the spatial resolution capability of the system for low and high contrast objects, and measuring the mean CT number of water or a reference material.

(2) Instructions on the use of the phantom(s) including a schedule of testing appropriate for the system, allowable variations for the indicated parameters, and a method to store as records, quality assurance data.

(3) Representative images obtained with the phantom(s) using the same processing mode and CT conditions of operation as in paragraph (c)(3) of this section for a properly functioning system of the same model. The representative images shall be of two forms as follows:

(i) Photographic copies of the images obtained from the image display device.

(ii) Images stored in digital form on a storage medium compatible with the CT x-ray system. The CT x-ray system shall be provided with the means to display these images on the image display device.

(Information collection requirements approved by the Office of Management and Budget under number .)

(e) [Reserved]

(f) *Control and indication of conditions of operation*—(1) *Visual indication.* The CT conditions of operation to be used during a scan or a scan sequence shall be indicated prior to initiation of a scan or a scan sequence. On equipment having all or some of these conditions of operation at fixed values, this requirement may be met by permanent markings. Indication of the CT conditions of operation shall be visible from any position from which scan initiation is possible.

(2) *Timers.* (i) Means shall be provided to terminate the x-ray exposure automatically by either deenergizing the x-ray source or shuttering the x-ray beam in the event of equipment failure affecting data collection. Such termination shall occur within an interval that limits the total scan time to no more than 110 percent of its preset value through the use of either a backup timer or devices which monitor equipment function. A visible signal shall indicate when the x-ray exposure has been terminated through these means and manual resetting of the CT conditions of operation shall be required prior to the initiation of another scan.

(ii) Means shall be provided such that the exposure from the system does not exceed the radiation levels specified in § 1020.30(k) except when x-ray transmission data are being collected for use in image production or technique factor selection.

(iii) Means shall be provided so that the operator can terminate the x-ray exposure at any time during a scan, or series of scans under x-ray system control, of greater than one-half second duration. Termination of the x-ray exposure shall necessitate resetting of the CT conditions of operation prior to the initiation of another scan.

(g) *Tomographic plane indication and alignment.* (1) For any single tomogram system, means shall be provided to permit visual determination of the tomographic plane or a reference plane offset from the tomographic plane.

(2) For any multiple tomogram system, means shall be provided to permit visual determination of the location of a reference plane. The relationship of the reference plane to the planes of the tomograms shall be provided to the user in addition to other information provided according to § 1020.30(h). This reference plane can be offset from the location of the tomographic planes.

(3) The distance between the indicated location of the tomographic plane or reference plane and its actual location may not exceed 5 millimeters.

(4) For any offset alignment system, the manufacturer shall provide specific instructions with respect to the use of this system for patient positioning, in addition to other information provided according to § 1020.30(h).

(5) If a mechanism using a light source is used to satisfy the requirements of paragraph (g) (1) and (2) of this section, the light source shall allow visual determination of the location of the tomographic plane or reference plane under ambient light conditions of up to 500 lux.

(Information collection requirements approved by the Office of Management and Budget under number .)

(h) *Beam-on and shutter status indicators.* (1) Means shall be provided on the control and on or near the housing of the scanning mechanism to provide visual indication when and only when x rays are produced and, if applicable, whether the shutter is open or closed. If the x-ray production period is less than one-half second, the indication of x-ray production shall be actuated for one-half second. Indicators at or near the housing of the scanning mechanism shall be discernible from any point external to the patient opening where insertion of any part of the human body into the primary beam is possible.

(2) For systems that allow high voltage to be applied to the x-ray tube continuously and that control the emission of x rays with a shutter, the radiation emitted may not exceed 100 milliroentgens (2.58×10^{-5} coulomb/kilogram) in 1 hour at any point 5 centimeters outside the external surface of the housing of the scanning mechanism when the shutter is closed. Compliance shall be determined by measurements averaged over an area of 100 square centimeters with no linear dimensions greater than 20 centimeters.

(i) *Scan increment accuracy.* The deviation of indicated scan increment from actual scan increment may not exceed 1 millimeter. Compliance shall be measured as follows: The determination of the deviation of indicated versus actual scan increment shall be based on measurements taken with a mass 100 kilograms or less, on the patient support device. The patient support device shall be incremented from a typical starting position to the maximum incrementation distance or 30 centimeters, whichever is less, and then returned to the starting position. Measurement of actual versus indicated scan increment may be taken anywhere along this travel.

(j) *CT number mean and standard deviation.* (a) A method shall be provided to calculate the mean and standard deviation of CT numbers for an array of picture elements about any location in the image. The number of elements in this array shall be under user control.

(2) The manufacturer shall provide specific instructions concerning the use of the method provided for calculation of CT number mean and standard deviation in addition to other information provided according to § 1020.30(h).

(Information collected requirements approved by the Office of Management and Budget under number .)

Effective date. This regulation shall be effective September 3, 1985, except for the following, which shall be effective November 29, 1984: § 1020.30 (a), (b) (36) (iii)–(v), (58)–(62), (h)(3)(vi)–(viii), and (n); §§ 1020.31 and 1030.32 (introductory texts); § 1020.33 (a), (b), and (c)(2); and § 1020.33(c)(1) as it affects § 1020.33(c)(2).

(Sec. 358, 82 Stat. 1177–1179 (42 U.S.C. 263f); secs. 201, 501, 502, 701, 52 Stat. 1040–1042 as amended, 1049–1051 as amended, 1055–1056 as amended (21 U.S.C. 321, 351, 352, 371))

Dated: July 13, 1984.

Mark Novitch,

Acting Commissioner of Food and Drugs.

[FR Doc. 84-23154 Filed 8-30-84; 8:45 am]

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Friday
August 31, 1984

Part VI

Department of Commerce

Patent and Trademark Office

37 CFR Part 1

Patent Maintenance Fees; Final Rulemaking

DEPARTMENT OF COMMERCE

Patent and Trademark Office

37 CFR Part 1

[Docket No. 40442-4092]

Final Rules for Patent Maintenance Fees

AGENCY: Patent and Trademark Office, Commerce.

ACTION: Notice of final rulemaking.

SUMMARY: The Patent and Trademark Office is amending the rules of practice in patent cases, Part I of Title 37, Code of Federal Regulations, to provide rules and procedures for the payment of patent maintenance fees. Public Law 96-517, enacted on December 12, 1980 and Pub. L. 97-247, enacted on August 27, 1982, provided for the payment of maintenance fees at intervals of 3½, 7½ and 11½ years from the date of grant of the patent for maintaining in force an original patent, a reissue patent of an invention, and under Pub. L. 96-517, a plant patent and reissues thereof. The changes provide specific rules and procedures which will assist patentees in avoiding the inadvertent expiration of patent for failure to pay the appropriate maintenance fee.

EFFECTIVE DATE: November 1, 1984.

FOR FURTHER INFORMATION CONTACT: R. Franklin Burnett by telephone at (703) 557-3054 or by mail marked to his attention and addressed to the Commissioner of Patents and Trademarks, Washington, D.C. 20231.

SUPPLEMENTARY INFORMATION: This rule change is designed primarily to (1) establish a set of rules and procedures for the payment of patent maintenance fees; and (2) effect the provisions of Pub. L. 96-517 and 97-247 with respect to payment of maintenance fees. The proposed rules were published on April 24, 1984, in Volume 49 of the **Federal Register**, pages 17692 through 17698; and on May 8, 1984, at Volume 1042 of the *Official Gazette*, pages 22 through 38. A public hearing was held on the proposed rule changes on June 26, 1984.

A public briefing on the Office's maintenance fee payment plans was announced at 49 FR 2806 on January 23, 1984, and at 1038 *Official Gazette* 293 on January 31, 1984. The public briefing was held on February 22, 1984.

Discussion of Specific Rules

Section 1.1, is amended as proposed to add a new paragraph (d) to provide a "Box M. Fee" in the Patent and Trademark Office to which all maintenance fee correspondence and payments should be directed. Changes in small entity status in patents and changes in the "fee address" under § 1.363, as well as payments of maintenance fees should be directed to "Box M. Fee".

Section 1.9, paragraph (d) is amended as proposed to make a change in citation and title of the rule of the Small Business Administration which relates to the small business size standard for paying reduced patent fees. This change was published in the **Federal Register** as a final rule on February 9, 1984 at 49 FR 5024-5048. The wording of the rule itself was not changed. This change is made to bring the wording of title 37, Code of Federal Regulations into conformance with title 13, Code of Federal Regulations.

Section 1.17, is amended as proposed to establish in paragraph (h) a fee of $120 for review of a decision refusing to accept and record payment of a maintenance fee filed prior to the expiration of a patent. Paragraph (h) of § 1.17 is also amended to establish a fee of $120 for reconsideration of a decision on petition refusing to accept the delayed payment of a maintenance fee in an expired patent.

Section 1.19, is amended as proposed to add new paragraphs (f) and (g). New paragraph (f) provides for a $10.00 fee for a microfiche copy of a patent file wrapper record. Microfiche copies of these patent files have recently become available for patents issued after January 1, 1984. No fee had previously been set by rule for this service. This fee is not directly related to maintenance fees but is set at this time for convenience. New paragraph (g) establishes a $3.00 fee for providing an uncertified statement indicating either the status of payment of maintenance fees due on a patent or the expiration of a patent. This charge does not apply to any receipt normally provided to the fee addressee as a result of the payment of a maintenance fee, but does apply in any other instance when written evidence of the status of payment of maintenance fees on a patent is requested, whether by the patentee or a member of the public.

Section 1.20, is amended as proposed to add new paragraphs (k), (l) and (m). New paragraph (k) provides for a $100.00 surcharge for paying a maintenance fee during the 6-month grace period following the expiration of three years and six months, seven years and six months, and eleven years and six months after the date of the original grant of a patent based on an application filed on or after December 12, 1980 and before August 27, 1982. Since Pub. L. 96-517 did not provide for small entities, the surcharge amount of $100 applies to all such patents. New paragraph (l) provides for a $100 surcharge for patentees other than a small entity and a $50 surcharge for small entity patentees when paying a maintenance fee during the 6-month grace period following the expiration of three years and six months, seven years and six months, and eleven years and six months after the date of the original grant based on an application filed on or after August 27, 1982. This surcharge of $100 is subject to a 50% reduction for small entities pursuant to Pub. L. 97-247.

New paragraph (m) provides for a $500 surcharge for accepting payment of a maintenance fee after expiration of a patent for non-timely payment of a maintenance fee. This $500 surcharge applies only under Pub. L. 97-247 where the patent is based on an application filed on or after August 27, 1982 and where the delay in payment is shown to the satisfaction of the Commissioner to have been unavoidable. The requirement that the delay be "unavoidable" is the same as that for reviving an abandoned application under 35 U.S.C. 133. However, the amount of evidence required will depend upon when the showing that the delay was "unavoidable" is made. This surcharge does not apply to patents based on applications filed prior to August 27, 1982 since acceptance of a maintenance fee after expiration of a patent for non-timely payment is not possible under Pub. L. 96-517. Since this surcharge is provided for under 35 U.S.C. 41(c), it is not subject to a 50% reduction for small entities. The surcharge in paragraph (m) is not in addition to the surcharge in paragraph (1), but is in lieu thereof.

Section 1.33 is amended as proposed to add a new paragraph (d) which allows a "correspondence address" or change thereto to be filed during the enforceable life of the patent. The "correspondence address" will be used in correspondence relating to maintenance fees unless a separate "fee address" has been specified. Paragraph (d) also includes a reference to § 1.363 relating to the "fee address" to be used for maintenance fee purposes.

New § 1.362 is added to provide for times for payment of maintenance fees. New paragraph (a) sets forth the requirement that maintenance fees as set forth in § 1.20(e)-(j) must be paid in order to maintain a patent in force if the application maturing into a patent was filed on or after December 12, 1980 and is subject to the payment of maintenance fees. The maintenance fee amounts set in § 1.20(e)-(g) are subject to adjustment in accordance with the

provisions of Pub. L. 96–517. The maintenance fee amounts set in § 1.20(h)–(j) are subject to adjustment in accordance with the provisions of Pub. L. 97–247 on October 1, 1985, and every third year thereafter, to reflect fluctuations occurring during the previous three years in the Consumer Price Index, as determined by the Secretary of Labor. Other patent fees are also subject to similar adjustments.

New paragraph (b) of § 1.362 stipulates that no maintenance fees are due for plant patents if the plant patent application was filed on or after August 27, 1982 or for any design patents. Maintenance fees are not required for a reissue patent if the patent being reissued did not require maintenance fees. New paragraph (c) defines the pertinent application filing dates for purposes of determining whether maintenance fees are applicable. Paragraph (c)(1) establishes that for national applications not claiming benefit of an earlier application, the actual United States filing date controls. Paragraph (c)(2) establishes that for national applications claiming benefit of an earlier foreign application under 35 U.S.C. 119, the United States filing date controls. Paragraph (c)(3) provides that for continuing national applications claiming benefit of a prior application under 35 U.S.C. 120, the actual United States filing date of the continuing application is the controlling date. Paragraph (c)(4) provides that for a reissue application, the United States filing date of the application which matured into the original patent upon which the reissue application is based will control. Paragraph (c)(5) establishes that for an international application which has entered the United States as a Designated Office under 35 U.S.C. 371, the international filing date granted under Article 11(1) of the Patent Cooperation Treaty controls. This is consistent with 35 U.S.C. 363.

Paragraph (d) of new § 1.362 sets forth the time periods when maintenance fees can be paid without a surcharge. Those periods, referred to generally as the "window period," are the six-month periods preceding each due date, i.e., 3 years through 3 years and six months, 7 years through 7 years and six months, and 11 years through 11 years and six months after grant of the patent. The "due dates" are defined in 35 U.S.C. 41(b). A maintenance fee paid on the last day of a window period can be paid without surcharge. The last day of a window period is the same date (anniversary date) the patent was granted 3 years and six months, 7 years and six months, or 11 years and six months after grant of the patent. Paragraph (d) has been modified from the proposal to add "and" between items (2) and (3) and change the comma at the end of the paragraph to a period.

Paragraph (e) of new § 1.362 sets forth the grace periods during which maintenance fees, under either Pub. L. 96–517 or Pub. L. 97–247, may be paid with the surcharge under § 1.20 (k) or (l). The grace periods are the six-month periods immediately following each due date, i.e., after 3 years and six months and up to 4 years, after 7 years and six months and up to 8 years, and after 11 years and six months and up to 12 years after grant of the patent. A maintenance fee may be paid with the surcharge on the same date (anniversary date) the patent was granted in the 4th, 8th, or 12th year after grant to prevent the patent from expiring.

Paragraph (f) of new § 1.362 specifies that where the last day for paying a maintenance fee falls on a Saturday, Sunday, or a federal holiday within the District of Columbia, the maintenance fee may be paid on the next succeeding day which is not a Saturday, Sunday, or federal holiday. For example, if the "window period" provided by paragraph (d) for paying a maintenance fee without surcharge ended on a Saturday, Sunday, or a federal holiday within the District of Columbia, the maintenance fee can be paid without surcharge on the next succeeding day which is not a Saturday, Sunday, or federal holiday. Likewise, if the grace period provided by paragraph (e) for paying a maintenance fee with surcharge ended on a Saturday, Sunday, or a federal holiday within the District of Columbia, the maintenance fee could be paid with surcharge on the next succeeding day which is not a Saturday, Sunday, or federal holiday. In the latter situation, the failure to pay the maintenance fee and surcharge on the next succeeding day which is not a Saturday, Sunday, or federal holiday will result in the patent expiring on a date (4, 8, or 12 years after the date of grant) earlier than the last date on which the maintenance fee and surcharge could be paid. This situation results from the provisions of 35 U.S.C. 21, but those provisions do not extend the expiration date of the patent if the maintenance fee and any requried surcharge are not paid when required. For example, if the grace period ended on Saturday, the maintenance fee and surcharge could be paid on the next succeeding business day, e.g. Monday, but the patent will have expired at midnight on Saturday if the maintenance fee and surcharge were not paid on the following Monday. Paragraph (f) has been modified from the proposal to explicitly refer to "any necessary surcharge" for clarity since the ability to pay on the next succeeding day which is not a Saturday, Sunday, or federal holiday within the District of Columbia applies to the maintenance fee, including any necessary surcharge.

Paragraph (g) of new § 1.362 establishes that if the proper fees are not received within the time period specified in paragraphs (d), (e), or (f) the patent expires at the end of the grace period set forth in paragraph (e). Paragraph (g) also specifies that a patent which expires for the failure to pay the maintenance fee will expire at the end of the same date (anniversary date) the patent was granted in the 4th, 8th, or 12th year after grant.

New § 1.363 is added as proposed to provide for a "fee address" for maintenance fee purposes. New paragraph (a) specifies that the correspondence address used during prosecution of the application will be used unless (1) a "fee address" is provided for maintenance fee purposes when submitting the issue fee, (2) a correspondence address change for all purposes is filed after payment of the issue fee, or (3) a "fee address" or a change in the 'fee address" is filed after payment of the issue fee.

Paragraph (b) of new § 1.363 specifies that an assignment does not result in a change of address for maintenance fee purposes. Due to the possible expiration of a patent for failure to timely pay the appropriate maintenance fee, patentees should ensure that the Patent and Trademark Office is properly notified of the proper "fee address" to which all maintenance fee communications are to be directed. Under both Pub. L. 96–517 and Pub. L. 97–247 the burden is on the patentee to timely pay maintenance fees. The Patent and Trademark Office will attempt to assist patentees through appropriate courtesy notices. However, the failure to receive one or more notices will not relieve the patentee of the obligation to timely pay the appropriate maintenance fee to prevent the patent from expiring by operation of law if the maintenance fee is not paid. Section 1.363 does not provide for maintenance fee correspondence to be directed to more than one address.

New § 1.366 is added to establish the guidelines and procedures for submission of maintenance fees, including any necessary surcharges. New paragraph (a) states that the patentee may pay maintenance fees and any necessary surcharges or any person or organization may pay maintenance fees and any necessary surcharges on

behalf of the patentee without filing in the Patent and Trademark Office evidence of authorization by the patentee to pay maintenance fees. This will enable patentees to pay the maintenance fees and any necessary surcharges themselves or authorize some person or organization to pay maintenance fees and any necessary surcharges on their behalf. No verification of the authority to pay maintenance fees and any necessary surcharges in a particular patent will be made by the Patent and Trademark Office. While anyone may pay the maintenance fees and any necessary surcharges on a patent, any Patent and Trademark Office notices relating to maintenance fees will be mailed to the "fee address" set forth in § 1.363. Paragraph (a) has been modified from the proposal to explicitly refer to "any necessary surcharges" for clarity.

Paragraph (b) of new § 1.366 specifies that a maintenance fee and any necessary surcharge for a patent must be submitted in the amount due on the date the maintenance fee and any necessary surcharge are paid, and at the proper time, i.e., within the periods set forth in § 1.362. Paragraph (b) has been modified from the proposal by changing "proper amount" to "amount due on the date the maintenance fee and any necessary surcharge are paid." This change results from adoption of a suggestion that a maintenance fee payment made during the window period should not require adjustment if the maintenance fees are thereafter increased to reflect increases in the Consumer Price Index. Under paragraph (b) as adopted herein, if the amount of the maintenance fee is correct on the date it is paid and credited to the patent, a later change in the maintenance fees to reflect changes in the Consumer Price Index will not require a modification in the amount paid. However, in order for the maintenance fee to be considered paid it must be submitted in accordance with § 1.366. Paragraph (b) has also been modified from the proposal to explicitly refer to § 1.362(f) for purposes of clarity where the last day for paying a maintenance fee with or without a surcharge falls on a Saturday, Sunday, or a federal holiday within the District of Columbia. In such circumstances, the fee with any necessary surcharge may be paid on the next succeeding day which is not a Saturday, Sunday, or federal holiday. The maintenance fee and any necessary surcharge may be paid in the manner set forth in § 1.23, i.e., it should be in United States specie, Treasury notes, national bank notes, post office money orders, or by certified check. As indicated in § 1.23, if the maintenance fee payment is sent in any other form, the Office may delay or cancel the credit until collection is made. For example, a personal or other uncertified check drawn on a United States bank which is not immediately negotiable, e.g., because of lack of signature or insufficient funds, will not constitute payment of a maintenance fee. However, a personal check drawn on a United States bank can be used if it is immediately negotiable. Any remittances from foreign countries must be payable and immediately negotiable in the United States for the full amount of the maintenance fee required.

Paragraph (b) of new § 1.366 also provides that maintenance fees may be paid by an authorization to charge a deposit account established pursuant to § 1.25. The authorization to charge the deposit account must be submitted within the periods set forth in § 1.362 and must be limited to maintenance fees payable on the date of submission. The authorization to charge the deposit account cannot, under paragraph (b), be submitted prior to the third, seventh, or eleventh year after the grant of the patent. If an authorization to charge a deposit account were submitted to pay the maintenance fee due at three years and six months after grant, a new authorization to charge a deposit account or other form of payment will have to be submitted at the appropriate time for each of the maintenance fees due at 7 years and six months and 11 years and six months. Paragraph (b) also specifies that any payment or authorization filed at any time other than that set forth in § 1.362 (d), (e) or (f) will not serve as a payment of the maintenance fee, except insofar as a delayed payment of the maintenance fee is accepted by the Commissioner pursuant to § 1.378. Paragraph (b) also specifies that a payment of less than the required amount, a payment in a manner other than that set forth in § 1.23, or the filing of an authorization to charge a deposit account having insufficient funds, will not constitute payment of a maintenance fee on a patent. The authorization is required to authorize the immediate charging of the fee to the deposit account. An authorization would be improper if it only authorized the fee to be charged at a later date, e.g., on the last possible day of payment without surcharge. Such an authorization would not serve as payment of the maintenance fee. Any payment which fails to result in the entire proper amount of the maintenance fee being present on the due date will not constitute payment of the maintenance fee. Paragraph (b) also specifies that the certificate of mailing procedures of § 1.8 or the mailing by "Express Mail" provisions of § 1.10 may be utilized in paying maintenance fees. The specific requirements of either § 1.8 or § 1.10 must be fully complied with if either is used.

Paragraph (c) of new § 1.366 establishes the data necessary and desired when submitting maintenance fee payments and any necessary surcharges. New paragraph (c) specifies that maintenance fee payments and any necessary surcharges must include at least the (1) patent number and (2) United States application serial number. Paragraph (c) has been modified from the proposal to explicity refer to "any necessary surcharges" for clarity since the identifying information must also be supplied when submitting surcharges. The wording of § 1.366(c) has also been changed from the proposal to clarify that the required application serial number is that of the application upon which the patent issued. This change from the proposal makes clear that the serial number required to be submitted is not that of a prior parent application but rather, the actual application which matured into the patent for which maintenance fees are to be paid. If the maintenance fee is being paid on a reissue patent, the serial number required is that of the reissue application. Since this required information will be used as a cross-check to ensure that the maintenance fee is properly credited, the application serial number must correspond to the patent which issued therefrom. If less than the required information is submitted, the Office will not credit the payment. Additionally, if notice is required that the proper identifying data has not been submitted, it would result in requiring the payment of a surcharge if the necessary data is submitted after the "window period" closes. If the required information is not submitted until after the end of the grace period, the patent would have expired because of the failure to properly identify the patent to which the maintenance fee payment is to be credited prior to the expiration of the grace period. The patentee in such a circumstance could proceed under § 1.378, if appropriate, or could file a petition under § 1.377 within the period set therein seeking to have the maintenance fee accepted as timely even though all of the proper identifying data was not present prior to the expiration of the grace period.

Paragraph (d) of new § 1.366 specifies that the following information should also be submitted for each patent on

which a maintenance fee or surcharge is paid: (1) Whether it is the 3½, 7½, or 11½ year fee, (2) whether small entity status is being changed or claimed with the payment, (3) the amount of the maintenance fee and any surcharge being submitted, (4) any assigned payor number, (5) patent issue date and (6) United States application filing date. Paragraph (d) has been modified from the proposal to explicitly refer to "any necessary surcharges" for clarity. Paragraph (d) has also been changed from the proposal to emphasize that when the payment is being made on a reissue patent the required patent number and application serial number are those of the reissue patent and reissue application. Where the payment is a maintenance fee and any necessary surcharge on a reissue patent, in addition to the information requested for all payments, paragraph (d) as adopted herein also requests certain identifying data relating to the original patent, i.e., original patent number, original patent issue date, and original United States application filing date. The reason for requesting the original patent number, original patent issue date, and original United States application filing date is that the original filing and issue dates are the dates which control if and when maintenance fees must be paid to prevent the reissue patent from expiring. The reference to a payor number has been added. A payor number will be assigned to each "fee address" in order to facilitate data input and subsequent changes in the location of the "fee address." Details of the "payor number" system will be announced to the public in a future *Official Gazette* notice. Although the submission of the information requested in paragraph (d) is not mandatory, it would expedite the processing of the maintenance fee payments.

The final rule thus requires less mandatory information, i.e., the patent number and U.S. application serial number, than would have been required by the proposed rule. The required information is considered to be the least that is required to make a cross-check and thus assure that the maintenance fee is being credited to the proper patent. The patent issue date and the application filing date, which were included in the proposed rule as mandatory information, are included in the final rule as desirable, but not mandatory, information. The effect of this change is that an error in either the patent issue date or the application filing date, or both, by the person paying the maintenance fee would not result in a refusal to accept the maintenance fee and to credit the payment thereof to the patent, if the patent number and United States application serial number were correct, i.e., in agreement. However, if any error included either the patent number or the United States application serial number such that they were not in agreement the payment would not be accepted and credited until correction was made. The date of the correction would be the date the maintenance fee payment is credited as being made.

Paragraph (e) of new § 1.366 specifies that maintenance fee payments and any surcharges relating thereto must be submitted separate from any other payments for fees or charges, whether submitted in the manner set forth in § 1.23 or by an authorization to charge a deposit account. Maintenance fee payments and surcharge payments relating thereto which are co-mingled with payments for other fees or charges, e.g., application filing fees, issue fees, petition fees, document supply fees, etc., will not be accepted. The maintenance fees require processing by a separate area of the Office and are not processed in the same manner as other fees and charges. Maintenance fees for a number of patents can be submitted together in one submission and one payment. Paragraph (e) specifies that if maintenance fee payments for more than one patent are submitted together, they should be submitted on as few sheets as possible, listing the patent numbers in increasing patent number order. If the payment submitted, which can be made as a single payment, is insufficient to cover the maintenance fees and any surcharges for all the listed patents, the payment will be applied in the order the patents are listed. In such a circumstance where the fees are insufficient, the maintenance fee and any surcharge for one or more of the last listed patents will not be paid.

Paragraph (f) of new § 1.366 serves as a reminder to patentees of the necessity to check for the loss of small entity status prior to paying each maintenance fee on a patent. This is already a requirement of § 1.28(b). Paragraph (f) provides that notification of any change in status resulting in loss of entitlement to small entity status must be filed in a patent prior to paying, or at the time of paying, the earliest maintenance fee due after the date on which status as a small entity is no longer appropriate. If status as a small entity has been previously established by filing a statement and such status is checked and is found to be proper, no notification is required. It is not necessary to file new verified statements claiming small entity status at this point if the status as a small entity has been established and is still proper even if rights have been transferred to a small entity who has not previously filed a verified statement. The requirement is to notify the Patent and Trademark Office of the loss of entitlement and to pay the maintenance fee in the proper amount for other than a small entity where appropriate. The refund provisions of § 1.28(a) for later submitted small entity statements will apply to maintenance fees.

Paragraph (g) of new § 1.366 provides that maintenance fees and surcharges relating thereto will not be refunded except in accordance with §§ 1.26 and 1.28(a). A patentee cannot obtain a refund of a maintenance fee which was due and payable on the patent. Any duplicate payment will be refunded to the fee address.

New § 1.377 is added as proposed to provide a mechanism for review of a decision refusing to accept and record payment of a maintenance fee filed prior to the expiration of a patent. Paragraph (a) of new § 1.377 specifies that a patentee who is dissatisfied with the refusal of the Patent and Trademark Office to accept and record a mantenance fee which was filed prior to the expiration of the patent may petition the Commissioner to accept and record the maintenance fee. This petition may be used, for example, in situations where an error is present in the identifying data required by § 1.366(c) with the maintenance fee payment, i.e., either the patent number or the application serial number are incorrect. A petition under § 1.377 would provide an avenue for seeking relief. A petition under § 1.377 would not be appropriate where there is a complete failure to include at least one correct mandatory identifier as required by § 1.366(c) for the patent since no evidence would be present as to the patent on which the maintenance fee was intended to be paid. If the maintenance fee payment with an incorrect mandatory identifier was made near the end of the grace period, the patent might expire since the Office would not credit the fee to a patent. For patents based on applications filed between December 12, 1980 and August 27, 1982, there is no provision for acceptance of a maintenance fee after the grace period such as in § 1.378 and so the filing of a petition under § 1.377 would not be appropriate where the patentee paid a maintenance fee on one patent when the patentee intended to pay the maintenance fee on a different patent but through error identified the wrong patent by patent number and application serial number. Likewise, a

petition under § 1.377 would not be appropriate where the entire maintenance fee payment, including any necessary surcharge, was not filed prior to expiration of the patent.

Paragraph (b) of new § 1.377 specifies that any petition under new § 1.377 must be filed within 2 months of the action complained of, or within such other time as may be set in the action complained of. The petition must be accompanied by the petition fee of $120 provided for in the amendment to § 1.17(h). Paragraph (b) also provides that the petition may include a request that the petition fee be refunded if the refusal to accept and record the maintenance fee is determined to have resulted from an error by the Patent and Trademark Office.

Paragraph (c) of new § 1.377 specifies that any petition filed under the section must comply with the requirements of paragraph (b) of § 1.181 and must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest. A person or organization whose only responsibility insofar as the patent is concerned is the payment of a maintenance fee is not a party in interest for purposes of paragraph (c) of § 1.377. The petition must be in the form of a verified statement if made by a person not registered to practice before the Patent and Trademark Office. If the petition is signed by a person not registered to practice before the Patent and Trademark Office, the petition must include the authority of the person signing the petition as patentee, assignee, or other party in interest.

New § 1.378 is added as proposed to establish the procedure for acceptance of the delayed payment of a maintenance fee in an expired patent. This procedure is only available under Pub. L. 97–247 where the application on which the patent is based was filed on or after August 27, 1982. If the maintenance fee is due under Pub. L. 96–517, i.e., the application on which the patent is based was filed on or after December 12, 1980, and before August 27, 1982, the delayed payment of the maintenance fee is not provided for by statute and cannot be accepted after expiration of the patent, and the patent cannot be reinstated.

Paragraph (a) of new § 1.378 provides that the Commissioner may accept the payment of any maintenance fee due on a patent based on an application filed on or after August 27, 1982, after expiration of the patent if, upon petition, the delay in payment of the maintenance fee is shown to the satisfaction of the Commissioner to have been unavoidable. The surcharge set forth in § 1.20(m) must be paid as a condition of accepting payment of the maintenance fee. No separate petition fee is required for this petition. If the Commissioner accepts payment of the maintenance fee upon petition, the patent shall be considered as not having expired, but will be subject to the intervening rights provisions of 35 U.S.C. 41(c)(2).

Paragraph (b) of new § 1.378 specifies the requirements of a petition for acceptance of the delayed payment of a maintenance fee filed within six months of the expiration of the patent. Under paragraph (b), the petition must include the required maintenance fee set forth in § 1.20 (h)–(j); the surcharge set forth in § 1.20(m); and a showing that the delay was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely. The showing must enumerate the steps taken to ensure timely payment of the maintenance fee. In view of the requirement to enumerate the steps taken to ensure timely payment of the maintenance fee, an argument that the patentee was ignorant of the requirement to pay maintenance fees will not constitute a showing of unavoidable delay. Evidence that despite reasonable care on behalf of the patentee and/or the patentee's agents, and reasonable steps to ensure timely payment, the maintenance fee was unavoidably not paid, could be submitted in support of an argument that the delay in payment was unavoidable. For example, an error in a docketing system could possibly result in a finding that a delay in payment was unavoidable if it were shown that reasonable care was exercised in designing and operating the system and if it were shown that the patentee took reasonable steps to ensure that the patent was entered into the system to ensure timely payment of the maintenance fees.

Paragraph (c) of new § 1.378 specifies the requirements of a petition for acceptance of the delayed payment of a maintenance fee filed more than six months after the expiration of a patent. These requirements are much more stringent in view of the heavy burden of proof that the delay was unavoidable. The legislative history of Pub. L. 97–247, House Report No. 97–542 (Committee on the Judiciary), indicates that "[a]fter the expiration of a reasonable period of time, the patentee would bear a heavy burden of proof that the delay was unavoidable." The six-month period provided for petition under paragraph (b) is considered to be a reasonable period of time within which to seek reinstatement of a patent which expired for failure to pay the maintenance fee. Any petition filed more than six months after expiration must meet the more stringent requirements of paragraph (c). Under paragraph (c), the petition must include the same elements as in paragraph (b) and, in addition, must demonstrate that the failure to pay the maintenance fee was unavoidable due to circumstances outside of the control of the patentee and those acting on behalf of the patentee in paying the maintenance fee. The showing in a petition under paragraph (c) must be sufficient in scope and content to meet the heavy burden of proof required to show that a delay in payment of the maintenance fee of more than six months after expiration of the patent was unavoidable. In contrast to a petition under paragraph (b), a showing in a petition under paragraph (c) of an error in a docketing system will not be sufficient to find that the delay was unavoidable. Instead, a petition filed under paragraph (c) must demonstrate that the circumstances resulting in the delay were entirely outside the control of the patentee and those acting on behalf of the patentee in paying the maintenance fee, e.g., serious efforts without success to raise the funds required to pay the maintenance fee.

Paragraph (d) of new § 1.378 requires that a petition filed under § 1.378 be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest. A person or organization whose only responsibility insofar as the patent is concerned is the payment of a maintenance fee is not a party in interest for purposes of paragraph (d) of § 1.378. Under paragraph (d), the petition must be in the form of a verified statement if made by a person not registered to practice before the Patent and Trademark Office. If the petition is signed by a person not registered to practice before the Patent and Trademark Office, the petition must include the authority of the person signing the petition as patentee, assignee, or other party in interest.

Paragraph (e) of new § 1.378 provides a mechanism for obtaining reconsideration of a decision refusing to accept a maintenance fee upon petition filed pursuant to paragraph (a). This mechanism is a petition for reconsideration which may be filed within two months of, or such other time as set in the decision refusing to accept the delayed payment of the maintenance fee. In contrast to petitions filed under paragraph (a), the petition for reconsideration filed under paragraph

(e) of new § 1.378 will require the separate petition fee set forth in the amendment to § 1.17(h). Paragraph (e) also provides that after the decision on the petition for reconsideration, no further reconsideration or review of the matter will be undertaken by the Commissioner. Paragraph (e) also provides for refund of the maintenance fee and the surcharge set forth in § 1.20(m) if the delayed payment of the maintenance fee is not accepted. The refund will be made following the decision on the petition for reconsideration, or after the expiration of the time for filing such a petition for reconsideration, if none is filed. Paragraph (e) specifies that the fee for filing the petition for reconsideration will not be refunded unless the refusal to accept and record the maintenance fee is determined to result from an error by the Patent and Trademark Office.

Response to Comments on the Rules

Specific comments were received on a number of the proposed rule changes. Eight letters submitting written comments were received. Oral testimony was presented by two persons (one person testified on behalf of the American Intellectual Property Law Association) at the public hearing conducted on June 26, 1984. All of the written and oral comments were considered in adopting the changes set forth herein. The comments submitted appear below along with responses thereto.

Comment

One comment suggested that the surcharge set at 37 CFR 1.20(m) for accepting a maintenance fee after expiration of the patent should be reduced from $500.00 to $50.00 and that this amount should be reduced by 50 percent for small entities.

Reply

The suggestion has not been adopted. The surcharge set at 37 CFR 1.20(m) is considered to be appropriate in view of the importance of the relief being obtained. Before a surcharge under 37 CFR 1.20(m) is due the patent will have already expired due to the failure to pay a maintenance fee within a one-year period provided for the payment. Setting a lower amount as the surcharge would tend to denigrate the importance of the relief obtained by the acceptance of a maintenance fee after expiration of a patent. Further, a lower surcharge is not justified in view of the ample opportunity for payment of the maintenance fee which is presented by the one-year period in which payment can be made and the fact that the public is now on notice that maintenance fees are due and payable. Further, the Patent and Trademark Office will provide courtesy notices regarding the need to pay maintenance fees at a plurality of points in time before the patent expires. Such a notice now appears on the patent grant and presently plans are to print such a courtesy notice on the Notice of Allowance and the Issue Fee Receipt. Notices will be printed in the *Official Gazette* listing the patent number ranges of patents on which maintenance fees can be paid and a notice will be mailed to the patentee during the grace period if the maintenance fee is not paid. Therefore, relatively few patentees should fail to pay the maintenance fee before expiration of the patent due to unavoidable circumstances. The surcharge set at 37 CFR 1.20(m) is established pursuant to 35 U.S.C. 41(c) and therefore the small entity provisions of Pub. L. 97–247 do not apply to this fee. Also, Pub. L. 97–247 provides that the surcharge set at 37 CFR 1.20(m) could be in addition to any surcharge established for payment of the maintenance fee during the grace period as set at 37 CFR 1.20(l). The Patent and Trademark Office has established a separate surcharge set at 37 CFR 1.20(m) not in addition to the surcharge set at 37 CFR 1.20(l), but in lieu thereof. The amount set at 37 CFR 1.20(m) is not seen to be excessive.

Comment

Two comments suggested that the small entity reduced fee provisions of Pub. L. 97–247 should have been applied to maintenance fees required under Pub. L. 96–517.

Reply

The maintenance fee amounts under Pub. L. 96–517 set at 37 CFR 1.20(e)–(g) were previously set and are not part of the present rulemaking. It should be noted, however, that Pub. L. 96–517 did not provide for reduction of fees for small entities. Reductions of fees for small entities were established in Pub. L. 97–247 only for fees under 35 U.S.C. 41 (a) and (b) thereof. The maintenance fee levels in 37 CFR 1.20(e)–(g), however, were established under 35 U.S.C. 41 (c) of Pub. L. 96–517 rather than 35 U.S.C. 41(a) or (b) of Pub. L. 97–247. Therefore, the fee amounts previously set at 37 CFR 1.20(e)–(g) are not seen to be subject to reduction for small entities.

Comment

One comment suggested that the Office permit any of the maintenance fees to be paid in advance, either at the time of paying the issue fee or during any of the window periods. Another comment suggested that the Office should accept a fee payment earlier than the window period if the fee has no possibility of being changed due to changes in the Consumer Price Index.

Reply

These suggestions have not been adopted. The second comment listed above points out the problem with regard to the suggestion in the first comment. Public Law 97–247 provided for adjustments of the maintenance fees every third year to reflect any fluctuations occurring during the previous three years in the Consumer Price Index, as determined by the Secretary of Labor. Allowing maintenance fees to be paid in advance would preclude such adjustments to these maintenance fees unless very burdensome administrative steps were implemented to require adjustments in the fee amount previously paid when the maintenance fees are adjusted at a later time. Requiring maintenance fees to be paid in a consistently time-ordered basis as in § 1.362 will also be helpful administratively and for budgeting purposes. As to the second comment above, it is not seen that there would be substantial benefit to the public since the period would be short during which a maintenance fee could not change due to changes in the Consumer Price Index. Thus, the patentee would only be able to make the maintenance fee payment a short time before the period during which payment may be made pursuant to § 1.362.

Comment

Two comments suggested that a maintenance fee made during the window period should not require adjustment if the maintenance fees are thereafter increased to reflect increases in the Consumer Price Index.

Reply

These comments have been adopted by an appropriate change in paragraph (b) of § 1.366. Maintenance fees which are paid during the window period in the amount required on the date of payment will be accepted as proper and full payment. If the maintenance fees change after such a proper payment, no adjustment in the amount will be required or permitted. Thus, if the maintenance fee increases before the close of the window period, the patentee will not be required to make up any deficiency between the amount properly paid during the window period and the new increased fee. Likewise, if the maintenance fee decreases before the close of the window period, no refund will be permitted of part of the

maintenance fee properly paid in the amount due when the payment was made. Payments must be made in the amount proper on the date of payment. For example, if payment is made during the grace period, the payment must be made in the amount then required irrespective of the amount of the maintenance fee which would have been due if payment had been made during the window period.

Comment

Three comments were directed to the proposed requirements in § 1.366(c) for data identifying the patent upon which maintenance fee payments are being made. One comment indicated that many computer annuity systems now existing have a data base designed to accept only two identifying numbers. This comment and one other comment suggested that the patent number and issue date be required to be submitted with the maintenance fee to identify the patent number. Another comment suggested that the required identifying data be the patent number, issue date, name of the inventor and title of the invention.

Reply

The suggested changes to the proposed rule have been adopted in part. The requirement for identifying data to uniquely identify the patent for which maintenance fees are being paid is an important one. The Patent and Trademark Office and the public must be able to determine with certainty which patents are in force and which patents have expired because the maintenance fees were not paid. The comments seem to recognize that at least two identifiers are necessary so that a cross-check can be made to avoid errors. The suggested use of the issue date with the patent number would not provide a reliable cross-check. In excess of one thousand patents usually issue on each issue date. Therefore a mistake in the last four digits in the patent number supplied with the maintenance fee payment would often not be detected by use of the issue date as a cross-check. The Patent and Trademark Office has determined that the two best identifying data units for use as a cross-check are the patent number and the application serial number. These identifiers are unique since each is specific to one patent or application and are thus required to be provided with a maintenance fee payment by the final rule. The application serial number and the patent number are both listed on the issue patent and in the *Official Gazette* and therefore should be readily available to patentees.

Comment

One comment suggested that no petition fee should be charged for filing a petition under 37 CFR 1.377 seeking review of a decision refusing to accept and record payment of a maintenance fee filed prior to expiration of a patent. The comment further suggested that, if a fee is charged, the filing of a petition thereunder should be presumed to be a request for a return of the petition fee if it is determined that the refusal to accept and record a maintenance fee payment was due to Patent and Trademark Office error.

