creditor agency should accept requests if the employee can show that the delay was because of circumstances beyond his or her control or because of failure to receive notice of the time limit (unless otherwise aware of it).

(g) *Form of hearings, written responses, and final decisions.* (1) Define the form and content of hearings, written responses, and written decisions to be provided when the employee exercises his or her rights under § 5514 and this subpart.

(2) The form and content of hearings granted under this subpart will depend on the nature of the transactions giving rise to the debts included within each debt collection program. Agencies should refer to 4 CFR 102.3(c) for information on hearing form and content.

(3) Written decisions provided after a request for hearing must, at a minimum, state the facts purported to evidence the nature and origin of the alleged debt; the hearing official's analysis, findings and conclusions, in light of the hearing, as to the employee's and/or creditor agency's grounds, the amount and validity of the alleged debt and, where applicable, the repayment schedule.

(h) *Method and source of deductions.* Identify the method and source of deductions. At a minimum, agency regulations must identity the method of collection as salary offset and the source of deductions as current disposable pay, except as provided in paragraphs (l) and (m) of this section.

(i) *Limitation on amount of deductions.* Prescribe the limitations on the amount of the deduction. Ordinarily, the size of installment deductions must bear a reasonable relationship to the size of the debt and the employee's ability to pay (see the FCCS). However, the amount deducted for any period must not exceed 15 percent of the disposable pay from which the deduction is made, unless the employee has agreed in writing to the deduction of a greater amount.

(j) *Duration of deductions.* Prescribe the duration of deductions. Ordinarily, debts must be collected in one lump-sum where possible. However, if the employee is financially unable to pay in one lump-sum or the amount of the debt exceeds 15 percent of disposable pay for an officially established pay interval, collection must be made in installments. Such installment deductions must be made over a period not greater than the anticipated period of active duty or employment, as the case may be, except as provided in paragraphs (l) and (m) of this section.

(k) *When deductions may begin.* Prescribe when deductions will be scheduled to begin in internal agency collections.

(l) *Liquidation from final check.* Provide for offset under 31 U.S.C. 3716, if the employee retires or resigns or if his or her employment or period of active duty ends before collection of the debt is completed, from subsequent payments of any nature (e.g., final salary payment, lump-sum leave, etc.) due the employee from the paying agency as of the date of separation to the extent necessary to liquidate the debt.

(m) *Recovery from other payments due a separated employee* Provide for offset under 31 U.S.C. 3716 from later payments of any kind due the former employee from the United States, where appropriate, if the debt cannot be liquidated by offset from any final payment due the former employee as of the date of separation. (See 4 CFR 102.3.)

(n) *Interest, penalties, and administrative costs.* Provide for the assessment of interest, penalties, and administrative costs on debts being collected under this subpart. These charges and the waiving of them must be prescribed in accordance with 4 CFR 102.13.

(o) *Non-waiver of rights by payments.* Provide that an employee's involuntary payment, of all or any portion of a debt being collected under 5 U.S.C. 5514 must not be construed as a waiver of any rights which the employee may have under 5 U.S.C. 5514 or any other provision of contract or law, unless there are statutory or contractual provisions to the contrary.

(p) *Refunds.* (1) Provide for promptly refunding to the appropriate party, amounts paid or deducted under this subpart when—

(i) A debt is waived or otherwise found not owing to the United States (unless expressly prohibited by statute or regulation); or

(ii) The employee's paying agency is directed by an administrative or judicial order to refund amounts deducted from his or her current pay.

(2) Refunds do not bear interest unless required or permitted by law or contract.

§ 550.1105 Review and approval of agency regulations.

(a) *Initial OPM review of agency regulations.* (1) Creditor agencies must submit regulations to the Office of Personnel Management (OPM) for review in accordance with 5 U.S.C. 5514 and this subpart prior to publication of final regulations or prior to implementation, if intragency collection procedures are not published. Submissions must be for agency-wide and/or Government-wide collections.

(2) Creditor agency regulations must contain all provisions specified in § 550.1104. If agency regulations are incomplete, OPM will return them with information as to what must be done to obtain approval.

(b) *Proposed changes in salary offset regulations.* If a creditor agency proposes significant changes in the regulations covering provisions specified in § 550.1104, the proposed revisions must be submitted to OPM for review and approval prior to implementation.

(c) *Supplemental regulations.* When a creditor agency has issued approved regulations covering the provisions specified in § 550.1104, the agency may issue any supplemental regulations or instructions, consistent with its approved regulations, which are necessary for solely internal operations, without prior OPM approval.