Reply

The suggestion that no petition fee be charged has not been adopted. The petition fee, although required in advance, will be retained by the Patent and Trademark Office only in those instances where the refusal to accept and record the fee resulted from an error on the part of someone other than the Patent and Trademark Office. In those instances where the refusal to accept and record the fee resulted from a Patent and Trademark Office error the Office intends to refund the petition fee, either based upon the request included in the petition or upon the initiative of the Office. The reason for including a request for a refund, where appropriate, in the petition is to ensure that such request is not inadvertently overlooked. In view of the expense involved, it would be inappropriate to process a petition without a petition fee where the error necessitating the petition was made by the petitioner or someone acting on behalf of the patentee.

Comment

One comment suggested that the term "unavoidable" should be more specifically defined in 37 CFR 1.378 (b)(3) and (c)(3), if possible.

Reply

As stated in this rulemaking, the requirement that the delay in payment of the maintenance fee be "unavoidable" is the same as that for reviving an abandoned application under 35 U.S.C. 133. This standard has been in effect for many years and should be well understood by the public. The rule is seen to be adequate as written, especially in view of the discussion in this rulemaking which includes several specific examples based on when the petition to accept the delayed payment of a maintenance fee is filed.

Comment

One comment suggested that Pub. L. 97–247 should be "liberally interpreted" to permit acceptance of delayed payments of maintenance fees required under Pub. L. 96–517. Proposed 37 CFR 1.378 was limited to patents issuing on applications filed on or after August 27, 1982, the effective date of Pub. L. 97–247.

Reply

The final rule has not been changed from the proposal. The remedy suggested by the comment cannot be provided in view of the language of 35 U.S.C. 41(c)(1) which applies only to maintenance fees required by 35 U.S.C. 41(b) of Pub. L. 97–247. Section 17(a) of Pub. L. 97–247 clearly states "the maintenance fees provided for in section 3(b) of this Act shall not apply to patents applied for prior to the date of enactment of this Act."

Comment

Several of the comments received were directed to proposed statutory changes which were said to be desirable in the area of maintenance fees.

Reply

These comments were not suggesting that the proposed rules were not in compliance with the present statutes, but rather that the statutes themselves should be changed. These comments are beyond the scope and purpose of this rule change.

Implementation of Maintenance Fee Payment Procedures

The Patent and Trademark Office is presently developing its internal working procedures for processing maintenance fee payments and for notifying the public as to the status of maintenance fee payments on particular patents. The first maintenance fees become due early in 1985. In order to be as helpful as possible in informing the public as to the Patent and Trademark Office's current plans it is useful to outline the basic procedures the Patent and Trademark Office intends to adopt to process maintenance fees so that the interrelationship with the rules is understood. These basic procedures are subject to change as experience and circumstances dictate.

Notices by the Patent and Trademark Office

Under the statutes, the Patent and Trademark Office has no duty to notify patentees when their maintenance fees are due. It is the responsibility of the patentee to assure that the maintenance fees are paid to prevent expiration of the

patent. The Patent and Trademark Office will, however, provide some notices as reminders that maintenance fees are due, but the notices, errors in the notices, or the lack of notices, will in no way relieve a patentee from the responsibility to make timely payment of each maintenance fee to prevent the patent from expiring by operation of law. The notices provided by the Patent and Trademark Office will be merely courtesy in nature and intended to aid patentees. These notices, errors in these notices, or the lack of notices, will in no way shift the burden of monitoring the time for paying maintenance fees on patents from the patentee to the Patent and Trademark Office.

Preprinted Standard Notice Wording

The patent grant currently includes a reminder that maintenance fees may be due. The Notice of Allowance and Issue Fee Receipt are presently planned to be revised to contain reminder notice wording that maintenance fees may be due.

Official Gazette Notice

A notice will appear in each issue of the *Official Gazette* which will indicate which patents have been granted 3, 7 and 11 years earlier, that the window period has opened and that maintenance fee payments will now be accepted for these patents.

Another *Official Gazette* notice published after expiration of the grace period will indicate any patent which has expired due to non-payment of maintenance fees and any patents which have been revived under 35 U.S.C. 41(c). An annual compilation of such expirations and revivals will also be published.

Courtesy Reminder Notice

Since patentees are expected to maintain their own record systems and since most patentees are expected to pay their maintenance fees during the "window period" to prevent payment of a surcharge, the Office will not send any reminder notices to patentees at the fee address until after the grace period has begun. This will reduce and simplify the mailing of notices but still give patentees an opportunity to pay their maintenance fees with surcharge during the grace period before expiration of their patents. Such notices will be mailed to the fee address as set forth in § 1.363.

Action Notices

The Office will issue a receipt for payment of maintenance fees after entry of the maintenance fee payment. Such a receipt will provide an opportunity for the patentee to check if the Office has properly credited the payment. The original document submitted by the patentee when paying the maintenance fee will also be appropriately marked and returned to the fee address. If actual experience indicates that they are not needed, the receipt notices and/or the return of the original document may be discontinued.

The patentee will also be notified by mail at the fee address as set forth in § 1.363 of any expiration or revival of the patent.

Fee Address

The patentee may provide the Patent and Trademark Office with a fee address under § 1.363, which address may be different from the correspondence address under § 1.33, when submitting the issue fee or in a separate later-filed paper. The fee address will be used by the Office for all correspondence directed to the patentee concerning maintenance fees. If no separate fee address is provided by the patentee under § 1.363, the correspondence address under § 1.33 will also be used for maintenance fee purposes.

Payment of Maintenance Fees

Transmittals of maintenance fees may be limited to a single patent or may involve several patents. If a transmittal involves several patents they should be listed in increasing numerical order. The following format is suggested for use when paying maintenance fees and any necessary surcharges. Although only the mandatory identification elements consisting of the patent number and United States application serial number, set forth in § 1.366(c) are required, the items referred to in § 1.366(d) should also be included to expedite processing of maintenance fees and any necessary surcharges. In addition, the indication of the fee code used by the Patent and Trademark Office would assist in proper financial crediting within the Office. It is also suggested that the telephone number of the person submitting the payment be supplied.

February 22, 1984.

Commissioner of Patents and Trademarks,
Box M. Fee, Washington, D.C. 20231

Dear Sir: Enclosed is a check drawn for the amount of $1,500 for the payment of the maintenance fees on the following patents.

Patent No.	Serial No.	Patent date	Application filing date	Payment year	Small entity	Amount paid		Surcharge	Fee code
P.P. 5,188	380,062	Feb. 7, 1984	May 20, 1981	4		$200			170
Re. 31,522	481,494	Feb. 14, 1984	Apr. 1, 1983	4		200		$100	170/176
*(4,374,741)		(Feb. 22, 1983)	(July 21, 1981)						
4,429,419	339,620	Feb. 7, 1984	Jan. 15, 1982	4		200			170
4,429,433	412,101	Feb. 7, 1984	Aug. 27, 1982	4	No	400			173
4,429,439	458,474	Feb. 7, 1984	Jan. 17, 1983	4	Yes	200			273
**4,432,000	360,681	Feb. 14, 1984	Aug. 26, 1981	4		200			170
		Subtotal				1,400		100	
		Total amount paid					1,500		

*NOTE.—Information from original patent is included in parenthesis for the reissue patent for which payment is being made.
**NOTE.—Application Filing Date is the PCT International Filing Date.

The Commissioner is hereby authorized to charge any deficiency in the required fee or to credit any overpayment to Account No. 12-3456.

Respectfully submitted,
John Doe
(703) 557-3054

Environmental, energy, and other considerations: The rule change will not have a significant impact on the quality of the human environment or conservation of energy resources.

The rule change is in conformity with the requirements of the Regulatory Flexibility Act (Pub. L. 96-354), Executive Order 12291, and the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 et seq.

The General Counsel of the Department of Commerce certified to the Small Business Administration that the rule change will not have a significant adverse economic impact on a substantial number of small entities (Regulatory Flexibility Act, Pub. L. 96-354). Public Law 97-247 has taken into consideration the impact it may have on small entities.

The Patent and Trademark Office has determined that this rule change is not a major rule under Executive Order 12291. The annual effect on the economy will be less than $100 million. There will be no major increase in costs or prices for consumers, individual industries, federal, state, or local government

agencies, or geographic regions. There will be no significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The maintenance fee payment information collection requirement contained in the final rules has been submitted to OMB for review under section 3504(h) of the Paperwork Reduction Act. Comments relating to this requirement should be directed to the Office of Information and Regulatory Affairs of OMB, Attention: Desk Officer for Commerce, Patent and Trademark Office.

List of Subjects in 37 CFR Part 1

Administrative practice and procedure, Authority delegations (government agencies), Conflict of interests, Courts, Inventions and patents, Lawyers.

Notice is hereby given that pursuant to the authority granted to the Commissioner of Patents and Trademarks by 35 U.S.C. 6, Pub. L. 96–517 and Pub. L. 97–247, the Patent and Trademark Office is amending Title 37 of the Code of Federal Regulations as set forth below.

PART 1—[AMENDED]

37 CFR Part 1, is amended as follows:

1. Section 1.1 is amended by adding a new paragraph (d) to read as follows:

§ 1.1 All communications to be addressed to Commissioner of Patents and Trademarks.

* * * * *

(d) Payments of maintenance fees in patents and other communications relating thereto should be additionally marked "Box M. Fee."

§ 1.9 [Amended]

2. Paragraph (d) of § 1.9 is amended by changing the citation "13 CFR 121.3–18, published on September 30, 1982 at 47 FR 43273." to "13 CFR 121.12." and by changing the words "§ 121.3–18 Definition of small business for paying reduced patent fees under Title 35, U.S. Code" to "§ 121.12 Small business for paying reduced patent fees."

3. Section 1.17 is amended by adding to the end of paragraph (h) the following:

§ 1.17 Patent application processing fees.

* * * * *

(h) * * *

§ 1.377—for review of decision refusing to accept and record payment of a maintenance fee filed prior to expiration of patent

§ 1.378(e)—for reconsideration of decision on petition refusing to accept delayed payment of maintenance fee in expired patent

* * * * *

4. Section 1.19 is amended by adding new paragraphs (f) and (g) to read as follows:

§ 1.19 Document supply fees.

* * * * *

(f) Microfiche copy of patent file record.....$10.00

(g) Uncertified statement as to status of the payment of maintenance fees due on a patent or expiration of a patent.....$3.00

5. Section 1.20 is amended by adding new paragraphs (k), (l) and (m) to read as follows:

§ 1.20 Post-issuance fees.

(k) Surcharge for paying a maintenance fee during the 6-month grace period following the expiration of three years and six months, seven years and six months, and eleven years and six months after the date of the original grant of a patent based on an application filed on or after December 12, 1980 and before August 27, 1982.....$100.00

(l) Surcharge for paying a maintenance fee during the 6-month grace period following the expiration of three years and six months, seven years and six months, and eleven years and six months after the date of the original grant of a patent based on an application filed on or after August 27, 1982:

By a small entity (§ 1.9(f)).....$50.00

By other than a small entity.....$100.00

(m) Surcharge for accepting a maintenance fee after expiration of a patent for non-timely payment of a maintenance fee on a patent based on an application filed on or after August 27, 1982, where the delay in payment is shown to the satisfaction of the Commissioner to have been unavoidable.....$500.00

6. Section 1.33 is amended by adding a new paragraph (d) to read as follows:

§ 1.33 Correspondence respecting patent applications, reexamination proceedings, and other proceedings.

* * * * *

(d) A "correspondence address" or change thereto may be filed with the Patent and Trademark Office during the enforceable life of the patent. The "correspondence address" will be used in any correspondence relating to maintenance fees unless a separate "fee address" has been specified. See § 1.363 for "fee address" used solely for maintenance fee purposes.

7. A new center heading and § 1.362 is added to Subpart B to read as follows:

Maintenance Fees

§ 1.362 Time for payment of maintenance fees.

(a) Maintenance fees as set forth in § 1.20 (e)–(j) are required to be paid in all patents based on applications filed on or after December 12, 1980, except as noted in paragraph (b) of this section, to maintain a patent in force beyond 4, 8 and 12 years after the date of grant.

(b) Maintenance fees are not required for plant patents based on applications filed on or after August 27, 1982 or for any design patents. Maintenance fees are not required for a reissue patent if the patent being reissued did not require maintenance fees.

(c) The application filing dates for purposes of payment of maintenance fees are as follows:

(1) For an application not claiming benefit of an earlier application, the actual United States filing date of the application.

(2) For an application claiming benefit of an earlier foreign application under 35 U.S.C. 119, the United States filing date of the application.

(3) For a continuing (continuation, division, continuation-in-part) application claiming the benefit of a prior patent application under 35 U.S.C. 120, the actual United States filing date of the continuing application.

(4) For a reissue application, the United States filing date of the original non-reissue application on which the patent reissued is based.

(5) For an international application which has entered the United States as a Designated Office under 35 U.S.C. 371, the international filing date granted under Article 11(1) of the Patent Cooperation Treaty which is considered to be the United States filing date under 35 U.S.C. 363.

(d) Maintenance fees may be paid in patents without surcharge during the periods extending respectively from:

(1) 3 years through 3 years and 6 months after grant for the first maintenance fee,

(2) 7 years through 7 years and 6 months after grant for the second maintenance fee, and

(3) 11 years through 11 years and 6 months after grant for the third maintenance fee.

(e) Maintenance fees may be paid with the surcharge set forth in § 1.20 (k) or (l) during the respective grace periods after:

(1) 3 years and 6 months and through the day of the 4th anniversary of the grant for the first maintenance fee,

(2) 7 years and 6 months and through the day of the 8th anniversary of the

grant for the second maintenance fee, and

(3) 11 years and 6 months and through the day of the 12th anniversary of the grant for the third maintenance fee.

(f) If the last day for paying a maintenance fee without surcharge set forth in paragraph (d) of this section, or the last day for paying a maintenance fee with surcharge set forth in paragraph (e) of this section, falls on a Saturday, Sunday, or a federal holiday within the District of Columbia, the maintenance fee and any necessary surcharge may be paid under paragraph (d) or paragraph (e) respectively on the next succeeding day which is not a Saturday, Sunday, or federal holiday.

(g) Unless the maintenance fee and any applicable surcharge is paid within the time periods set forth in paragraphs (d), (e) or (f) of this section, the patent will expire as of the end of the grace period set forth in paragraph (e) of this section. A patent which expires for the failure to pay the maintenance fee will expire at the end of the same date (anniversary date) the patent was granted in the 4th, 8th, or 12th year after grant.

8. A new § 1.363 is added to Subpart B to read as follows:

§ 1.363 Fee address for maintenance fee purposes.

(a) All notices, receipts, refunds, and other communications relating to payment or refund of maintenance fees will be directed to the correspondence address used during prosecution of the application as indicated in § 1.33(a) unless:

(1) A "fee address" for purposes of payment of maintenance fees is set forth when submitting the issue fee, or

(2) A change in the correspondence address for all purposes is filed after payment of the issue fee, or

(3) A "fee address" or a change in the "fee address" is filed for purposes of receiving notices, receipts and other correspondence relating to the payment of maintenance fees after the payment of the issue fee, in which instance, the latest such address will be used.

(b) An assignment of a patent application or patent does not result in a change of the "correspondence address" or "fee address" for maintenance fee purposes.

9. A new § 1.366 is added to Subpart B to read as follows:

§ 1.366 Submission of maintenance fees.

(a) The patentee may pay maintenance fees and any necessary surcharges, or any person or organization may pay maintenance fees and any necessary surcharges on behalf of a patentee. Authorization by the patentee need not be filed in the Patent and Trademark Office to pay maintenance fees and any necessary surcharges on behalf of the patentee.

(b) A maintenance fee and any necessary surcharge submitted for a patent must be submitted in the amount due on the date the maintenance fee and any necessary surcharge are paid and may be paid in the manner set forth in § 1.23 or by an authorization to charge a deposit account established pursuant to § 1.25. Payment of a maintenance fee and any necessary surcharge or the authorization to charge a deposit account must be submitted within the periods set forth in § 1.362 (d), (e) or (f). Any payment or authorization of maintenance fees and surcharges filed at any other time will not be accepted and will not serve as a payment of the maintenance fee except insofar as a delayed payment of the maintenance fee is accepted by the Commissioner in an expired patent pursuant to a petition filed under § 1.378. Any authorization to charge a deposit account must authorize the immediate charging of the maintenance fee and any necessary surcharge to the deposit account. Payment of less than the required amount, payment in a manner other than that set forth in § 1.23, or the filing of an authorization to charge a deposit account having insufficient funds will not constitute payment of a maintenance fee or surcharge on a patent. The certificate of mailing procedures of either § 1.8 or § 1.10 may be utilized in paying maintenance fees and any necessary surcharges.

(c) In submitting maintenance fees and any necessary surcharges, identification of the patents for which maintenance fees are being paid must include the following:

(1) The patent number, and

(2) The serial number of the United States application for the patent on which the maintenance fee is being paid.

(d) Payments of maintenance fees and any surcharges should identify the fee being paid for each patent as to whether it is the 3½, 7½ or 11½ year fee, whether small entity status is being changed or claimed, the amount of the maintenance fee and any surcharge being paid, any assigned payor number, the patent issue date and the United States application filing date. If the maintenance fee and any necessary surcharge is being paid on a reissue patent, the payment must identify the reissue patent by reissue patent number and reissue application serial number as required by paragraph (c) of this section and should also include the original patent number, the original patent issue date and the original United States application filing date.

(e) Maintenance fee payments and surcharge payments relating thereto must be submitted separate from any other payments for fees or charges, whether submitted in the manner set forth in § 1.23 or by an authorization to charge a deposit account. If maintenance fee and surcharge payments for more than one patent are submitted together, they should be submitted on as few sheets as possible with the patent numbers listed in increasing patent number order. If the payment submitted is insufficient to cover the maintenance fees and surcharges for all the listed patents, the payment will be applied in the order the patents are listed, beginning at the top of the listing.

(f) Notification of any change in status resulting in loss of entitlement to small entity status must be filed in a patent prior to paying, or at the time of paying, the earliest maintenance fee due after the date on which status as a small entity is no longer appropriate. See § 1.28(b).

(g) Maintenance fees and surcharges relating thereto will not be refunded except in accordance with §§ 1.26 and 1.28(a).

10. A new § 1.377 is added to Subpart B to read as follows:

§ 1.377 Review of decision refusing to accept and record payment of a maintenance fee filed prior to expiration of patent.

(a) Any patentee who is dissatisfied with the refusal of the Patent and Trademark Office to accept and record a maintenance fee which was filed prior to the expiration of the patent may petition the Commissioner to accept and record the maintenance fee.

(b) Any petition under this section must be filed within 2 months of the action complained of, or within such other time as may be set in the action complained of, and must be accompanied by the fee set forth in § 1.17(h). The petition may include a request that the petition fee be refunded if the refusal to accept and record the maintenance fee is determined to result from an error by the Patent and Trademark Office.

(c) Any petition filed under this section must comply with the requirements of paragraph (b) of § 1.181 and must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest. Such petition must be in the form of a verified statement if made by a

person not registered to practice before the Patent and Trademark Office.

11. A new § 1.378 is added to Subpart B to read as follows:

§ 1.378 Acceptance of delayed payment of maintenance fee in expired patent to reinstate patent based on application filed on or after August 27, 1982.

(a) The Commissioner may accept the payment of any maintenance fee due on a patent based on an application filed on or after August 27, 1982, after expiration of the patent if, upon petition, the dalay in payment of the maintenance fee is shown to the satisfaction of the Commissioner to have been unavoidable and if the surcharge required by § 1.20(m) is paid as a condition of accepting payment of the maintenance fee. If the Commissioner accepts payment of the maintenance fee upon petition, the patent shall be considered as not having expired, but will be subject to the conditions set forth in 35 U.S.C. 41(c)(2).

(b) Any petition to accept the delayed payment of a maintenance fee filed under paragraph (a) of this section within six months of the expiration of the patent must include:

(1) The required maintenance fee set forth in § 1.20(h)-(j);

(2) The surcharge set forth in § 1.20(m); and

(3) A showing that the delay was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely. The showing must enumerate the steps taken to ensure timely payment of the maintenance fee.

(c) Any petition to accept the delayed payment of a maintenance fee filed under paragraph (a) of this section more than six months after the expiration of the patent must include:

(1) The required maintenance fee set forth in § 1.20(h)-(j);

(2) The surcharge set forth in § 1.20(m); and

(3) A showing that the delay was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and the failure to timely pay the maintenance fee was due entirely to circumstances outside of the control of the patentee. The showing must enumerate the steps taken to ensure timely payment of the maintenance fee and the circumstances which were outside of the control of the patentee and those acting on behalf of the patentee in paying the maintenance fee. The showing must be sufficient in scope and content to meet the heavy burden of proof required to show that a delay in payment of the maintenance fee of more than six months after expiration of the patent was unavoidable.

(d) Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest. Such petition must be in the form of a verified statement if made by a person not registered to practice before the Patent and Trademark Office.

(e) Reconsideration of a decision refusing to accept a maintenance fee upon petition filed pursuant to paragraph (a) of this section may be obtained by filing a petition for reconsideration within two months of, or such other time as set in, the decision refusing to accept the delayed payment of the maintenance fee. Any such petition for reconsideration must be accompanied by the petition fee set forth in § 1.17(h). After decision on the petition for reconsideration, no further reconsideration or review of the matter will be undertaken by the Commissioner. If the delayed payment of the maintenance fee is not accepted, the maintenance fee and the surcharge set forth in § 1.20(m) will be refunded following the decision on the petition for reconsideration, or after the expiration of the time for filing such a petition for reconsideration, if none is filed. The fee set forth in § 1.17(h) for filing the petition for reconsideration will not be refunded unless the refusal to accept and record the maintenance fee is determined to result from an error by the Patent and Trademark Office.

Dated: July 30, 1984.

Gerald J. Mossinghoff,

Commissioner of Patents and Trademarks.

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Part VII

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 Fiscal Year 1985 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[BERC-279-F]

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

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

ACTION: Final Rule.

SUMMARY: This final rule amends the Medicare regulations published as an interim final rule on September 1, 1983 (48 FR 39752) and a final rule 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-related groups.

In addition, in the addendum to this final rule, we are making 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 are applicable in the second year of the three-year transition period for the prospective payment system.

We are also implementing in this final rule certain changes in the inpatient hospital prospective payment system resulting from the enactment of Pub. L. 98-369 on July 18, 1984.

EFFECTIVE DATES: With certain exceptions, these regulations are effective with discharges occurring on or after October 1, 1984, or with hospital cost reporting periods beginning on or after October 1, 1984. We refer the reader to section VII.A. of this preamble for a detailed discussion of effective dates.

FOR FURTHER INFORMATION, CONTACT:

Paul Elstein, (301) 597-1755—Transfers; Referral Centers; Indirect Medical Education Costs; CRNAs

Paul Olenick (301) 594-9349—Urban/Rural Areas; Prospective Payment Rates

Sheridan Gladhill (301) 594-9440—Rehabilitation Units

Thomas Hoyer (301) 594-9446—Physician Attestation

George Cray (301) 597-3674—Base Year Appeals

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary of the Final Rules Implementing Inpatient Hospital Prospective Payment System

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 for inpatient hospital services 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 a 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 made entirely under national DRG payment rates.

We published an interim final 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.

B. Summary of July 1984 Proposed Rule

On July 3, 1984 we published a notice of proposed rulemaking (NPRM) in the **Federal Register** (49 FR 27422) to amend 42 CFR Part 405 in order to make further changes in the prospective payment regulations. We proposed to—

- Pay cost outlier payments to a transferring hospital for extraordinarily high-cost cases;
- Revise the definition of full-time direction for an excluded rehabilitation unit;
- Make less restrictive the criteria for expansion of an excluded rehabilitation unit;
- Clarify the scope of the physician's certification statement and the accompanying penalty statement;
- Provide a special adjustment for hospitals redesignated by the Executive Office of Management and Budget (EOMB) to be no longer a part of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA);
- Clarify which census division a hospital belongs to if an MSA or NECMA crosses a census division boundary;
- Authorize additional administrative actions as a basis upon which a prospective recalculation of a hospital's base year cost may be made; and
- Expand the definition of a referral center to encompass more rural hospitals.

In addition, in the addendum to the NPRM (49 FR 29438), we proposed 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.

In section II. of this preamble and section II. of the addendum to this document, we describe changes we are making to those proposals in response to public comments that we received timely.

C. Summary of Recent Legislation (Title III of Pub. L. 98-369)

On July 18, 1984, the President signed into law Pub. L. 98-369, the Deficit Reduction Act of 1984. Title III of Division B of this Act, the Medicare and Medicaid Budget Reconciliation Amendments of 1984, contains several changes relating to the hospital

prospective payment system. Section 2311 of Pub. L. 98–369, which is related to specific proposals we had set forth in the NPRM, is discussed in section II. of this preamble. Section III. of this preamble contains a discussion of the following changes to the prospective payment system mandated by sections 2307(b) and 2312 of Pub. L. 98–369:

- In determining the indirect medical education adjustment, the interns and residents in approved programs are to be counted regardless of whether they are employed by the hospital in which they are working (section 2307(b)).
- Hospitals will be paid on a reasonable cost basis for anesthesia services provided by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiology assistants) (section 2312 requires such payment for CRNAs).

In addition, the provisions in section 2310 (rate of increase limitation) of Pub. L. 98–369 that affect the FY 1985 prospective payment rates are discussed in the addendum to this final rule.

D. Number and Types of Public Comments

A total of 3,951 letters were received containing comments on the proposed regulations by the comment-period deadline of August 2, 1984. Among the many issues raised, the following subjects prompted the majority of comments:

- Criteria for classification as a referral center;
- Physician attestation requirement as part of the discharge summary;
- Reduction of the weighting factors by 2.4 percent;
- Wage index (especially rural);
- Outlier policies especially with regard to transfer cases;
- Budget neutrality adjustments and availability of data;
- Dialysis services especially when admitted for unrelated treatment;
- Criteria for classification as a rehabilitation hospital or unit; and
- General concerns about the net increase in rates.

In addition to comments received as a result of the NPRM, we also received a small number of comments on issues not discussed in the NPRM.

II. Changes to Current Regulations Resulting From the NPRM or Resulting From Pub. L. 98–369

A. Payment of Cost Outliers to Hospitals That Transfer Patients (§ 405.470)

Under § 405.470(c)(4), a hospital that transfers a patient receives a per diem payment determined by dividing the full payment rate for the discharge by the average length of stay for the applicable DRG assigned to the case. Payment to a transferring hospital may not exceed the full DRG rate regardless of the length of stay or exceptionally costly care provided.

Based on our experience during the first year under the prospective payment system, we now believe that cost-outlier payments (additional payments) should be available to transferring hospitals for exceptionally costly cases. We are modifying § 405.470(c)(4) as proposed in the NPRM, to permit a transferring hospital to receive cost-outlier payments, for patients transferred on or after October 1, 1984, if the cost-outlier criteria in § 405.475(d) are met.

We received comments from hospitals and hospital associations regarding this provision. The issues raised by the commenters are as follows:

Comment—All the comments we received regarding the change in the transfer payment policy were in favor of our extending cost outlier payments to transferring hospitals. However, several commenter questioned our rationale for not providing day outlier payments to transferring hospitals. They stated that medical review should be adequate to identify appropriate day outlier cases in transferring hospitals. In the absence of the addition of day outlier payments, the commenters suggested that we amend § 405.475(a)(2) to allow the transferring hospital to receive cost outlier payments even if the discharge qualified for day outlier payment.

One commenter suggested that in the NPRM (49 FR 27422) we implied that those patients who are kept in the transferring hospital long enough to qualify for day outlier payments are usually receiving inappropriate care. The commenter stated that it is not unusual for critically ill patients, such as severely burned patients, who would meet day outlier criteria to be transferred to an acute rehabilitation unit.

Response—We do not agree that extending day outlier payments to transferring hospitals is appropriate. We regret that our rationale in the NPRM concerning day outlier payments to transferring hospitals was perceived to be objectionable. However, for FY 1985 a discharge 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 believe that it is reasonable to state that any severely ill patient who needs to be transferred for more specialized care would in all likelihood be transferred before this threshold is met. One commenter mentioned severely burned patients as an exception to this situation. Discharges for neonates and burn patients (DRGs 385 and 456 respectively) represent situations in which patients are transferred to another facility for specialized care. We revised § 405.470(c) in the January 3, 1984 final rule (49 FR 314) to state that these discharges are not subject to the transfer payment policy. Rather, the weighting factors for these two DRGs are based on the assumption that the patient will be transferred. The transferring hospital in these instances is paid the full DRG rate plus any applicable outlier payments in the same manner as the rules that apply to nontransferring hospitals.

We recognize that an individual hospital may experience a case in which a patient is kept for a sufficient number of days, and would meet the day outlier threshold, before it is determined that the patient should be transferred. However, we continue to believe that the vast majority of transfer cases would not qualify as day outliers.

We do not wish to discourage needed transfers from occurring more promptly by offering the possibility of day outlier payments. At the same time, we believe that the average day outlier threshold is sufficiently high that we do not expect that the preclusion of day outlier payments will be an incentive for hospitals under the prospective payment system to move unusually demanding cases into other hospitals.

However, at the same time, we do not wish to encourage inappropriate transfers in cases where cost outlier patients are about to stay past the day outlier threshold. We agree with the commenter who suggested that we pay the cost outlier payment in these cases.

Because we believe that day outliers are inapplicable to transferring hospitals, day outlier criteria (and thresholds) should not apply. Likewise, the preclusion of cost outlier status for hospitals that meet day outlier criteria under sections 1886(d)(5)(A) (i) and (ii) of the Act does not apply to transferring hospitals. Therefore, we are granting cost outlier payments to transferring hospitals where cost outlier patients stay past the day outlier threshold.

(Payments to transferring hospitals are exceptions to ordinary payment amounts, as authorized under section 1886(d)(5)(C)(iii) of the Act, and the terms under which outlier payments are granted to transferring hospitals are therefore also subject to the Secretary's discretion under section 1886(d)(5)(C)(iii).)

After October 1, 1984, we will be receiving bills for cost outlier payments for transferring hospitals. As we have stated in previous documents, we will continue to make such adjustments to the interim transfer policy as warranted by our review of these payments.

Comment—One commenter stated that the present cost outlier thresholds make it literally impossible for a hospital to qualify for cost outlier payments based on costs incurred for transferred patients. The commenter recommended that the cost outlier thresholds for transferred patients be redefined as the greater of 1.5 times the DRG payment rate multiplied by the ratio of actual days prior to transfer divided by the average length-of-stay per DRG, or $12,000 multiplied by that ratio (actual days divided by the average length-of-stay). The commenter believes that this change would recognize the specific needs of small rural facilities that are often the areas of first resource utilization in stabilizing patients for transfer to another facility.

Response—We do not agree with the commenter's estimation that no transfer situations will qualify for the cost outlier thresholds. It was the realization that such cases actually have occurred that led to this change in the transfer payment policy. In one example brought to our attention, a small hospital treated a very ill patient for a number of complications over a period of 10 days incurring charges of $25,378. The patient developed renal failure and was transferred to another hospital where dialysis could be provided. The second hospital, which discharged the patient, was paid the DRG rate for dialysis treatment. The first hospital was paid per diem payments limited to the DRG rate of the patient's principal diagnosis in that hospital which was $6,789. Had the first hospital qualified for cost outlier payments, the payment would have been about $10,000.

In another example, a patient was transferred back to the first hospital after being transferred to receive specialized care. Thus, the first hospital not only qualified for per diem payments as a transferring hospital, but received DRG and outlier payments as the discharging hospital as well. The second hospital provided specialized care incurring costs that reached the cost outlier threshold but was entitled only to per diem payments as the transferring hospital. Thus, it is quite possible for a transferring hospital to incur costs reaching the outlier thresholds.

However, this commenter illustrates our point that a hospital that admits a patient, evaluates his condition as requiring transfer, and stabilizes the patient would not incur the same high front-end costs as a hospital that evaluates a patient on admission and contemplates providing all the services that the patient will need. In this latter situation, the hospital may have to transfer the patient for specialized acute care even though it initially intended to provide all services. This hospital is likely to incur costs qualifying for the cost outlier thresholds.

Comment—Some commenters stated that the beginning of a patient's course of treatment is the most resource intensive, and, therefore, the transferring hospital should receive the full payment rate or should be paid in some other manner such as a sliding scale, which reflects this resource intensive phase of treatment.

Response—There are little data in support of the position that in typical transfer cases the beginning of a patient's course of treatment is the most resource intensive. Furthermore, as we pointed out in the January 3, 1984 final rule (49 FR 245), there is no generally acceptable method of measuring this resource intensity. Therefore, using this approach would not be feasible.

Comment—Many commenters were opposed to our goal of making one payment to the final discharging hospital instead of making per diem payments to transferring hospitals. They believe it would impose a great administrative burden on hospitals to tend to discourage hospitals from undertaking appropriate transfers.

One commenter stated that under the prospective payment system more hospitals are expected to specialize in the services that are delivered most efficiently and minimize activity in areas of inefficiency. The commenter believes that the move toward one payment would inhibit transfers and undermine this tendency toward greater efficiency. Several commenters suggested that we develop a methodology that would provide incentives for appropriate transfers, such as full DRG payment or cost reimbursement to the transferring hospital. Another commenter maintained that a single payment would force hospitals to formalize financial agreements for referral arrangements with many hospitals in order to anticipate all possible transfer situations.

Response—We do not agree with the commenter's proposal that we change our goal of providing one payment to the final discharging hospital, and continue to pay per diem payments to transferring hospitals. The prospective payment system is intended to provide full payment less applicable deductibles and coinsurances for all inpatient services associated with a particular episode of hospitalization. Our transfer policy is an interim policy to be used until we restructure the payment methodology for making one payment to the final discharging hospital for the full treatment. In these situations, the final discharging hospital would arrange to provide compensation to the transferring hospital for a portion of the inpatient services. Therefore, hospital managers should anticipate our final discharge payment policy and incorporate this eventual change into their financial and management planning and enter into cooperative agreements.

We agree with the commenter's belief that the final move to one payment in transfer cases should encourage hospitals to formalize agreements for referrals of specific types of cases to the hospitals that have become more efficient in the delivery of that type of care. We do not think that it is unreasonable to expect a hospital to anticipate referral needs for situations it may encounter and eventually enter into transfer and reimbursement agreements with other hospitals.

Comment—Several commenters requested that we amend § 405.470(c) to state that a patient transferred from a hospital's acute-care bed to a swing-bed is considered discharged.

Response—Prior to the prospective payment system, a patient receiving a skilled nursing facility (SNF) level of care in a hospital with swing-bed approval was considered to have been discharged from the hospital and readmitted to the SNF, even though the patient did not physically leave the facility. The distinction in this situation for a hospital subject to the prospective payment system is that the acute-care stay is paid on a prospective payment basis rather than a cost reimbursement basis. Under § 405.120, a hospital with swing-bed approval continues to be considered an SNF when it is delivering an SNF level of care. Thus, patients receiving an SNF level of care in these hospitals are considered to be discharged as already provided for under § 405.470(c) because they are transferred to another hospital or unit that is excluded from the prospective payment system.

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).

Specifically, 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 or 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.

Many hospitals and some national organizations have expressed dissatisfaction with our application of the full-time director requirement, especially with respect to "small" rehabilitation units, because they believe that in many cases this requirement is unnecessary and burdensome.

After reconsideration of our position, we decided that we should relax our full-time director requirement to some degree, and we proposed to amend § 405.471(c)(4)(iii)(F)(1) to remove the requirement for full-time service by directors of excluded rehabilitation units. We proposed to replace that requirement with a provision that specified that the director of a unit must provide services to the unit and its inpatients for at least 20 hours per week.

We also proposed a clarifying change to §§ 405.471(c)(2)(v)(A) and (c)(4)(iii)(F)(1) to specify that time spent by the director of a rehabilitation hospital or unit in providing services to the rehabilitation hospital or unit and to its inpatients is to be counted in meeting the direction requirement.

We received comments on these provisions from hospitals, hospital associations, and individuals. The specific comments and our responses are as follows:

Comment—One commenter suggested that we not change our current requirement for full-time direction of excluded rehabilitation units. This commenter is concerned that the proliferation of rehabilitation units resulting from the relaxation of requirements may undermine the prospective payment system.

Response—We share the commenter's concern about the need to avoid changing our exclusion criteria in a way that would lead to an unintended proliferation of excluded rehabilitation units. However, for the reasons stated above, and as outlined in the NPRM (49 FR 27423), we believe that some relaxation of the current requirement is warranted. Therefore, we did not adopt this comment.

Comment—One commenter stated that if we revise the current regulations to eliminate the requirement for full-time service by unit directors, we should include other provisions in the regulations to ensure that directors actually perform services for a unit and its patients, and do not serve as "directors" in name only.

Response—First, we wish to point out that the medical direction provision is not the only requirement a unit must meet to be excluded. Among the many other requirements a unit must meet are those relating to the medical condition of patients, the types of therapies available, and the preadmission screening of potential patients. We believe that it is very unlikely that a unit that is sufficiently involved in rehabilitation to meet all these requirements could function with a director who provided only nominal services. Most physicians expect to be compensated for service as unit directors, and it is also unlikely that a hospital would pay a director for services that were not actually performed.

We are continuing to monitor the implementation of the prospective payment system, and we will consider imposing other requirements if it appears that the exclusion provisions are being abused by hospitals with unit directors who provide only nominal services. However, based on our experience to date, we do not believe that further requirements concerning a unit director's duties are needed.

Comment—Several commenters noted that the Conference Committee Report on Pub. L. 98-369 included language that reflects their views on the full-time director requirement for rehabilitation units. The report states, "The conferees do not believe this regulatory requirement to be necessary. Alternatively, the conferees expect that professionally established standards will be relied upon—for example, those of the Joint Commission on Accreditation of Hospitals (JCAH) or of the Commission on Accreditation of Rehabilitation Facilities (CARF), and these do not contain a full-time medical director requirement." (H.R. Rep. No. 98-861, 98th Congress, 2d session 1356 (1984).) Another commenter cited similar statements that appeared in the Congressional Record.

The commenters who referred to these statements of congressional views on this issue made different recommendations. Some commenters suggested that we not apply the medical direction requirement to any facility accredited by JCAH or CARF. Others suggested that we eliminate any minimum time requirement for unit directors.

Response—In developing the basic exclusion criteria for rehabilitation hospitals and units that were published on September 1, 1983, we reviewed the JCAH and CARF accreditation criteria. Based on this review, we concluded that facilities accredited by either JCAH or CARF could be deemed to have met certain criteria. However, the JCAH and CARF accreditation requirements relate primarily to the management of individuals' rehabilitation programs rather than to the direction of rehabilitation hospitals or units. Moreover, neither the JCAH nor the CARF requirements specify the minimum time a physician must spend in unit direction. Because of these factors, we did not adopt the comment suggesting that we permit rehabilitation units to substitute JCAH or CARF accreditation for unit direction in qualifying for exclusion.

Moreover, we share the concern of one commenter that it is important to avoid criteria that could result in only nominal direction of rehabilitation units. To help prevent this from occurring, we believe it is necessary to maintain a minimum time requirement for unit directors. Therefore, we did not adopt the recommendation that we delete that requirement.

Comment—Some commenters suggested that any relaxation of the current full-time direction requirement for units should be made retroactive to the beginning of the prospective payment system, that is, effective for all cost reporting periods beginning on or after October 1, 1983. Retroactive applicability of this provision would allow units that previously did not meet the exclusion requirements to benefit from our change in policy. The commenters believe that a retroactive effective date would be appropriate in this case because the limited time available for preparation and distribution of the exclusion criteria did not allow many hospitals the opportunity to recruit full-time directors for their rehabilitation units.

Response—We are sympathetic to the concerns of those who believe the statutorily imposed schedule for implementing the prospective payment system made it difficult for hospitals to meet the exclusion criteria. However, for the reasons detailed below, we did not adopt the comment regarding retroactive exclusions.

First, there would be numerous administrative problems created by such a retroactive change. All payments made thus far under the prospective payment system to units that would qualify for retroactive exclusion would be invalid, and the amounts to be paid would have to be recalculated on the basis of cost reimbursement. This would be administratively cumbersome and burdensome to the hospitals, their intermediaries, and our staff.

More significant than administrative problems, however, are our concerns about fairness. Hospitals subject to the prospective payment system that transferred patients to units that were not excluded at the time may have collected less than full payment for those patients. This occurs because of the payment rules applicable to "transfers" from one prospective payment system hospital to another. Had the units been excluded at the time, the different payment rules applicable to "discharge" from the transferring hospital and "admission" to the excluded unit would have resulted in more favorable payment to the discharging hospital. If we were to retroactively adjust those payments, another layer of administrative difficulty is added. If we did not, fairness to the discharging hospital would become an issue.

Some beneficiaries would be subject to unexpected retroactive liability for previous services. This would be caused by the way we handle inpatient days after benefits are exhausted under the prospective payment system. For those beneficiaries who exhaust their regular benefit days during a stay in a hospital subject to the prospective payment system, all subsequent nonoutlier days are "free"; that is, the beneficiary cannot be charged for them and they are not counted as lifetime reserve days. Similarly, for those beneficiaries who exhaust their lifetime reserve days during such a stay, all subsequent nonoutlier days are "free". In excluded units, the handling of those days is quite different. After exhausting regular benefit days, the beneficiary is liable for all subsequent days unless he or she elects to use lifetime reserve and be liable for sizable coinsurance amounts on each lifetime reserve day. If all lifetime reserve days are exhausted, the beneficiary is liable for all subsequent days.

In summary, to make this change retroactive would benefit only a very small number of units and only for a period of one year. By contrast, the cost would be—

- Increased administrative burden on those units, their intermediaries, and HCFA;
- Inequitable treatment of other hospitals; and
- Unfair retroactive imposition of liability on some beneficiaries.

On balance, we do not believe the costs of such a policy are justified by the limited benefits.

Comment—One commenter stated that it is arbitrary to apply the same minimum time requirement for the directors' services to all rehabilitation units' regardless of the units size. This commenter recommended that the minimum time requirement for each unit be related to the size and services of the unit.

Response—We agree that the amount of time a physician must spend to direct a unit can vary greatly depending on the unit's size, its scope of services, and other factors. Moreover, the time required may also vary because of differences in the types of medical conditions for which patients are treated, or the severity of patients' conditions. However, we have no objective data that would permit us to classify units by size and types of services furnished and establish a separate minimum time requirement for each. In the absence of these data, it would be impractical to use variable requirements. We believe it is both simpler and more equitable to prescribe a minimum time requirement for all units. Therefore, we did not adopt this comment.

Comment—One commenter stated that both our current and proposed unit direction requirements have the unintended effect of requiring physicians who serve as unit directors to perform administrative duties that are generally performed by nonphysicians. The commenter stated that this is inconsistent with current medical practice and is not cost effective.

Response—We do not agree that either requirement would have this effect. On the contrary, under our requirements, the physician who directs a rehabilitation unit would be free to delegate certain administrative duties to nonphysician hospital employees, if this would result in a more effective use of his or her time.

Comment—One commenter suggested that, in determining which services performed by the director may be considered services to a unit and its patients, we take into account the variety of services that physicians specializing in rehabilitation medicine currently perform in hospitals. This commenter stated that the services that count toward meeting the unit direction requirement should include the following:

- Preadmission screening of patients not yet admitted to the unit, and postdischarge review of patients' conditions for purposes of assessing the unit's quality of care.
- Educational activities concerning rehabilitation that are conducted for the benefit of health professionals who work in other areas of the hospital.
- Direction of rehabilitation-related activities in other hospital departments such as the physical therapy department.

To assure that these activities are counted toward the unit director's service, this commenter recommended that services be considered services to a unit and its patients if—

- The services have a direct benefit to the unit and its patients; and
- The services are consistent with existing standards of practice for rehabilitation units that have been adopted by the field of rehabilitation and its national standard-setting associations.

Response—We agree with this commenter's view that not all activities performed by a physician who is a director of a rehabilitation unit will necessarily involve current patients of the unit, or be carried on within the physical area designated as the rehabilitation unit. However, we are concerned that the definition of "services to a unit and its patients" proposed by the commenter is so broad that it could cover some services (for example, general educational activities on rehabilitation techniques) that only very indirectly provide benefits to the unit and its patients. Therefore, we did not revise the proposed regulations based on this comment.

We are continuing to monitor the implementation of the prospective payment system with regard to excluded units and will issue further instructions on this issue as they are needed.

C. Expansion of Excluded Rehabilitation Units and Exclusion of New Rehabilitation Hospitals and 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 medical conditions listed in that paragraph.

We proposed a change concerning the application of the 75 percent rule to

those already excluded rehabilitation units that intend to expand. We proposed to 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.

We also specified in the NPRM that if a unit increased in size beyond the level that would be specifically permitted under the amendment discussed in the previous paragraph, 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 also proposed to codify in the regulations our policy that 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.

Comments on these issues were received from hospitals, hospital associations, and individuals and follows:

Comment—One commenter suggested that we not make any changes in policy that would allow hospitals to expand or add excluded rehabilitation units. The commenter's opinion is that these changes could permit hospitals to avoid the cost-restraining effects of the prospective payment system and that this would be contrary to its purpose.

Response—We share this commenter's concern about the importance of avoiding any changes that would create an incentive for the proliferation of rehabilitation beds or units. However, we believe that it is possible to permit expansions without creating such an incentive. Therefore, we did not adopt this comment.

Comment—Most of those who commented on this section of the NPRM approved of the concept of adopting a more flexible policy on the expansion of excluded rehabilitation units. Some commenters also supported the specific proposals that were set forth in the NPRM. However, many other commenters stated that our proposed revisions would not give hospitals the flexibility they need to respond to changes in the need for rehabilitation services. These commenters also criticized our proposal to require additions that exceed the 10 percent limit described in the NPRM to be in operation for a 12-month cost reporting period before they can be eligible for exclusion. The commenters believe that this policy would be cumbersome to administer and financially disadvantageous to hospitals, and that it could restrict a patient's access to rehabilitation services.

In this context, we also received a number of comments expressing opposition to our policy stated in the preamble to the final regulations published on January 3, 1984 (49 FR 241) that new rehabilitation hospitals and units must be in operation for a full 12-month cost reporting period before they can be eligible for exclusion. The commenters stated that this provision created serious financial problems for new hospitals and units and is particularly unfair to those hospitals and units that were in planning or under construction before the prospective payment system was implemented.

Commenters suggested various approaches that they believe would avoid the perceived inequities of our current policy while providing adequate protection against unnecessary proliferation of rehabilitation facilities. Some recommended that new rehabilitation hospitals and units should be excluded on a provisional basis for their first cost reporting period of operation, with a restrospective payment adjustment for those that did not meet the 75 percent requirement. Other commenters suggested that both new and expanded hospitals and units should be excluded during their first cost reporting period of operation or expansion based on certifications by the hospital or unit that they will comply with the 75 percent requirement. Operating data for the first 12-month cost reporting period of the new or newly expanded facility would be used in determining whether the facility would continue to be excluded for the next cost reporting period.

Response—The requirement that rehabilitation hospitals and units have a full 12-month cost reporting period history of furnishing intensive rehabilitation before they can initially be excluded from the prospective payment system was intended to avoid unintentional incentives to convert acute-care beds to rehabilitation beds merely to avoid inclusion into the prospective payment system. The 12-month waiting period to qualify for exclusion was intended to ensure that the hospital was actually furnishing intensive rehabilitation care. However, the rule has proven to be unnecessarily harsh when applied to new hopitals and units seeking exclusion for the first time. Consequently, we have added provisions in §§ 405.471 (d) and (e) to permit a new hospital or unit to certify that it will meet the 75 percent rule for its initial excluded cost reporting period.

A new hospital is one that seeks exclusion as a rehabilitation hospital for the first full 12-month cost reporting period of its participation in Medicare as a hospital. A new unit is one that has been added to an existing hospital. Any hospital that previously sought exclusion (successfully or not) for a rehabilitation unit will not be recognized as creating a "new" unit. Nor will mere conversion of existing hospital beds and facilities be recognized as creation of a "new" unit. New beds are defined as ones for which the hospital has obtained approval by increasing its bed capacity under both State licensure and Medicaid certification. Note that there is no net increase if the hospital "adds" 20 "new" beds and deletes 20 previously licensed and certified beds, even if the beds and their location are different. We view this as another form of conversion. The hospital may identify legitimate new beds as a new rehabilitation unit only or the *first* full 12-month cost reporting period that the beds are used to furnish inpatient care. We recognize that hospitals may occasionally need to combine some new beds with some existing beds to create a rehabilitation unit, and it is not always feasible to artificially keep the two types of beds separate. Consequently we will recognize a unit as "new" if more than half of its beds are new.

By applying these principles to the expansion of existing units, we will permit a hospital to expand an already-excluded unit by adding new beds for the first full 12-month cost reporting period that the new beds are used to furnish inpatient care. The definition of "new beds" is the same as for new units, explained in the preceding paragraph. The population actually treated in the unit during its most recent 12-month cost reporting period must conform to the 75 percent rule for the unit's exclusion to be renewed, but the hospital may certify that the population to be treated in the new beds will meet the 75 percent rule for their initial excluded cost reporting period.

These changes in the rules for exclusion of new hospitals, new units, and new beds are applicable only once—when the facilities first gain excluded status. We will verify that hospitals and units remain eligible for continued exclusion in future years by examining the prior 12-month cost reporting period records. In any case where the 75 percent rule is not complied with during an excluded cost reporting period, exclusion for the next cost reporting period will be denied.

Comment—A commenter objected to our policy of recognizing a change in the

size of an excluded unit only at the start of a cost reporting period. The commenter believes that most hospitals have the accounting capability to determine the costs attributable to changes in the unit's bed size that take place during a cost reporting period. The suggestion is that since hospitals can manage the data, we should recognize these changes for purposes of exclusion from the prospective payment system as soon as possible. However, another commenter supported our policy and stated that considering an expansion as part of an excluded unit only at the beginning of a cost reporting period is essential to ensure proper payment.

Response—We recognize that some hospitals have accounting systems that are sophisticated enough to find and apportion the costs that result from changes in unit size that occur during a cost reporting period. However, in the interest of administrative simplicity and accurate payment, we continue to believe that we should recognize changes in unit size only at the start of a cost reporting period. We have adopted this policy because we are concerned that serious billing, cost reporting, and other payment problems could arise if a hospital or unit is paid under different systems (prospective payment and reasonable cost) for different parts of the same cost reporting period. Also, this policy would result in uncontrolled fluctuation as hospitals add or subtract beds in their excluded units. This unwarranted instability would undermine the prospective payment system. Therefore, we did not make any change in the final regulations based on the first comment.

Comment—One commenter stated that recognition of changes in unit size only at the start of a cost reporting period is not consistent with the Provider Reimbursement Manual instructions on separate cost entities, which permit separate cost entities to be recognized for quarters of cost reporting periods. The commenters also stated that our proposed policy is too inflexible to permit hospitals to respond quickly to changes in patient need for rehabilitation services. This commenter recommended that we recognize changes in unit size effective with the beginning of the calendar month after the month in which the changes occur.

Response—The provisions of the Provider Reimbursement Manual cited by the commenter relate to the establishment of separate cost entities in hospitals that are reimbursed on a reasonable cost basis. The implications of these changes are less complex than those of the exclusion of a unit, since the latter situation requires the operation of two different payment systems within the same hospital and use of different payment systems for certain beds during different parts of the same cost reporting period. In view of this, we do not believe it is inconsistent to apply a different rule to each situation.

We share the commenter's view that some flexibility is needed to permit hospitals to adapt to shifts in the demand for various types of services. However, we are also aware of the danger that uncontrolled fluctuation in unit size could prevent accurate payment and lead to other problems outlined above. Therefore, we are making no changes based on this commenter's recommendation.

D. Physician Attestation (§ 405.472)

Section § 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. In addition, 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.

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 proposed the following modifications to both the language and the positioning of the statements to clarify the scope of the statements and to provide additional guidance to the hospitals in their implementation of the attestation requirement:

- In order to clarify that the physician is attesting only to the diagnoses and procedures performed, we proposed to replace the word "identification" with the phrase "narrative descriptions."
- We also proposed to add the word "major" before the phrase "procedures performed" to clarify that the physician is not attesting to minor procedures that were performed of which he or she is unaware.
- We proposed that the certification statement appear on the discharge summary sheet, rather than on another type of hospital form.
- We proposed to separate the certification statement from the penalty statement. The certification would 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. As proposed, 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.

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

- We further noted in the preamble to the NPRM 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.

The comments we received on this proposal were from physicians and hospitals and the organizations that represent them and medical records personnel.

Comment—Many commenters, primarily physicians and organizations that represent them, commented that the entire physician attestation requirement, including both the certification and the notice to physicians, should be eliminated. In support of their comment, they noted that these requirements do not impose a new liability upon physicians but, rather, simply underline existing statutory requirements. They also asserted that rules governing medical records already accomplish the objectives of this requirement and that our requirements are not necessary to

achieve our purpose. They further commented that retaining the requirement would create an unnecessary recordkeeping burden for them and for hospitals and constituted an affront to the dignity of the medical profession. They recommended that any attestation should be obtained from the entity seeking payment; that is, the hospital.

Response—As we noted in the NPRM (49 FR 27425), the use of certification and penalty statements is standard in Federal programs that involve the obligation of Federal funds. These statements have always appeared on cost reports and claim forms used by physicians and other providers as part of the Medicare and Medicaid programs. As we noted at the time, 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. In fact, the necessity of these statements for successful prosecution of wrongdoers was also noted in the NPRM in a quote from a communication from the U.S. Department of Justice. We believe that the physician is the key person in the diagnosis and treatment of a patient and that it is upon the physician that we should rely for information about his or her diagnosis and the procedures performed.

We recognize that many physicians object in principle to the use of a certification and of a cautionary statement. We believe, however, that the provisions we proposed, as they are modified in this final rule, go as far as possible in dealing with these concerns given our overall responsibility for effective management of the Medicare program.

Comment—Most commenters approved of our proposal to make physician acknowledgment of the penalty statement an annual requirement with the hospital responsible for obtaining it and keeping it on file. However, many physicians and some hospital administrators commented that this requirement still imposes a burden on providers and will continue to present an affront to physicians.

Response—Our proposal does not eliminate the requirement, but we believe that it does significantly lessen the problems about which physicians complained. The penalty statement is not a prominent part of the medical record and is not routinely encountered by physicians when they complete the certification. At the same time, our proposal still creates the explicit acknowledgment of the effects of misrepresentation we believe is essential to the prosecution of the few wrongdoers who may be identified. We believe the requirements we proposed go as far as possible towards meeting the concerns of physicians and we have retained them in the final regulations.

Comment—The proposed regulations indicated that the hospital, in submitting each claim, would certify that it had on file an acknowledgment from the physician as required by § 405.472(d). Some commenters noted that certification on a claim-by-claim basis would be unnecessarily burdensome and that the current Medicare bill does not contain a space for such certification. It was suggested that claim-by-claim certification not be required.

Response—We agree. The final regulations simply establish as a requirement for the prospective payment system that the hospital obtain the signed acknowledgments before claims are submitted and that it keep them on file. We will monitor compliance through the DRG validation process. Certifications will not be required on hospital bills.

Comment—Several commenters raised questions as to the acceptability of rubber stamps and electronic signatures in completing the physician attestation. There were also questions as to whether the term "in writing" precluded the use of typed narrative descriptions or computer-generated narrative descriptions.

Response—The requirement for the physician's signature is meant to elicit an actual signature by the attending physician. Rubber stamps and facsimile signatures of other types are not acceptable. We believe such methods of affixing a signature are primarily used by persons other than the person whose signature is being affixed. Since we plan to rely very heavily on the information and because the accuracy of the information is the personal responsibility of the physician and he or she is liable for any inaccurate information attested to, we believe it is essential to assure that the physician personally sign the certification. We also know, however, that some hospitals have systems under which the narrative description of the diagnoses and procedures are generated in the medical records department, sometimes mechanically, and presented to the attending physician for his or her approval. We believe this is appropriate and do not intend the regulation to preclude it so long as the attending physician agrees to it and signs his or her name to the certification.

Comment—Some commenters, especially medical records professionals, objected to the use of the term "major" in connection with procedures performed. The term was used in both the certification and notice statements contained in the proposed regulations. The commenters noted that the term "major" could cause confusion. It was also noted that procedures that could be termed "major" and "minor" could be significant for DRG classification. It was suggested that the term be deleted.

Response—The term "major" was inserted into the certification and penalty statements in response to physician comments that the word "procedures," unmodified, appeared to make them responsible for listing all procedures, whether major or minor and whether or not they had personally performed them or had knowledge of them. They noted that there are occasions upon which procedures are performed without the direct knowledge of the attending physician. As we noted in the proposed regulation, we did not intend to require that the attending physician attest to all the procedures performed but only to those procedures of which he or she was aware. We agree with the commenters that the word "major" could cause confusion if it were taken to have a precise technical meaning; however, we have used the word in a more general sense for the purposes discussed above and do not intent to further define it or to require that it be used as a technical test to determine which procedures should be listed and which ones should be omitted. Accordingly, we are retaining the word "major" in both the certification and penalty statements with the understanding that it be construed as discussed above.

Comment—Several commenters suggested that the identification of the principal and secondary diagnoses is primarily a payment convention and should be left to hospitals rather than required of physicians.

Response—We do not agree. It is our intention to use the physician attestation process to identify (after study) the reason why an attending physician admitted a patient to the hospital for treatment. While payment is determined on the basis of this information, we do not believe it is merely a payment convention which may be left to the hospital. We believe that the physician is the key figure in the diagnosis and treatment of patients and that it is most appropriate to rely upon his or her decisions in this matter.

Comment—In the revised language of the acknowledgment statement proposed in the July 3 document, we omitted the word "intentional" in connection with language about misrepresentation, falsification, and concealment of information. Some commenters suggested that this omission represented a decision to expand the liability of physicians to include unintentional errors.

Response—As we have noted previously, the statement that we are seeking physicians to read and acknowledge does not add or diminish legal liability for misconduct. It simply provides a reminder that there are currently laws that impose penalties for misrepresentation, falsification, and concealment of information. We omitted the word "intentional" because it does not accurately describe the applicable criminal and civil liabilities and therefore does not provide fair warning to physicians of the consequences of misconduct. Again, however, we note that the language of the notice will not affect the legal liability of physicians under applicable laws.

Comment—The largest number of commenters, primarily medical records professionals and hospital administrators, commented that a requirement that the certification appear on a specific document is unnecessarily restrictive and that the requirement that it be placed on the hospital discharge summary presents real problems in terms of medical records completion and hospital administration. A major problem is that the discharge summary is required by the Joint Commission on the Accreditation of Hospital (JCAH) standards to be completed in a "reasonable" time. In practice, this has been taken to be from 15 to 30 days. Some delay is encountered as physicians wait for final laboratory results that may not be available at discharge. Often there is also some delay in transcribing dictated statements. Standards of the JCAH do not require a dictated discharge summary for all cases. For example, a final progress note may be substituted for a discharge summary in the case of patients who have problems of a minor nature and require less than 48 hours of hospital care. In some instances, these summaries are prepared by physicians other than the attending physician.

Two basic concerns about the use of discharge summaries arise from these comments. One is that pressure from hospitals for early completion of discharge summaries in order to assure adequate cash flow may well lead to a deterioration in the quality and quantity of information reported. Another concern is that delays in completing the summaries could add two weeks or more to the length of time it takes a hospital to submit a claim for payment.

Response—We agree with these comments. We had specified the use of the discharge summary in the proposed regulation as a means of assuring that the physicians understood that they were attesting to the diagnoses and procedures performed rather than the medical codes applied to them; however, we did not intend to cause any of the unfortunate results pointed out in these comments. Accordingly, we have dropped the requirement that the certification be placed on the discharge summary. The location of the certification in the medical record may be determined by the hospital. We note again, however, that we do not intend the physician to be responsible for more than his or her own narrative statement of the diagnoses and procedures. A physician is not responsible for hospital coding accuracy.

F. 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 as provided 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 Area (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.

Periodically, EOMB revises the list of MSA or 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 recognize these reclassifications, for the purpose of determining payment, beginning with the start of 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)(8) of the Act, as added by section 2311(c) of Pub. L. 98–369, provides for an adjustment to the payment amounts for hospitals reclassified from urban to rural after April 20, 1983. Therefore, we are revising §§ 405.473(b) and (c) and adding a new paragraph § 405.476(i) to provide that, effective with hospital cost reporting periods beginning on or after October 1, 1983, 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. The hospital will receive, in addition to its rural Federal rate, in the first cost reporting period, 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 reporting period, one-third of the difference. The adjustment will be applied for two successive cost reporting periods beginning with the cost reporting period in which we recognize the reclassification.

Of course, if the hospital is subsequently reclassified during this special transition period as urban, the special adjustments would cease to apply.

In the NPRM (49 FR 27426), we proposed that a hospital meet a qualifying test in order to receive the special two-year adjustment. For a hospital to be eligible for the additional payments, the hospital-specific portion had to exceed the hospital's Federal rural rate after the Federal rate was adjusted by the hospital's rural area wage level index and by the doubled indirect teaching adjustment factor. Because section 2311(c) of Pub. L. 98–369 does not require this test or a similar qualifying test, we are eliminating the qualifying test in this final rule.

We also proposed to make the special adjustment effective for two Federal fiscal years because the Federal rates are updated according to the Federal fiscal year.

However, the law specifically makes the special adjustment effective according to cost reporting periods, beginning on or after October 1, 1983. Therefore, we are modifying the final regulations to conform to the requirement of Pub. L. 98–369.

As a result of EOMB's June 30, 1983 revision of the MSA or 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. Under the new section 1886(d)(8) of the Act, each of these hospitals will also be eligible to receive the two year adjustment effective with their cost reporting periods that began in Federal fiscal year (FY) 1984.

Comment—One commenter noted that section 2311(c) of Pub. L. 98–369 provides that additional payments be made to hospitals reclassified as rural hospitals on or after April 20, 1983. The additional payments are effective with cost reporting periods beginning on or after October 1, 1983. The commenter recommended that we revise § 405.476(i) to conform the effective date of this provision with the date contained in the legislation.

Response—We agree with the commenter and have revised § 405.476(i) to provide that the effective date of the reclassified rural hospitals' provision is with a hospital's cost reporting period beginning on or after October 1, 1983. We note that, based on section 2311(b) of Pub. L. 98–369, we are also revising the effective date in § 405.473(b)(6)(ii) for a hospital located in an MSA or NECMA that crosses over two or more census divisions. The effective date of these provisions is also with a hospital's cost reporting period beginning on or after October 1, 1983.

Comment—Several commenters agreed with our proposal to permit hospitals located in counties that lost their urban designation after April 20, 1983 to receive an additional payment. However, one commenter proposed that additional criteria be provided under which a hospital located in a rural county could be considered urban and paid an urban rate.

Response—The rationale for providing additional payment under § 405.476(i) is to prevent serious financial hardship to a hospital that could not have anticipated a redesignation of the county as rural. In order to permit a smooth transition to the rural rate, additional payments are made for two cost reporting years. This should allow hospitals adequate time to budget and plan expenses in terms of a rural rate. We do not believe that the full urban rate should be paid since the hospital is now designated rural, and this payment is only a supplement to the rural rate.

As we have explained previously, the designation of a county as urban or rural is based on whether or not it is located within an MSA or NECMA as designated by EOMB. The standards for determining whether or not a particular location qualifies as an MSA or NECMA are not within the technical control of the Department of Health and Human Services. EOMB determines the MSAs and their effective dates based on standards prepared by the Federal committee on MSAs which advised EOMB on metropolitan area definitions. As stated previously, we are not aware of any criteria that are as objective as the MSA criteria for use in determining whether a hospital is urban or rural. We do not believe it would be appropriate to establish criteria in the regulations that have been derived solely to allow a targeted hospital or groups of hospitals to be classified as urban. Rather, any such criteria should have broad applicability and serve to delineate common characteristics that objectively define urban and rural areas.

In addition at the end of the two cost reporting periods, the hospital will be receiving a national rate. As part of the development of a national rate, Congress has requested a study due at the end of FY 1985 on the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates. Based on that study and other studies mandated by Congress, we will be evaluating the continuing necessity of establishing separate urban national rates and rural national rates.

Comment—A number of commenters stated that the NPRM did not adequately address what they believe are fundamental inequities in the urban/rural classification system that is based on EOMB's definition of urban areas. A few commenters believe that the urban rates were too high in comparison to the rural rates that are applied to rural hospitals.

Response—It appears that a number of commenters share the erroneous impression that we are arbitrarily using EOMB's MSA/NECMA definitions in determining urban versus rural areas under the prospective payment system. We have employed EOMB's definitions of Standard Metropolitan Statistical Areas (SMSAs) as the bases of an urban/rural classification system since the implementation, in 1974, of the hospital routine cost limits under section 223 of Pub. L. 92–603, and subsequently for the total inpatient hospital cost limits in 1982 under Pub. L. 97–248. Moreover, section 601(e) of Pub. L. 98–21 specifies that hospitals must be grouped by urban or rural location within the United States and each census region (established by the Bureau of the Census) when calculating the standardized payment rates. The law (section 1886(d)(2)(D) of the Act) requires that separate average standardized amounts be computed for hospitals located in rural as opposed to urban areas. The law further defines an urban area as an area within an SMSA as designated by EOMB or within such similar area as the Secretary has recognized under the regulations establishing limits on total inpatient operating costs under Pub. L. 97–248. Hospitals located outside these areas are considered to be located in rural areas.

On June 30, 1983, EOMB began using MSAs in lieu of SMSAs. MSAs are designated and defined following a set of new standards prepared by the Federal committee on MSAs which advised EOMB on metropolitan area definitions. We believe that the MSA system is the only one currently available that meets the requirements for use as a classification system in a national payment program. The MSA classification is a widely accepted 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. The objective standards used to establish MSAs are based on 1980 census data and include not only population criteria, but also standards for determining the degree of economic and social integration among potentially qualifying counties.

We believe that section 1886(d) of the Act prescribes the precise method to be employed for computing the standardized Federal urban and rural rates. This method takes into account the actual costs of hospitals located in urban and rural areas. We refer the reader to more detailed discussions in the September 1, 1983 interim final rule (48 FR 39763) and the January 3, 1984 final rule (49 FR 251).

Comment—One commenter recommended that we adopt the definition of urbanized areas used by the Census Bureau in lieu of EOMB's definitions of MSAs/NECMAs. Yet, another commenter recommended against using Census Bureau data.

Response—Our employment of some other classification method of urban/rural categories would not resolve many of the problems raised by the commenters. We believe that any classification system will produce

situations in which hospitals believe that they are not fairly represented by the classification system. It is questionable whether adopting the Census Bureau's definition of urbanized areas in lieu of EOMB's definitions would improve the circumstances of those hospitals which are currently classified as rural under the prospective payment system. Although applying the Census Bureau's definition would result in more areas being defined as urban, it would not necessarily increase the number of hospitals classified as urban. The Census Bureau's definition is based on the population of cities and villages, whereas EOMB's definition is county specific, thereby generally encompassing a larger geographic area than the Census Bureau definition for the same metropolitan area. Therefore, some hospitals that are classified as urban under EOMB's definition may be classified as rural under the Census Bureau's definition.

In addition, because the Census Bureau's definitions are city or village specific rather than county specific, we would be unable to correlate these geographic areas with the wage and employment data provided to us by the Bureau of Labor Statistics (BLS) for the construction of the hospital wage index. However, even if the BLS data were available on a city or village specific basis, we believe the sharper urban/rural distinctions would further exacerbate differences in the urban and rural payment rates.

Comment—One commenter argued that the proposed remedy for reclassified rural hospitals fails to rectify the problems caused by variations in rural wage rates. These are the problems that the current hospital wage index also fails to address. The commenter also believes that the NPRM does not address the problem of hospitals that experience high average costs per discharge due to the greater intensity of services furnished in the hospital.

Response—We agree with the commenter that the regulations (§ 405.473(c)(2)(i)(D)) do not address variations in rural wage rates or the inability of the current hospital wage index to measure and control for variations in wage rates that occur in rural areas throughout each state. These regulations, as proposed in the NPRM and as amended by section 2311(c) of Pub. L. 98–369, are not intended to address problems with the wage index. Rather, the provisions serve to alleviate a major inequity resulting from a hospital being reclassified from urban to rural status, and the abrupt disruption to its cash flow that may accompany such a change. The problems with the wage index have been discussed in the August 30, 1983 final rule implementing provisions of Pub. L. 97–248 (48 FR 39433) and in the January 3, 1984 final rule (49 FR 257). We have maintained that the inability of the current wage index to measure and control for difficulties arising from the variation in rural wage levels is a result of the lack of suitable alternative data for determining appropriate labor markets for rural hospitals. Simply extending the definition of urban areas to include hospitals in adjacent rural counties and applying the urban wage index to these hospitals, as some previous commenters have suggested, is not a solution we can accept without clear evidence indicating that these hospitals are in the same labor market as hospitals within the urban boundaries. While we are mindful of the need to improve the sensitivity of the wage index to variations in wage rates paid throughout rural areas, thus far no one has come forth with a better method than the current one for identifying appropriate rural labor market areas.

It should be noted that hospitals, reclassified as rural, whose intensity of services and costs more closely resemble that of urban hospitals, may meet the criteria for rural referral centers contained in § 405.476(g)(1) of the regulations. A hospital that meets these requirements may receive the urban Federal standardized payment rate applicable to the census division in which the hospital is located rather than the rural rate.

F. Census Division Boundaries (§ 405.473)

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 payment 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 division boundaries. Currently, there are 14 MSAs that overlap census division boundaries resulting in two or more basic Federal payment rates applying to the same urban area.

Section 1886(d)(2)(D) of the Act, as amended by section 2311(b) of Pub. L. 98–369, authorizes the Secretary to deem a hospital to be located in the region in which the largest number of hospitals in the same MSA are located or the largest number of discharges occur. We elected to assign hospitals to an MSA or NECMA based on the census division with the largest number of hospitals rather than the largest number of discharges in order to maintain consistency with the present method of computing the Federal standardized amounts.

We are, therefore, amending §§ 405.473(b) and (c), by revising the method for determining the census area in which an MSA or NECMA is located for the purpose of computing the Federal standardized payment rates.

Henceforth, a hospital in an MSA or NECMA that crosses two or more census divisions will be deemed to belong to the census division in which most of the MSA's or NECMA's hospitals are located. This revised definition is effective with cost reporting periods beginning on or after October 1, 1983.

As an exception to this definition, section 2311(d)(2) of Pub. L. 98–369 requires that the new payment rates, for those hospitals that are placed in a less advantageous position because the majority of hospitals in their respective MSAs or NECMAs are in a census division with a lower Federal standardized rate, are not to be effective for cost reporting periods occurring in FY 1984. The deeming provisions apply to these hospitals effective with their cost reporting periods beginning on or after October 1, 1984.

In addition to revising the effective date (to cost reporting periods beginning in Federal FY 1984) that was proposed in the NPRM, because of the legislation affecting those hospitals which will be assigned a census division with a lower federal rate, we deleted the transitional one-year only payment (for FY 1985) to those hospitals. We eliminated the payment provision because the legislation provides these hospitals with a transitional grace period in FY 1984 to the extent that the lower rate will not apply to them for their cost reporting periods that begin during this year.

Because we decided to deem a hospital located in an MSA or NECMA that crosses census divisions to belong to the census division in which the largest number of hospitals within the MSA or NECMA are located, we needed to resolve the situation in which an equal number of hospitals are located in each part of an MSA or NECMA that

overlaps two or more census divisions. Section 2311 of Pub. L. 98–369 refers only to the assignment of hospitals on the basis of hospitals or discharges. This section, however, does not specifically preclude assignment on other bases. Neither does it give any instructions for dealing with the exceptional condition of an equal number of either hospitals or discharges. Hence, in the case in which an equal number of hospitals are located in each part of an MSA or NECMA that crosses census division boundaries, we believe assigning hospitals to the census division with the higher Federal rate, as proposed in the NPRM (49 FR 27436), is consistent with Congressional intent to remedy the problem of multiple Federal rates being established for hospitals within the same urban area. Furthermore, because this provision does not adversely affect hospitals, and is relatively easy to administer, we are retaining it in the final rule.

Comment—One commenter noted that under section 2311(b) of Pub. L. 98–369 the Secretary is authorized to deem the location of hospitals within an MSA or NECMA that crosses census divisions to one of the census divisions. The basis for deciding to which census division a hospital is to be assigned would be either the census division in which the largest number of hospitals in the MSA or NECMA is located or in which the greatest number of discharges occurs. The commenter recommended that we base the assignment of hospitals on the greatest number of discharges rather than on the largest number of hospitals as we had proposed in the NPRM.

Response—We considered deeming the location of hospitals on the basis of discharges, along with other alternative bases, but elected the largest number of hospitals provision as the most appropriate basis for several reasons. First, the number of hospitals located within and MSA or NECMA is much more likely to remain stable from year to year than the number of discharges. The number of discharges may fluctuate significantly for a number of reasons including the opening or closing of patient services, deliberate manipulation by hospitals, or unexpected events such as a fire. Fluctuation in discharges could result in shifting the deemed location of the MSA or NECMA from one census division to another in the two succeeding years. This, we believe, would enormously complicate the rate setting process and create uncertainty for hospitals as to which Federal rate they could expect to receive for the final year of the prospective payment system transition period.

Second, the calculation of the standardized rates is determined based on an average cost per case across all hospitals in a region without regard to weighting based on the number of discharges in each hospital. Thus, assignment of hospitals based on the greatest number of hospitals maintains consistency with the method of calculating the standardized rates. Furthermore, to assure that assignment of hospitals to one census division or another was based on a complete count of discharges, we would have to use data that was at least one year old because of the delay in receiving bills, especially from large hospitals that tend to have a greater proportion of outlier cases than small hospitals. In contrast, the largest number of hospitals provision can be determined immediately. Thus, for administrative simplicity, and assurance of accuracy in deeming the location of an MSA or NECMA, we have elected to utilize the number of hospitals as the basis for deeming.

Finally, were we to deem the location of hospitals on the basis of discharges rather than on the largest number of hospitals, it is likely that, based on the latest data available, more hospitals would experience reduction in their Federal payment rates than would occur using the methodology we have elected.

Comment—One commenter inquired how hospitals would be assigned when an MSA or NECMA crosses over three census divisions. The commenter suggested that the situation may arise in which the census division with the lowest of the three Federal standardized rates may have the largest number of hospitals, although the number of hospitals combined in the other two census divisions exceeds the first. The commenter believes that it is inequitable to assign all hospitals within the MSA to the lowest paying census division because the combined number of hospitals in the other two census divisions exceeds the first.

Response—There are hospitals located in MSAs that cross over three census divisions, but none in which the combined number of hospitals in two of the census divisions exceeds the number in the third census division having the largest number. However, even if such a case were to occur in FY 1986 (the last year that rates will be set for each census division), we believe that § 405.473(c)(2)(ii)(A), which describes the largest number of hospitals provision, is sufficiently broad to cover this situation. Our use of the term "most" in referring to the location of the largest number of hospitals, rather than the term "majority," is specifically intended to resolve these situations. Furthermore, section 2311(b) of Pub. L. 98–369 clearly supports the largest number of hospitals provision. There is no authority under the law to base a hospital's rate, in a situation involving an MSA or NECMA that crosses over three census divisions, on the rate paid to the majority of hospitals when that majority spans two or three census regions. We also note that § 405.473(c)(2)(ii)(B), which provides for hospitals to receive the higher Federal payment rate when an equal number of hospitals in the MSA or NECMA are located in each of the intersected census divisions, is applicable only in those situations in which the location of the MSA or NECMA cannot be determined based on the largest number of hospitals provision.

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 the exception set forth at § 405.474(b)(3), in making a change to the estimate, the intermediary 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 the NPRM, we proposed to revise § 405.474(b)(3) to include the results of a reopening and revision of a cost report determination under §§ 405.1885 through 405.1889, a prehearing order or finding under §§ 405.1821 or 405.1853, or a final administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877, as a basis upon which a recalculation of a hospital's base year costs may be made on a prospective basis (49 FR 27437).

In this final rule, we are including the results of an Administrator's review under § 405.1875, as well as the administrative actions specified in the NPRM, as a basis upon which a recalculation of a hospital's base year may be made on a prospective basis. This change provides an additional basis upon which the recalculation may be made. In addition, we are clarifying that the term "final administrative or judicial review decision" in § 405.474(b)(3)(i)(C)(*1*)(*iii*) (redesignated as § 405.474(b)(3)(i)(C)(*1*)(*iv*) in this final rule) means a decision that is no longer subject to review under applicable law or regulations by a higher reviewing

authority. This change does not affect the current provision in § 405.474(b)(3)(i)(C)(*2*), and therefore, the intermediary will recalculate a hospital's base year costs effective with the first day of the hospital's first cost reporting period beginning on or after the date of the decision. The date that the decision is no longer subject to review will not be used for this purpose.

Our responses to the comments that we received from hospital associations and related organizations are as follows:

Comment—Several commenters supported our proposal in § 405.474(b) to include other administrative actions as a basis of recalculating base year costs, but took the position that the adjustments to base year costs should be applied retroactively to a hospital's entry into the prospective payment system. Another commenter urged that we revise the proposed changes to require retroactive adjustments that would suggest alternative methods for payment of the retroactive amounts due. One other commenter recommended that the adjustments to base year costs be effective 30 days after final resolution, and that a lump sum payment be made for all discharges occurring between the hospital's entry into the prospective payment system and the effective date. Finally, another commenter stated that base year costs should be permitted to be recalculated retroactively with no limits placed on the basis for making such recalculations.

Response—The matters of retroactive application versus prospective effect and the limited basis for recalculating base year costs are not related to our proposed changes as stated in the NPRM. We do not believe that there is a valid reason to change the views we expressed on these matters in the January 3, 1984 final rule (49 FR 259–260). In taking into account additional costs recognized as allowable costs for a hospital's base year, we believe that only a prospective revision for subsequent years based on information developed independent of the prospective payment system is appropriate. We believe that this policy and the regulatory changes in this final rule are consistent with congressional recognition that, during the transition period, establishment of the prospective payment rates would have to be done rapidly based on the best data available (Joint Explanatory Statement of the Committee of Conference, Item 3.B, Congressional Record—House, p. H1773, March 24, 1983).

Comment—One commenter believes that the proposed changes would allow intermediaries to reopen base year cost report determinations to "retroactively" affect payment rates. For this reason, the commenter suggested that reopenings should be limited to adjustments of those specific costs that are appealed by the provider.

Response—We believe that the proposed changes that are incorporated in this final rule do address the concern of this commenter. Under those regulations at §§ 405.474(b)(3)(i)(C)(1) and (2), the intermediary's estimate of base year costs and modifications thereto may be changed only to take into account additional costs recognized as allowable costs. These allowable costs that result from a reopening and revision are effective with the hospital's first cost reporting period beginning on or after the date of the revision. The revised base year costs will not be used to recalculate the hospital-specific portion for fiscal years beginning before the date of the revision.

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).

Section § 405.476(g)(1) provides that a referral center 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 adjustment provisions are in § 405.476(g)(2) and state that rural referral centers which have 500 or more beds are paid prospective payment rates based on the urban rather than the rural, adjusted standardized amounts as adjusted by the applicable DRG weighting factor and the hospital's area wage index. There are no payment adjustments for rural referral centers with less than 500 beds.

While we believe that the criteria for referral center status are reasonable, upon further analysis of the special circumstances applicable to rural referral centers of less than 500 beds and based on information we received from the industry since publication of the interim final rule in September 1983, we proposed in the NPRM a separate set of criteria that would meet these unique circumstances. We proposed to add the following alternative 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 an 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 proposed 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 1.03 case-mix figure by a factor of 1.0585. This factor represented 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 based 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 was estimated that the indexes were, on average, understated by 5.85 percent. (See section II.C. of the addendum for a more detailed discussion of the estimated increase in a hospital's case-mix index.)

- 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.

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 for Osteopathic Specialists.
- 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.

• 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.

We proposed that these criteria 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 proposed 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 proposed that rural hospitals that meet the criteria in § 405.476(g)(1)(ii) (related to percentage of Medicare patients referred and proximity of Medicare patients' residences to the hospital) 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.

We did not include in the NPRM any payment adjustment for urban hospitals that meet the referral center criteria in § 405.476(g)(1)(ii) because of a lack of data on these hospitals.

The NPRM also stated that we are considering instituting a periodic review of the status 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.

Section 2311(a) of Pub. L. 98–369 amended section 1886(d)(5)(C)(i) of the Act by providing that, effective October 1, 1984, rural hospitals can appeal to the Secretary to be classified as rural referral centers based on criteria established by the Secretary. These criteria would allow a hospital to demonstrate that it should be classified as a referral center because certain of its operating characteristics are similar to those of a typical urban hospital located in the same census region.

Because we have regional data available on case-mix indexes and the number of discharges, for the period represented in the data base used to establish the standard amounts (1981 cost and billing data), we developed regional measures for these two criteria which we think represent operating characteristics that are similar to those of a typical urban hospital in the same census region. For each region we compared the median case-mix index values and the median number of discharges of urban hospitals to the criteria we proposed in the NPRM. We used the median rather than the mean to avoid discrepancies that may arise with hospital case-mix index values or number of discharges that, because they are extremely high or low, would distort the average for urban hospitals.

The median case-mix index values for urban hospitals on a regional basis using the 1981 MEDPAR data were as follows:

Region	Median urban case mix
1	1.055
2	1.071
3	1.035
4	1.046
5	1.010
6	1.022
7	0.972
8	1.056
9	1.073

The comparing the regional case-mix index values with the 1.03 case-mix benchmark for 1981 as proposed in § 405.476(g)(1)(iii)(A) of the NPRM, all but three regions have an average case-mix index for urban hospitals above the 1.03 criterion proposed to establish eligibility for referral center status. We considered replacing the 1.03 case-mix index value with the regional case-mix index values but decided not to do so because a number of hospitals in the six regions with higher case-mix index values would no longer meet this criterion. Instead, we are revising § 405.476(g)(1)(iii)(A) to permit hospitals to meet the case-mix criterion by having a published case-mix index value that is equal to or greater than—

• 1.03 in 1981 based on the index values published in the September 1, 1983 interim final rule (48 FR 39847); or

• The median urban case-mix index value for the region in which the hospital is located for 1981 as contained in the table above.

In addition, we are allowing hospitals the alternative of meeting the case-mix index criterion if the hospital's case-mix index is at least 1.1053 for the hospital's first cost reporting period subject to the prospective payment system.

We are also allowing hospitals the alternative of meeting the case-mix index criterion if the hospital's case mix index for the hospital's first cost reporting period subject to the prospective payment system is equal to or greater than the following regional benchmarks:

Region	Adjusted median urban case mix
1	1.132
2	1.149
3	1.111
4	1.122
5	1.084
6	1.097
7	1.043
8	1.133
9	1.151

These values represent an adjustment (7.31 percent) to the median urban case mix index values determined from the 1981 MEDPAR data. The adjusted regional medians are the regional benchmarks equivalent to the 1.1053 general overall standard.

Because the law now requires hospitals to request referral center status in the quarter before the first quarter of the hospital's cost reporting period for which the change is requested in most cases the request will need to be made before the end of the first year subject to the prospective payment system. Therefore, the determination under the alternative standard must of necessity be made on less than a full year's worth of claims. However, every attempt will be made to include as many months as is possible.

Our data show that the number of hospital discharges also varies considerably among regions. The median number of discharges for 1981 for urban hospitals on a regional basis determined from the data used to establish the standard amounts is as follows:

Region	Urban discharges
1	7,467
2	8,601
3	7,785
4	9,309
5	8,330
6	8,515
7	5,888
8	9,928
9	5,564

In comparing the regional number of discharges with the 6,000 discharges requirement as proposed in § 405.476(g)(1)(iii)(B) of the NPRM, all but two of the regions have an average number of discharges that exceeds the 6,000 discharges criterion used to establish eligibility for referral center status. We considered replacing the 6,000 discharges requirement with the regional numbers of discharges but decided not to do so because a number of hospitals in the seven regions with a greater number of discharges than the

6,000 discharges would no longer meet this criterion. Instead, we are revising § 405.476(g)(1)(iii)(B) to permit hospitals to meet the number-of-discharges requirement by providing that the hospital's number of discharges (excluding discharges from subprovider units) is at least—

- 6,000 for the hospital's cost reporting period that ended in 1981;
- 6,000 for the hospital's most recently completed cost reporting period; or
- The median number of discharges of urban hospitals for the region in calendar year 1981 in which the hospital is located for either the cost reporting period that ended in 1981 or its most recently completed cost reporting period.