§ 550.1106 Requesting recovery when the current paying agency is not the creditor agency.

(a) Under 4 CFR 102.3(b)(3), agencies may not initiate offset to collect a debt more than 10 years after the Government's right to collect the debt first accrued, with certain exceptions explained in that paragraph.

(b) *Format of the request for recovery.* (1) Upon completion of the procedures established by the creditor agency under 5 U.S.C. 5514, the creditor agency must complete and certify the appropriate debt claim form specified by OPM.

(2) The creditor agency must certify, in writing, that the employee owes the debt, the amount and basis of the debt, the date on which payment(s) is due, the date the Government's right to collect the debt first accrued, and that the creditor agency's regulations implementing § 5514 have been approved by OPM.

(3) If the collection must be made in installments, the creditor agency must also advise the paying agency of the number of installments to be collected, the amount of each installment, and the commencing date of the first installment, if a date other than the next officially established pay period is required. Ordinarily, hearings may consist of informal conferences before a hearing official in which the employee and creditor agency will be given full opportunity to present evidence, witnesses, and argument. The employee may represent him or herself or be represented by an individual of his or her choice. The creditor agency must provide for maintaining a summary record of the hearings provided under this subpart.

(4) Unless the employee has consented to the salary offset in writing or signed a statement acknowledging receipt of the required procedures and the writing or statement is attached to the debt claim form, the creditor agency must also indicate the action(s) taken under § 5514(b) and give the date(s) the action(s) were taken.

(c) *Submitting the request for recovery.* (1) *Current employees.* The creditor agency must submit the appropriate debt claim form, agreement, or other instruction on the payment schedule to the employee's paying agency.

(2) *Employees who are separating or have separated.*—(i) *Employees who are in the process of separating.* If the employee is in the process of separating, the creditor agency must submit its debt claim to the employee's paying agency for collection as provided in § 550.1104(l). The paying agency must certify the total amount of its collection and notify the creditor agency and the employee as provided in paragraph (c)(2)(iii) of this section. If the paying agency is aware that the employee is entitled to payments from the Civil Service Retirement and Disability Fund, or other similar payments, it should send a copy of the debt claim and certification to the agency responsible for making such payments as notice that a debt is outstanding. However, the creditor agency must submit a properly certified claim to the agency responsible for making such payments before collection can be made.

(ii) *Employees who have already separated.* If the employee is already separated and all payments due from his or her former paying agency have been paid, the creditor agency may request, unless otherwise prohibited, that monies which are due and payable to the employee from the Civil Service Retirement and Disability Fund (5 CFR 831.1801 *et seq.*) or other similar funds, be administratively offset in order to collect the debt (see 31 U.S.C. 3716 and the FCCS).

(iii) *Employees who transfer from one paying agency to another.* If, after the creditor agency has submitted the debt claim to the employee's paying agency, he or she transfers to a position served by a different paying agency before the debt is collected in full, the paying agency from which the employee separates must certify the total amount of the collection made on the debt. One copy of the certification must be furnished to the employee, another to the creditor agency along with notice of the employee's transfer. The original of the debt claim form must be inserted in the employee's official personnel folder along with a copy of the certification of the amount which has been collected. Upon receiving the official personnel folder, the new paying agency must resume the collection from the employee's current pay account and notify the employee and the creditor agency of the resumption. It will not be necessary for the creditor agency to repeat the due process procedures described by 5 U.S.C. 5514 and this subpart in order to resume the collection. However, it will be the responsibility of the creditor agency to review the debt upon receiving the former paying agency's notice of the employee's transfer to make sure the collection is resumed by the new paying agency.

(d) *Processing the debt claim upon receipt by the paying agency.*—

(1) *Incomplete claims.* If the paying agency receives an improperly completed debt claim form, it must return the request with a notice that procedures under 5 U.S.C. 5514 and this subpart must be provided and a properly completed debt claim form received before action will be taken to collect from the employee's current pay account.

(2) *Complete claim.* If the paying agency receives a properly completed debt claim form, deductions should be scheduled to begin prospectively at the next officially established pay interval. A copy of the debt claim form must be given to the debtor, along with notice of the date deductions will commence if different from that stated on the debt claim form.

(3) The paying agency is not required or authorized to review the merits of the creditor agency's determination with respect to the amount or validity of the debt as stated in the debt claim form.

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