The statute also requires that these appeals must be submitted during the quarter before the first quarter of a hospital's cost reporting period. (Hospitals whose cost reporting periods begin in October 1984 would be allowed to submit their appeals during the first quarter of that period.) A final determination on the appeal must be made within 60 days after the date the appeal was submitted. Any payment adjustments required due to a hospital's new classification as a referral center will be made effective as of the beginning of the cost reporting period.

In addition, section 2311(a) of Pub. L. 98-369 states that the characteristics that the Secretary establishes for determining rural referral centers may include wages, scope of services, service area, and the mix of medical specialties. We are retaining the criteria we proposed in the NPRM because we believe they adequately conform to the operating characteristics suggested in the legislation at section 2311(a) for the reasons discussed below.

- *Scope of services.*—Although we did not propose to set a numeric qualifier on the scope (that is, number) of services offered by a rural referral center, one of the three optional criteria (§ 405.476(g)(1)(iii)(C)) would specify that "more than 50 percent of the hospital's medical staff are specialists." In addition, we proposed a qualifier based on case-mix index values of at least 1.03. We believe that these two criteria are the best criteria we have at this time to describe scope of services.
- *Service area*—We believe that the optional criterion we proposed in § 405.476(g)(1)(iii)(D) adequately addresses this aspect of the legislation. This provision requires that a hospital would have to have at least 60 percent of its discharges made for inpatients who reside more than 25 miles from the hospital.
- *Mix of medical specialties*—This characteristic appears to be closely related to the scope of services characteristic. As mentioned above, one of the optional criteria would require that more than 50 percent of a hospital's medical staff are specialists. We believe that this criterion is adequate to meet congressional intent.
- *Wages*—None of our proposed criteria addresses the issue of the comparability of a rural hospital's wages to those of a "typical urban hospital in the same region." We believe that this criterion presents a serious problem. We must define the range within which the rural facility's wages resemble those of the typical urban hospital.

Since the Bureau of Labor Statistics (BLS) will not release wage data on individual hospitals, we currently do not have adequate data that can be used both to compute a typical (average) urban wage rate by region and to determine a hospital specific wage level. In fact, BLS will not reveal even comparative measures, which would allow indirect identification of individual hospitals. However, the wage survey currently being conducted by HCFA will provide the needed information. With data from the wage survey, it will be relatively easy to compute an average urban wage level by region, in addition to an average wage for individual hospitals. While individual hospital wage information could be obtained from a hospital's cost report, the survey data incorporate elements of consistency and uniformity of definition.

We believe that we should not adopt a wage criterion at this time for the following reasons:

- Wages are the operating characteristic least directly representative of a hospital's performance as a referral center.
- It is questionable whether rural referral centers compete directly with their urban counterparts for nonprofessional staff.
- Wages can be driven by a variety of forces unrelated to the services available in the hospital; for example, union contracts, local labor shortages, and management choice.
- A wage criterion presents irreconcilable boundary disputes inherent in the entire urban/rural classification problem.
- Because wage rates are directly controllable by the hospitals and due to the present payment adjustment (that is, the urban standardized payment), there would be some incentive to bid up wage rates.

We received comments on the proposed provisions for referral centers from hospitals, hospital associations, and individuals. Our responses to those comments are as follows:

Comment—Several commenters questioned the definition of "specialists" that we proposed in one of the rural referral center criteria (§ 405.476(g)(1)(iii)(C). They pointed out that the American Board of Medical Specialties does not recognize specific training requirements. Rather, it recognizes specialty boards, and these boards establish the training requirements necessary for admission to the certification process. Therefore, they believe that the definition of "specialists" should be clarified. Some commenters asked whether family practitioners, radiologists, pathologists, or anesthesiologists could be counted as specialists.

Response—We have clarified the definition of specialists in § 405.476(g)(1)(iii)(C). The new definition provides that a specialist either must be certified as a specialist by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists; have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialities or the Advisory Board of Osteopathic Specialists; or have successfully completed a residency program in a medical specialty accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. All specialists that meet this definition can count toward meeting this criterion.

Comment—Some commenters asked whether the term "medical staff" as used in § 405.476(g)(1)(iii)(C) refers to only active medical staff.

Response—We believe that the definition of medical staff should be limited to active medical staff and are revising § 405.476(g)(1)(iii)(C) accordingly. Some hospitals have staff members in the categories of courtesy staff, consulting staff, or honorary staff. It is highly unlikely that physicians will refer patients to a hospital solely because of the presence of these types of staff. Therefore, they will not be counted in the percentage of specialists that a hospital may need to meet to qualify for referral center status.

Comment—Several commenters were unclear about where a hospital should submit the material to justify its rural referral center status and the process that is followed in making the determination.

Response—In the September 1, 1983 interim final rule (48 FR 39783), we stated that a hospital seeking referral center status should submit documentation to its fiscal intermediary. The intermediary would review the material, make a recommendation, and forward the material to the appropriate HCFA regional office. The regional office would review the documentation, also make a recommendation for or against approval, and submit the material to HCFA central office where a final decision would be made. Because of the volume of hospitals that we expect will qualify for referral center status under the revised regulations, we have determined that it will be more efficient, and hospitals will receive determinations more promptly, if the regional office handles all stages of the review. Thus, we are altering the current procedure to eliminate both the intermediary and central office review. A hospital should submit its request and documentation directly to its appropriate regional office. The regional office will review the data to determine if additional information is needed. If additional data are necessary the regional office will notify the intermediary in a timely manner and the intermediary will supply the documentation to the regional office also in a timely fashion. The regional office will then make a final determination within 60 days after receipt of the hospital's request and notify the hospital of its decision.

Comment—Several commenters inquired whether hospitals meeting the proposed criteria would receive retroactive adjustment to October 1, 1984.

Response—In the NPRM, we stated that the criteria published in § 405.476(g)(1) (i) and (ii) and the criteria proposed in § 405.476(g)(1)(iii) would be effective for discharges occurring on or after October 1, 1984. However, after the NPRM was published, Pub. L. 98–369 was enacted. Section 2311(a) of Pub. L. 98–369 states that a hospital must submit its request for rural referral center status during the quarter preceding the start of its fiscal year (except that hospitals with a fiscal year starting on October 1, 1984 have until January 1, 1985 to submit their requests). Based on the law, we are altering our proposed effective date to conform with the statutory requirement. If we determine that a hospital meets the criteria for rural referral center status, payments will be effective with the start of the provider's cost reporting period.

Comment—A number of commenters pointed out a problem with the alternative criterion for hospitals that do not meet the 1.03 case-mix index criterion for 1981. We proposed that a hospital may meet this criterion if its case-mix index for the first cost reporting period under the prospective payment system is at least 1.0903. The commenters stated that the reduction in the DRG relative weights of 2.4 percent effective October 1, 1984 makes it more difficult for hospitals, whose accounting year began after October 1, 1983, to reach that index because their case mix is lowered by the reduced weights.

Response—We agree with the commenters' statement and did not intend to penalize those hospitals attempting to meet the 1.0903 case-mix criterion. Therefore, we are revising the regulations at § 405.476(g)(1)(iii)(A) to incorporate the following change. If a hospital does not have a case-mix index of at least 1.03 for 1981, it may still meet this criterion if it has a case-mix index of at least 1.1053 for its first cost reporting period under the prospective payment system, that is, cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984. For this purpose only, the DRG relative weights in effect during Federal fiscal year 1984 would apply in calculating the case-mix index values. Based on approximately 2.5 million admissions processed in HCFA, representing about half the admissions in FY 1984, we have found an increase in average case mix of 7.31 percent over the 1981 levels. Since average case mix has increased in this fashion, the case-mix index criteria applicable for determining referral center status should be similarly increased to reflect the change. This is necessary to assure that designation as a referral center under the alternative standards reflects the present complexity of cases so that the expectation for qualification based on experience in the first year under the prospective payment system is on a par with that observed in the 1981 data. We note that each additional update of Medicare claims data shows that the average case mix is increasing. It should be noted that the question of whether the increase in case mix is "real" or merely the result of more accurate coding, which is relevant to the issue of budget neutrality described below, is not relevant to setting appropriate criteria for rural referral centers. As discussed above, based on section 2311(a) of Pub. L. 98–369, a hospital may also meet the case-mix index criterion if its case mix for 1981 is at least the median urban case-mix index for the region in which the hospital is located for either the cost reporting period that ended in 1981 or its most recently completed cost reporting period.

Also, as stated previously, hospitals are required to submit their requests for rural referral center status during the quarter preceding the start of their fiscal year (except that hospitals with a fiscal year starting October 1, 1984 have until January 1, 1985). If approved, the adjustment will be effective with the start of the hospital's second cost reporting period subject to the prospective payment system (that is, cost of reporting periods beginning on or after October 1, 1984).

Comment—Several commenters believe that if a hospital's 1981 case-mix index value was not at least 1.03 and, therefore, it does not meet the mandatory criteria set forth in § 405.476(g)(1)(iii)(A), then the hospital should be allowed to use other criteria. The following are the commenters' suggestions:

- Hospitals should be given the option of requesting a recalculation of their 1981 case-mix index value based on data from 100 percent of its cases.
- Hospitals should be allowed to substitute data from the Commission on Professional Hospital Activities (CPHA) to demonstrate the complexity of their cases.
- Hospitals should be permitted to average their 1980 and 1981 index values to meet the 1.03 standard.

Another commenter believes that the 1.03 standard is too low and that it should be raised to 1.05 to more accurately identify true referral centers and minimize the impact on budget neutrality.

Response—We do not believe that hospitals should be allowed to substitute other criteria for the one we published in the NPRM. We selected the 1981 case-mix index for this criterion because it represents the most current published data available. Specifically, we are not accepting any of the suggestions for the reasons set forth below.

The basic tenet of the prospective payment system is that the rates paid to hospitals are determined prospectively and are based on the best data available at the time. Thus, a hospital knows in advance what its payment amounts will be. In addition, revisions to case-mix index values, whether upward or downward, would upset the budget neutrality adjustment. Therefore, we have denied any hospital the right to request review of its 1981 case-mix index value based on 100 percent of its cases. This policy holds whether the request for review is for purposes of meeting the referral center criteria or for

determining the hospital-specific portion of a hospital's payment rate.

We cannot allow substitution of the CPHA data in lieu of our published 1981 case-mix index because these data are developed and published by a source totally independent of HCFA. We have no way to verify either the raw data submitted by the hospital to CPHA or CPHA's processing of the data except by performing a 100 percent review ourselves. We do not believe a review by HCFA is appropriate.

Also, we do not agree that we should allow a hospital to average its 1980 and 1981 index values in order to meet the 1.03 case-mix criterion. Averaging of index values is inconsistent with our policy of using the most currently published data available. In addition, if we made the averaging mandatory, some hospitals that have a 1981 index value of at least 1.03 might be disqualified if forced to average their 1980 and 1981 values.

Finally, we believe that the 1.03 case-mix index value is an adequate measure of the complexity of a hospital's cases and we do not believe that increasing the value to 1.05 would be appropriate.

Comment—We received comments that disagreed with our setting the discharges level specified in the criterion set forth in § 405.476(g)(1)(iii)(B) at 6,000. Some of these commenters pointed out that, because of the greater emphasis that is currently being placed on alternatives to hospitalization, many hospitals will be experiencing a decline in admission rates. Therefore, the discharge level should be lowered. In contrast, one commenter suggested that the required number of discharges should be increased to lower the number of hospitals that will meet the referral center criteria and, thus, lessen the impact on budget neutrality.

Response—We believe that the 6,000 discharges requirement helps to ensure that only above average size hospitals qualify for referral center status. At the same time, we do not believe that this number needs to be increased to guarantee that only a limited number of hospitals meet the criteria.

However, in response to those commenters concerned about decreasing admission rates, we are revising the regulations at § 405.476(b)(1)(iii)(B) to allow a hospital to meet the 6,000 discharge figure either for its cost reporting period ending in 1981 or for its most recent cost reporting period completed before it applies for referral center status.

Comment—Several commenters questioned whether the 6,000 discharge criterion should be based on a hospital's total discharges or its Medicare discharges. Other commenters urged that the criterion be based on hospitals' total discharges because the nationwide distribution of Medicare beneficiaries is not uniform.

Response—Although we did not specify in the NPRM whether the criterion is based on a hospital's total discharges or its Medicare discharges, the criterion is to be based on 6,000 total discharges. We agree with commenters that requiring 6,000 Medicare discharges would place an unfair hardship on some facilities.

Comment—Some of the commenters stated that hospitals that fail to meet the mandatory criteria in §§ 405.476(b)(1)(iii) (A) and (B) by only a small margin, and therefore fail to qualify as referral centers, end up with a payment rate that is significantly different from those hospitals that meet the criteria by only a small margin. Examples cited by commenters were cases where one hospital has a 1981 case-mix index value of 1.03 and another hospital has a 1981 case-mix index value of 1.02, or one hospital has just over 6,000 discharges in one of the required cost reporting periods and another has slightly less than 6,000. In both cases, the first hospital receives payment based on the urban standardized amounts and the second hospital receives significantly less because its payment rate is based on rural standardized amounts.

Response—Whenever numeric standards are established, there will be those entities that narrowly miss meeting them as well as those that narrowly succeed in meeting them. Regardless of the standards selected, this will be true. If we did allow exceptions to these criteria, they would have to be limited to certain tolerances that, again, some hospitals would fail to meet by a small margin.

Both of the mandatory criteria specified in § 405.476(g)(1)(iii) are measures of a hospital's referral center status. The case-mix index criterion measures the complexity of a facility's cases and differentiates a true referral center from other hospitals. With regard to the 6,000 discharge criterion, as noted in the NPRM (49 FR 27429), we believe that Congress intended that referral center status be granted only to those facilities of above average size and utilization. As also noted in the NPRM (49 FR 27433), we project that approximately 113 facilities will meet these two criteria; thus, we continue to believe that our criteria meet congressional intent and are not unduly stringent.

Finally, it should be noted that hospitals that do not meet the referral center criteria as provided in § 405.476(g)(1)(iii) can still qualify for referral center status if they meet the criteria in § 405.476(g)(1)(ii). Also, hospitals that do not meet the 1981 case-mix index criterion have the opportunity to qualify if they meet the alternative case-mix index value of 1.1053 during their first cost reporting period subject to the prospective payment system or if they meet the median case-mix index for the region in which they are located.

Comment—One commenter stated that the establishment of the two mandatory criteria of case-mix index and patient discharge is inconsistent with Congressional intent. However, the majority of commenters who responded to our NPRM agreed that the mandatory criteria should be met by a hospital in order to qualify as a referral center.

Response—We believe that the two mandatory criteria set forth in §§ 405.476(g)(1)(iii) (A) and (B) are the principal characteristics that distinguish a hospital as a referral center. A hospital that meets one of the three case-mix index criteria demonstrates a level of complexity that we believe is consistent with the intent of Congress when it included the referral center provision in the prospective payment legislation.

The criterion relating to hospital discharges was chosen as one of the mandatory criteria because we believe Congress intended that the referral center provision apply to hospitals of above average size and utilization (Congressional Record, Vol. 129, No. 34, March 17, 1983, S3224). We believe that a reliable measure of a hospital's operation is the number of patients discharged.

Comment—A commenter was concerned that the proposed revisions to the referral center criteria do not conform to the statutory changes enacted in Pub. L. 98–369. However, another commenter stated that we should not include any of those statutory changes in this final rule because they should first be published as an NPRM so the public will have an opportunity to comment.

Response—Section 2311(a) of Pub. L. 98–369 amended section 1886(d)(5)(c)(i) of the Act to provide that rural hospitals may appeal to the Secretary to be classified as a rural referral center on the basis of criteria to be established by the Secretary. We believe that the regulatory changes stated in § 405.476(g) of this final rule regarding regional referral center criteria conform with the Congressional interest and statutory

provisions in section 2311(a) of Pub. L. 98-369.

Therefore, we are not publishing a notice of proposed rulemaking for these provisions (see section VI.C. of the preamble), although we will monitor the impact of these provisions on referral centers.

Comment—Several commenters recommended a different approach for determining referral center status. They suggested that we should define "referral" based on specialty rather than on the criteria set forth in the proposed regulations. Under this proposal, a hospital that treats more expensive cases than the average for particular DRGs would receive adjustment only for those DRGs.

Response—Although we are not certain whether the data would indicate large enough cost differences within individual DRGs to justify referral status for hospitals treating patients within those DRGs, we will continue to review and consider this suggestion.

Comment—We received several comments that expressed concern about the optional criteria that require 60 percent of all discharges to be made for inpatients who reside more than 25 miles from the hospital and require that at least 40 percent of all inpatients have been referred to the hospital (§§ 405.476(g)(1)(iii) (D) and (E)).

Response—As we indicated in the NPRM (49 FR 27429), the alternative set of criteria we proposed were designed to meet the unique circumstances of rural referral centers with less than 500 beds. We believe that, in order to meet the intent of Congress, a rural referral center should satisfy criteria that ensure that the hospital draws its patients from a wide geographic area. The proposed criteria were structured using the best information available to us. Since there are limited specific data on referral patterns available, we specifically solicited comments on these criteria.

As a result of the comments received, we believe that the criteria set forth in the NPRM are fairly stated. We received only two comments on the 60 percent residence and 40 percent referral optional criteria, and neither commenter suggested criteria that would better express the intent of the legislation.

One of the main reasons we established special treatment regulations for rural referral centers was to allow hospitals that serve a substantial number of patients outside a local area a more favorable rate of payment. We believe that the criterion related to patient residency conforms with congressional intent (that is, the 60-percent qualification best establishes what is meant by "a substantial number of patients live outside the local area") and, therefore, will allow those hospitals that are truly referral centers to qualify.

In light of comments received, we believe that there is no reason to change the criterion that states that at least 40 percent of all inpatients treated at the hospital are referred to the hospital either from physicians not on the hospital's staff or from other hospitals. This criterion gives weight to the actual referral, which we believe was one of the basic objectives of the provision. It is reasonable to expect that a considerable number of a referral center's patients would come from actual referrals. In addition, it is our opinion that the source of the patient population of a referral center should differ from that of a typical rural hospital. By meeting this 40-percent criterion, a hospital would demonstrate this difference.

Comment—One commenter suggested that a referral center should be evaluated based on the extent to which it meets the total health care needs of the community; that is, whether the majority of the Medicare beneficiaries that reside in a referral center's service area receive care at the center. The commenter also said that a referral center should be evaluated based on whether the center provides services without having to transfer patients to other hospitals.

Response—Without a precise definition of a referral center's "service area", such a criterion is difficult to develop and evaluate. We believe that one of our optional criteria, that at least 60 percent of a referral center's total discharges be for inpatients who live more than 25 miles from the hospital, addresses this issue from a different approach.

Also, we believe that one of our optional criteria for referral centers, while providing a different approach, responds to the commenter's latter suggestion. Rather than monitoring the number of patients that a hospital transfers, we are monitoring the percentage of patients referred to the referral center.

Comment—One commenter urged that a rural referral center wage index be determined based on the wage index of the nearest urban area or on an average of the wage index of the nearest urban area and the rural wage index for the State in which the hospital is located.

Response—We believe that using the wage index of the nearest urban area would be unrealistic because of difficulties in determining which urban area is closest to the rural hospital, especially in rural areas that are bounded by two or more urban areas. In addition, we do not believe that the wages paid by all rural referral centers would necessarily equal those of nearby urban facilities. For example, it is questionable whether rural referral centers compete directly with urban hospitals for nonprofessional staff. Therefore, it remains our opinion that the rural wage index is appropriate for rural referral centers, and, therefore, we have not adopted this commenter's suggestion.

Comment—One commenter believes that the criterion set forth at § 405.476(g)(1)(iii)(E) is incomplete. That criterion provides that at least 40 percent of all inpatients treated at a hospital must have been referred to the hospital either from physicians not on the hospital's staff or from other hospitals. The commenter contends that patients are likely to consult a physician on the choice of a hospital and then later have themselves admitted to that hospital; thus, they would be self-referred patients. However, the criterion does not allow self-referred patients to be applied to the 40 percent requirement.

Response—This criterion is designed to give weight to the actual fact of referral, which is an essential feature of a rural referral center. We agree that the scenario described by the commenter will occur occasionally; however, we believe that in most cases these patients will be seeking admission to small rural hospitals. In these cases, if the patient requires further specialized attention, he or she will be referred to a larger facility that can furnish those services. It is these facilities that we believe should be receiving rural referral center status.

Comment—In the NPRM (49 FR 27429), we specifically requested comments on one aspect of the criteria set forth in §§ 405.476(g)(1)(iii) (D) and (E). The former criterion measures the percentage of a hospital's inpatients who reside more than 25 miles from the hospital and the latter measures the percentage of a hospital's inpatients who are referred. In both cases, we are basing the criteria on all inpatients; however, we requested input from the public on whether or not we should base the criteria on only Medicare inpatients. We received numerous comments most of which were in favor of our basing these criteria on the entire inpatient population.

Response—We agree with the majority of the commenters that in computing these percentages we should take all of the hospital's inpatients into account. We believe this is appropriate because the type of services furnished, the intensity of care, and the population

radius served by the hospital would be based on total inpatient population. Referral centers have higher costs because of the services they provide to all inpatients, not only those who are Medicare beneficiaries.

Comment—Some hospitals suggested that the mix of mandatory and optional criteria that are set forth in § 405.476(g)(1)(iii) should be revised. For example, a few commenters recommended that the mandatory 6,000 discharge criterion should become one of the optional criteria, and hospitals should have to meet three of the four optional criteria. Another suggestion was that none of the criteria should be mandatory and a hospital should have a wider range of optional criteria to meet. This commenter suggested that we should add criteria related to wages and scope of services (for example, 24-hour emergency care, intensive care unit, nuclear medicine) and then allow a hospital to meet four out of seven of these criteria.

Response—As we stated in the NPRM (49 FR 27429), we believe that the two mandatory criteria (that is case-mix index and number of discharges) are the key factors that allow us to satisfy what we understand congressional intent to be in enacting this provision. The level of complexity and the high technology of the care furnished are, in our opinion, among the principal characteristics that distinguish hospitals that are referral centers from typical rural hospitals. We also believe that Congress intended a referral center to be above average size. It is our contention that case-mix and number of discharges are the suitable measures for these characteristics. Therefore, we are retaining these two mandatory criteria in order to adequately classify hospitals as referral centers.

Concerning the additional optional criteria mentioned by the commenters, as stated earlier in the preamble, we currently have no means of comparing wages and, even when we are able to gather data, we are not certain that wages are directly representative of a hospital's performance as a referral center for patients from a wide area. With regard to scope of services, those specialized services suggested by the commenters are typically furnished in many rural hospitals, not just those that should qualify as referral centers; therefore, we do not believe specialized services to be a unique characteristic of referral centers.

Comment—Several commenters requested that we give prompt attention to developing referral center criteria for urban hospitals.

Response—In the NPRM (49 FR 27429), we stated that it will not be possible to make payment adjustments for urban hospitals until we have the opportunity to examine and analyze in detail information pertaining to these hospitals. Since we have received only two applications from urban hospitals applying for referral center status, we have not yet gathered enough information to compare urban referral centers to other urban hospitals.

Comment—In response to our request for comments on the possibility of our conducting periodic reviews of referral centers to determine if they continue to meet the criteria, we received a limited number of suggestions. Most commenters suggested that if the reviews are conducted, then they should be done at 12 to 24-month intervals and that a hospital should not lose its referral center status unless it has failed to meet the criteria for at least two consecutive years. Two commenters proposed that if a referral center fails to meet the criteria for two consecutive years, there should be a transition period to prevent the hospital from suffering hardship due to its return to a lower payment rate.

Response—We have determined that periodic reviews of rural referral centers should take place every three years. We feel that this would avoid penalizing a hospital that falls slightly below the criteria in a given year.

A hospital that fails to continue to meet the criteria needed to qualify for rural referral status in its first two years of participation as such, will automatically be disqualified after the third year. The facility will have the right to reapply and requalify in the future.

In other situations we will look to the hospital's performance during the third year in conjuction with experience in the first two years to determine if referral center status should be continued. Following the end of the first quarter of the hospital's third year as a referral center (or the third year following renewal in future years) the hospital will be required to submit sufficient data (records of Medicare claims, discharge projections, information supporting the optional criteria) to permit evaluation of the hospital's expected performance during the period. If the hospital meets the criteria in the third year and has met them in either of the two preceding years, referral center status will be continued. If the hospital fails to meet the criteria in the third year and has failed in either or both of the preceding years, referral center status will be terminated. If the provider fails to meet the criteria in the third year but has met the criteria in both of the preceding years referral center status will be presumed to continue but that hospital will be reviewed again in the immediately following year. If the hospital fails to meet the criteria in the immediately following year as well, referral center status will be terminated. The review will be completed by the end of the third quarter of the reporting period in which it is conducted so that the provider may be notified of the result in advance of the ensuing year. A hospital that is found to qualify upon review will receive an additional three years of referral center status, except for those hospitals for which referral center status was presumed subject to second review. But, if the hospital is determined not to meet the criteria for referral center status upon completion of the third year review, it will no longer be classified as a rural referral center.

We would have to perform reviews of the two mandatory criteria of case-mix index and number of discharges in different ways. Since we are requiring, for our third year review, a less than complete year of data (as of the end of the third quarter of the hospital's accounting year), the third year case-mix index criterion will be based on a nine-month period at the most.

The second mandatory criterion of having at least 6000 discharges is based on the hospital's most recent cost reporting period before it applies for rural referral center status. Therefore, we will be able to review three complete cost reporting periods to determine if the provider continues to meet the discharge criterion.

A facility that is determined ineligible to continue as a rural referral center will lose its status after the third cost reporting period. A hospital that has qualified as a referral center beginning January 1, 1985, and which upon our review no longer meets the qualifications to continue being paid as a referral center, would revert back to payment as a rural facility as of the beginning of its cost reporting period, January 1, 1988.

We believe that no transitional or phase-in period is necessary to accompany this change in status. Those hospitals that are disqualified as rural referral centers have already benefitted from at least three years of payment at the urban rate. Therefore, after appropriate notification, we believe that a decrease in the facility's payment is inappropriate.

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. Based on our assessment of the impact of providing inpatient dialysis, we proposed not to provide special treatment for inpatient dialysis.

Comment—Several commenters expressed concern that, because end-stage renal disease (ESRD) beneficiaries require inpatient dialysis whenever they are admitted to a hospital are concentrated in certain hospitals, these hospitals are bearing the brunt of the added expense of furnishing inpatient dialysis. Consequently, if additional payment is not provided for the extra expense, the commenters believe that hospitals will no longer provide this service resulting in a hardship to patients.

Response—Based on the comments received, we are providing an additional payment for hospitals that have a significant number of ESRD beneficiary discharges. While the overall impact of providing inpatient dialysis is not great, we recognize that where these beneficiaries are concentrated in a few facilities, a disincentive to treat ESRD beneficiaries might result. We are providing an additional payment to hospitals in which ten percent or more of the Medicare dischages are ESRD beneficiary discharges in a cost reporting period. To determine the number of ESRD discharges, discharges classified in DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) and DRG No. 317 (Admit for Renal Dialysis) are excluded. In these DRGs, dialysis is not ordinarily limited to ESRD beneficiaries and the relative weights adequately reflect dialysis because it occurs relatively frequently.

In most hospitals, the likely incidence of inpatient dialysis is small in relationship to the patient population and can be considered to be represented in the Federal standardized amounts. However, we think those few hospitals most extremely impacted by the ESRD beneficiary population should be afforded some protection against the chance of encountering inpatient dialysis expenses which could not be offset by revenue from cases in which the DRG payment was greater than the hospital's cost. Therefore, a special payment is being provided. Consistent with the objectives of the prospective payment system, the special payment is not intended to recognize the actual cost an individual hospital might incur in delivering inpatient dialysis service or to provide full reimbursement of all costs in every case. Rather, it is intended to ameliorate those circumstances in which the concentration of beneficiaries receiving dialysis may be such that the hospital would not be able to absorb the entire expense with revenue from other less costly cases.

The additional payment provided will be based on the average length of stay for ESRD beneficiaries in that facility times a factor based on the average direct cost of furnishing dialysis during a usual beneficiary stay. The average direct cost of dialysis was determined from the data obtained in connection with establishing the composite rate reimbursement for outpatient maintenance dialysis. The data used was from hospital-based facilities. An average of those cost directly representative of the dialysis service was determined. The average number of dialysis sessions per week was obtained from the same data base. This was done to avoid any incentive for increasing the frequency of dialysis sessions which could exist if payment were related to the number of dialysis sessions in the current period.

In order to estimate the additional cost above the DRG rate that a hospital would incur to furnish dialysis, we selected only those costs representing the direct cost of furnishing this service and excluded all overhead cost. Overhead cost of the inpatient service would be reflected in the DRG rate. Using salary, employee health and welfare, drugs, supplies, and laboratory costs, we determine a cost of $111.67 per session. These costs were broken down as follows:

Salary	$52.67
EH & W	11.59
Drugs	3.09
Supply	39.69
Lab	4.63
Total	111.67

This amount will be paid only on the Federal portion of the payment rate. The cost of furnishing dialysis is already appropriately reflected in the hospital-specific portion. A hospital qualifying for the payment in a reporting period will receive an amount equal to the estimated weekly cost of dialysis times the hospital's average ESRD length of stay expressed as a ratio to one week multiplied by the number of ESRD beneficiary discharges, excluding discharges classified in DRG Nos. 302, 316 and 317.

III. Changes to Regulations Based on Pub. L. 98–369

As previously noted, Pub. L. 98–369 was enacted on July 18, 1984. This section contains a discussion of two provisions in that law relating to the hospital prospective payment system.

A. Payment for Indirect Medical Education (§ 405.477)

Section 2307(b) of Pub. L. 98–369 amends section 1886(d)(5)(B) of the Act to require that we not distinguish between interns and residents employed by the hospital and those providing services in the hospital but employed by others, in determining the additional payment amount for indirect medical education due hospitals under the prospective payment system.

For hospitals in the first year under the prospective payment system, we counted only interns and residents who were employed by the hospital. In the final rule, published January 3, 1984 (49 FR 234), on the prospective payment system, we revised our policy to include in the count of interns and residents those employed by other organizations with a longstanding historical relationship for medical education with the hospital. In each case, the organizations were required to be sole employers of substantially all of the interns and residents furnishing services at the hospital.

The change mandated by section 2307(b) of Pub. L. 98–369 is to be effective for cost reporting periods beginning on or after October 1, 1984. (See revised § 405.477(d)(2) of these regulations for changes regarding calculation of indirect medical education costs.)

Because the law requires that we do not distinguish, in counting interns and residents, on the basis of who employs the individual, we are required to establish a system of counting on the basis of where services are provided and to calculate full-time employees on that basis. No intern or resident will be counted as more than one full-time employee in any reporting period, regardless of the number of hospitals in which he or she works. Therefore, when working at more than one hospital, each intern's or resident's time will be apportioned to each facility. To avoid the potential for counting interns and residents more than once, we are requiring that hospitals submit quarterly reports to their intermediaries that contain the following information:

- Monthly listing of all interns and residents providing services during the month;

• Each intern's and resident's social security number; and

• The actual hours worked at the hospital during each month.

Where the hospital is unable to supply documentation of the times worked by interns and residents, their services will not be counted as part of the overall calculation of the payment amount.

The final lump-sum payment for indirect medical education costs will not be made until the fiscal intermediary completes audits of the first year's cost reports.

To conform § 405.477(d)(2) to the revised policy, we are also deleting the requirements regarding employment and other relationships.

We invite public comments on this issue and if, after consideration of all comments received, we determine that the policy should be revised, we will publish the changes in the **Federal Register** and address all comments received on this issue.

B. Payment for Non-Physician Anesthetists (§ 405.477)

Section 2312 of Pub. L. 98–369 amends sections 1886(a)(4) and 1886(d)(5) of the Act to require that we pay an additional amount to hospitals paid under the prospective payment system, for "reasonable costs incurred" for anesthesia services provided by certified registered nurse anesthetists. See the new § 405.477(c)(3) in these regulations regarding determination of this payment amount.

Section 2312(a) provides for reimbursement to hospitals on a reasonable cost basis as a pass-through for the costs that hospitals under prospective payment incur in connection with the services of certified registered nurse anesthetists (CRNAs). (See the discussion below in this section of our use of the term "nonphysician anesthetist" in lieu of CRNA.) It further provides that this shall be the only payment made to the hospital for such services. Section 2312(b) excludes anesthesia services furnished by a CRNA from the definition of the term "operating costs of inpatient hospital services." Section 2312(c) provides that the amendment is effective for hospital cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

The statute establishing the prospective payment system did not directly address the services of nonphysician anesthetists. As such, they would have been treated under provisions of section 602(e) of Pub. L. 98–21 (section 1862(a)(14) of the Act) which excluded from Medicare coverage all items, supplies and services furnished to hospital inpatients other than physicians' services that are not directly furnished by the hospital or by others under arrangements with the hospital. That is, the costs attributable to nonphysician anesthetists' services (including those billed "incident to" physicians' services under Part B) would have been included in a hospital's base period costs and hospital-specific portion of the total payment amount.

However, during the process of developing the interim final rule implementing the prospective payment system, it was decided that there should be an exception to the section 1862(a)(14) exclusion (under the authority in section 602(k) of Pub. L. 98–21) to recognize the unique relationship between the physician-employer and anesthetist-employee. The exception permitting the continuation of part B billing by physicians for the services of their anesthetist employees applied to such arrangements that existed on the last day of the hospital's prospective payment base period for the duration of the transition period (cost reporting periods beginning prior to October 1, 1986.) Thus, for the first year under the prospective payment system, payment was made for the services of nurse anesthetists either through prospective payment to the hospital or through billings by eligible physicians.

The conference report that accompanied section 2312 does not discuss the rationale for the amendment. However, there is a clear indication that it was the intent of Congress that Medicare payment methods not discourage the use of CRNAs by hospitals. In addition, the conference report indicates that the conferees expect the exception permitting "incident to" billing by physicians who employ CRNAs to be modified to sanction such billings resulting from employment relationships that began after the base period under the prospective payment system ended.

The conference agreement limited the provision to "anesthesia services furnished by certified registered nurse anesthetists." The conferees then define such services as, "those related to the preparation for, administration of, and recovery from anesthesia."

It is questionable whether the benefits associated with a strict interpretation of the term "anesthesia services" would be worth the burden that extensive time studies of the activities of each hospital-employed nonphysician anesthetist would impose. In the absence of evidence to the contrary, it can be argued that, generally, everything a nonphysician anesthetist does in a hospital is related to the provision of anesthesia services. However, we should not pass through the costs of a nonphysician anesthetist who is functioning in a position outside the field. For example, we would not want to create an incentive for hospitals to hire a CRNA and receive the pass-through payment amount even though the individual is serving in another nursing capacity. In the case of independently contracting nonphysician anesthetists whose services a hospital obtains under arrangements, all such services could be presumed to be related to the provision of anesthesia. For the purpose of implementing the amendment, nonphysician anesthetists will be defined to exclude any such anesthetists not actively engaged in functioning as an anesthetist without further differentiation according to specific services or time allocations.

The original exception in the interim final rule applies to situations where a physician employed "anesthetists" as of the last day of the hospital's base period. As presented in the preamble and regulations text of the interim final rule, we did not limit its application only to services of CRNAs. The exception also applied to services of physician-employed Anesthesiology Assistants (AAs) assuming all other related requirements were satisfied. The amendment and the conference report use the terms "certified registered nurse anesthetist" and "CRNA" throughout. However, despite the precise wording of the amendment and conference report, we believe that it was congressional intent to apply this pass-through payment amount to the services of all qualified hospital-employed nonphysician anesthetists (that is, CRNAs and AAs consistent with applicable State law) for the following reasons:

• It is consistent with the current exception (§ 405.553(b)(4)).

• It is consistent with the goal of discouraging the substitution of interns and residents for the services of any qualified anesthetist, not just CRNAs (§ 405.421(d)(6)).

• It is consistent with the current standard for hospital departments of anesthesia (§ 405.1031(b)(2)(iv)) that the hospital staff designates those persons qualified to administer anesthesia.

• It would help to assure that prospective payments to hospitals reflect the same services whether the anesthetist is employed by a physician or by a hospital.

The current exception under § 405.553(b)(4) applies to the services of all physician-employed anesthetists where certain criteria are met. It is

stated in the conference report that it is the understanding of the conferees that those physicians meeting the current exception could, ". . . continue to bill for CRNA services. . . ." Further, the report goes on to indicate that physicians not meeting the current exception could begin to bill for all the services of CRNAs they "subsequently employed" for the duration of the time-limited exception. These "understandings" are not reflected in the statutory language.

The exception is modified (see § 405.553(b)(4)) to require only a valid employment relationship to sanction "incident to" billing of anesthesia services and to eliminate the provision tying the exception to the prospective payment base period. An employment relationship for this purpose is not established where the anesthesiologist and the anesthetist are both compensated by a hospital, medical school, or another entity, other than an incorporated group practice of physicians, for services furnished in a hospital. Additionally, we would like to stress that the exception requires close coordination between the intermediary and the carrier. The intermediary should notify the appropriate carriers of the dates of cost reporting periods of hospitals in its service area when changes in employment relationships between physicians and anesthetists occur so that the appropriate time units may be used in the computation of reasonable charges. The exception will apply to existing and new employment relationships between physicians and anesthetists beginning with hospital cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

Under section 2312 of Pub. L. 98-369, costs of anesthesia services furnished by certified registered nurse anesthetists are removed from the definition of "operating costs" of inpatient hospital services. Therefore, in all hospitals paid under the prospective payment system the costs of such services and those of anesthesiology assistants included in calculation of base period costs will be removed for purposes of determining the hospital-specific portion of the total payment amount. These recalculations of base period costs will be performed by intermediaries.

With regard to the Federal rates, the costs attributable to the services of nonphysician anesthetists have been estimated based on the best information available to us, and we have removed these costs from the Federal rates. This is necessary to avoid paying for these services twice. Accordingly, the standardized amounts have been revised to reflect this change. As a result, as discussed in the impact analysis, we expect that in FY 1985, about $160 million will be passed through and paid on a cost basis.

We invite public comments on this issue and if, after consideration of all comments received, we determine that the policy should be revised, we will publish the changes in the **Federal Register** and address all comments received on this issue.

IV. Other Changes to Regulations

In the September 1, 1983 interim final rule, we erroneously deleted § 405.452(c)(5) regarding the cost apportionment method of allocating costs for home health agencies (HHAs). To remedy this mistake, we are amending § 405.452 in this document by adding a new paragraph (a)(3) that restores the deleted material.

V. Summary of Changes

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

A. Payment of Cost Outliers to Transferring Hospitals

We are amending §§ 405.470(c)(4) and 405.475(a) to permit a transferring hospital to be paid an additional payment for extraordinarily high cost cases that meet the cost outlier critera in § 405.475(d).

B. Direction of Rehabilitation Units

We are revising § 405.471(c)(4)(iii)(F) 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. Exclusion of New Rehabilitation Hospitals and Units and Expansion of Already Excluded Rehabilitation Units

We are adding new §§ 405.471 (d), (e), and (f) to provide the following:

- 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.
- New rehabilitation hospitals and units that seek first-time exclusion and an already excluded unit that seeks to add new beds may certify that they intend to serve a population that meets the requirements of the 75-percent rule instead of actually demonstrating that they have met these requirements for the previous 12-month cost reporting period.

D. Physician Attestation

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

E. Hospitals in Areas Redesignated as Rural

We are adding 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 state that we will provide for a two year phase-in of the rural Federl payment amounts to a hospital, located in an area redesignated as rural. For the first cost reporting period, the additional amount is 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 cost reporting period, the additional amount is 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 new § 405.473(c)(2), we are clarifying to which census division a hospital belongs when an MSA or NECMA crosses a census division boundary.

- In § 405.473(c)(2), for the purpose of MSAs or NECMAs that overlap census divisions, we deem hospitals in 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 are not applying this change in FY 1984 to hospitals that are adversely affected by such a change; that is, as a result of a redesignation in which a hospital ends up in a census division with a lower Federal rate. 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 deem all the hospitals to belong to the census division with the highest Federal rate.

G. Base Year Appeals

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

H. Referral Centers

We are adding an alternative set of criteria to § 405.476(g)(1) that expand the definition of referral centers to encompass more rural hospitals. We are paying hospitals that meet these criteria the urban (rather than the rural) adjusted standardized amounts. We are also revising § 405.476(g)(2) so that rural hospitals that meet the criteria set forth in § 405.476(g)(1)(ii) are also paid the urban (rather than the rural) adjusted standardized amounts for cost reporting periods on or after October 1, 1984. In addition, we are adding a new § 405.476(g)(3) to provide for a triennial review of referral centers to determine if they continue to meet the criteria of § 405.476(g)(1).

I. Inpatient Renal Dialysis

We are adding criteria in § 405.476(j)(1) that would provide additional payments to a hospital for inpatient dialysis provided to ESRO beneficiaries if the hospital has established that ten percent or more of its total Medicare discharges are ESRO patient discharges, excluding discharges classified into DRG Nos. 302, 316 or 317. The additional payment to the hospital will be equal to the average length of stay of ESRO patients, expressed as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRO patient discharges.

J. Payment for Indirect Medical Education

In determining indirect medical education costs of hospitals, we are revising § 405.477(d)(2) to allow interns and residents to be counted on the basis of where their services are provided and to calculate FTEs on that basis. Hospitals will be required to submit quarterly reports to their intermediaries documenting the time worked by interns and residents. The final lump-sum payment for indirect medical education costs will not be made until the fiscal intermediary completes audits of the first year's cost reports.

K. Payment for Nonphysician Anesthetists

We are adding a new § 405.477(c)(3) to pay hospitals for the reasonable costs incurred for anesthesia services provided by qualified nonphysician anesthetists. We are also revising §§ 405.470 and 405.474 reflecting the change that estimated costs of anesthetists' services are removed in determining the Federal and hospital-specific rates. These provisions are effective with hospital cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

L. Home Health Agency Cost Apportionment Method

As discussed in section IV. above, we are adding a new § 405.452(a)(3) to replace the provision that was erroneously deleted by providing that the cost per visit by type-of-service method applies to the allocation of HHA service costs.

VI. 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 a regulatory flexibility analysis be performed and made available for each 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 implemented by 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 results in substantially increased payments for one group of hospitals under the prospective payment system is 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 changes that increase payments for some hospitals, such as the provision affecting the hospitals located in areas redesignated rural by EOMB in June 1983, do not have a substantial effect on total payments, and have negligible effects on the budget neutrality adjustment factors.

However, some of the provisions of this rule will result in increases in payments to certain groups of hospitals large enough so that the budget neutrality mechanism results 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 changes will 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 may meet the new referral center criteria, will certainly be significant. Therefore, a regulatory flexibility analysis is required.

In the discussion below, we discuss the expected impacts of these 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

These changes 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 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 changes 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

Paying cost outlier payments to transferring hospitals will benefit those hospitals incurring such costs and will be more equitable than our current payment policy. Although it may appear that this change will 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 will be negligible compared to total payments for inpatient hospital services. We do not believe it is necessary or desirable to reflect this change either our budget neutrality methodology or in the determination of cost outlier trim points. As a result, we do not expect any hospitals will be disadvantaged by this change.

D. Rehabilitation Hospitals and Units

We are making two changes in the regulations governing rehabilitation hospitals and units excluded from the propsective payment system—

• We will no longer require the director of a unit to be full-time; and

• We are eliminating the 12-month waiting period before exclusion from the prospective payment system for new or expanding rehabilitation hospitals or units.

These revisions will result in the accelerated approval of rehabilitation hospitals, units, and beds for exclusion from the prospective payment system, which in turn will 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 noted in the proposed rule, we expected to have excluded around 80 hospitals and around 440 units under the current regulations, by October 1, 1984. (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.) As of July 31, 1984, we have recognized 43 rehabilitation hospitals and 284 rehabilitation units for purposes of excluding them from the prospective payment system.

Of the 85 hospitals that had been denied exclusion of a potential rehabilitation unit as of July 31, 1984, 31 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 will be approved under the new requirements. Any unit so approved will be excluded from the prospective payment system beginning with its next cost reporting period.

Further, with regard to the revisions affecting 12 months of prior operations for new hospitals and units, we expect a number of facilities to elect exclusion effective with their first cost reporting period beginning on or after October 1, 1984. However, this entails some risk for a facility, since it must commit itself to meeting all the requirements for that period in order to retain excluded status for its subsequent cost reporting period. Therefore, we do not expect all the potential new hospitals and units to elect exclusion on this basis. As of July 1984, we had denied exclusion requests from several hospitals that wanted to begin operation of a unit, but that had not yet operated the unit for 12 months. However, we have no way of knowing how many hospitals did not file such requests due to their knowledge about the requirement of a full year's operation.

We expect these changes to permit an increased rate of growth of the total number of rehabilitation beds (and associated costs) excluded from the prospective payment system. 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 changes.

It has been suggested that permitting expansion or opening of new hospitals or units without requiring 12-months of prior operation might create opportunities for hospitals to "game" the prospective payment system by avoiding its cost constraining incentives. We agree that this type of provider behavior, if it did result, would be undesirable. However, for several reasons, we do not believe this will be a significant problem. 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 minimize per case costs. We do not believe these incentives will be altered significantly by this change. Second, and more important, since the undesirable behaviors mentioned are very familiar to us, there are already mechanisms in place that 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 change in physician attestation practice is merely 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 still require a signed certification statement for each discharge; however, the penalty statement will 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.

We did receive a number of comments that argued that requiring the attestation to be on the discharge summary would be a burden to hospitals and could adversely affect their cash flow. As discussed elsewhere in this preamble, this was not intended, and we have revised the requirement to avoid these consequences. There is still some paperwork burden associated with the attestation requirement, and particularly with the maintenance of a separate file for signed penalty statements, but we do not believe this burden to be excessive, in view of the advantages achieved in

terms of prevention and control of fraud, abuse, and waste.

F. MSA Redesignations

As discussed above, we will 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, effective with cost reporting periods beginning on or after October 1, 1983.

In the NPRM, we had proposed to make additional payments only to those hospitals that had hospital-specific rates greater than their rural Federal rates. We projected that the 32 hospitals that would receive two-thirds of the difference between the urban rate they would otherwise have received and their rural rate would be paid an estimated $4 million for FY 1985. However, we are now implementing the two-year phase-in beginning with FY 1984 cost reporting periods. Note that the impact is affected by the size of the Federal portion of the transition payment rates. Thus, for cost reporting periods beginning in FY 1984, we will calculate two-thirds of the difference between urban and rural rates for only the 25 percent Federal portion, and for cost reporting periods beginning in FY 1985, we will calculate one-third of the difference between urban and rural rates for the 50 percent Federal portion.

We estimate that this provision will initially affect 51 hospitals affected by the June 1983 EOMB redesignation, located for the most part in the East North Central and West South Central regions. There may be future redesignations, but we have no way to predict them or estimate their impact. Considering the payment to each hospital of two-thirds of the difference the first year and of one-third the second year, this will cost an estimated $4 million in additional payments for cost reporting periods beginning in FY 1984, and $4 million for cost reporting periods beginning in FY 1985.

For fiscal years 1984 and 1985, significantly increasing payments for a group of hospitals results in reduced payment to other hospitals through the budget neutrality mechanism. These additional payments affect few hospitals and are too small in the aggregate to have a large effect on the budget neutrality adjustment factors. As we stated in the proposed rule, increasing FY 1985 payments by $4 million would result in a decrease in the average payment to other hospitals of less than 50 cents.

G. Census Division Boundaries

As explained above, a hospital that is located in an MSA or NECMA that crosses census division boundaries will be deemed 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 effected MSAs continue to participate in the Medicare program, and that no new hospitals emerge in those areas, we estimate that this change will have a significant affect on only 23 of the 146 hospitals in the 14 MSAs affected:

- 11 hospitals will be paid at a higher Federal regional rate; and
- 12 hospitals will be paid at a lower adjusted Federal regional rate. (By statute, these hospitals will be held harmless for cost reporting periods beginning in FY 1984.)

Of the 146 hospitals in affected MSAs, 120 will not be reclassified. The remaining three hospitals 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 will receive about $135 more per case than they could receive if we did not implement this change. The 12 hospitals adversely affected will receive about $90 less per case.

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 will be experienced by hospitals in the East North Central region. Hospitals located in the East South Central region will benefit the most.

We estimate that the total payment increase for benefited hospitals will amount to about $3 million in the aggregate for cost reporting periods beginning in FY 1984, and $5 million for cost reporting periods beginning in FY 1985. The corresponding decrease to adversely affected hospitals will amount to about $3 million for cost reporting periods beginning in FY 1985. We also estimate that our decision not to impose these reductions for cost reporting periods beginning FY 1984 will result in program costs of about $2 million. The FY 1985 net increase of about $2 million, considering payments to all 23 directly affected hospitals ($5 million−$3 million = $2 million) will result in a negligible effect on other hospitals through the budget neutrality mechanism, reducing the average FY 1985 per case payment by less than 50 cents.

H. Base Year Appeals

We do not expect a significant economic impact to result from the 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 will 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 will not be substantial enough to affect our overall expectations of program expenditures. This change has no effect on the budget neutraliy adjustment calculations.

I. Referral Centers

The additional criteria permitting rural hospitals to qualify as referral centers and be paid at urban rates will result in a significant number of new referral centers being recognized. As explained in the NPRM 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 1981 MEDPAR data. Based on just this data, in the NPRM we projected that as many as 113 hospitals might qualify as referral centers under the proposed criteria. We expect that incorporating regional criteria for rural referral centers, as discussed above, will permit about another 25 hospitals to meet the case-mix and discharge criteria, resulting in a total of around 139 hospitals that we can identify as potential rural referral centers.

We expect that nearly all of the hospitals that are able to meet both the discharge and case-mix criteria, will also meet one or more of the other criteria. In addition, some rural hospitals with less than 500 beds may qualify as referral centers under the existing criteria at § 405.476(g)(1)(ii). We will pay those hospitals at the urban rate, too. We cannot be sure how many hospitals may qualify under § 405.476(g)(1)(ii), how many of the hospitals that meet the discharge and case-mix criteria may be denied referral center status under the other criteria, or how many of the hospitals not represented by our data base may qualify for rural referral center payment. However, these uncertainties tend to balance out.

Therefore, considering all the limitations of currently available data, we do not believe the total number of potential rural referral centers with less than 500 beds is likely to differ significantly from the projected total population of 139 potential new rural referral centers identified solely on the basis of 1981 discharge and case mix.

We have identified some potential new rural referral centers in every region, but there are significant regional differences in their distribution. As noted in the NPRM, 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 and Middle Atlantic regions each have less than seven potential referral centers. The regions benefiting most from the new regional criteria are the East South Central, West North Central, West South Central, and Pacific regions.

Considering the difference between urban and rural rates, the increased aggregate payments to these hospitals will be substantial. We project that in FY 1985 these hospitals could be paid, in the aggregate, about $100 million more than they would be paid based on their rural rates. Due to the budget neutrality mechanism, the estimated increased payments to new referral centers will result in reduced payments to all other hosptials. We estimate that the average FY 1985 per case payment to other hospitals will be reduced by about $12 as a result of this change.

J. Payment for Inpatient Renal Dialysis

As discussed above in response to comments we have decided to make additional payments for maintenance dialysis treatments to those hospitals that have ESRD patients representing 10 percent or more of their total Medicare discharges, excluding discharges in DRG 302, 316, and 317.

Based on the data available to us, we expect approximately 8 to 12 hospitals will qualify for these extra payments annually. Each of these hospitals will be paid $335 for each week-equivalent of ESRD beneficiary inpatient stays. We estimate that affected hospitals would be paid approximately an additional $1.4 million for ESRD beneficiary discharges occurring in FY 1985.

K. Payment for Services of Anesthetists

As required by section 2312 of Pub. L. 98-369, we will pay for the costs of anesthetists' services on a pass-through basis. Ideally, we would be able to implement this in a manner that had no net effect on program expenditures, in that we would adjust the prospective payment rates (both Federal and hospital-specific portions) to take into account an aggregate amount that was exactly equal to the aggregate cost-based payments that we would make instead. However, it must be realized that a prospective estimate of such precision is impossible; all that can be done is to make the best estimate possible and adopt administrative measures that ensure that potential over or under payments are as small as possible. We believe the process described in section III.B of this preamble will accomplish this. As a result, we expect any effect on program costs to be negligible.

Nonetheless, this provision will result in substantial redistribution of payments, since we estimate the costs of anesthetists' services related to inpatient services furnished to Medicare beneficiaries will be about $160 million for hospital accounting years beginning in FY 1985. Through the Federal rate calculation methodology, these costs have been averaged in and paid to all hospitals. However, hospitals do not all incur comparable costs for such services: in some hospitals anesthesia is induced only by physicians, and in others by anesthetists employed by physicians. As a result of averaging, it could be argued that Federal rates result in overpayment to those hospitals that do not incur such costs, and underpayment to those hospitals that incur high costs for anesthetists' services. By paying these costs as a pass-through, and reducing prospective payments accordingly, hospitals that do not incur these costs will experience a reduction in revenues, and hospitals that do will experience an increase.

L. Indirect Medical Education Costs

The new rules governing the counting of interns and residents will probably result in greater numbers of them being considered in computing payment for indirect medical education costs for a substantial number of hospitals. This will result in increased payments to those hospitals.

At this time, we have no way of estimating how much this count and the related payments might increase. We expect that our increased audit activity will avoid overcounting, and may even result in reduced payments to some hospitals. We do not expect that such potential reductions would be large enough to offset all the increased payments.

Based on the audit data we accumulate, we will reexamine the teaching-adjustment factor. A substantial increase in the number of interns and residents recognized would suggest that a smaller effect on indirect costs would be attributable to each one. This in turn would suggest that a lower percentage adjustment factor would be more accurate. However, we do not have data at this time that would suggest such a reduction. Therefore, we are continuing to use the current factor of 11.59 percent.

M. Adjustments for Area Wage Levels

As discussed in the Addendum to this rule, we have attempted to develop a new area wage index based on our own survey of hospital wages, instead of the current wage index based on data collected by the Bureau of Labor Statistics (BLS) of the Department of Labor. Under the Medicare prospective payment system, the area wage index has two principal functions:

- To adjust the per case costs of each hospital in the data base used to compute urban and rural regional and national adjusted average standardized amounts (Federal rates) in order to remove the effects of differing area wages; and
- In computing the actual payment for an inpatient hospital case, to adjust the labor portion of the Federal rate.

Using a different area wage index would not affect aggregate payments under the prospective payment system. However, it would result in a different distribution of payments among hospitals. This redistribution would be the result not only of increases and decreases of the index values for particular urban or rural areas, but, during the transition period, of the necessary restandardization of Federal regional rates for all regions.

Many commenters, particularly those from rural areas, hoped that a new area wage index would correct perceived inequities resulting from the current wage index. We grant that our analysis to date suggests that use of the new wage data would affect the wage index values for a number of areas. However, as must be expected in any revision of an index such as this, not all the changes would benefit the affected hospitals—it appears likely that the new data would result in reductions for several areas, which would correspondingly reduce payments to hospitals in those areas. We expect that, if we were to implement a new wage index based on the wage survey data we accumulated this year, a significant redistribution of payments might result. Before imposing such a redistribution, we must take steps to ensure that any revised wage index values are based on survey data that are reasonably complete and that have been verified for accuracy.

Our decision not to change the index at this time should not be considered to have an impact equivalent to changing the index, since section 2316 of Pub. L. 98–369 requires that we make a new index effective for cost reporting periods beginning on or after October 1, 1983. Thus, the impact would result from the delay in the redistribution, and, though not inconsequential, we do not expect the adverse consequences of this delay to exceed the problems likely to result from premature implementation of an inaccurate index. See the Addendum for a further discussion of these issues.

N. Updated Payment Rates

One of the primary functions of this document is to publish 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 regulations, sets forth tables of 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 1985 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 hosptial-specific and 50 percent Federal.

For FY 1985, 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 1985 prospective payments for inpatient hospital services are projected to be the same as they would have been for those services in FY 1985 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 1985 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 1985 payment rates would increase over the FY 1984 rates in accordance with sections 1886(b)(3)(B) (as amended by section 2310 of Pub. L. 98–369) and 1886(d)(3)(A) of the Act, by the percentage increase in the hospital market basket index (an input price index) plus 0.25 percentage point. For FY 1985, we estimate that increase would be about 6.62 percent. However, as a result of the budget neutrality and other adjustments, the proposed Federal payment rates as published will increase by 5.2 percent. The hospital-specific payment rates will increase from 6.62 to 7.14 percent, before application of the budget neutrality adjustment factor, depending on the starting date of the hospital's cost reporting period. The budget neutrality adjusted rates will increase from 5.88 percent to 6.40 percent.

The main factors that contribute to the reduction of the rate of increase below 6.62 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 to 110 percent of the mean per care costs 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 1984. 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 1984 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 months of FY 1985. Reflection of this situation in the budget neutrality calculations for FY 1985, which eliminates the disparity, results in some reduction of the published FY 1985 rates; and

• Finally, increases in payments to certain hospitals as discussed elsewhere in this analysis, which must be offset by decreases in the Federal and hospital-specific payment rates due to the statutory requirement of budget neutrality

However, in addition, to the factors that would decrease the rates, we expect other factors to 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 $2967 in FY 1984 (adding labor and non-labor components). This rate, increased by 6.62 percent, would be $3163 for FY 1985, before adjustment for budget neutrality. However, the FY 1985 urban Federal regional rate for New England is $3122, or $41 less than the rate would have been if we had simply increased the FY 1984 rate by 6.62 percent. The example below indicates how the requirement for budget neutrality accounts for the 41 dollar difference. (See Section V of the Addendum, Technical Explanation of Budget Neutrality Adjustment Methodology, for more details.)

EXAMPLE

FY 1984 Rate: New England urban	$2,967
Increase by 6.62 percent	+196
Additional year of rate of increase limits and elimination of 25% allowance for costs in excess of limits	−30
Reduce case-mix limits from 115% to 110% of mean	−13
Phase-in disparity	−12
Effect of regulatory changes	−31
Adjust for transfers under prospective payment	+15
Adjust for change in outlier policy	+30
FY 1985 Rate: New England urban	3,122

We expect that the actual average *payment* per case during FY 1985 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 1985 will be higher than in FY 1984 because a higher proportion of admissions in FY 1985 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 1985 will be higher than in FY 1984 because a higher proportion

of admissions in FY 1985 will be associated with hospitals with higher payments related to indirect medical education cost.

• Hospitals with reporting periods starting later in FY 1984 are expected to have higher base year costs and hospital-specific rates because of the continuing increases in costs. This will further increase FY 1985 average prospective payments over FY 1984 average prospective payments.

• Several provisions allow for increased payments to some hospitals for FY 1985. 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.

In sum, considering all the factors affecting the level of payments, we expect Medicare payments to hospitals to increase by more than nine percent in FY 1985.

Comment—We received numerous comments concerning the inadequacy of prospective rate increases. Commenters stated that the 5.6 percent increase in the rates, when offset by the across the board reduction in the DRG weights and the 0.75 percent reduction in the technology adjustment (to market basket plus one-quarter of a percentage point, as mandated by section 2310 of Pub. L. 98–369), results in only a nominal overall rate increase that violates the Department's commitment to increase the payment rates to reflect market basket increases. Virtually all commenters strongly objected to the 2.4 percent reduction in the DRG weights. Some stated that this is an arbitrary adjustment which violates Congressional intent as indicated in the Conference Committee Report accompanying Pub. L. 98–369. In this report, the conferees stressed that the appropriateness of the new payment levels would be vital to the success of the program.

Many commenters also stated that the nature of the adjustment to the weights was inappropriate since it reflects changes in case-mix indexes for any and all reasons. These commenters believe that hospitals should not be penalized for responding appropriately to incentives created by the prospective payment system. Most commenters urged that the reduction in the DRG weights be eliminated and that the 5.6 percent increase in the rates be maintained.

Response—We stress that the FY 1985 reduction of the rate of inflation permitted under the prospective payment system, as well as of the target rate percentages for those hospitals excluded from the prospective payment system and subject to the rate-of-increase limits as specified in § 405.463, is mandated by section 2310 of the (Pub. L. 98–369). Under the law, the percentage change in the rates cannot exceed the market basket plus one-quarter of one percentage point (rather than, as under prior law, market basket plus one percentage point). However, it is important to note that the ultimate level of the prospective payment rates for FY 1985 is dictated by the budget neutrality requirement of section 1886(e)(1) of the Act which is not altered by Pub. L. 98–369.

By the same token, making no reduction in the DRG weights would require a decrease in the budget neutrality factor. In establishing the payment levels for FY 1985 we are required by law to maintain total prospective payments at the same level that would have been paid under the law in effect prior to the enactment of the prospective payment system. The TEFRA legislation (Pub. L. 97–248) enacted a new section 1886(a) of the Act, which established a system of limits on inpatient operating costs per case and target percentage increases designed to restrain increases in overall payments for inpatient hospital services in FY 1983 through FY 1985. Allowable costs per case were limited to no more than 120 percent of the average for similar hospitals in FY 1983, lowered to 115 percent in FY 1984 and 110 percent in FY 1985. That legislation also enacted a new section 1886(b) of the Act, which established separate rate-of-increase limits, expressed as hospital-specific target amounts, with bonuses for hospitals with costs less than their target amounts and penalties for hospitals whose costs exceeded their target amounts. For FY 1984, hospitals with costs in excess of their target amounts were reimbursed 25 percent of the excess. This 25 percent payment was eliminated for FY 1985. This change, when combined with the reduction in allowable total costs per case, substantially restrained increases in projected total expenditures under the TEFRA rules in FY 1985. It was therefore necessary to reduce the rates in order to remain within the TEFRA limits and achieve budget neutrality.

Budget neutrality considerations also mandate that all factors which will affect the level of total DRG payments be considered in establishing the prospective payment rates. Therefore, it was necessary to consider increases in case-mix indexes because of their direct impact on the amounts paid for each case. During the early stages of the prospective payment system, changes in hospital behavior are a natural outgrowth of adaptation to the new system. While we anticipated these behavior changes at the time the DRG system was developed, we were unable to accurately assess their impact until we had actual experience under the program. Based on billing experience thus far under the prospective payment system, we determined that the aggregate increase in hospital case-mix has exceeded our initial estimate of 3.38 percent. This additional increase in case-mix indexes will result in actual payments under the prospective payment system that are higher than predicted from the 1981 MEDPAR data and our initial study of PSRO data, which only reflected changes occurring from improvement in the overall reporting of patient data. Therefore, in order to ensure budget neutrality, we must consider changes in case-mix indexes resulting not only from improved medical recordkeeping, but also from other changes in hospital behavior, since more cases are falling within the higher weighted DRGs.

As explained in the proposed notice, we elected to adjust for the additional increase in case-mix indexes through an overall reduction in the DRG relative weights. We believe this approach is more desirable than applying the adjustment through the budget neutrality factor, which would result in an actual decrease in the hospital-specific rates from the prior year. 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. We believe adjusting the DRG weights in the manner we have is more equitable and will benefit hospitals by maintaining a more even cash flow.

Since we are bound by the requirement in the law to maintain budget neutrality, we are not in a position to eliminate the overall reduction in the DRG weights without reducing the budget neutrality adjustment factor. Within the constraints of the budget neutrality requirements and methodology, we stress again that if the adjustments for increased case-mix indexes is not achieved through reduction of the weights, then it must be accomplished through the budget neutrality adjustment factor. While an adjustment for changes in case mix may be one which would be

made in any event, the legal requirement for budget neutrality makes the adjustment imperative for FY 1985. Not to make the adjustment is not an option available to us under current law. The only choice given to us was to make the adjustment to the weights or the rates. Given the consequences of adjusting the rates, particularly the hospital-specific portion, we opted for a reduction in the DRG weights as a more equitable way to achieve the same result.

Comment—A commenter suggested that hospitals that enter the prospective payment system later will not be paid more than hospitals that entered it earlier.

Response—We analyzed the distribution of hospitals as they enter the prospective payment system, and found that hospitals that are concentrated in areas with higher wage index values, and in the regions with higher Federal regional rates, enter the system later. Further, these same hospitals have higher average indirect teaching payments. Therefore, hospitals that enter the prospective payment system later will have higher average reimbursement.

O. Excluded Hospitals and Units

Section II.A.3. of the Addendum to this final rule sets forth the estimated values of the market basket plus 0.25 percentage point for calendar years 1984 through 1986. In addition to being used for updating the average standardized amounts on which Federal payment rates under the prospective payment system are based, these values will be used to determine the target amounts for those hospitals that are excluded from the prospective payment system but subject to the rate-of-increase limits required by section 1886(b) of the Act.

Section 2310 of Pub. L. 98–369 amended section 1886(b)(3)(B) of the Act to specify that the annual target amount for each hospital and unit subject to the rate of increase limit be updated annually using a target rate percentage equal to the market plus one-quarter of one percentage point, rather than the market basket plus one percentage point. This will apply to cost reporting periods beginning on or after October 1, 1984. For the affected cost reporting periods, a hospital or unit that has per case costs in excess of its target amount (a hospital-specific ceiling on reimbursable inpatient operating costs per case) will not be paid any of the costs in excess of its target amount. However, a hospital or unit that has per case costs less than its target amount will be paid its allowable inpatient operating cost per case plus the lower of 50 percent of the difference between the hospital's or unit's per case costs and the target amount or 5 percent of the target amount. As a result, this change in setting the target amount will affect each hospital or unit in one of three ways.

- If a hospital's costs would have exceeded its target amount using a market-basket-plus-one percentage-point target rate percentage, it will exceed its new target amount by an even greater amount, and will have its Medicare reimbursement reduced accordingly.
- If a hospital's costs are lower than its target amount as calculated using the new target rate pecentage, it will receive additional payments, as described above, but these payments will be lower than could have been paid had the target rate percentage been set at market basket plus one percentage point. This difference represents a cost to hospitals and units affected this way.
- Finally, some hospital's and units will have per case costs greater than its target amount as calculated using the market-basket-plus-one-quarter target rate percentage, but less than the target amount that would have resulted using the old target rate percentage formula. The total cost of this change to these hospitals and units equal the costs disallowed using the new target amount plus the amount of additional payments that would have been received under the old target amount.

P. 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 changes would have on the overall level of total payments could be considered negligible. To the extent that any aggregate change results at all, it will be the result of our inability to reflect all these changes explicitly 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 changes will 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 provisions 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 these regulations 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 provisions 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 will be relatively small.

We believe that, from this perspective, the higher payment rates afforded to those hospitals directly and quantifiably advantaged by these rule changes, as well as the nonquantifiable benefits afforded to rehabilitation units and hospitals with affected transfer outlier cases and base year appeals, more than offset the costs resulting from those provisions. For the above reasons, we believe that this document meets the objectives of E.O. 12291 and the Regulatory Flexibility Act.

VII. Other Required Information

A. Effective Dates

Generally, the changes to the regulations implemented by this final rule are effective with cost reporting periods beginning on or after October 1, 1984. However, certain other effective dates are involved.

The change in § 405.452 (HHA cost apportionment method), which corrects an erroneous deletion from the September 1, 1983 interim final rule, is effective October 1, 1983.

As a result of the enactment of Pub. L. 98–369, two regulatory changes, § 405.473 (Census division boundaries) and § 405.476 (Hospitals in areas redesignated as rural), are effective with cost reporting periods beginning on or after October 1, 1983. However, those hospitals that would receive a lower Federal rate as a result of the changes in § 405.473 will not receive that rate until their cost reporting periods that begin on or after October 1, 1984.

The following regulatory amendments are effective with cost reporting periods beginning on or after October 1, 1984:

§ 405.471 Rehabilitation facility direction and expansion.
§ 405.476 Rural referral center criteria.
§ 405.477 Indirect medical education and CRNA services.

The changes in § 405.472 that relate to physician attestation requirements are effective October 1, 1984. Despite this effective date, for a reasonable time hospitals may continue to use the language and positioning of the certification and penalty statements prescribed in the January 3, 1984 final rule. However, we fully expect that hospitals will expeditiously implement the new requirements.

The changes to § 405.474 (Base year appeals) are effective on October 1, 1984. In addition, the changes in the payment of cost outliers to transferring hospitals (§ 405.470), and the provisions for additional payments to a hospital that has ten percent or more ESRD patient discharges (§ 405.476), are effective with discharges occurring on or after October 1, 1984.

B. Waiver of 30-day Delay of Certain Effective Dates

Generally, we provide a 30-day delay in the effective date of a substantive rule. As stated above, most of the changes to the regulations in this final rule have effective dates that apply to hospital cost reporting periods beginning on or after October 1, 1984. However, certain changes have other effective dates for which we are waiving the customary delay.

There are two provisions that are effective with cost reporting periods beginning on or after October 1, 1983. The effective date for these regulations changes (that is, the MSA/NECMA redesignation in § 405.473 and census boundary divisions in § 405.476) are mandated by section 2311 of Pub. L. 98–369, which was enacted on July 18, 1984. To comply with this statutory mandate, and to inform the public generally and affected hospitals in particular about these changes, we have included these provisions in this final rule. We also note that the NPRM contained proposed changes concerning these matters, and we have responded to those comments in this final rule. Therefore, we believe that a delay in the effective date is unnecessary and contrary to the public interest, and we find good cause to waive the requirement.

As discussed above, we are also restoring material unchanged to § 405.452 (concerning HHAs), which was erroneously deleted in the September 1, 1983 interim final rule. The effective date is October 1, 1983. Because this is a technical amendment to correct an error, we find that a delay in the effective date is unnecessary. Therefore, we find good cause to waive a delay in the effective date here also.

C. Waiver of Proposed Rulemaking

The APA (5 U.S.C. 553) requires us to publish a notice of proposed rulemaking in the **Federal Register** for substantive rules and to afford a period for public comment. The notice generally is to include a description of the subjects and issues involved. However, this requirement does not apply if an agency finds good cause that such a notice-and-comment procedure is impractical, unnecessary or contrary to the public interest. In this case, the agency must incorporate an explanation of its finding in the rule to be issued.

We issued an NPRM on July 3, 1984 (49 FR 27422) and provided a period for public comment on most of the regulatory amendments contained in this final rule. Only the changes concerning regional criteria for referral centers (§ 405.476(g)), payments for anesthesia services (§ 405.477(c)), and payments for indirect medical education costs were not described in the NPRM. These regulatory amendments implement sections 2307(b), 2311(a) and 2312 of Pub. L. 98–369 respectively. The statute which was enacted on July 18, 1984, provided that these provisions are effective with cost reporting periods beginning on or after October 1, 1984. It is clear, therefore, that undergoing a proposed rulemaking process with respect to these provisions was impractical and, in terms of notifying affected parties of the implementing regulations before the statutory effective date was not in the public interest. In addition, beneficiaries are not adversely affected by the three provisions, and, since each of these provisions will result in additional payments to certain hospitals, we believe the hospital industry, on balance, will experience greater benefit than disadvantage. Therefore, we find good cause to waive proposed rulemaking for these regulatory provisions.

D. Paperwork Reduction Act

Section 405.477(d)(2)(v)(B) requires hospitals to report on the hours worked by interns and residents. This reporting requirement is subject to EOMB approval under section 3507 of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 and following). We are seeking approval of this information collection requirement, and we will publish the EOMB control number in the **Federal Register** when the requirements are approved.

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.

42 CFR Part 405 is 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

A. Subpart D is amended to read as follows:

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:

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

3. Section 405.452 is amended by revising the section title and adding a new paragraph (a)(3) to read as follows:

§ 405.452 Determination of cost of services to beneficiaries.

(a) Principle. * * *

(3) *Cost per visit by type-of-service method—Home health agencies.* For cost reporting periods beginning on or after October 1, 1980, all home health agencies must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of

service, the number of Medicare covered visits is multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to cost limits published by HCFA (see § 405.460).

* * * * *

4. In § 405.470, paragraphs (a)(1) and (b)(4) are revised; the introductory language of paragraph (b)(5) is reprinted unchanged; paragraph (b)(5)(iv) is revised; a new paragraph (b)(5)(v) is added; paragraph (c)(4) is redesignated as paragraph (c)(4)(i); and a new paragraph (c)(4)(ii) is added to read as follows:

§ 405.470 Prospective payment general provisions.

(a) *Scope*—(1) *Purpose.* Sections 405.470 through 405.477 of this subpart implement section 1886(d) of the Act by establishing a prospective payment system for inpatient hospital services furnished to beneficiaries in cost reporting periods beginning on or after October 1, 1983. Under the prospective payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (capital-related costs, kidney acquisition costs incurred by hospitals with approved renal transplantation centers, direct costs of medical education, and, for cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987, the costs of qualified nonphysician anesthetists' services) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, and indirect medical education costs. Under the prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

* * * * *

(b) *Basis of Payment.* * * *

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

(i) Capital-related costs, as described in § 405.414 and an allowance for return on equity, as described in § 405.429.

(ii) Direct medical education costs, for those approved education programs described in § 405.421.

(iii) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in § 405.521.

(iv) Kidney acquisition costs incurred by a certified renal transplantation centers.

(v) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987, costs of qualified nonphysician anesthetists' services.

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

* * * * *

(iv) Bad debts of Medicare beneficiaries (see §§ 405.420 and 405.477(d)(1)); and

(v) ESRD beneficiary discharges if such discharges are 10 percent or more of the hospital's total Medicare discharges (see § 405.476(j)).

(c) Discharges and transfers.

* * * * *

(4) Payment to a hospital transferring an inpatient to another hospital.

* * * * *

(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 outliners as described in §§ 405.475(a)(2) and (d).

* * * * *

5. In § 405.471, the introductory language of paragraphs (c)(2) and (c)(2)(v) is reprinted unchanged; paragraphs (c)(2)(ii) and (c)(2)(v)(A) are revised; the introductory language of paragraphs (c)(4)(iii) and (c)(4)(iii)(F) is reprinted unchanged; paragraphs and (c)(4)(iii)(A) and (c)(4)(iii)(F)(1) are revised; and new paragraphs (d), (e), and (f) are added 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—

(ii) Except as provided in paragraph (d) of this section, have treated, during its most recent 12-month cost reporting period, an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(A) Stroke.

(B) Spinal cord injury.

(C) Congenital deformity.

(D) Amputation.

(E) Major multiple trauma.

(F) Fracture of femur (hip fracture).

(G) Brain injury.

(H) Polyarthritis, including rheumetoid arthritis.

(I) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(J) Burns.

* * * * *

(v) Have a director of rehabilitation who—

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

* * * * *

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

* * * * *

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

(A) Except as provided in paragraph (e) of this section, have treated, during its most recent 12-month cost reporting period, an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

(*1*) Stroke.

(*2*) Spinal cord injury.

(*3*) Congenital deformity.

(*4*) Amputation.

(*5*) Major multiple trauma.

(*6*) Fracture of femur (hip fracture).

(*7*) Brain injury.

(*8*) Polyarthritis, including rheumatoid arthritis.

(*9*) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(*10*) Burns.

* * * * *

(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) *First-time exclusion of new rehabilitation hospitals.* A hospital that seeks exclusion as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (c)(2)(ii) of this section instead of showing that it has treated such a population during its most recent 12-month cost reporting period.

(e) *Exclusion of new rehabilitation units and expansion of excluded rehabilitation units—(1) New units.* If a hospital has not previously sought exclusion for any rehabilitation unit,

and has obtained approval for added bed capacity under State licensure and under its Medicare certification, it may identify the new beds as a new rehabilitation unit for the first full 12-month cost reporting period during which the beds are used to furnish inpatient care. A unit that is comprised of some beds that were previously licensed and certified, and some new beds, will be recognized as a new rehabilitation unit only if the majority of beds are new. For the first cost reporting period in which a hospital seeks exclusion of a new rehabilitation unit, the hospital may provide a written certification that the inpatient population it intends the unit to serve meets the requirements of paragraph (c)(4)(iii)(A) of this section instead of showing that it has treated such a population during its most recent 12-month cost reporting period.

(2) *Expansion of excluded units.* If a hospital that has an excluded rehabilitation unit has obtained approval for added bed capacity, under State licensure and under its Medicare certification, and seeks to add the new beds to its existing excluded unit for the first full 12-month cost reporting period during which the new beds are used to furnish inpatient care, the hospital may provide a written certification that the inpatient population that the new beds are intended to serve meets the requirements of paragraph (c)(4)(iii)(A) of this section instead of showing that those beds were used to treat such a population during the unit's most recent 12 month cost reporting period.

(f) *Changes in the size of 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.

6. 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 the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record. 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 have on file a current 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 in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

The acknowledgement must have been completed within the year prior to the submission of the claim.

* * * * *

7. Section 405.473 is amended by revising paragraphs (b)(6) and (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.

* * * * *

(b) Federal rates for fiscal year 1984. * * *

(6) *Geographic classifications.* (i) For purposes of paragraph (b)(5) of this section, 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.

(B) If a hospital would receive a lower Federal rate because most of the hospitals are located in a census division with a lower Federal rate than the rate applicable to the census division in which the hospital is located, the payment rate will not be reduced for any cost reporting period beginning before October 1, 1984.

(C) If an equal number of hospitals within the MSA or NECMA are located in each census division, such hospitals are deemed to be in the census division with the higher Federal rate.

* * * * *

(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 rural 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.

(B) A hospital that receives a higher Federal rate for its cost reporting period that began before October 1, 1984, because it meets the conditions described in paragraph (b)(6)(ii)(B) of this section will receive the lower Federal rate applicable to all hospitals in the MSA or NECMA in which it is located effective with the hospital's cost reporting period that begins on or after October 1, 1984.

(C) 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) of 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.

8. In § 405.474, paragraph (b)(2)(i) is revised, 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.*

* * * * *

(2) *Modifications to base year costs.* (i) Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base year inpatient operating costs, as necessary,

to eliminate nursing differential costs (as described in § 405.430), direct medical education costs (as described in § 405.421), capital-related costs (as described in § 405.414), kidney acquisition costs incurred by hospitals approved as renal transplantation centers (as described in § 405.476(h)), and, for cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987, the costs of qualified nonphysician anesthetists' services (see § 405.477(c)(3)). Kidney acquisition costs in the base year will be determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period. Malpractice insurance costs will be included in the inpatient operating costs, as described in § 405.452. Also, higher costs that were incurred for purposes of increasing base year costs, or either one-time nonrecurring higher costs or revenue offsets that have the effect of distorting base year costs as an appropriate basis for computing the hospital-specific rate or higher costs that result from changes in hospital accounting principles initiated in the base year, will be excluded from base year costs for purposes of this section.

* * * * *

(3) *Limitations on modifying calculations.* (i) The intermediary will use the best data available at the time in estimating each hospital'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;

(*iii*) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA under § 405.1875 that resolved a matter at issue in the hospital's base year notice of amount of program reimbursement; or

(*iv*) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and 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.

* * * * *

9. Section 405.475 is amended by revising and redesignating paragraph (a) as (a)(1), adding a new paragraph (a)(2) to read as follows, and revising paragraph (d)(1) to read as follows:

§ 405.475 Payment for outlier cases.

(a) *General rule.* (1) Except as provided in paragraph (a)(2) of this section concerning transferring hospitals, HCFA will provide for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by HCFA, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if—

(i) The beneficiary's length of stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length of stay for the applicable DRG by the lesser of—

(A) A fixed number of days, as specified by HCFA; or

(B) A fixed number of standard deviations, as specified by HCFA;

(ii) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a national cost/charge ratio, exceed the greater of—

(A) A fixed dollar amount (adjusted for area wage levels) as specified by HCFA; or

(B) A fixed multiple of the Federal prospective payment rate. During the transition period, the Federal rate is a combination of the national rate and regional rate as follows:

Federal fiscal year	Regional rate percentage	National rate percentage
October 1, 1983	100	
October 1, 1984	75	25
October 1, 1985	50	50
October 1, 1986		100

(2) *Outlier cases in transferring hospitals.* HCFA will provide cost outlier payments to a transferring hospital that does not receive payment under § 405.470(b)(2) for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a national cost/charge ratio, exceed the greater of the criteria specified in paragraphs (a)(1)(ii)(A) or (B) of this section.

* * * * *

(d) *Payment for extraordinarily high-cost cases (cost outliers).* (1) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with paragraph (a)(1)(ii) of this section.

* * * * *

10. Section 405.476 is amended by revising the section title; amending paragraph (a) by adding new paragraphs (a)(6) and (7); revising paragraph (g); and adding new paragraphs (i) and (j) 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(b)(6)(i)(D) or 405.473(c)(2)(i)(D). The criteria for this adjustment are set forth in paragraph (i) of this section.

(7) *Hospitals that have a high percentage of ESRD beneficiary discharges.* HCFA will make an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in paragraph (j) 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 cost reporting periods beginning 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 case-mix index is at least—

(*1*) 1.03 in 1981;

(*2*) 1.1053 for the hospital's first year under the prospective payment system (for this purpose only, the DRG relative weights in effect during Federal fiscal year 1984 would apply in calculating the case-mix index values);

(*3*) For the cost reporting period that ended in 1981 the median urban case-mix index values in calendar year 1981 calculated by HCFA for the region in which the hospital is located; or

(*4*) For the first cost reporting period under the prospective payment system, the adjusted median urban case-mix index values calculated by HCFA for initial cost reporting periods under the prospective payment system for the region in which the hospital is located.

(B) The hospital's number of discharges (excluding discharges from subprovider units) is at least—

(*1*) 6,000 for the hospital's cost reporting period that ended in 1981;

(*2*) 6,000 for the hospital's cost recently completed cost reporting period; or

(*3*) For either the cost reporting period that ended in 1981 or its most recently completed cost reporting period, the median number of discharges of urban hospitals for cost reporting periods ending in 1981 for the region in which the hospital is located.

(C) More than 50 percent of the hospital's active medical staff are specialists who—

(*1*) Are certified as specialists by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists;

(*2*) Have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists; or

(*3*) Have successfully completed a residency program in a medical specialty accredited by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(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 cost reporting periods beginning 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)(1)(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.

(3) *HCFA review of referral center status.* The status of each hospital that is receiving a referral center adjustment will be reviewed by the HCFA regional office every three years to determine if the hospital still meets the criteria set forth in paragraph (g)(1)(i), (g)(1)(ii), or (g)(1)(iii) of this section. If the determination is to the effect that the hospital no longer qualifies for a referral center adjustment, the adjustment will be discontinued beginning on the first day of the hospital's next cost reporting period.

* * * * *

(i) *Hospitals reclassified as rural.* Effective with cost reporting periods beginning on or after October 1, 1983, a hospital reclassified as rural, as defined in §§ 405.473(b)(6)(i)(D) or 405.473(c)(2)(i)(D), may receive an adjustment to its rural Federal payment amount for two successive cost reporting periods.

(1) *First year adjustment.* The hospital 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 cost reporting period for which an adjustment is made.

(2) *Second year adjustment.* A hospital that continues to be reclassified as rural 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 cost reporting period for which an adjustment is made.

(j) *Hospitals that have a high percentage of ESRD beneficiary discharges.*—(1) *Criteria for classification.* Effective for discharges occuring on or after October 1, 1984, HCFA will provide an additional payment to a hospital, as described in paragraph (j)(2) of this section, for inpatient dialysis provided to ESRD beneficiaries if the hospital has established that ten percent or more of its total Medicare discharges are ESRD beneficiary discharges, excluding discharges classified into DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) or DRG No. 317 (Admit for Renal Dialysis), in a cost reporting period beginning on or after October 1, 1984.

(2) Additional payment. A hospital that meets the criteria of paragraph (j)(1) of this section will be paid an additional payment for each ESRD beneficiary discharge except for those excluded under paragraph (j)(1) of this section. The payment is based on the estimated weekly cost of dialysis and the average length of stay of ESRD beneficiaries for the hospital. The estimated weekly cost of dialysis is the average number of dialysis sessions furnished per week during the 12-month period that ended June 30, 1983 multiplied by the average cost of dialysis for the same period. The average cost of dialysis includes only those costs determined to be directly related to the dialysis service. (These costs include salary, employee health

and welfare, drugs, supplies, and laboratory services.) The average cost of dialysis will be reviewed and adjusted, if appropriate, at the time the composite rate reimbursement for outpatient dialysis is reviewed. The payment to a hospital will be equal to the average length of stay of ESRD beneficiaries in the hospital, expressed as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRD beneficiary discharges except for those excluded under paragraph (j)(1) of this section. This payment is made only on the Federal portion of the payment rate.

11. Section 405.477 is amended by adding a new paragraph (c)(3), and revising paragraphs (d)(2)(v) and (d)(2)(vi) to read as follows:

§ 405.477 Payments to hospitals under the prospective payment system.

* * * * *

(c) *Payments determined on a reasonable cost basis*—* * *

(3) *Anesthesia services of hospital employed nonphysician anesthetists.* For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987, payment will be determined on a reasonable cost basis for anesthesia services provided in the hospital by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiology assistants) employed by the hospital.

(d) *Additional payments.* * * *

(2) Indirect medical education costs. * * *

(v) In order to have interns and residents included in the count under paragraph (d)(2)(ii)(A) of this section, the following requirements must be met:

(A) The interns and residents must be enrolled in a teaching program approved under §405.421 (excluding those employed by the hospital, but furnishing services at another site).

(B) The hospital must submit quarterly reports to its fiscal intermediary. The reports must include the following information:

(*1*) Monthly listing of all interns and residents providing services during the month;

(*2*) The social security number of each intern and resident; and

(*3*) The actual hours worked at the hospital during each month.

(C) No intern or resident will be counted as more than one full-time employee in any reporting period, regardless of the number of hospitals in which he or she is providing services. When working at more than one hospital, each intern's or resident's time will be apportioned proportionately to each facility.

(D) Fiscal intermediaries must complete audits of cost reports verifying the correct count of interns and residents.

(vi) Except as provided in paragraph (d)(2)(vi)(C) of this section, the number of full-time equivalent interns and residents under paragraph (d)(2)(ii)(A) of this section must equal the sum of—

(A) Interns and residents providing services for 35 hours or more per week; and

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

(C) The number of interns and residents that provide services in more than one hospital will be apportioned proportionately to each facility.

* * * * *

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement of Services of Hospital Interns, Residents, and Supervisory Physicians

B. Subpart E is amended to read as follows:

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

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842(b) and (h), 1861(b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886 and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395K, 1395l(a), 1395u(b) and (h), 1395x(b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww and 1395xx).

2. Section 405.553 is amended by revising paragraph (b)(4) to read as follows:

§ 405.553 Reasonable charges for anesthesiology services.

* * * * *

(b) *Services furnished by an anesthesiologist or by an anesthetist employed by the anesthesiologist.* * * *

(4) The provisions of paragraph (b)(1)(ii) of this section do not apply to inpatient hospital services furnished by an anesthetist employed by a physician if the services are furnished during a cost reporting period beginning on or after October 1, 1984 and before October 1, 1987.

* * * * *

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

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 27, 1984.

Margaret M. Heckler,

Secretary.

[**Editorial Note:** The following addendum will not appear in the Code of Federal Regulations.]

Addendum—*Schedule of Standardized 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, in accordance with §405.470(e)(2)(ii), we are making 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 on or after October 1, 1984 and before October 1, 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 1985, 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 making changes (proposed on July 3, 1984, 49 FR 27422) 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, affect the calculation of adjusted standardized amounts and the transition period prospective payment rates. As part of these changes, we are incorporating adjustments for the new market basket index and budget neutrality. We also included in the discussion below a summary of the comments we received on the addendum of the July 3, 1984

notice of proposed rulemaking (NPRM) and our responses to the comments.

We are also implementing changes to the prospective payment rates for FY 1985 resulting from the enactment of Pub. L. 98–369. Section 2307(b) of Pub. L. 98–369 requires that, in determining the indirect medical education adjustment, interns and residents in approved programs are to be counted regardless of who employs them. Section 2310 of Pub. L. 98–369 requires that, effective October 1, 1984, the annual inflation rate to be applied to hospitals will be equal to the annual rate of increase in the hospital market basket plus .25 percent. Section 2312 requires that anesthesia services provided by certified registered nurse anesthetists be paid for on a reasonable cost basis. We are expanding this payment method to also cover such services of anesthesiology assistants. Section 2316 of Pub. L. 98–369 requires that a wage index be developed that incorporates hospital wage differences between full-time and part-time workers. We discuss below the changes we are making to implement these provisions.

II. Changes to Prospective Payment Rates and DRG Weighting Factors for FY 1985

Section 1886(d)(3)(A) of the Act specifies that the FY 1984 Federal prospective payment rates be updated for FY 1985. In accordance with section 1886(b)(3) of the Act, the FY 1984 urban and rural average standardized amounts are to be increased by the applicable market basket index plus one percent. In FY 1985, these amounts are to be increased by the applicable market basket index plus .25 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 and final rule, referred to above.

Below, we discuss the manner in which we are changing some of the factors or methodology used for determining the prospective payment rates. These changes are effective with discharges occurring on or after October 1, 1984, or with hospital cost reporting periods beginning on or after October 1, 1984.

Comment—Several commenters maintained that one of the purposes of the prospective payment system, the establishment of fixed reliable reimbursement rates for Medicare inpatient cases, was being undermined by what were perceived to be continual regulatory changes in the payment methodology.

It was pointed out that many features of the prospective payment system, including provisions for certain retroactive adjustments, are so complicated as to cause confusion and uncertainty. This lack of stability was seen as reminiscent of the previous retrospective cost based reimbursement system.

Response—We sympathize with those who may find it difficult to understand or keep up with the changes in the prospective payment system. Several of its more technical features, such as the case-mix index, adjustment for indirect medical education costs, and computation of the budget neutrality reductions, are admittedly complex. However, we point out that most of these features were created in response to specific provisions of the law. Others, such as the provision to make additional payments to hospitals located in counties or county equivalents that have lost their urban status, were initially proposed to address perceived inequities in the system in response to comments received. The most recent revisions incorporated in this final rule, for example, the reduction in the annual inflation rate used to develop the FY 1985 rates from a rate equal to the market basket plus one percent to the market basket plus one quarter of one percent, reflect specific provisions of Pub. L. 98–369, which was enacted July 18, 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 system (FY 1984), 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 measure 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 1984. The BLS ES 202 system compiles information on employment and total wages for workers covered by unemployment insurance.

In the addendum to our proposed rule (49 FR 27438), we explained the basis for our decision not to use the data from HCFA's initial hospital wage survey to develop an improved wage index, one which particularly resolves the part time employment problem. Although we had hoped the quality of the records submitted in response to the survey initiated March 16, 1984 would have permitted the construction of a more refined index, our initial analysis of the reported data revealed a significant number of inaccurate or otherwise questionable entries. Although attempts were made to obtain corrected data for all hospitals for which obvious errors were detected in the survey reports, we concluded that the quality of the survey results, even after including corrected records, was suspect in enough areas so that a reliable wage index would not be constructed in time for the publication of the FY 1985 prospective payment rates. We stated, however, that we would continue to correct errors in the survey reports so that a data base of sufficient quality could be obtained to permit development of a revised wage index.

In order to ensure that any revised wage index would be developed from the best national records currently available, we decided to afford each hospital subject to the prospective payment system the opportunity to examine and verify the accuracy of the survey data reported for that hospital. On July 2, 1984, we sent a letter to each hospital through the Medicare fiscal intermediaries requesting each hospital to validate, and if necessary, to correct the survey information initially reported for that facility. We pointed out what we believed to be the sources of some of the more common errors in the survey reports previously submitted and asked hospitals to review and ensure the accuracy of certain key data items.

Each hospital was also requested to complete a signed certification attesting to the accuracy of the reported data and to submit the validated records directly to our central office. As of August 9, 1984, we had received certified survey forms from 4,367 hospitals.

Section 2316(a) of Pub. L. 98–369 requires the Secretary to conduct a study to develop an appropriate wage index, one which explicitly considers hospital wage differences between full-time and part-time workers. Provided that the certified survey data are determined to be accurate and reasonably complete, we plan to use these records for purposes of this study

and to construct a revised wage index that complies with this statutory requirement. Section 2316(b) of Pub. L. 98–369 also provides that any changes made in the hospital wage index under section 2316(a) shall be retroactive to October 1, 1983. We remain hopeful that the validated survey records that hospitals are certifying as being correct will permit the development of an improved measure of relative hospital wage levels in accordance with the requirements of Pub. L. 98–369.

Comment: Several commenters expressed concern that the proposed regulations did not correct the apparent disparities between the urban and rural wage indexes. One commenter suspected that in view of the volume of information collected on the Medicare cost report, our decision not to use the preliminary survey results to construct a revised wage index had more to do with the "unpopularity" of our findings rather than their inaccuracy.

Response: The basis for these comments is the belief that application of a single rural wage index to all rural counties within a State does not recognize the widely varying labor market conditions that may prevail throughout the State. Several rural hospitals located in countries adjacent to urban areas maintain that they are particularly disadvantaged by this policy because they incur labor costs comparable to urban hospitals. Although the present urban/rural distinction based on criteria established by EOMB is expressly mentioned in the statute, the implication of these comments is that an alternative means for aggregating rural counties to obtain wage indexes more reflective of economically integrated rural areas needs to be investigated. We are mindful of the need for further research in this area and have, in fact, acknowledged this in the final rule published August 30, 1983, which implemented the Medicare provisions of Pub. L. 97–248, the Tax Equity and Fiscal Responsibility Act of 1982 (see 48 FR 39433). This view was reiterated in the final rule for the first year of the prospective payment system published January 3, 1984 (49 FR 257). However, to date, the empirical basis for a superior alternative rural definition that recognizes more local hospital labor markets has not been presented.

Comments that suggest that the Medicare hospital cost report already provides sufficient information to develop an improved wage index, to overcome the major deficiencies of the BLS data, are simply not correct. Constructing a wage index based on currently available cost reports would not solve the part-time employment problem since the cost report does not use a standard definition of full-time equivalent (FTE) employee or provide total hours worked for all hospital personnel. In addition, the compliance rate among hospitals in completing those purely statistical items on the cost report, which could be used to derive an improved wage index, varies widely and would result in our inability to develop an index at all for many locales.

With respect to the suggestion that our decision not to use the initial survey results to implement a revised wage index was for reasons other than those presented in the NPRM, we deny this categorically. We pointed out in the addendum to the NPRM that we were attempting to obtain corrected survey reports from all hospitals for which questionable survey data had been submitted. On July 2, 1984, we sent a formal request to each hospital subject to the prospective payment system through the Medicare fiscal intermediaries to obtain validated survey data certified to be accurate. We find it rather discouraging that several of those hospitals that were critical of our seeming inability to develop an improved wage index in time for the FY 1985 version of the prospective payment system were among those providers that failed to submit a timely response to our July 2 request for verification of the accuracy of the data previously submitted on the survey reports.

Comment—One commenter maintained that multiplying the labor-related portion of the regional rates by the area wage index yielded Federal rates that inappropriately penalize rural hospitals. The commenter pointed out that rural hospitals have lower labor costs when compared to urban facilities. Thus, multiplying these lower labor costs by the applicable rural wage index represents a "double reduction" in computing the Federal rate.

Response—The commenter's statement fails to consider that the labor-related costs used to develop the Federal rates are standardized to remove the effects of differences in wage levels among hospital urban/rural areas. This adjustment is accomplished by dividing the labor-related portion of each hospital's average cost per discharge by the appropriate area wage index. The resulting labor deflated costs are averaged for all urban and rural areas within each region and within the nation. The prospective payment system methodology provides that the regional and national average labor deflated cost per discharge, multiplied by the hospital's area wage index, are the bases for computing the Federal rates. We point out that this method is a technically accurate basis for determining the payment rates that recognize local differences in hospital wage levels. It also complies with sections 1886(d)(2)(C)(ii) and 1886(d)(2)(H) of the Act.

The purpose of standardizing labor costs for area wage levels is to remove the effect of differences in hospital wages from the cost data prior to averaging. Theoretically, the standardized costs represent what labor costs would have been in each locale with hospital wage levels equal to the national average. However, paying hospitals in each area the average labor deflated cost per discharge would result in overpayments to providers in low wage areas and underpayments to hospitals in high wage areas. Therefore, in computing the Federal rates it is necessary to multiply the standardized labor-related regional and national rates by the area wage index in order that the payment rates appropriately reflect local wage levels.

Comment—One commenter was dismayed by the fact that we have not yet developed a wage index that addresses the technical limitations in the BLS data currently used to construct the measure. The commenter inquired whether any improved wage index would be implemented effective October 1, 1984 as required by section 2316(b) of Pub. L. 98–369.

Response—We had hoped that the accuracy of the data provided in response to HCFA's hospital wage survey would have permitted the development of an improved index, one that particularly resolves the inability of the BLS records to control for area differences in hospital part-time employment in time for the fiscal year 1985 update of the prospective payment system. Unfortunately, for reasons explained in our July 3, 1984 proposed rule, as well as in our previous response above, the incompleteness of some of the survey data precluded the implementation of a more refined hospital wage index effective October 1, 1984. We have asked hospitals to verify the accuracy of key items reported in the wage survey. Because of this action, we remain hopeful that the final survey results will provide a data base of sufficiently high quality so that an improved index can be constructed as soon as practicable.

Section 2316(a) of Pub. L. 98–369 provides that the Secretary shall conduct a study to develop an appropriate wage index, one which

explicitly considers wage differences between full-time and part-time workers. Section 2316(b) also provides that any changes made in the wage index pursuant to section 2316(a) shall be retroactive to October 1, 1983. Therefore, in compliance with the law, any revised wage index that addresses the part-time employment problem will be effective October 1, 1983.

Comment—One commenter urged HCFA to expedite the development of a new wage index for the FY 1985 prospective payment system rates. The commenter requested that the new index recognize area differences in full-time versus part-time employment, and in salary and wage scales for rural and urban areas. The commenter suggested that we should not delay in developing a new wage index merely because of the data quality concerns and that those hospitals that refuse to participate in the wage survey or supply erroneous data should be penalized. It was noted that section 2316 of Pub. L. 98–369 required the Secretary to report to Congress within 30 days after the enactment of Pub. L. 98–369 on a new wage index that takes into account wage differences of full-time and part-time workers. In addition, the commenter noted that this report was to include criteria under which a hospital may obtain an adjustment to its wage index if the index does not accurately reflect hospital wage levels in the labor market area serving the hospital.

Response—Contrary to the commenter's position, we believe that the issue of data quality is of utmost importance in deriving a new wage index. As we have explained in prior Federal Register documents, the wage index is a measure of the relative differences in wages paid throughout the various areas of the country. Because the wage index is a crucial part of the prospective payment system payment formula, the data must be of uniform high quality across all areas. If data are missing from a large number of hospitals, or the quality of the data is uneven, the index will be distorted. This would lead to prospective payments that are too low in some areas, and correspondingly too high in other areas. While the commenter suggests that hospitals that do not cooperate with the wage survey effort be penalized, we know of no way this can be accomplished within the framework of the wage index.

In this connection, we note that one major association supported our attempt to obtain accurate data for use in constructing a new wage index. In the view of this association, the importance of data quality has been heightened by the requirement in section 2316(b) of Pub. L. 98–369 that the new wage index be retroactive to October 1, 1983.

The commenter also confuses the issue of full-time and part-time employment, and the issue of labor markets. Provided that accurate data are obtained from the wage survey, an index can be constructed that would take into account differences among areas with respect to full-time and part-time employment.

The issue of labor markets, however, is not one which can be addressed solely through the gathering of appropriate data elements. Rather, the issue is how the data are grouped or aggregated. Under the current construction of the wage index, urban areas are those areas as defined by EOMB, that fall within the boundaries of MSAs or NECMAs. Rural areas are defined on a statewide basis as those counties in a State that do not fall within an MSA or NECMA. (These are the same urban and rural area designations that are used in deriving the Federal standardized amounts under section 1886(d)(2)(D) of the Act.) We realize that these designations, particularly with respect to rural areas, may not in all instances conform to hospital labor markets. We discuss this issue above as well as in previous Federal Register documents. While further research is warranted in this area, we currently have no other statistically valid and widely accepted measures of urban/rural areas comparable to the MSA and non-MSA designations. Consequently, the FY 1985 rates in this addendum continue to reflect usage of the EOMB designations in the construction of the wage index.

We are cognizant of the requirements of section 2316 of Pub. L. 98–369 regarding the development of a wage index. However, the law does not require the development of criteria for making wage index adjustments as part of the report to Congress on a wage index that takes into account wage differences between full-time and part-time workers. This report, as the commenter stated, was due to Congress within 30 days (by August 17, 1984) of the enactment of Pub. L. 98–369. On the other hand, section 2316(c) of Pub. L. 98–369 contains no specific due date for the report on proposed criteria for wage index adjustments. In view of this, and because we are committing our available resources to implementing the wage index report under section 2316(a) of Pub. L. 98–369, we do not intend to address the development of adjustment criteria in the near future.

Comment—One commenter suggested, with respect to designations of rural referral centers, that these centers be granted a wage index adjustment that would amount to a new wage index computed on a county-specific basis. According to this commenter, the current wage index, which aggregates all rural hospitals together in deriving an index value, does not provide adequate consideration to the actual labor market in which a rural referral center operates.

Response—As discussed above in the addendum to this final rule, as well as in previous Federal Register documents, we agree with the commenter's assessment that the state-wide non-MSA status is a less than perfect method for aggregating rural wage and employment data in order to compute a wage index for rural hospitals. As we have noted, this is an area that requires further research for alternative definitions of hospital labor markets.

However, we do not believe that a county-specific wage index represents an acceptable alternative to the current index. The county boundaries may be just as inaccurate as state-wide boundaries in defining hospital labor markets. In addition, the disaggregation of the data that is involved in developing a county-specific wage index magnifies any deficiencies or inaccuracies in the data. Because data from a relatively large number of facilities are used to compute an index (as under the current formula), data deficiencies or inaccuracies tend to balance off. This balancing protection would not occur under a county-specific formula.

Another problem with a county-specific index is that, because each index value would be based on the wages of only a few hospitals, such an index comes close to recognizing the actual wages paid by an institution, even though those wages may be too high relative to the average wage in the area. This method, in effect, would represent a partial return to the cost-based reimbursement system in effect prior to the implementation of the prospective system. (Under that system Medicare is paid on the basis of actual costs incurred by a hospital.) We reiterate that it is not the purpose of the prospective payment system wage index to represent the actual wage costs incurred by any one hospital; rather, the wage index is intended to represent the average cost of wages in a particular area as compared to average hospital wages nationwide.

With respect to the use of BLS data for deriving the wage index, we note that these data are subject to a

confidentiality requirement that would limit their usefulness in computing county-specific index values. Under this requirement, disclosure of actual data or indexes for areas that include fewer than three reporting units is prohibited. (A reporting unit is the smallest unit for which data are recorded on the employer's contribution report. Therefore, two or more hospitals owned by one organization could appear as one reporting unit.) The confidentiality requirement would be a particular problem with respect to rural counties where there are generally fewer hospitals than in urban areas. We note that the commenter was unable to provide county-specific indexes for a large number of rural counties because of the confidentiality requirement.

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 1985 the Federal rates are comprised of the national role (25 percent) and the regional rate (75 percent) (section 1886(d)(1)(D) of the Act). Therefore, we are revising 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 categories 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.

On June 29, 1984, EOMB announced, effective June 30, 1984, revised listings of MSA/NECMA designations that are used in calculating the standardized amounts. As stated in the January 3, 1984 final rule (49 FR 253), such changes in designation are not recognized in the prospective payment rates until the beginning of the next 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 updating the urban and rural average standardized amounts using the applicable target rate percentage specified in section 1886(b)(3)(B) of the Act as amended by section 2311 of Pub. L. 98–369. This section of the law specifies that, effective October 1, 1984, the annual inflation rate to be applied for updating the target rate applicable to hospitals that are subject to section 1886(b) of the Act, as well as to hospitals under the prospective payment system, will be equal to the annual rate of increase in the hospital market basket plus .25 percent instead of the annual rate of increase in the market basket plus one percent as previously provided. The market basket identifies the most commonly used categories of goods and services that contribute to total hospital inpatient operating expense and weights each category to reflect the estimated proportion of total hospital operating expenses attributable to that category. The table below includes the estimated percentages used for updating the average standardized amounts for calendar years 1984 through 1986.

MARKET BASKET PLUS .25 PERCENT

Calendar year	Percentage
1984	6.25
1985	6.75
1986	7.35

Section 1886(b)(3)(B) of the Act also requires that the market basket rate of increase plus .25 percent be applied 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.

Comment—Several commenters expressed concern that the reduction in the annual inflation rate used to compute the prospective payments from the market basket plus one percent to the market basket plus one quarter of one percent would result in inadequate reimbursement for new technology.

Response—Section 2310 of Pub. L. 98–369 amended section 1886(b)(3)(B) of the Act to provide that the inflation factor used to develop the prospective payment rates for FY 1985 and FY 1986 would be equal to the market basket rate plus one quarter of one percentage point. Although the commenters implied that the purpose of the previous one percent allowance was to provide an explicit adjustment for the costs of new technology, we point out that the precise basis for the add-on (one percent) was not specified by Congress in the conference committee reports that accompanied Pub. L. 97–248 and Pub. L. 98–21. One could also reasonably conclude that the purpose of the one percent add-on was to provide a tolerance factor for imprecision in the market basket forecasts, or to account for the net effect of those variables not reflected in the hospital imput price index, such as changes in population, productivity, or service intensity.

We believe the explicit language of section 2310 of Pub. L. 98–369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. Similarly, the revision to section 1886(b)(3)(B) of the Act also affects the updating of the hospital-specific portion of the prospective payment rates (again prior to adjusting for budget neutrality), as well as the maximum rate of increase in costs allowed for hospitals excluded from the prospective payment system. Although section 2310 of Pub. L. 98–369 requires a reduction in the add-on to the inflation factor used to trend the FY 1984 rates, the law makes no change in the budget neutrality provisions. Thus, while the Federal rates and updating factors used to trend the hospital-specific portion have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98–369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates and hospital-specific portion update factors attributable to section 2310 of Pub. L. 98–369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.

Comment—One commenter recommended that we adjust the prospective payment rates if our market basket estimates of inflation prove to be inaccurate. In order to preserve the prospective nature of the system, it was suggested that we compensate for market basket forecasting errors by providing for a corresponding adjustment in the rates for the following fiscal year.

Response—The main thought of this comment parallels comments raised in previous prospective payment regulations. As we have stated one of the purposes of the prospective payment system is the establishment of known payment rates prospectively.

Therefore, we have not adopted the suggestion that the rates be adjusted retroactively.

Comment—One commenter noted that only one firm, Data Resources Incorporated (DRI), currently prepares

the forecasts of the rate of change in the hospital input price index, (that is, the market basket), which is used to update the prospective payment system. It was recommended that we use several firms to obtain forecasts of the rate of increase in the market basket to trend the prospective payment system.

Response—The basis for the commenter's recommendation is that several estimates would increase the precision of the market basket forecasts used to develop the prospective payment rates. However, we have no reason to believe the use of several economic forecasting firms would yield superior or more accurate estimates of the rate of increase in the market basket than those currently provided by one contractor. Aside from the substantial additional expense that use of several firms would entail, there is no evidence that the forecasts provided to us to date have been biased. In addition, we point out that all economic forecasting firms have an equal opportunity to bid competitively for the contract under which the estimates of the rate of change in the hospital input price index are provided according to prescribed criteria.

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, the amounts for FY 1985 are increased by .13 percent. (We note that this figure (.13 percent) represents the same percentage increase that is used in FY 1984.) 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 under Part B.

b. *FICA Taxes.* Section 1886(b)(6) of the Act requires that adjustments be made for purposes of the target rate limits in recognition that certain hospitals were required to enter the Social Security system and begin paying FICA taxes as of January 1, 1984. As explained in the preamble of the interim final rule (48 FR 39766), the conference committee report accompanying Pub. L. 98–21 expressed the intent that the Federal rate under prospective payment also be adjusted to reflect this change (H.R. Rep. No. 98–47, 98th Cong., 1st Sess. 184 (1983)). We estimate the amount of the adjustment for FY 1985 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 1984.

Therefore, we are increasing 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 also 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 directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates in any year.

We are reducing the size of the reserve for outliers from 6.0 percent of total payments, which we had established for FY 1984, to 5.0 percent of total payments while providing proportionately greater payment for typical cases and avoiding any great risk of general disadvantage to hospitals. As we indicate in the final rule (49 FR 265), we will pay for any outlier that meets the criteria in § 405.475, even if 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 amounts for FY 1985 to take into account outlier payments of five percent of total payments based on the blended Federal rates. The outlier adjustment factors are as follows:

Regional—.950
National—.950

We are revising, as well, the day outlier and cost outlier thresholds so that total estimated outlier payments for FY 1985 would be 5.0 percent of total payments. A discharge in FY 1985 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 DRG outlier thresholds.

For FY 1985, 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 1985 but without regard to reductions for outlier payments in FY 1985.

Comment—We received comments from a number of teaching hospitals objecting to the proposd increase in the outlier thresholds necessary to maintain the reduction in the reserve for outliers from 6.0 percent of total payments to 5.0 percent of total payments. Because these hospitals generally have a higher incidence of outlier cases, they argued that we should retain the 6.0 percent outlier reserve.

Response—We believe that it is desirable to reduce the size of the outlier reserve from 6.0 percent to 5.0 percent because it allows proportionately greater payment for typical cases and avoids any great risk of general disadvantage to hospitals. Maintaining a 6.0 percent outlier reserve results in less payment to all hospitals for typical cases. While benefiting facilities with a greater incidence of outliers, it penalizes those hospitals with relatively few outlier 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 all hospitals with somewhat larger Federal rates for typical cases. We believe that the indirect medical education adjustment provided to teaching hospitals will help to minimize the effect that increases in the outlier thresholds might have on these hospitals.

As we indicated in the January 3, 1984 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 the estimated level.

Comment—We received comments suggesting that the mean lengths of stay by DRG should be recalculated based on actual prospective payment experience to date in order to reflect decreases in the average length of stay resulting from implementation of the prospective payment system. Since these numbers are used to calculate transfer and outlier payments, failure to recalculate the mean lengths of stay removes financial

incentives for additional improvements by the hospital industry.

Response—The standardized amounts reflect the number of inpatient days per case based on 1981 hospital experience. Therefore, if the mean length of stay were recalculated to reflect the actual changes in lengths of stay from the 1981 data base, adjustment to the standardized amounts would also be required to reflect the decreased costs resulting from shorter inpatient stays.

Comment—Several commenters objected to the increase in the outlier thresholds stating that recent HCFA reports indicate that outlier payments to date account for less than two percent of total DRG payments. This would indicate that the outlier thresholds established for FY 1984 were too high since outlier payments thus far under the prospective payment system appear to be well below the 6.0 percent expected outlier payment level. Therefore, while a reduction in the outlier reserve is appropriate, inceases in the outlier thresholds are not warranted. Also, one commenter stated that we have presented no evidence to demonstrate a quantitative relationship between the newly established thresholds and the expected reduction in outlier payments.

Response—The 2 percent figure cited by the commenters is misleading in that it represents the proportion of total DRG payments that were paid for outlier cases. The outlier adjustment, however, is applied only to the Federal portion of the payment amount (that is, 25 percent during the first year of the transition period). Since the cost of outlier cases are already reflected in each hospital's base period operating costs used to compute the hospital-specific portion of the blended rate during the transition period, the outlier adjustment is not applied to the hospital-specific portion of the DRG payment. Therefore, in determining the extent of outlier payments, only the Federal portion (25 percent) of total DRG payments should be considered rather than total DRG payments overall.

We calculated the revised outlier thresholds using 1981 MEDPAR data such that estimated outlier payments would equal 5.0 percent of total Federal DRG payments. The length-of-stay and cost outlier criteria were calibrated so that the national average shares of length-of-stay and cost outlier payments would be 85 and 15 percent respectively. Therefore, based on the revised outlier thresholds, we estimate that in total, 4.25 percent of Federal DRG payments will be for day outliers and .75 percent will be for cost outliers.

Based upon outlier and DRG payment data received through July 27, 1984, there is no evidence to suggest that total outlier payments are below the levels intended. Therefore, as discussed above, we are continuing to set the outlier thresholds on the basis of the 1981 MEDPAR data.

Comment—One commenter objected to the current provision that a case that qualifies for payment as a day outlier is not eligible for cost outlier payments. It was recommended that cost outlier status be granted for those cases in which a hospital could demonstrate a "significant financial loss" due to the requirement to treat such cases as day outliers.

Response—We recognize that hospitals may receive less payment under the day outlier criteria for cases that otherwise qualify as both day and cost outliers. This fact, however, does not mean that a hospital will incur a significant financial loss because the pospective payment system provides financial incentives for cases in which a provider's costs are less than the standard payment rate. Aside from the administrative burden presented by the need to establish standards under which a "significant financial loss" has occurred if the recommendation were adopted, we point out that the commenter's suggestion may be at odds with statutory intent. Under section 1886(d)(5)(D)(ii) of the Act, a case is eligible for payment as a cost outlier only if it cannot be considered a length of stay outlier. Our interpretation, which we believe is reasonable and supportable, precludes greater cost outlier payments if a case also qualifies as a day outlier. We previously responded to similar comments received in this connection in the interim final rule of September 1, 1983 (48 FR 39776). The reader is referred to a summary of the comments and our responses, which appeared in the final rule of January 3, 1984 (49 FR 266). For these same reasons we have not adopted the recommendation.

d. *Anesthetists' Services.* Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs by means of the budget neutrality adjustment methodology. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

By incorporating these estimated costs in the nonoperating costs of each hospital for purposes of the budget neutrality comparisons, we have, in effect, reduced the national adjusted average standardized amount by 0.32 percent, and reduced the regional adjusted average standardized amount by 0.42 percent. (The reason for the difference in the FY 1985 blending portions for Federal national and regional rates and the phasing in of cost reimbursement for anesthetists services at the beginning of each hospital's cost reporting period.)

Since the requirement of budget neutrality does not apply for FY 1986, next year we will adjust the average standardized amounts directly to take the costs of anesthetists services into account. Based on current data, we expect this to result in an 0.524 percent reduction in those amounts. Since the national and regional blending portions are equal for FY 1986 Federal rates, and since cost-based reimbursement for anesthetists' services is effective for all of FY 1986, the same reduction would apply in both cases.

e. *Budget Neutrality.* In accordance with section 1886(e)(1) of the Act, the prospective payment system 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 1984 and 1985, the prospective payment system must be "budget neutral".

During the transition period, 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 hosptial-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.

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

Regional—.950
National—.954

As with the regional outlier adjustment factor, the regional budget

neutrality factor represents estimated payments under the prospective payment system for FY 1985 as compared to estimated reimbursement under the law in effect prior to Pub. L. 98–21, for the same period (FY 1985), without regard to the reduction for either outlier payments in FY 1984 or budget neutrality in FY 1984.

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 Federal 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.

In the absence of a HCFA wage index, we decided to continue using the BLS wage index computed from the 1981 ES 202 data to adjust the Federal standardized rates applicable for FY 1985. The wage index appearing in the addendum to the September 1, 1983 interim final rule (48 FR 39871) was also computed from hospital wage and employment data for 1981 furnished to us from BLS through its ES 202 employment and wage system. However, the wage indexes appearing in Tables 4a and 4b of this addendum have been updated to reflect the most recent corrections in the 1981 ES 202 data. The revised wage indexes incorporate corrections that were—

- Published in the NPRM (49 FR 27442);
- Issued to regional offices after publication of the interim final rule; or
- Based on revised data reviewed subsequent to the last issuance to the regional office.

In addition, the index also reflects the most recent changes in urban area definitions. These new MSA definitions were announced by EOMB on June 29, 1984 (see EOMB Announcement 84–16 for further information).

As result of these corrections and revisions, the national average monthly wage for hospital workers has increased from the previous average of $1,071.50 used to compute the wage index in the September 1, 1983 document to $1,073.68. We believe that this is an appropriate time to recalculate all the urban and rural wage index values using the new national average wage so as to achieve the greatest accuracy possible for reflecting the relative differences in wage levels between the various urban and rural areas throughout the country. Usually, during the year when we receive corrected employment and wage data for a particular area from BLS, we revise only the index for that particular area. While the corrected data, depending on the magnitude of the correction, could also affect the national average, we do not revise all the index values at that time to reflect the new national average. We do not do so because generally the effect on the national average is minimal. Moreover, recalculating all the index values to take account of this new average would lead to continuing uncertainty amoung many hospitals as to the amount of payment they would receive for discharges. This uncertainty and its attendant administrative complexity would be compounded if there were several such changes during a particular period, as is frequently the case.

However, because we are now promulgating new rates for the second year of the prospective payment system, we believe that this is an appropriate time to fully revise the hospital wage index to reflect all the changes that have occurred over the previous year (FY 1984). In this manner, we hope to ensure the greatest possible accuracy in the wage index consistent with administrative simplicity and equitable treatment for all hospitals.

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 1985, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii is 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 turn 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 1984. To correct for the distortion caused by this higher than expected case mix, we are revising the payment system for FY 1985.

In the NPRM, we noted that, as of March 1984, we had observed an increase in case mix 2.4 percent more than the 3.38 percent anticipated for FY 1984. Additional data received through July 1984 indicate that average case mix has increased 7.3 percent, or 3.8 percent more than anticipated for FY 1984 (1.0338 x 1.038 = 1.073).

We believe that, for the most part, this does not represent a "real" increase in case mix, but a paper one. Recent study shows that, in the absence of the

prospective payment system, average case mix might have been expected to increase by about 0.3 percent through FY 1984. However, it is possible that a portion of the increase in case mix could have resulted from factors such as shifting lower intensity cases to the outpatient setting. As discussed in more detail below, commenters offered many explanations for the increase in average case mix that we have not been able to support from the data available to us currently. As a result, we plan to do a study that will enable us to identify with greater precision the relative influence of the various potential causes of this increase.

Since the results of such a study are not yet available, and considering the controversy resulting from the NPRM proposal to reduce DRG weights across-the-board by 2.4 percent, we have decided not to fully reduce, at this time, the DRG weights by the method proposed. Instead, we subtracted 0.3 percent (representing the estimated real increase in case mix that might have occurred in the absence of the prospective payment system) from 2.4 percent. The remaining 2.1 percent represents an increase in average case mix that may or may not be based on real increases in resource consumption per case. Because it is virtually certain that a substantial portion of this 2.1 percent increase in average case mix is not "real", but considering that we are not yet able to identify how much, we are reducing DRG weights by only half of that percent, or 1.05 percent.

Thus, for discharges occurring on or after October 1, 1984, we are reducing each DRG relative weight by an amount equal to only a portion of the observed increase in hospital case-mix values over the increase projected from fiscal year 1984. That is, we are reducing the DRG relative weights 1.05 percent by dividing each of the relative weights published in Table 5 of the interim final rule (48 FR 39876) by 1.0105. (We note that the relative weight for DRG 302 was corrected in a **Federal Register** notice published on October 19, 1983 (48 FR 48469).)

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.

We received comments from hospital associations and consultant groups. Most of the comments concerned the proposed reduction of the DRG relative weights.

Comment—Many commenters suggested that, since we had already adjusted the fiscal year 1984 standardized amounts downward to reflect a 3.38 percent improvement in coding, we should not make any further adjustments related to reporting diagnoses and procedures.

Response—We used the best data available at the time to adjust the fiscal year 1984 standardized amounts to take expected improvements in the accuracy of coding into account. However, we did not have data on how the payment incentives established by the prospective payment system would affect reporting of diagnoses and procedures. Therefore, the adjustments we made did not reflect potential behavioral changes related to those incentives. To date, we have now analyzed 2.5 million discharges under the prospective payment system, which fully reflect the effect of those incentives, and we believe this affords us a better measure of the effect of coding improvements in the average case mix.

Comment—Several commenters stated that the hospital industry should have timely access in the data and methodologies used to construct the prospective payment rates, the factor by which the DRG weights were reduced, and the calculation of the adjustment factors, especially the budget neutrality adjustment. It was also recommended that all data be released at the time the payment rates are published in the **Federal Register.** Some commenters recommended that the data used to compute the reduction in the DRG relative weights and the budget neutrality adjustment be published for review and comment, or that we at least offer additional opportunities to inspect and comment on the data and their utilization.

Response—We agree that hospitals should have access to the data used in connection with the development of the prospective payment system. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed at all or in the format desired by the requester, we will respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.

It should be noted that most of the data that the budget neutrality adjustment is based on has already been made available. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors.

We do not agree that all data should be released simultaneously with the publication of prospective payment rates in the **Federal Register.** The data are voluminous, and would be of no interest to many hospitals and individuals that are otherwise involved in hospital payments. In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register,** along with the many examples furnished, afford the reader all the information necessary for an understanding of the propective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this data under the Freedom of Information Act.

Furthermore, we disagree that additional opportunity to comment is warranted. In the NPRM, we included an explanation of the budget neutrality determination and the methodology used to reduce the relative weights that is sufficiently detailed to permit replication of the computation as noted above.

We believe this explanation meets the requirements of section 1886(d)(6) of the Act, which requires that the published notice of methodology, data, and rates includes an explanation of any adjustments. We fully expect to be actively involved in dialogue with hospitals and other parties during the continuing implementation of the prospective payment system. Further, we will publish future notices of methodology, data, and rates for public review and comment on an annual basis. Accordingly, we have not offered further opportunity for comment on this rulemaking as commenters suggested.

Also, as noted above, we will attempt to furnish all data that has not been previously released upon request under the Freedom of Information Act and that is consistent with maintaining the privacy of individuals and sound management of the program.

Comment—A number of commenters challenged our legal authority to reduce the DRG weights across the board as we proposed. Some stated that the

Secretary does not have the authority to recalibrate the DRG weights until FY 1986. Others said the law specifically states that budget neutrality adjustments should be made to the standardized amounts (for Federal rates) and to the updating factors (for hospital-specific rates) before application of the DRG weights.

Response—We believe that the reduction in the DRG weightings is fully authorized by the statute. The source of the Secretary's authority to assign particular weightings to each DRG is section 1886(d)(4)(B) of the Act, which provides that for each DRG "the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups." Thus, the Secretary has clear authority to assign any weightings to the DRGs as long as they collectively reflect the relative use of resources associated with the DRGs. The across-the-board reduction of the DRG weightings does not alter the relative relationship between the DRG weightings. The DRG weightings continue to reflect the relative hospital resources used for discharges within the DRG, and therefore are wholly consistent with the statutory requirement.

The commenters are not correct when they argue that the Secretary is prohibited from revising the DRG weightings prior to FY 1986. This argument is based on section 1886(d)(4)(C) of the Act, which states that "The Secretary shall adjust the classifications and weighting factors . . . for discharges in fiscal year 1986 and at least every four fiscal years thereafter, to reflect charges in treatment patterns, technology, and other factors which may change the relative use of hospital resources." In the first place, this provision is not the source of the Secretary's authority to assign DRG weightings, but is simply a requirement as to when and how the Secretary must, at a minimum, exercise the authority conferred by section 1886(d)(4)(B) of the Act to assign DRG classifications and weightings. The language of section 1886(d)(4)(C) does not purport to limit the Secretary's authority. Moreover, the legislative history of section 1886(d)(4)(C) demonstrates that it was intended simply to require periodic updating of the DRG weightings to keep the DRG system current. The reference to FY 1986 was evidently inserted into the statute by the Conference Committee to require the Secretary to update the DRGs *earlier* than would have been required under the versions of the bill passed by the House and the Senate. There is no indication that Congress intended to prohibit the Secretary from acting until FY 1986. Finally, section 1886(d)(4)(C) addresses only the issue of revising the DRG weightings to account for changes in the relative use of hospital resources. It is irrelevant to the issue of across-the-board revisions to the weightings that do not alter the relative weightings.

Section 1886(e)(1) of the Act requires that both the Federal portion and hospital-specific portion of transition period payment rates for FYs 1984 and 1985 be adjusted to be budget neutral—that is, that they be adjusted to ensure that the aggregate payment amounts resulting from prospective payment rates for the operating costs of inpatient hospital services are not greater or less than the aggregate payment amounts that would have been payable for such services under the law in effect before the enactment of Pub. L. 98–21 on April 20, 1983. Our methodology for determining the amount of these adjustments is described in section V. of this Addendum.

It is true that in developing the FY 1984 budget neutrality adjustment factors we included our estimate of the increase in case mix that we expected to result from improvements in coding. Further, we could include the new information we have on increases of case mix in the budget neutrality adjustment factors for FY 1985. Several considerations contributed to our decision not to do that. First, we identified that there was an increase of case mix significantly in excess of our earlier estimated increase. Second, we determined that, if we took no action to take this increase into account, we would be making aggregate payments under the prospective payment system at a case-mix level significantly higher than intended, and higher than we estimated would have resulted in response to the case-mix adjusted limits and rate of increase limits established under TEFRA. This would violate the requirement of budget neutrality, and would also undercut the understanding on which prospective payment rates were initially set. Finally, we considered various ways of taking this change in case mix into account. One means was through the budget neutrality adjustment methodology. However, as discussed below, we determined that this alternative would have adverse consequences that could be avoided by adjusting the DRG weights.

By maintaining the level of the average case-mix index, we are able to eliminate the need to decrease the budget neutrality adjustment factor, since the reduction in the DRG weights effectively negates the increased payments associated with higher valued case-mix indexes. Nonetheless, this adjustment, while it certainly affects the budget neutrality adjustment, is not a budget neutrality adjustment per se. Rather, it is an adjustment designed to ameliorate certain undesirable effects of the budget neutrality adjustment. Furthermore, even if this reduction in the weights were construed purely as a budget neutrality adjustment, we believe it conforms to the intent of the law.

If the adjustment to reflect increased case-mix indexes were included in the budget neutrality factors for FY 1985, the hospital-specific payment amounts would be reduced below the level set for FY 1984. This reduced hospital-specific rate would continue for some hospitals into FY 1986, after the DRG weights have been recalibrated, and would adversely affect the revenues of some hospitals. Those hospitals that have cost reporting periods beginning early in FY 1985 would bear a disproportionate budget neutrality burden in order to compensate for those hospitals whose reporting periods begin late in FY 1985. Therefore, we believe periods begin late in FY 1985. Therefore, we believe applying an overall adjustment to the DRG weights is more equitable, since it distributes the burdens of the adjustment more equitably and provides a more even cash flow for all hospitals. We do not believe we have acted counter to the intent of the law by reducing the DRG weights in order to alleviate the adverse impact such an adjustment would have if it was applied to the updating factors for computing the hospital-specific portion of the payment rate. It should be emphasized that reducing the DRG weights instead of the updating factors does not affect aggregate payments to hospitals.

Comment—We received comments from hospitals whose cost reporting periods begin later in the Federal fiscal year objecting to making the across-the-board reduction in the DRG weights effective October 1, 1984. They do not believe this is equitable, since hospitals with cost reporting periods beginning earlier in the Federal fiscal year have the benefit of more months of DRG payments at the higher cost weights.

Response—We believe it is appropriate to apply an adjustment to take into account the higher case-mix indexes resulting from improved coding and other changes in hospital behavior and that this adjustment should be applied to all providers on the same

basis through adjustment of the DRG weighting factors.

Hospitals whose cost reporting periods begin later in the Federal fiscal year did not enter the prospective payment system until later and remained under cost reimbursement for a longer time relative to hospitals whose cost reporting periods begin early in the Federal fiscal year. These hospitals had greater opportunity to adapt to the new system and to implement improved coding practices as well as other changes in behavior prior to entering the prospective payment system. Therefore, we believe the timing of the adjustment should be the same for all hospitals, since it is expected that the same degree of behavior adjustments will have been implemented in all hospitals regardless of their cost reporting periods. The alternative, which is to take account of increased case-mix indexes through the budget neutrality adjustment to the Federal standardized amounts and the hospital-specific rates, would have meant that hospitals whose cost reporting periods begin later in the Federal fiscal year would have been subsidized at the expense of those hospitals whose periods begin earlier in the Federal fiscal year. This could hardly be characterized as an equitable solution, given the greater opportunity of those whose reporting periods begin later in the Federal fiscal year to anticipate and adapt to the new system.

Comment—We received many comments suggesting that a large part of the reported increase in the average case-mix index is "real" and that we should allow for the full amount of the "real" increase in the prospective payment rates. Commenters suggested that the increase in case mix was due to increased use of outpatient services for low-severity cases, leaving a higher case mix in the inpatient setting. Commenters also suggested that Medicare beneficiaries are growing older and sicker with a resulting higher inpatient case mix. Many comments suggested that admission levels have dropped and that we should not reduce the rates.

Response. As noted above, we are planning to do a study that will enable us to identify the relative influence of the various potential causes of the increase in average case mix.

The budget neutrality adjustment factors are determined by computing an estimated reimbursement level under TEFRA and comparing it to estimated payment levels under the prospective payment system, separately for both Federal and hospital-specific rates, as if there were no budget neutrality requirement.

The estimated reimbursement level under TEFRA is computed by estimating each hospital's cost per admission limited by each hospital's estimated peer group limit and target amount limit. Any increase in "real" case mix result in increased costs per admission and are built into our assumptions on the rate of increase in cost per admission. To the extent that the cost per admission assumptions used in determining the TEFRA payments recognize an increase in case mix, case-mix increases that would have occurred under TEFRA have already been recognized in the calculation of the TEFRA cost per admission. We would be recognizing case mix increases twice in the prospective payment rates if we failed to make any adjustment for reported case mix.

It is apparent that many of the commenters were not aware that, even if the observed case-mix increase would have occurred under TEFRA, it would have been recognized only under the exceptions process, because section 1886(a) of the Act allowed for adjustments to the limits only due to increases in costs per admission and in the hospital market basket.

Under our regulations at §§ 405.460 and 405.463, we would not have, except under limited circumstances, adjusted the TEFRA limits for reported increases in case mix. We estimate these limited case-mix adjustments to have a negligible effect on the overall average per case costs under TEFRA, so we did not adjust the estimated payments under the TEFRA limits for changes in case mix. (See also the next comment and response.)

In estimating the payment level under the prospective system, we must reflect all changes in case mix from the 1981 MEDPAR level, regardless of cause, since payments are directly proportional to the case-mix level. If we ignored changes in case mix, we would incorrectly estimate the prospective payment level. The budget neutrality ratio is computed by dividing the estimated TEFRA reimbursement by the estimated prospective payment amount.

We modeled the expected increase in average case mix due to the aging of the Medicare population. Assuming that the case mix level of each age-sex interval would not change from the 1981 MEDPAR level, we computed the average case mix for the estimated Medicare population for the next 25 years. After 25 years, the case-mix level was 0.1 per cent higher than the first-year case-mix level. Over three to four years, the change in case-mix level attributable to aging is negligible. This analysis suggests that the aging of the Medicare population is not the cause of the observed increase in case-mix level.

We compared the average case-mix levels of the 1979, 1980, and 1981 MEDPAR files. The case-mix level increased 0.3 percent in 1980 and decreased 0.1 percent in 1981. This relatively small change in average case-mix level would not lead us to expect the increase in average case-mix observed under the prospective payment system.

For the three waiver States that do not reimburse on the basis of DRGs (Maryland, Massachusetts, and New York), we compared the 1984 case-mix level with the 1981 MEDPAR case-mix level. In each case, the 1984 average case mix is slightly lower than the 1981 average case mix.

We compared increases in admission levels for admissions under TEFRA and the prospective payment system using the admission notices and discharge notices through July 1984. We found that admission rates under TEFRA and the prospective payment system were about the same. If low-severity cases are now being treated on an outpatient basis, this is a continuation of a trend in medical practice that began before the prospective payment system.

We also cannot adjust payment rates for the observed decline in admission levels since admissions for all patients, not just Medicare, are declining. This decline in admissions cannot be attributed to the incentives of the prospective payment system.

We have analyzed the patterns of case-mix increases as hospitals phase into the prospective payment system. If the case-mix increase were entirely "real", it would continue to progressively increase both before and after the hospital was on the prospective payment system. Our analysis shows that case-mix increases almost immediately when the hospital comes onto the prospective payment system and then remains at that level.

Comment— Some commenters argued that in determining the changes in case-mix indexes resulting from implementation of the prospective payment system we failed to consider changes in case-mix under the TEFRA provisions which may have affected the level of payment under TEFRA. One commenter pointed to the provisions in the regulations that establish changes in case-mix as a basis for an exception to both the limit on allowable cost (§405.460(g)(9)) and the rate of increase ceiling (§405.463(e)). According to this commenter, these exceptions would

certainly impact payments under TEFRA.

Response— While changes in case-mix indexes may have occurred under TEFRA, the effect on the level of payments would be negligible, since hospitals are paid actual cost up to an established limit. The regulations do permit the granting of exceptions to the TEFRA cost limits and rate of increase ceiling based on changes in case mix. However, these exceptions are granted only on a limited basis and only where the provider can demonstrate that it has experienced an abrupt change in case mix due to the addition of new services or the discontinuance of previously provided services. Therefore, in the aggregate, changes in case mix under TEFRA would have little effect on total cash outlays since only a comparatively few hospitals will be granted increases in their TEFRA cost limits or rate of increase ceiling. To date, only a handful of exceptions have been granted. In addition, we do not believe the same incentives to improve coding of bills exist under TEFRA since hospital payments are not dependent on the DRG to which a case is assigned.

Finally, it should be noted that budget neutrality and adjustments for increases in case mix are based on estimates using the best data available and are made on a prospective basis. To the extent definitive data could be obtained on exceptions and adjustments, it would not be available until some time after the estimates were made. For example, final determinations on exception requests are generally not made until many months or even years after the period to which they pertain has closed.

Comments— Some commenters suggested that hospitals would increase their reported case mix under TEFRA, especially if they felt they would be affected by the TEFRA limits in later years.

Response— While this scenario is likely, it would not "pass through" these reported increases in case mix for the following reasons.

1. The FY 1985 TEFRA limits would have been based on the 1982 MEDPAR experience, which is almost entirely pre-TEFRA experience.

2. Even if TEFRA data with higher case mix were used to set TEFRA limits in later years, the limits would not increase by the magnitude of the reported increase in case mix because we would continue to divide the cost experience by the case mix in computing peer group means. We would then apply each hospital's case mix to the peer group means to compute the hospital's limit. Since we would, on average, divide and multiply by the same average case mix, the only way the limits could increase is by increases in actual costs. True underlying increases in case mix would increase the limits because they are part of overall cost increases, even though reported increases in case mix would not affect the average level of the limits.

Comment—Many commenters suggested that the proposed 2.4 percent adjustment for increase in case mix be withdrawn because the adjustment was based on inadequate and biased data. Many comments stated that the hospitals that started early under prospective payment are unlike the hospitals that start later, especially in terms of case mix.

Response—The proposed 2.4 percent adjustment for case mix increase was based on analysis of approximately 896,000 admissions processed in HCFA representing about 15 percent of the prospective payment admissions expected during FY 1984. These were the best data at the time the NPRM was published. Our analysis showed that average case mix under prospective payment had increased about 5.85 percent above the 1981 levels. This was 2.4 percent greater than we had estimated case mix would increase due to improved coding. We now have approximately 2.5 million admissions processed in HCFA, representing about half of the admissions in FY 1984. These data show that the increase in average case mix is 7.3 percent rather than 5.85 percent. Because we cannot identify with certainty why each additional update of the data shows that the average case mix is increasing, we are undertaking a study, as described above, that will enable us to identify with greater precision the causes of this increase.

Comment—Some comments suggested that we assumed that hospitals would have identical diagnosis and admission patterns every year for purposes of computing case-mix increases.

Response—We assumed that case-mix index patterns averaged over all hospitals would be about the same every year. Since we observed a stable case-mix level over the 1979 through 1981 MEDPAR files, we believe that this assumption was reasonable.

Comment—Some commenters suggested that new diagnostic and treatment services would increase the case weights which is part of the reason for the increase in average reported case mix.

Response—Since we did not recalibrate the DRGs, these new diagnostic and treatment services are not included in the DRG weights. The only way reported case mix can increase is by changing the relative frequency of different DRGs, not by the treatment mode for any particular DRG.

Comment—Some commenters suggested that because some healthy beneficiaries elected to continue to receive health benefits coverage from their employers, Medicare is left with a sicker population with a higher case mix.

Response—Even though these hospital stays are reimbursed by a plan other than Medicare, Medicare will pay for any gaps in coverage. Further, these hospital stays are still applied to the beneficiary's spell of illness. Therefore, we must receive bills for these purposes. Since the bills must have diagnostic information, they are also included in the calculation of the average case mix. The fact that a beneficiary may elect to have his health coverage provided by his employer has no effect on the average case mix.

Comment—Many commenters suggested that hospital inpatients are now more acutely ill than previously, and that is part of the reason for increases in reported case mix.

Response—We are puzzled by the term "more acutely ill" because of its unclear meaning. Some of the factors that determine the assignment of a DRG are the particular illness, the presence of additional illnesses that may complicate the case, age, sex, and the presence or absence of certain procedures. The degree of illness is not a factor in assigning a DRG. If a particular case of an illness is more severe than average, we have outlier provisions to handle these cases, even though the DRG does not change. It is not clear that more acutely ill patients would necessarily increase the average case mix.

Comment—Several comments suggested that we should not reduce the DRG weights because admissions are lower than the level of projected admissions used to determine Medicare expenditures as projected in the Federal budget. These commenters seemed to believe that the purpose of reducing the DRG weights was to achieve some targeted amount of savings. They argued that the lower level of admissions would result in substantial savings and that we should not seek more.

Response—Under Medicare, we pay only when beneficiaries receive covered services. Budget neutrality requires that for FYs 1984 and 1985 we pay in the aggregate the same amount for covered services furnished under the prospective payment system as would have been paid for those services under TEFRA. The amount submitted to the Federal budget is a projection for planning

purposes, not a promise to pay a specific amount. Therefore, in determining payment rates under the prospective payment system, we do not have to make up any differences between projected and actual admissions. As discussed above and in section V of this addendum, we do not believe that the decline of admissions is a consequence of the prospective payment system.

Comment—We received many comments suggesting that we should not reduce the DRG relative weights because of a few hospitals "gaming" the system. We should address gaming on an institution by institution basis.

Response—The increase in case mix is pervasive and is spread throughout the country. Because of the extent of the case-mix increase, it is not possible to attribute this increase solely to a few "gaming" hospitals. Since the prospective payment system sets a payment rate for a DRG, we cannot set rates differently for different Hospitals, other than the adjustments specified in the law.

Comment—Some comments stated that the severe winter weather raised the case-mix level by postponing elective admissions, and that the increased case-mix level would decline in the spring and summer.

Response—When we analyzed case-mix data through July 1984, we didn't see the increased level in case-mix decrease in spring and summer. Rather, it continued to increase.

Comment—A commenter suggested that a higher reported case mix implies greater resource consumption. The commenter also suggested that we shouldn't compare case mix to the 1984 level and that we are assuming a 2.4 percent case-mix increase from 1984 to 1985, but that our assumed increase in case mix from 1981 to 1984 is zero percent. It was also suggested that the validity of the case-mix adjustment for 1985 was not addressed.

Response—Even though the reported case mix has increased, we do not believe that resources are being consumed at a higher rate. The substantial decrease in the rates of hospital cost increases suggests that resource consumption may possibly be declining. We must compare case-mix levels to 1981, since the 1981 case mix was used to set the payment rates. We are not projecting a 2.4 percent case-mix increase from FY 1984 to FY 1985. At the time of the NPRM, we had observed an increase in case mix of 2.4 percent beyond what we expected. Subsequently, the observed FY 1984 case mix level is 3.8 percent higher than expected. We are projecting no further increase in the case-mix level for FY 1985.

We expect the FY 1985 case-mix level to be as valid as the FY 1984 case mix for payment purposes. Diagnostic coding is now being reviewed, and we expect the level of review to be similar in FY 1985.

Comment—A commenter suggested that more intense cases should be paid for at the value of care given.

Response—The DRG system was constructed to achieve this result in the aggregate.

Comment—A commenter stated that its length of stay dropped from 9 days to 7 days.

Response—We have not reduced payments for decreases in length of stay.

Comment—Some commenters suggested that we should adjust only those DRG weights that cause the increase in average case mix.

Response—Although some DRG weights affect the average case mix more than others due to a greater relative frequency and higher values, we cannot adjust the relative weights for individual DRGs simply because more discharges fall into them. The relative weights of DRGs reflect their relative resource consumption. Adjusting the weights of individual DRGs to reflect frequency would distort the relationship of these relative measures.

Comment—A commenter suggested that the 2.4 percent reduction in the DRG relative weights is inappropriate because we had no sound actuarial techniques for estimating what case-mix change would have been payable under TEFRA, because the 1979 to 1981 change in case mix is inaccurate and has no bearing on the 1981 to 1984 period, and because the 0.5 percent annual change in case mix from 1979 to 1981 is significant.

Response—The statement that case mix increased at a 0.5 percent annual rate from 1979 to 1981 is incorrect. The case mix changed at a 0.1 percent annual rate over the period 1979 to 1981. Whatever case mix level hospitals would have reported under TEFRA if there was no prospective payment system, we would not, except under extraordinary circumstances, have adjusted the TEFRA limits for changes in case mix level. If the cost per admission increased because of increases in case mix, we would have paid the increased cost subject to the TEFRA limits. Hence we have reliable estimates what case mix change would have been payable under TEFRA.

Even though the MEDPAR data do not have the most accurate diagnostic information, we believe that comparing the trends in case-mix in the 1979, 1980, and 1981 MEDPAR files is valid for the following reasons:

1. All the MEDPAR years used the ICD–9 codes and the same DRG Grouper program.

2. The reporting incentives and level of review were the same in all three years.

3. We feel the biases in all three years are similiar and that analyzing trends in case mix is valid. We believe that the 1979 to 1981 experience has a bearing on the 1981 to 1984 case mix trends. We do not expect the mix of diseases to change greatly and permanently.

Comment— One commenter noted that the outlier threshold values in Table 5 of the addendum to the NPRM (49 FR 27451), that is, DRGs 223, 224, and 225, were incomplete.

Response— The outlier threshold values for DRGs 223, 224, and 225 were misprinted in the addendum to the NPRM. Those values for DRGs 223, 224, and 225 should be 29, 24, and 15 respectively. The corrected values are listed in Table 5 of the addendum to this final rule.

D. Further Changes as a Result of Pub. L. 98–369

This section contains a discussion of two changes made as a result of enactment of Pub. L. 98–369. Both changes are effective with cost reporting periods beginning on or after October 1, 1984.

1. Indirect Medical Education

In accordance with section 2307(b) of Pub. L. 98–369, in counting the number of interns and residents for purposes of calculating the additional payment for indirect medical education, we are counting on the basis of where services are provided and not on the basis of who employs them. Additionally, as required under § 405.477(d)(2)(v)(B) (as revised), hospitals must submit quarterly reports regarding interns and residents and final payment will not be made until cost reports are audited and the correct number of interns and residents verified by the fiscal intermediaries.

2. Payment for Services of Nonphysician Anesthetists

Section 2312 requires that the anesthesia services of certified registered nurse anesthetists be paid for on a reasonable cost basis. Also, as described in the new § 405.477(c)(3), we are paying on this basis for anesthesia services of anesthesiology assistants. Because hospitals will receive additional payment amounts for these

services, we are removing such costs, based on our best estimates, from the Federal rates and hospital-specific rates.

E. Calculation of Prospective Payment Rates for FY 1985

FY 1985 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:

Prior Year Hospital-Specific Portion × Updating Factor × 50 percent × DRG Weight—For a more detailed discussion of the hospital-specific portion, we refer the reader to the interim final rule (48 FR 39772).

Comment—Several commenters cited problems with the formula for determining the hospital-specific portion in calculating the prospective payment rates for FY 1985 (49 FR 27445). Specifically, they stated that the formula was unclear and appeared to be inconsistent with the updating factors used in determining the hospital-specific portion.

Response—We agree that the summary formula expressing the calculation of the hospital-specific portion for the second year of the prospective payment system was confusing and inconsistent with the updating factors. We have revised the formula accordingly to indicate that for FY 1985 the hospital-specific portion is—

Prior Year Hospital-Specific Portion × Updating Factor × 50 percent × DRG Weight.

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 year.

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. The applicable factor for adjusting the hospital-specific portion to maintain budget neutrality in FY 1985 is .993. This factor has been included in the updating factor discussed in section b below.

b. Updating Factor. For cost reporting periods ending between September 30, 1984 and August 31, 1986, we are applying 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 .993. The table below sets forth the updating factors applicable to discharges in FY 1985.

If cost reporting period ends	And second cost reporting period under PPS ends	Updating factor
Sept. 30, 1984	Sept. 30, 1985	1.05878
Oct. 31, 1984	Oct. 31, 1985	1.05920
Nov. 30, 1984	Nov. 30, 1985	1.05961
Dec. 31, 1984	Dec. 31, 1985	1.06003
Jan. 31, 1985	Jan. 31, 1986	1.06052
Feb. 28, 1985	Feb. 28, 1986	1.06102
Mar. 31, 1985	Mar. 31, 1986	1.06151
Apr. 30, 1985	Apr. 30, 1986	1.06201
May 31, 1985	May 31, 1986	1.06251
June 30, 1985	June 30, 1986	1.06300
July 31, 1985	July 31, 1986	1.06350
Aug. 31, 1985	Aug. 31, 1986	1.06400

If a hospital's cost reporting period ends on a date other than those listed above, the update factor for the month nearest to the actual ending date (that is, either before or after) 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 must contact HCFA for the appropriate adjustment factor.

Comment—One commenter suggested that the language in the NPRM (49 FR 27445) describing the inclusive dates for which the updating factors apply was inaccurate. The commenter believes that, in our discussion, we imply that the updating factors would apply only to cost reporting periods ending on or after September 30, 1984 and through August 30, 1986. He suggests that the updating factors apply to cost reporting periods ending on or after September 30, 1985 and before September 1, 1986.

Response—We agree that the cost reporting dates for applying the updating factors do not clearly express our intention that the factors cover periods ending up through August 31, 1986. We have revised this discussion of cost reporting periods above to include the August 31, 1986 end-date. However, contrary to the commenter's understanding, the updating factors apply to cost reporting periods that begin during Federal FY 1985. Therefore, the period covered by these updating factors begins with the September 30, 1984 end-date.

c. *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 making the following changes in determining prospective payment rates for FY 1985:

A. Calculation of Adjusted Standardized Amounts

- Update the market basket index.
- Reduce the updating factors to the market basket plus .25 percent in accordance with section 2310 of Pub. L. 98–369.
- Update the cost-of-living adjustment factors for hospitals in Alaska and Hawaii.
- Revise the table of adjusted standardized amounts to include 20 standardized amounts, that is, nine regional figures and a national figure for labor-related and non-labor-related amounts (Table 1).
- Adjust the average standardized amounts upward to reflect more recent

data in estimating costs previously billed 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.
- Adjust the average standardized amounts (and hospital-specific portion) to reflect the removal of costs of nonphysician anesthetists' services.

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 this final 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)	2,453.88	668.56	2,098.04	507.22
2. Middle Atlantic (PA, NJ, NY)	2,205.94	660.71	2,088.21	514.40
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,296.98	612.25	1,889.46	427.43
4. East North Central (IL, IN, MI, OH, WI)	2,452.00	712.68	2,052.37	478.79
5. East South Central (AL, KY, MS, TN)	2,085.43	544.93	1,905.97	399.94
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2,391.81	634.00	1,915.33	410.91
7. West South Central (AR, LA, OK, TX)	2,248.19	599.67	1,845.62	398.47
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,208.95	636.52	1,913.21	447.21
9. Pacific (AK, CA, HI, OR, WA)	2,325.13	745.34	1,999.49	521.49
10. National	2,320.61	664.44	1,943.21	438.18

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX (Taylor, TX)	.9395
Akron, OH (Portage, OH, Summit, OH)	1.0713
Albany, GA (Dougherty, GA, Lee, GA)	.8897
Albany-Schenectady-Troy, NY (Albany, NY, Greene, NY, Montgomery, NY, Rensselaer, NY, Saratoga, NY, Schenectady, NY)	.8907
Albuquerque, NM (Bernalillo, NM)	1.0558
Alexandria, LA (Rapides, LA)	.9716
Allentown-Bethlehem, PA-NJ (Warren, NJ, Carbon, PA, Lehigh, PA, Northampton, PA)	1.0496
Alton-Granite City, IL (Jersey, IL, Madison, IL)	.9699
Altoona, PA (Blair, PA)	1.0228
Amarillo, TX (Potter, TX, Randall, TX)	.9677
Anaheim-Santa Ana, CA (Orange, CA)	1.2419
Anchorage, AK (Anchorage, AK)	1.5417
Anderson, IN (Madison, IN)	1.0142
Anderson, SC (Anderson, SC)	.8729
Ann Arbor, MI (Washtenaw, MI)	1.2065
Anniston, AL (Calhoun, AL)	.8608
Appleton-Oshkosh-Neenah, WI (Calumet, WI, Outagamie, WI, Winnebago, WI)	.9644
Asheville, NC (Buncombe, NC)	.9503
Athens, GA (Clarke, GA, Jackson, GA, Madison, GA, Oconee, GA)	.8800
Atlanta, GA (Barrow, GA, Butts, GA, Cherokee, GA, Clayton, GA, Cobb, GA, Coweta, GA, De Kalb, GA, Douglas, GA, Fayette, GA, Forsyth, GA, Fulton, GA, Gwinnett, GA, Henry, GA, Newton, GA, Paulding, GA, Rockdale, GA, Spalding, GA, Walton, GA)	.9395
Atlantic City, NJ (Atlantic, NJ, Cape May, NJ)	1.0627
Augusta, GA-SC (Columbia, GA, McDuffie, GA, Richmond, GA, Aiken, SC)	.9595
Aurora-Elgin, IL (Kane, IL, Kendall, IL)	.9937
Austin, TX (Hays, TX, Travis, TX, Williamson, TX)	1.0631
Bakersfield, CA (Kern, CA)	1.2246
Baltimore, MD (Anne Arundel, MD, Baltimore, MD, Baltimore City, MD, Carroll, MD, Harford, MD, Howard, MD, Queen Annes, MD)	1.0920
Bangor, ME (Penobscot, ME)	.9253
Baton Rouge, LA (Ascension, LA, East Baton Rouge, LA, Livingston, LA, West Baton Rouge, LA)	1.0154
Battle Creek, MI (Calhoun, MI)	1.0578
Beaumont-Port Arthur, TX (Hardin, TX, Jefferson, TX, Orange, TX)	.9854
Beaver County, PA (Beaver, PA)	1.0841
Bellingham, WA (Whatcom, WA)	1.0522
Benton Harbor, MI (Berrien, MI)	.8716
Bergen-Passaic, NJ (Bergen, NJ, Passaic, NJ)	1.0269
Billings, MT (Yellowstone, MT)	.9628
Biloxi-Gulfport, MS (Hancock, MS, Harrison, MS)	.8692
Binghamton, NY (Broome, NY, Tioga, NY)	.9507
Birmingham, AL (Blount, AL, Jefferson, AL, Saint Clair, AL, Shelby, AL, Walker, AL)	1.0026
Bismarck, ND (Burleigh, ND, Morton, ND)	1.0080
Bloomington, IN (Monroe, IN)	.9289
Bloomington-Normal, IL (McLean, IL)	1.0096
Boise City, ID (Ada, ID)	1.0733
Boston-Lawrence-Salem-Lowell-Brockton, MA (Essex, MA, Middlesex, MA, Norfolk, MA, Plymouth, MA, Suffolk, MA)	1.0927
Boulder-Longmont, CO (Boulder, CO)	.9952
Bradenton, FL (Manatee, FL)	.9180
Brazoria, TX (Brazoria, TX)	.8392
Bremerton, WA (Kitsap, WA)	.8972
Bridgeport-Stamford-Norwalk-Danbury, CT (Fairfield, CT)	1.1548
Brownsville-Harlingen, TX (Cameron, TX)	.9198
Bryan-College Station, TX (Brazos, TX)	.9059
Buffalo, NY (Erie, NY)	.9768
Burlington, NC (Alamance, NC)	.8463
Burlington, VT (Chittenden, VT, Grand Isle, VT)	.9632
Canton, OH (Carroll, OH, Stark, OH)	.9778
Casper, WY (Natrona, WY)	1.0235
Cedar Rapids, IA (Linn, IA)	.9360
Champaign-Urbana-Rantoul, IL (Champaign, IL)	1.0224
Charleston, SC (Berkeley, SC, Charleston, SC, Dorchester, SC)	1.0241
Charleston, WV (Kanawha, WV, Putnam, WV)	1.1011
Charlotte-Gastonia-Rock Hill, NC-SC (Cabarrus, NC, Gaston, NC, Lincoln, NC, Mecklenburg, NC, Rowan, NC, Union, NC, York, SC)	.9756
Charlottesville, VA (Albemarle, VA, Charlottesville City, VA, Fluvanna, VA, Greene, VA)	1.2899
Chattanooga, TN-GA (Catoosa, GA, Dade, GA, Walker, GA, Hamilton, TN, Marion, TN, Sequatchie, TN)	.9680
Chicago, IL (Cook, IL, Du Page, IL, McHenry, IL)	1.2240
Chico, CA (Butte, CA)	1.0536

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Cincinnati, OH-KY-IN (Dearborn, IN, Boone, KY, Campbell, KY, Kenton, KY, Clermont, OH, Hamilton, OH, Warren, OH)	1.0543
Clarksville-Hopkinsville, TN-KY (Christian, KY, Montgomery, TN)	.8325
Cleveland, OH (Cuyahoga, OH, Geauga, OH, Lake, OH, Medina, OH)	1.2004
Colorado Springs, CO (El Paso, CO)	1.1046
Columbia, MO (Boone, MO)	1.1334
Columbia, SC (Lexington, SC, Richland, SC)	.9583
Columbus, GA-AL (Russell, AL, Chattanoochee, GA, Muscogee, GA)	.9180
Columbus, OH (Delaware, OH, Fairfield, OH, Franklin, OH, Licking, OH, Madison, OH, Picksway, OH, Union, OH)	1.0402
Corpus Christi, TX (Nueces, TX, San Patricio, TX)	.9528
Cumberland, MD-WV (Allegeny, MD, Mineral, WV)	.8897
Dallas, TX (Collins, TX, Dallas, TX, Denton, TX, Ellis, TX, Kaufmsn, TX, Rockwall, TX)	1.0766
Danville, VA (Danville City, VA, Pittsylvania, VA)	.8682
Davenport-Rock Island-Moline, IA-IL (Scott, IA, Henry, IL, Rock Island, IL)	.9818
Dayton-Springfield, OH (Clark, OH, Greene, OH, Miami, OH, Montgomery, OH)	1.1095
Daytona Beach, FL (Volusia, FL)	.9673
Decatur, IL (Macon, IL)	.8611
Denver, CO (Adams, CO, Arapahoe, CO, Denver, CO, Douglas, CO, Jefferson, CO)	1.2076
Des Moines, IA (Dallas, IA, Polk, IA, Warren, IA)	1.0587
Detroit, MI (Lapeer, MI, Livingston, MI, Macomb, MI, Monroe, MI, Oakland, MI, Saint Clair, MI, Wayne, MI)	1.1945
Dothan, AL (Dale AL, Houston, AL)	.8830
Dubuque, IA (Dubuque, IA)	1.0260
Duluth, MN-WI (St. Louis, MN, Douglas, WI)	.9148
East St. Louis-Belleville, IL (Clinton, IL, St. Clair, IL)	.9469
Eau Claire, WI (Chippewa, WI, Eau Claire, WI)	.9549
El Paso, TX (El Paso, TX)	.8973
Elkhart-Goshen, IN (Elkhart, IN)	.8907
Elmira, NY (Chemung, NY)	1.0236
Enid, OK (Garfield, OK)	.9000
Erie, PA (Erie, PA)	.9906
Eugene-Springfield, OR (Lane, OR)	.9862
Evansville, IN-KY (Posey, IN, Vanderburgh, IN, Warrick, IN, Henderson, KY)	1.0247
Fargo-Moorhead, ND-MN (Clay, MN, Cass, ND)	1.0031
Fayetteville, NC (Cumberland, NC)	.9311
Fayetteville-Springdale, AR (Washington, AR)	.8290
Flint, MI (Genesee, MI)	1.1500
Florence, AL (Colbert, AL, Lauderdale, AL)	.8072
Florence, SC (Florence, SC)	.8055
Fort Collins-Loveland, CO (Larimor, CO)	.9259
Fort Lauderdale-Hollywood-Pompano Beach, FL (Broward, FL)	1.1082
Fort Myers-Cape Coral, FL (Lee, FL)	.9223
Fort Pierce, FL (Martin, FL, St. Lucie, FL)	.9923
Fort Smith, AR-OK (Crawford, AR, Sebastian, AR, Sequoyah, OK)	.9685
Fort Walton Beach, FL (Okaloosa, FL)	.7857
Fort Wayne, IN (Allen, IN, De Kalb, IN, Whitley, IN)	.9348
Fort Worth-Arlington, TX (Johnson, TX, Parker, TX, Tarrant, TX)	.9826
Fresno, CA (Fresno, CA)	1.1927
Gadsden, AL (Etowah, AL)	.9216
Gainesville, FL (Alachua, FL, Bradford, FL)	.9690
Galveston-Texas City, TX (Galveston, TX)	1.1798
Gary-Hammond, IN (Lake, IN, Porter, IN)	1.1395
Glenns Falls, NY (Warren, NY, Washington, NY)	.8795
Grand Forks, ND (Grand Forks, ND)	.9873
Grand Rapids, MI (Kent, MI, Ottawa, MI)	.9963
Great Falls, MT (Cascade, MT)	1.0286
Greeley, CO (Weld, CO)	1.0807
Green Bay, WI (Brown, WI)	.9783
Greensboro-Winston-Salem-High Point, NC (Davidson, NC, Davie, NC, Forsyth, NC, Guilford, NC, Randolph, NC, Stokes, NC, Yadkin, NC)	.9558
Greenville-Spartanburg, SC (Greenville, SC, Pickens, SC, Spartanburg, SC)	.9455
Hagerstown, MD (Washington, MD)	.9635
Hamilton-Middletown, OH (Butler, OH)	1.0414
Harrisburg-Lebanon-Carlisle, PA (Cumberland, PA, Dauphin, PA, Lebanon, PA, Perry, PA)	1.0335
Hartford-New Middletown-Britain-Bristol, CT (Hartford, CT, Litchfield, CT, Middlesex, CT, Tolland, CT)	1.0670
Hickory, NC (Alexander, NC, Burke, NC, Catawba, NC)	.9484
Honolulu, HI (Honolulu, HI)	1.1448
Houma-Thibodaux, LA (Lafourche, LA, Terrebonne, LA)	.9766

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Houston, TX (Fort Bend, TX, Harris, TX, Liberty, TX, Montgomery, TX, Waller, TX)	1.1097
Huntington-Ashland, WV-KY-OH (Boyd, KY, Carter, KY, Greenup, KY, Lawrence, OH, Cabell, WV, Wayne, WV)	.9830
Huntsville, AL (Madison, AL)	.8972
Indianapolis, IN (Boone, IN, Hamilton, IN, Hancock, IN, Hendricks, IN, Johnson, IN, Marion, IN, Morgan, IN, Shelby, IN)	1.0786
Iowa City, IA (Johnson, IA)	1.1400
Jackson, MI (Jackson, MI)	1.0260
Jackson, MS (Hinds, MS, Madison, MS, Rankin, MS)	.9092
Jacksonville, FL (Clay, FL, Duval, FL, Nassau, FL, St. Johns, FL)	.9894
Jacksonville, NC (Onslow, NC)	.8800
Janesville-Beloit, WI (Rock, WI)	.9022
Jersey City, NJ (Hudson, NJ)	1.0890
Johnson City-Kingsport-Bristol, TN-VA (Carter, TN, Hawkins, TN, Sullivan, TN, Unicoi, TN, Washington, TN, Bristol City, VA, Scott, VA, Washington, VA)	.9221
Johnstown, PA (Cambria, PA, Somerset, PA)	1.0263
Joliet, IL (Grundy, IL, Will, IL)	1.1024
Joplin, MO (Jasper, MO, Newton, MO)	.9560
Kalamazoo, MI (Kalamazoo, MI)	1.2244
Kankakee, IL (Kankakee, IL)	.9125
Kansas City, KS-MO (Johnson, KS, Leavenworth, KS, Miami, KS, Wyandotte, KS, Cass, MO, Clay, MO, Jackson, MO, Lafayette, MO, Platte, MO, Ray, MO)	.9861
Kenosha, WI (Kenosha, WI)	1.0786
Killeen-Temple, TX (Bell, TX, Coryell, TX)	.9383
Knoxville, TN (Anderson, TN, Blount, TN, Grainger, TN, Jefferson, TN, Knox, TN, Sevier, TN, Union, TN)	.9146
Kokomo, IN (Howard, IN, Tipton, IN)	1.0096
LaCrosse, WI (LaCrosse, WI)	.9543
Lafayette, LA (Lafayette, LA, St. Martin, LA)	1.0141
Lafayette, IN (Tippecanoe, IN)	.9240
Lake Charles, LA (Calcasieu, LA)	.9921
Lake County, IL (Lake, IL)	1.1061
Lakeland-Winter Haven, FL (Polk, FL)	.9257
Lancaster, PA (Lancaster, PA)	1.0351
Lansing-East Lansing, MI (Clinton, MI, Eaton, MI, Ingham, MI)	1.0493
Laredo, TX (Webb, TX)	.8544
Las Cruces, NM (Dona Ana, NM)	.8438
Las Vegas, NV (Clark, NV)	1.2165
Lawrence, KS (Douglas, KS)	.9778
Lawton, OK (Comanche, OK)	.9257
Lewiston-Auburn, ME (Androscoggin, ME)	.9149
Lexington-Fayette, KY (Bourbon, KY, Clark, KY, Fayette, KY, Jessamine, KY, Scott, KY, Woodford, KY)	.9555
Lima, OH (Allen, OH, Auglaize, OH)	.9967
Lincoln, NE (Lancaster, NE)	.8998
Little Rock-North Little Rock, AR (Faulkner, AR, Lonoke, AR, Pulaski, AR, Saline, AR)	1.0162
Longview-Marshall, TX (Gregg, TX, Harrison, TX)	.8544
Lorain-Elyria, OH (Lorain, OH)	1.0528
Los Angeles-Long Beach, CA (Los Angeles, CA)	1.3010
Louisville, KY-IN (Clark, IN, Floyd, IN, Harrison, IN, Bullitt, KY, Jefferson, KY, Oldham, KY, Shelby, KY)	1.0832
Lubbock, TX (Lubbock, TX)	1.0067
Lynchburg, VA (Amherst, VA, Campbell, VA, Lynchburg City, VA)	.9221
Macon-Warner Robins, GA (Bibb, GA, Houston, GA, Jones, GA, Peach, GA)	.9830
Madison, WI (Dane, WI)	1.0621
Manchester-Nashua, NH (Hillsboro, NH, Merrimack, NH)	.9327
Mansfield, OH (Richland, OH)	.9158
McAllen-Edinburg-Mission, TX (Hidalgo, TX)	.8438
Medford, OR (Jackson, OR)	.9833
Melbourne-Titusville, FL (Brevard, FL)	.9314
Memphis, TN-AR-MS (Crittenden, AR, De Soto, MS, Shelby, TN, Tipton, TN)	1.0744
Miami-Hialeah, FL (Dade, FL)	1.1468
Middlesex-Somerset-Hunterdon, NJ (Hunterdon, NJ, Middlesex, NJ, Somerset, NJ)	1.0611
Midland, TX (Midland, TX)	1.0761
Milwaukee, WI (Milwaukee, WI, Ozaukee, WI, Washington, WI, Waukesha, WI)	1.0419
Minneapolis-St. Paul, MN-WI (Anoka, MN, Carver, MN, Chisago, MN, Dakota, MN, Hennepin, MN, Isanti, MN, Ramsey, MN, Scott, MN, Washington, MN, Wright, MN, St. Croix, WI)	1.0250
Mobile, AL (Baldwin, AL, Mobile, AL)	.9311
Modesto, CA (Stanislaus, CA)	1.0773
Monmouth-Ocean, NJ (Monmouth, NJ, Ocean, NJ)	.9843
Monroe, LA (Ouachita, LA)	.9531
Montgomery, AL (Autauga, AL, Elmore, AL, Montgomery, AL)	.9706
Muncie, IN (Delaware, IN)	.9673
Muskegon, MI (Muskegon, MI)	.9216
Naples, FL (Collier, FL)	1.1170
Nashville, TN (Cheatham, TN, Davidson, TN, Dickson, TN, Robertson, TN, Rutherford, TN, Sumner, TN, Williamson, TN, Wilson, TN)	1.2232
Nassau-Suffolk, NY (Nassau, NY, Suffolk, NY)	1.2068
New Bedford-Fall River-Attleboro, MA (Bristol, MA)	.9643
New Haven-West Haven-Waterbury-Meriden, CT (New Haven, CT)	1.0645
New London-Norwich, CT (New London, CT)	1.0646
New Orleans, LA (Jefferson, LA, Orleans, LA, St. Bernard, LA, St. Charles, LA, St. John The Baptist, LA, St. Tammany, LA)	1.0115
New York, NY (Bronx, NY, Kings, NY, New York City, NY, Putnam, NY, Queens, NY, Richmond, NY, Rockland, NY, Westchester, NY)	1.3629
Newark, NJ (Essex, NJ, Morris, NJ, Sussex, NJ, Union, NJ)	1.1265
Niagara Falls, NY (Niagara, NY)	.8723
Norfolk-Virginia Beach-Newport News, VA (Chesapeake City, VA, Gloucester, VA, Hampton City, VA, James City Co., VA, Newport News City, VA, Norfolk City, VA, Poquoson, VA, Portsmouth City, VA, Suffolk City, VA, Virginia Beach City, VA, Williamsburg City, VA, York, VA)	.9763
Oakland, CA (Alameda, CA, Contra Costa, CA)	1.2590
Ocala, FL (Marion, FL)	1.0080
Odessa, TX (Ector, TX)	.9756
Oklahoma City, OK (Canadian, OK, Cleveland, OK, Logan, OK, McClain, OK, Oklahoma, OK, Pottawatomie, OK)	1.0502
Olympia, WA (Thurston, WA)	1.0543
Omaha, NE-IA (Pottawattamie, IA, Douglas, NE, Sarpy, NE, Washington, NE)	.8982
Orange County, NY (Orange, NY)	1.0041
Orlando, FL (Orange, FL, Osceola, FL, Seminole, FL	1.0125
Owensboro, KY (Daviess, KY)	.8809
Oxnard-Ventura, CA (Ventura, CA)	1.1962
Panama City, FL (Bay, FL)	.9022
Parkersburg-Marietta, WV-OH (Washingtron, OH, Wood, WV)	.9933
Pascagoula, MS (Jackson, MS)	1.0118
Pensacola, FL (Escambia, FL, Santa Rosa, FL)	.9092
Peoria, IL (Peoria, IL, Tazewell, IL, Woodford, IL)	1.1269
Philadelphia, PA-NJ (Burlington, NJ, Camden, NJ, Gloucester, NJ, Bucks, PA, Chester, PA, Delaware, PA, Montgomery, PA, Philadelphia, PA)	1.1736
Phoenix, AZ (Maricopa, AZ)	1.1099
Pine Bluff, AR (Jefferson, AR)	.8757
Pittsburgh, PA (Allegheny, PA, Fayette, PA, Washington, PA, Westmoreland, PA)	1.1364
Pittsfield, MA (Berkshire, MA)	.9795
Portland, ME (Cumberland, ME, Sagadahoc, ME, York, ME)	.9632
Portland, OR (Clackamas, OR, Multnomah, OR, Washington, OR, Yamhill, OR)	1.1172
Portsmouth-Dover-Rochester, NH (Rockingham, NH, Strafford, NH)	.8438
Poughkeepsie, NY (Dutchess, NY)	1.0897
Providence-Pawtucket-Woonsocket, RI (Bristol, RI, Kent, RI, Newport, RI, Providence, RI, Statewide, RI, Washington, RI)	.9753
Provo-Orem, UT (Utah, UT)	.9452
Pueblo, CO (Pueblo, CO)	1.1576
Racine, WI (Racine, WI)	1.0124
Raleigh-Durham, NC (Durham, NC, Franklin, NC, Orange, NC, Wake, NC)	1.0118
Reading, PA (Berks, PA)	1.0265
Redding, CA (Shasta, CA)	1.0522
Reno, NV (Washoe, NV)	1.2962
Richland-Kennewick, WA (Benton, WA, Franklin, WA)	.9528
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)	.9281
Riverside-San Bernardino, CA (Riverside, CA, San Bernardino, CA)	1.1729
Roanoke, VA (Botetourt, VA, Roanoke, VA, Roanoke City, VA, Salem City, VA)	.9998
Rochester, MN (Olmsted, MN)	1.0235
Rochester, NY (Livingston, NY, Monroe, NY, Ontario, NY, Orleans, NY, Wayne, NY)	1.0357
Rockford, IL (Boone, IL, Winnebago, IL)	1.0323
Sacramento, CA (Eldorado, CA, Placer, CA, Sacramento, CA, Yolo, CA)	1.2061
Saginaw-Bay City-Midland, MI (Bay, MI, Midland, MI, Saginaw, MI)	1.0928
St. Cloud, MN (Benton, MN, Sherburne, MN, Stearns, MN)	.8788
St. Joseph, MO (Buchanan, MO)	.9856
St. Louis, MO-IL (Monroe, IL, Franklin, MO, Jefferson, MO, St. Charles, MO, St. Louis, MO, St. Louis City, MO)	1.0694
Salem, OR (Marion, OR, Polk, OR)	1.0559
Salinas-Seaside-Monterey, CA (Monterey, CA)	1.2737
Salt Lake City-Ogden, UT (Davis, UT, Salt Lake, UT, Weber, UT)	.9649
San Angelo, TX (Tom Green, TX)	.9269
San Antonio, TX (Bexar, TX, Comal, TX, Guadalupe, TX)	1.0488
San Diego, CA (San Diego, CA)	1.1873
San Francisco, CA (Marin, CA, San Francisco, CA, San Mateo, CA)	1.3946
San Jose, CA (Santa Clara, CA)	1.2928
Santa Barbara-Santa Maria-Lompoc, CA (Santa Barbara, CA)	1.1094
Santa Cruz, CA (Santa Cruz, CA)	1.1363
Santa Fe, NW (Los Alamos, NM, Santa Fe, NM)	1.0089
Santa Rosa-Petaluma, CA (Sonoma, CA)	1.1808
Sarasota, FL (Sarasota, FL)	.9859
Savannah, GA (Chatham, GA, Effingham, GA)	.9501
Scranton/Wilkes Barre, PA (Columbia, PA, Lackawanna, PA, Luzerne, PA, Monroe, PA, Wyoming, PA)	.9742
Seattle, WA (King, WA, Snohomish, WA)	1.0859
Sharon, PA (Mercer, PA)	.9640
Sheboygan, WI (Sheboygan, WI)	.8574
Sherman-Denison, TX (Grayson, TX)	.8997
Shreveport, LA (Bossier, LA, Caddo, LA)	1.0634
Sioux City, IA-NE (Woodbury, IA, Dakota, NE)	1.0301
Sioux Falls, SD (Minnehaha, SD)	.9428
South Bend-Mishawaka, IN (St. Joseph, IN)	.9715
Spokane, WA (Spokane, WA)	1.1170
Springfield, IL (Menard, IL, Sangamon, IL)	1.1394
Springfield, MO (Christian, MO, Greene, MO)	.9518
Springfield, MA (Hampden, MA, Hampshire, MA)	.9855
State College, PA (Centre, PA)	1.0543
Steubenville-Weirton, OH-WV (Jefferson, OH, Brooke, WV, Hancock, WV)	.9743
Stockton, CA (San Joaquin, CA)	1.1624
Syracuse, NY (Madison, NY, Onondaga, NY, Oswego, NY)	1.4527
Tacoma, WA (Pierce, WA)	1.0424
Tallahassee, FL (Gadsden, FL, Leon, FL)	.9251
Tampa-St. Petersburg-Clearwater, FL (Hernando, FL, Hillsborough, FL, Pasco, FL, Pinellas, FL)	.9963
Terre Haute, IN (Clay, IN, Vigo, IN)	.8809
Texarkana-TX-Texarkana, AR (Miller, AR, Bowie, TX)	1.1081
Toledo, OH (Fulton, OH, Lucas, OH, Wood, OH)	1.1307
Topeka, KS (Shawnee, KS)	1.1108
Trenton, NJ (Mercer, NJ)	1.0365
Tucson, AZ (Pima, AZ)	1.0141
Tulsa, OK (Creeks, OK, Osage, OK, Rogers, OK, Tulsa, OK, Wagoner, OK)	1.0386
Tuscaloosa, AL (Tuscaloosa, AL)	1.0166
Tyler, TX (Smith, TX)	1.0008
Utica-Rome, NY (Herkimer, NY, Oneida, NY)	.9332
Vallejo-Fairfield-Napa, CA (Napa, CA, Solano, CA)	1.3266
Vancouver, WA (Clark, WA)	1.0807
Victoria, TX (Victoria, TX)	.8616
Vineland-Millville-Bridgeton, NJ (Cumberland, NJ)	.9479
Visalia-Tulare-Porterville, CA (Tulare, CA)	1.1331
Waco, TX (McLennan, TX)	.8313
Washington, D.C.-MD-VA (District of Columbia, DC, Calvert, MD, Charles, MD, Frederick, MD, Montgomery, MD, Prince Georges, MD, Alexandria City, VA, Arlington, VA, Fairfax, VA, Fairfax City, VA, Falls Church City, VA, Loudoun, VA, Manassas City, VA, Manassas Park City, VA, Prince William, VA, Stafford, VA)	1.1577
Waterloo-Cedar Falls, IA (Black Hawk, IA, Bremer, IA)	.9081
Wausau, WI (Marathon, WI)	.9428
West Palm Beach-Boca Raton-Delray Beach, FL (Palm Beach, FL)	.9990
Wheeling, WV-OH (Belmont, OH, Marshall, WV, Ohio, WV)	.9811
Wichita, KS (Butler, KS, Sedgwick, KS)	1.1191
Wichita Falls, TX (Wichita, TX)	.8701

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Williamsport, PA (Lycoming, PA)	1.0242
Wilmington, DE-NJ-MD (New Castle, DE, Cecil, MD, Salem, NJ)	1.0871
Wilmington, NC (New Hanover, NC)	.8996
Worcester-Fitchburg-Leominster, MA (Worcester, MA)	.9750
Yakima, WA (Yakima, WA)	1.0018
York, PA (Adams, PA, York, PA)	1.0286
Youngstown-Warren, OH (Mahoning, OH, Trumbull, OH)	1.1017
Yuba City, CA (Sutter, CA, Yuba, CA)	1.0807

TABLE 4b.—WAGE INDEX FOR RURAL AREAS

Non-urban area	Wage index
Alabama	.7775
Alaska	1.4383
Arizona	.8931
Arkansas	.7794
California	1.0100
Colorado	.8317
Connecticut	.9953
Delaware	.8997
Florida	.8682
Georgia	.8481
Hawaii	1.1747
Idaho	.8984
Illinois	.8708
Indiana	.8708
Iowa	.8158
Kansas	.8118
Kentucky	.8146
Louisiana	.8322
Maine	.8648
Maryland	.9370
Massachusetts	.9690
Michigan	.9471
Minnesota	.8572
Mississippi	.8004
Missouri	.8280
Montana	.8694
Nebraska	.7411
Nevada	1.0157
New Hampshire	1.0297
New Jersey [1]	
New Mexico	.9149
New York	.8698
North Carolina	.8487
North Dakota	.8309
Ohio	.9126
Oklahoma	.8582
Oregon	.9543
Pennsylvania	1.0306
Rhode Island [1]	
South Carolina	.8071
South Dakota	.7857
Tennessee	.7860
Texas	.8104
Utah	.8211
Vermont	.8757
Virginia	.8502
Washington	.9477
West Virginia	.9163
Wisconsin	.8454
Wyoming	.9546

[1] All counties within the State are classified urban.

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

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.3199	19.4	41
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.2488	15.8	38
3	1	SURG	* CRANIOTOMY AGE <18	2.9183	12.7	35
4	1	SURG	SPINAL PROCEDURES	2.2219	16.0	38
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6606	9.8	31
6	1	SURG	CARPAL TUNNEL RELEASE	.3952	2.6	8
7	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE >69 +/OR C.C.	1.0172	5.3	27
8	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE <70 W/O C.C.	.7164	4.1	23
9	1	MED	SPINAL DISORDERS + INJURIES	1.3813	9.1	31
10	1	MED	NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR C.C.	1.2951	9.6	32
11	1	MED	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	1.2415	8.5	31
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.1020	9.4	31
13	1	MED	MULTIPLE SCLEROSIS + CEREBELLAR ATAXIA	1.0045	8.9	31
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3386	9.9	32
15	1	MED	TRANSIENT ISCHEMIC ATTACKS	.6604	5.6	24
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	.8503	7.4	29
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	.8305	7.2	29
18	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE >69 AND/OR C.C.	.7833	6.6	29
19	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	.6903	5.7	28
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.3004	7.6	30
21	1	MED	* VIRAL MENINGITIS	.6236	4.5	15
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	.7787	6.4	28
23	1	MED	NONTRAUMATIC STUPOR + COMA	1.1448	5.9	28
24	1	MED	SEIZURE + HEADACHE AGE >69 AND/OR C.C.	.7203	5.6	26
25	1	MED	SEIZURE + HEADACHE AGE 18-69 W/O C.C.	.6326	4.9	25
26	1	MED	* SEIZURE + HEADACHE AGE 0-17	.4304	3.3	13
27	1	MED	* TRAUMATIC STUPOR + COMA, COMA >1 HR	1.1250	4.1	26
28	1	MED	TRAUMATIC STUPOR + COMA, COMA <1 HR AGE >69 AND/OR C.C.	1.0590	5.9	28
29	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 18-69 W/O C.C.	.7100	3.8	25
30	1	MED	* TRAUMATIC STUPOR + COMA <1 HR AGE 0-17	.3539	2.0	8
31	1	MED	CONCUSSION AGE >69 AND/OR C.C.	.5988	4.6	27
32	1	MED	CONCUSSION AGE 18-69 W/O C.C.	.4472	3.3	19
33	1	MED	* CONCUSSION AGE 0-17	.2457	1.6	5
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE >69 AND/OR C.C.	.9824	7.1	29
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	.8372	6.2	28
36	2	SURG	RETINAL PROCEDURES	.7019	5.0	15
37	2	SURG	ORBITAL PROCEDURES	.5571	3.4	11
38	2	SURG	PRIMARY IRIS PROCEDURES	.4280	3.0	9
39	2	SURG	LENS PROCEDURES	.4958	2.8	6
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.3936	2.4	7
41	2	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3657	1.6	4
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS + LENS	.5845	3.8	12
43	2	MED	* HYPHEMA	.3788	4.2	12
44	2	MED	ACUTE MAJOR EYE INFECTIONS	.6233	6.5	22
45	2	MED	NEUROLOGICAL EYE DISORDERS	.5582	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.	.5902	4.1	23
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O C.C.	.5011	3.0	12
48	2	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.4018	2.9	13
49	3	SURG	MAJOR HEAD + NECK PROCEDURES	2.5007	13.6	36
50	3	SURG	SIALOADENECTOMY	.7086	4.6	14
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6632	4.2	15
52	3	SURG	* CLEFT LIP + PALATE REPAIR	.6421	3.8	11
53	3	SURG	SINUS + MASTOID PROCEDURES AGE >17	.5834	3.5	11
54	3	SURG	* SINUS + MASTOID PROCEDURES AGE 0-17	.6889	3.2	11
55	3	SURG	MISCELLANEOUS EAR, NOSE + THROAT PROCEDURES	.4110	2.5	7
56	3	SURG	RHINOPLASTY	.4101	2.8	8
57	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE >17	.5196	2.7	9
58	3	SURG	* T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE 0-17	.3097	1.5	3
59	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >17	.3114	2.0	4
60	3	SURG	* TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	.2616	1.5	3
61	3	SURG	* MYRINGOTOMY AGE >17	.4229	2.1	9
62	3	SURG	* MYRINGOTOMY AGE 0-17	.3089	1.3	3
63	3	SURG	OTHER EAR, NOSE + THROAT O.R. PROCEDURES	1.0975	5.8	28
64	3	MED	EAR, NOSE + THROAT MALIGNANCY	1.0700	5.7	28
65	3	MED	DYSEQUILIBRIUM	.4807	4.6	17
66	3	MED	EPISTAXIS	.4073	3.7	15
67	3	MED	* EPIGLOTTITIS	.6692	4.3	17
68	3	MED	OTITIS MEDIA + URI AGE >69 AND/OR C.C.	.6224	6.0	22
69	3	MED	OTITIS MEDIA + URI AGE 18-69 W/O C.C.	.5361	4.8	19
70	3	MED	* OTITIS MEDIA + URI AGE 0-17	.3659	3.1	10
71	3	MED	* LARYNGOTRACHEITIS	.3552	2.9	9
72	3	MED	NASAL TRAUMA + DEFORMITY	.4807	3.8	18
73	3	MED	OTHER EAR, NOSE + THROAT DIAGNOSES AGE >17	.5163	3.5	17
74	3	MED	* OTHER EAR, NOSE + THROAT DIAGNOSES AGE 0-17	.3427	2.1	9
75	4	SURG	MAJOR CHEST PROCEDURES	2.5773	14.4	36
76	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST WITH C.C.	1.8539	10.6	33
77	4	SURG	O.R. PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST W/O C.C.	1.7989	9.5	32
78	4	MED	PULMONARY EMBOLISM	1.3949	10.4	32
79	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE >69 AND/OR C.C.	1.7795	11.2	33
80	4	MED	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 18-69 W/O C.C.	1.7264	10.9	33
81	4	MED	* RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 0-17	.8652	6.1	28
82	4	MED	RESPIRATORY NEOPLASMS	1.1282	7.4	29
83	4	MED	MAJOR CHEST TRAUMA AGE >69 AND/OR C.C.	.9707	8.1	30
84	4	MED	* MAJOR CHEST TRAUMA AGE <70 W/O C.C.	.7658	5.3	22
85	4	MED	PLEURAL EFFUSION AGE >69 AND/OR C.C.	1.1342	8.4	30
86	4	MED	PLEURAL EFFUSION AGE <70 W/O C.C.	1.1100	7.6	30
87	4	MED	PULMONARY EDEMA + RESPIRATORY FAILURE	1.5368	7.7	30
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0304	7.5	30
89	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE >69 AND/OR C.C.	1.0914	8.5	31
90	4	MED	SIMPLE PNEUMONIA + PLEURISY AGE 18-69 W/O C.C.	.9747	7.6	29

* MEDPAR DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
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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

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
91	4	MED	* SIMPLE PNEUMONIA + PLEURISY AGE 0-17	.5078	4.6	14
92	4	MED	INTERSTITIAL LUNG DISEASE AGE >69 AND/OR C.C.	1.0262	7.8	30
93	4	MED	INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	.9623	6.9	29
94	4	MED	PNEUMOTHORAX AGE >69 AND/OR C.C.	1.4225	9.2	31
95	4	MED	PNEUMOTHORAX AGE <70 W/O C.C.	1.1135	7.7	30
96	4	MED	BRONCHITIS + ASTHMA AGE >69 AND/OR C.C.	.7913	6.9	24
97	4	MED	BRONCHITIS + ASTHMA AGE 18-69 W/O C.C.	.7181	6.2	21
98	4	MED	* BRONCHITIS + ASTHMA AGE 0-17	.4231	3.7	11
99	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.7952	5.5	27
100	4	MED	RESPIRATORY SIGNS + SYMPTOMS AGE <70 W/O C.C.	.7650	5.1	24
101	4	MED	OTHER RESPIRATORY DIAGNOSES AGE >69 AND/OR C.C.	.8941	6.8	29
102	4	MED	OTHER RESPIRATORY DIAGNOSES AGE <70	.8930	5.1	28
103	5	SURG	* HEART TRANSPLANT	.0000	.0	0
104	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + WITH CARDIAC CATH	6.7815	20.9	43
105	5	SURG	** CARDIAC VALVE PROCEDURE WITH PUMP + W/O CARDIAC CATH	5.1764	16.2	38
106	5	SURG	** CORONARY BYPASS WITH CARDIAC CATH	5.2077	20.4	42
107	5	SURG	** CORONARY BYPASS W/O CARDIAC CATH	3.9476	13.5	35
108	5	SURG	CARDIOTHOR PROC,EXCEPT VALVE + CORONARY BYPASS,WITH PUMP	4.3301	13.3	35
109	5	SURG	CARDIOTHORACIC PROCEDURES W/O PUMP	3.6579	12.1	34
110	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE >69 AND/OR C.C.	2.9023	14.3	36
111	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE <70 W/O C.C.	2.5582	13.2	35
112	5	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION	2.3256	11.2	33
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB + TOE	2.6522	21.6	44
114	5	SURG	UPPER LIMB + TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	2.0848	16.6	39
115	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT WITH AMI OR CHF	3.8743	15.8	38
116	5	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	2.8367	9.3	31
117	5	SURG	CARDIAC PACEMAKER REPLACE + REVIS EXC PULSE GEN REPL ONLY	1.8021	6.4	28
118	5	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	1.7624	4.2	18
119	5	SURG	VEIN LIGATION + STRIPPING	1.0500	7.2	29
120	5	SURG	OTHER O.R. PROCEDURES ON THE CIRCULATORY SYSTEM	2.4942	15.0	37
121	5	MED	** CIRCULATORY DISORDERS WITH AMI + C.V. COMP. DISCH. ALIVE	1.8454	11.9	34
122	5	MED	** CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.3509	9.8	32
123	5	MED	CIRCULATORY DISORDERS WITH AMI, EXPIRED	1.1242	3.1	25
124	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH + COMPLEX DIAG	2.1969	8.4	30
125	5	MED	CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG	1.6284	5.0	27
126	5	MED	ACUTE + SUBACUTE ENDOCARDITIS	2.6368	18.4	40
127	5	MED	HEART FAILURE + SHOCK	1.0300	7.8	30
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	.8549	9.6	28
129	5	MED	CARDIAC ARREST, UNEXPLAINED	1.5345	4.6	27
130	5	MED	PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR C.C.	.9545	7.1	29
131	5	MED	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	.9392	6.4	28
132	5	MED	ATHEROSCLEROSIS AGE >69 AND/OR C.C.	.9087	6.7	29
133	5	MED	ATHEROSCLEROSIS AGE <70 W/O C.C.	.8510	5.2	25
134	5	MED	HYPERTENSION	.6976	6.1	26
135	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE >69 AND/OR C.C.	.9819	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

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
136	5	MED	CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 18-69 W/O C.C.	.9573	4.9	27
137	5	MED	* CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 0-17	.6315	3.3	20
138	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE >69 AND/OR C.C.	.9200	5.7	27
139	5	MED	CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE <70 W/O C.C.	.8217	4.8	23
140	5	MED	ANGINA PECTORIS	.7470	5.5	21
141	5	MED	SYNCOPE + COLLAPSE AGE >69 AND/OR C.C.	.6408	5.0	21
142	5	MED	SYNCOPE + COLLAPSE AGE <70 W/O C.C.	.5621	4.3	18
143	5	MED	CHEST PAIN	.6743	4.4	19
144	5	MED	OTHER CIRCULATORY DIAGNOSES WITH C.C.	1.1150	7.0	29
145	5	MED	OTHER CIRCULATORY DIAGNOSES W/O C.C.	.9916	6.4	28
146	6	SURG	RECTAL RESECTION AGE >69 AND/OR C.C.	2.6801	19.1	41
147	6	SURG	RECTAL RESECTION AGE <70 W/O C.C.	2.4826	17.9	40
148	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	2.5228	17.0	39
149	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.1924	15.2	37
150	6	SURG	PERITONEAL ADHESIOLYSIS AGE >69 AND/OR C.C.	2.3499	15.3	37
151	6	SURG	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	2.0063	13.4	35
152	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	1.4697	10.6	33
153	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.2468	9.3	31
154	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE >69 AND/OR C.C.	2.6621	14.8	37
155	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 18-69 W/O C.C.	2.3094	13.0	35
156	6	SURG	* STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 0-17	.8382	6.0	20
157	6	SURG	ANAL PROCEDURES AGE >69 AND/OR C.C.	.7902	6.0	25
158	6	SURG	ANAL PROCEDURES AGE <70 W/O C.C.	.6341	5.2	19
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE >69 AND/OR C.C.	.9200	7.1	23
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE 18-69 W/O C.C.	.7596	6.0	18
161	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE >69 AND/OR C.C.	.6995	5.7	16
162	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	.5793	4.8	12
163	6	SURG	* HERNIA PROCEDURES AGE 0-17	.4313	2.1	6
164	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR C.C.	1.8130	11.9	33
165	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.5986	11.3	29
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR C.C.	1.4179	9.4	29
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.0706	7.4	22
168	6	SURG	PROCEDURES ON THE MOUTH AGE >69 AND/OR C.C.	.8541	4.3	25
169	6	SURG	PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	.8899	4.2	26
170	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE >69 AND/OR C.C.	2.6326	14.6	37
171	6	SURG	OTHER DIGESTIVE SYSTEM PROCEDURES AGE <70 W/O C.C.	2.3727	13.3	35
172	6	MED	DIGESTIVE MALIGNANCY AGE >69 AND/OR C.C.	1.2141	8.2	30
173	6	MED	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	1.0408	6.7	29
174	6	MED	G.I. HEMORRHAGE AGE >69 AND/OR C.C.	.9185	6.7	29
175	6	MED	G.I. HEMORRHAGE AGE <70 W/O C.C.	.8150	5.8	24
176	6	MED	COMPLICATED PEPTIC ULCER	1.2309	8.1	30
177	6	MED	UNCOMPLICATED PEPTIC ULCER >69 AND/OR C.C.	.7345	6.6	24
178	6	MED	UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	.6077	5.5	20
179	6	MED	INFLAMMATORY BOWEL DISEASE	1.0048	8.0	30
180	6	MED	G.I. OBSTRUCTION AGE >69 AND/OR C.C.	.8112	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.	.7763	5.9	28
182	6	MED	ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE >69 +/OR C.C.	.6121	5.4	22
183	6	MED	ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE 18-69 W/O C.C.	.5593	4.8	19
184	6	MED	* ESOPHAGITIS, GASTROENTERITIS + MISC. DIGEST. DISORDERS AGE 0-17	.3782	3.3	11
185	6	MED	DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE >17	.6612	4.2	26
186	6	MED	* DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE 0-17	.4112	2.9	11
187	6	MED	DENTAL EXTRACTIONS + RESTORATIONS	.3949	2.7	8
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR C.C.	.7367	5.1	27
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	.6508	4.5	23
190	6	MED	* OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.3344	2.1	8
191	7	SURG	MAJOR PANCREAS, LIVER + SHUNT PROCEDURES	4.1357	20.8	43
192	7	SURG	* MINOR PANCREAS, LIVER + SHUNT PROCEDURES	3.8790	20.1	42
193	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 +/OR C.C.	2.4258	17.3	39
194	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	1.9674	13.9	36
195	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR C.C.	2.1465	16.0	38
196	7	SURG	** TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	2.0380	15.8	38
197	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR C.C.	1.4714	11.5	29
198	7	SURG	** TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.2619	10.1	24
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.4319	17.9	40
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.5550	15.1	37
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7007	16.9	39
202	7	MED	CIRRHOSIS + ALCOHOLIC HEPATITIS	1.1841	9.3	31
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0823	8.0	30
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	.9581	7.5	30
205	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR C.C.	1.0710	7.9	30
206	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C.	.9151	6.8	29
207	7	MED	DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR C.C.	.8404	6.6	28
208	7	MED	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	.7239	5.5	24
209	8	SURG	MAJOR JOINT PROCEDURES	2.2674	17.1	39
210	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR C.C.	2.0617	17.8	40
211	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.9327	15.9	38
212	8	SURG	* HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.6954	11.1	33
213	8	SURG	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM + CONN. TISSUE DISORDERS	2.1094	14.3	36
214	8	SURG	BACK + NECK PROCEDURES AGE >69 AND/OR C.C.	1.8236	15.6	38
215	8	SURG	BACK + NECK PROCEDURES AGE <70 W/O C.C.	1.4765	13.0	35
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.5434	11.3	33
217	8	SURG	WND DEBRID + SKN GRFT EXC HAND,FOR MUSCSKELETAL + CONN.TISS.DIS	2.2587	13.1	35
218	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 +/OR C.C.	1.4102	10.9	33
219	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C.	1.0678	8.3	27
220	8	SURG	* LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	.9242	5.3	25
221	8	SURG	KNEE PROCEDURES AGE >69 AND/OR C.C.	1.2595	8.3	30
222	8	SURG	KNEE PROCEDURES AGE <70 W/O C.C.	.9794	6.4	28
223	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE >69 AND/OR C.C.	1.0612	6.9	29
224	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE <70 W/O C.C.	.8859	5.6	24
225	8	SURG	FOOT PROCEDURES	.6409	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.	.7901	5.1	27
227	8	SURG	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	.6271	4.2	18
228	8	SURG	GANGLION (HAND) PROCEDURES	.3588	2.2	7
229	8	SURG	HAND PROCEDURES EXCEPT GANGLION	.5936	3.4	14
230	8	SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES OF HIP + FEMUR	1.3453	8.9	31
231	8	SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES EXCEPT HIP + FEMUR	.9420	5.3	27
232	8	SURG	ARTHROSCOPY	.6000	3.6	15
233	8	SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE >69 +/OR C.C.	1.7553	13.1	35
234	8	SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE <70 W/O C.C.	1.2325	8.2	30
235	8	MED	FRACTURES OF FEMUR	1.7403	13.6	36
236	8	MED	FRACTURES OF HIP + PELVIS	1.3711	11.9	34
237	8	MED	SPRAINS, STRAINS, + DISLOCATIONS OF HIP, PELVIS + THIGH	.7847	6.4	28
238	8	MED	OSTEOMYELITIS	1.5350	12.3	34
239	8	MED	PATHOLOGICAL FRACTURES + MUSCULOSKELETAL + CONN.TISS.MALIGNANCY	1.0865	9.2	31
240	8	MED	CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR C.C.	.9608	8.6	31
241	8	MED	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	.8954	8.0	30
242	8	MED	SEPTIC ARTHRITIS	1.5715	11.2	33
243	8	MED	MEDICAL BACK PROBLEMS	.7473	7.5	30
244	8	MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE >69 AND/OR C.C.	.7711	7.5	30
245	8	MED	BONE DISEASES + SEPTIC ARTHROPATHY AGE <70 W/O C.C.	.7102	6.3	28
246	8	MED	NON-SPECIFIC ARTHROPATHIES	.7073	6.8	28
247	8	MED	SIGNS + SYMPTOMS OF MUSCULOSKELETAL SYSTEM + CONN TISSUE	.6491	5.8	27
248	8	MED	TENDONITIS, MYOSITIS + BURSITIS	.6072	5.4	24
249	8	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.0097	7.6	30
250	8	MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE >69 +/OR C.C.	.7351	6.0	28
251	8	MED	FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C.	.5902	4.2	26
252	8	MED	* FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 0-17	.3496	1.8	7
253	8	MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE >69 +/OR C.C.	.7388	6.6	29
254	8	MED	FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C.	.6193	5.3	27
255	8	MED	* FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4638	2.9	15
256	8	MED	OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	.8616	6.5	29
257	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.0970	9.3	23
258	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	1.0618	8.9	21
259	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.0036	7.4	29
260	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70	.9228	6.4	27
261	9	SURG	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY + LOC EXC	.7253	4.8	19
262	9	SURG	BREAST BIOPSY + LOCAL EXCISION FOR NON-MALIGNANCY	.4569	3.0	10
263	9	SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE >69 AND/OR C.C.	2.4480	21.3	43
264	9	SURG	SKIN GRAFTS FOR SKIN ULCER OR CELLULITIS AGE <70 W/O C.C.	2.1802	18.2	40
265	9	SURG	* SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS WITH C.C.	1.4804	8.6	31
266	9	SURG	SKIN GRAFTS EXCEPT FOR SKIN ULCER OR CELLULITIS W/O C.C.	.9386	5.9	28
267	9	SURG	PERIANAL + PILONIDAL PROCEDURES	.6049	5.0	18
268	9	SURG	SKIN,SUBCUTANEOUS TISSUE + BREAST PLASTIC PROCEDURES	.5332	3.0	15
269	9	SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE >69 +/OR C.C.	.9844	5.7	28
270	9	SURG	OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE <70 W/O C.C.	.8039	4.5	27

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DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
271	9	MED	SKIN ULCERS	1.3659	12.1	34
272	9	MED	MAJOR SKIN DISORDERS AGE >69 AND/OR C.C.	.8530	7.8	30
273	9	MED	MAJOR SKIN DISORDERS AGE <70 W/O C.C.	.8200	7.3	29
274	9	MED	MALIGNANT BREAST DISORDERS AGE >69 AND/OR C.C.	1.0003	7.5	30
275	9	MED	MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	.8920	6.4	28
276	9	MED	NON-MALIGANT BREAST DISORDERS	.6003	4.2	22
277	9	MED	CELLULITIS AGE >69 AND/OR C.C.	.8771	8.3	30
278	9	MED	CELLULITIS AGE 18-69 W/O C.C.	.8012	7.2	29
279	9	MED	* CELLULITIS AGE 0-17	.4739	4.2	13
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE >69 +/OR C.C.	.6137	5.4	27
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 18-69 W/O C.C.	.5321	4.2	23
282	9	MED	* TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 0-17	.3424	2.2	9
283	9	MED	MINOR SKIN DISORDERS AGE >69 AND/OR C.C.	.6328	5.3	27
284	9	MED	MINOR SKIN DISORDERS AGE <70 W/O C.C.	.5909	4.4	24
285	10	SURG	AMPUTATIONS FOR ENDOCRINE,NUTRITIONAL + METABOLIC DISORDERS	2.8360	24.0	46
286	10	SURG	* ADRENAL + PITUITARY PROCEDURES	2.8651	16.1	38
287	10	SURG	SKIN GRAFTS + WOUND DEBRIDE FOR ENDOC,NUTRIT + METAB DISORDERS	2.7851	22.8	45
288	10	SURG	* O.R. PROCEDURES FOR OBESITY	1.5532	10.0	24
289	10	SURG	PARATHYROID PROCEDURES	1.3593	8.3	29
290	10	SURG	THYROID PROCEDURES	.8460	6.0	17
291	10	SURG	* THYROGLOSSAL PROCEDURES	.4858	2.9	8
292	10	SURG	OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE > 69 +/OR C.C.	2.0096	10.8	33
293	10	SURG	* OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE <70 W/O C.C.	1.4796	8.0	30
294	10	MED	DIABETES AGE =>36	.8003	7.7	30
295	10	MED	DIABETES AGE 0-35	.7380	5.6	26
296	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE >69 AND/OR C.C.	.8886	7.3	29
297	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	.7841	6.0	28
298	10	MED	* NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 0-17	.7460	5.4	26
299	10	MED	INBORN ERRORS OF METABOLISM	.9309	6.8	29
300	10	MED	ENDOCRINE DISORDERS AGE >69 AND/OR C.C.	.9630	7.8	30
301	10	MED	ENDOCRINE DISORDERS AGE <70 W/O C.C.	.8058	6.4	28
302	11	SURG	KIDNEY TRANSPLANT	4.1840	24.1	46
303	11	SURG	KIDNEY,URETER + MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.5133	16.2	38
304	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE >69 +/OR C.C.	1.7765	12.8	35
305	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-MALIG AGE <70 W/O C.C.	1.6866	11.9	34
306	11	SURG	PROSTATECTOMY AGE >69 AND/OR C.C.	1.1281	8.6	30
307	11	SURG	PROSTATECTOMY AGE <70 W/O C.C.	.9414	7.2	26
308	11	SURG	MINOR BLADDER PROCEDURES AGE >69 AND/OR C.C.	1.0333	7.1	29
309	11	SURG	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	.9193	5.7	28
310	11	SURG	TRANSURETHRAL PROCEDURES AGE >69 AND/OR C.C.	.6998	4.9	20
311	11	SURG	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	.5810	4.1	15
312	11	SURG	URETHRAL PROCEDURES, AGE >69 AND/OR C.C.	.7347	5.2	22
313	11	SURG	URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	.6825	5.1	21
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4323	2.3	11
315	11	SURG	OTHER KIDNEY + URINARY TRACT O.R. PROCEDURES	2.4625	9.8	32

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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

DRG	MDC		TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED	RENAL FAILURE	1.3176	6.7	29
317	11	MED	* ADMIT FOR RENAL DIALYSIS	.2360	1.2	3
318	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE >69 AND/OR C.C.	.9047	5.5	28
319	11	MED	KIDNEY + URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	.7859	4.2	26
320	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE >69 AND/OR C.C.	.8039	7.0	29
321	11	MED	KIDNEY + URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	.6732	5.6	23
322	11	MED	* KIDNEY + URINARY TRACT INFECTIONS AGE 0-17	.4506	3.7	13
323	11	MED	URINARY STONES AGE >69 AND/OR C.C.	.7057	4.9	26
324	11	MED	URINARY STONES AGE <70 W/O C.C.	.5415	3.9	19
325	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.7172	5.4	27
326	11	MED	KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 18-69 W/O C.C.	.5814	4.3	21
327	11	MED	* KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 0-17	.4975	3.1	14
328	11	MED	URETHRAL STRICTURE AGE >69 AND/OR C.C.	.6440	4.8	22
329	11	MED	URETHRAL STRICTURE AGE 18-69 W/O C.C.	.5271	3.9	17
330	11	MED	* URETHRAL STRICTURE AGE 0-17	.2788	1.6	5
331	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE >69 AND/OR C.C.	.8826	6.3	28
332	11	MED	OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	.7682	5.0	27
333	11	MED	* OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 0-17	.5093	3.2	18
334	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH C.C.	1.5450	12.7	30
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.3449	11.8	29
336	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR C.C.	.9974	8.4	22
337	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	.8403	7.2	17
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.8975	6.3	28
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANT AGE >17	.6030	4.5	15
340	12	SURG	* TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	.4335	2.4	7
341	12	SURG	PENIS PROCEDURES	.9879	6.0	23
342	12	SURG	CIRCUMCISION AGE >17	.4184	2.8	10
343	12	SURG	* CIRCUMCISION AGE 0-17	.3788	1.7	4
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1088	7.4	29
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	.8247	5.6	27
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR C.C.	.9297	6.9	29
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O C.C.	.8218	5.7	28
348	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR C.C.	.8772	6.2	28
349	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	.6925	4.9	22
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6033	5.2	20
351	12	MED	* STERILIZATION, MALE	.2627	1.3	3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6319	4.4	20
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY + VULVECTOMY	1.9175	12.4	34
354	13	SURG	NON-RADICAL HYSTERECTOMY AGE >69 AND/OR C.C.	1.0993	9.6	20
355	13	SURG	NON-RADICAL HYSTERECTOMY AGE <70 W/O C.C.	1.0050	8.8	17
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.8372	8.1	18
357	13	SURG	UTERUS + ADENEXA PROCEDURES, FOR MALIGNANCY	1.8989	13.9	36
358	13	SURG	UTERUS + ADENEXA PROC FOR NON-MALIGNANCY EXCEPT TUBAL INTERRUPT	1.0777	8.0	30
359	13	SURG	* TUBAL INTERRUPTION FOR NON-MALIGNANCY	.4235	2.3	7
360	13	SURG	VAGINA, CERVIX + VULVA PROCEDURES	.5923	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	.4813	2.6	10
362	13	SURG	* LAPAROSCOPIC TUBAL INTERRUPTION	.3094	1.4	3
363	13	SURG	D+C,CONIZATION + RADIO-IMPLANT, FOR MALIGNANCY	.6448	4.3	18
364	13	SURG	D+C,CONIZATION EXCEPT FOR MALIGNANCY	.3986	2.6	9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7778	12.7	35
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR C.C.	.8356	5.2	27
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	.5726	3.5	24
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.7861	6.7	29
369	13	MED	MENSTRUAL + OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.6887	5.1	27
370	14	SURG	* CESAREAN SECTION WITH C.C.	.9809	7.6	15
371	14	SURG	* CESAREAN SECTION W/O C.C.	.7457	6.1	10
372	14	MED	* VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	.5476	3.8	9
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4021	3.2	9
374	14	SURG	* VAGINAL DELIVERY WITH STERILIZATION AND/OR D+C	.5435	3.6	7
375	14	SURG	* VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D+C	.6817	4.4	15
376	14	MED	* POSTPARTUM DIAGNOSES W/O O.R. PROCEDURE	.4115	2.9	10
377	14	SURG	* POSTPARTUM DIAGNOSES WITH O.R. PROCEDURE	.4712	2.2	8
378	14	MED	* ECTOPIC PREGNANCY	.8010	5.5	11
379	14	MED	* THREATENED ABORTION	.3136	2.2	8
380	14	MED	* ABORTION W/O D+C	.2677	1.5	4
381	14	MED	* ABORTION WITH D+C	.3565	1.4	4
382	14	MED	* FALSE LABOR	.1823	1.2	2
383	14	MED	* OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	.4272	3.4	14
384	14	MED	* OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3211	2.2	9
385	15		* NEONATES, DIED OR TRANSFERRED	.6811	1.8	14
386	15		* EXTREME IMMATURITY, NEONATE	3.6480	17.9	40
387	15		** PREMATURITY WITH MAJOR PROBLEMS	1.8267	13.3	35
388	15		** PREMATURITY W/O MAJOR PROBLEMS	1.1571	8.6	31
389	15		* FULL TERM NEONATE WITH MAJOR PROBLEMS	.5425	4.7	16
390	15		* NEONATES WITH OTHER SIGNIFICANT PROBLEMS	.3486	3.4	9
391	15		* NORMAL NEWBORNS	.2218	3.1	7
392	16	SURG	SPLENECTOMY AGE >17	2.7458	16.4	38
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5206	9.1	31
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD + BLOOD FORMING ORGANS	1.1030	6.1	28
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7758	6.1	28
396	16	MED	* RED BLOOD CELL DISORDERS AGE 0-17	.6230	4.1	18
397	16	MED	COAGULATION DISORDERS	.9761	6.7	29
398	16	MED	RETICULOENDOTHELIAL + IMMUNITY DISORDERS AGE >69 AND/OR C.C.	.8808	6.1	28
399	16	MED	RETICULOENDOTHELIAL + IMMUNITY DISORDERS AGE <70 W/O C.C.	.8371	5.6	28
400	17	SURG	LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	2.7978	16.9	39
401	17	SURG	LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROC AGE >69 AND/OR C.C.	1.2280	8.9	31
402	17	SURG	* LYMPHOMA OR LEUKEMIA WITH MINOR O.R. PROCEDURE AGE <70 W/O C.C.	1.1198	7.1	29
403	17	MED	LYMPHOMA OR LEUKEMIA AGE >69 AND/OR C.C.	1.1593	7.1	29
404	17	MED	LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C.	1.1665	6.4	28
405	17	MED	* LYMPHOMA OR LEUKEMIA AGE 0-17	1.0408	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.	2.2435	15.0	37
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	2.1144	13.3	35
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH MINOR O.R.PROC	1.1271	7.1	29
409	17	MED	* RADIOTHERAPY	.8049	5.7	28
410	17	MED	CHEMOTHERAPY	.3490	2.6	12
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.7146	4.7	27
412	17	MED	HISTORY OF MALIGNANCY WITH ENDOSCOPY	.3365	2.0	8
413	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE>69 +/OR C.C	1.0861	7.3	29
414	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O C.C.	1.0251	6.4	28
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS + PARASITIC DISEASES	2.9715	15.1	37
416	18	MED	SEPTECEMIA AGE >17	1.5343	9.2	31
417	18	MED	* SEPTECEMIA AGE 0-17	.7078	5.2	20
418	18	MED	POSTOPERATIVE + POST-TRAUMATIC INFECTIONS	.9864	8.4	30
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR C.C.	.8538	6.9	29
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	.7939	6.2	26
421	18	MED	VIRAL ILLNESS AGE >17	.5982	5.4	21
422	18	MED	* VIRAL ILLNESS + FEVER OF UNKNOWN ORIGIN AGE 0-17	.4315	3.2	10
423	18	MED	OTHER INFECTIOUS + PARASITIC DISEASES DIAGNOSES	1.1981	8.8	31
424	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	2.1710	14.2	36
425	19	MED	ACUTE ADJUST REACT + DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6741	5.8	28
426	19	MED	DEPRESSIVE NEUROSES	.9396	9.4	31
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.7598	6.9	29
428	19	MED	DISORDERS OF PERSONALITY + IMPULSE CONTROL	.9640	8.3	30
429	19	MED	ORGANIC DISTURBANCES + MENTAL RETARDATION	.9424	8.8	31
430	19	MED	PSYCHOSES	1.0820	10.8	33
431	19	MED	* CHILDHOOD MENTAL DISORDERS	2.2285	15.4	37
432	19	MED	* OTHER DIAGNOSES OF MENTAL DISORDERS	1.0416	7.2	29
433	20		** SUBSTANCE USE + SUBST INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	.4411	2.5	17
434	20		** DRUG DEPENDENCE	1.0296	9.1	31
435	20		** DRUG USE EXCEPT DEPENDENCE	1.0626	8.0	30
436	20		** ALCOHOL DEPENDENCE	.8761	8.1	30
437	20		** ALCOHOL USE EXCEPT DEPENDENCE	.6119	3.5	26
438	20		** ALCOHOL + SUBSTANCE INDUCED ORGANIC MENTAL SYNDROME	.8333	6.9	29
439	21	SURG	* SKIN GRAFTS FOR INJURIES	1.8030	8.9	31
440	21	SURG	* WOUND DEBRIDEMENTS FOR INJURIES	1.4653	7.2	29
441	21	SURG	* HAND PROCEDURES FOR INJURIES	.7105	3.0	16
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR C.C.	1.8828	9.1	31
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.5053	6.6	29
444	21	MED	MULTIPLE TRAUMA AGE >69 AND/OR C.C.	.8738	6.7	29
445	21	MED	MULTIPLE TRAUMA AGE 18-69 W/O C.C.	.7452	5.2	27
446	21	MED	* MULTIPLE TRAUMA AGE 0-17	.4796	2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4735	3.7	19
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3469	2.9	9
449	21	MED	TOXIC EFFECTS OF DRUGS AGE >69 AND/OR C.C.	.7255	5.6	28
450	21	MED	TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	.5895	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	.2882	2.1	8
452	21	MED	COMPLICATIONS OF TREATMENT AGE >69 AND/OR C.C.	.8404	5.5	28
453	21	MED	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	.8926	5.1	27
454	21	MED	OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE >69 AND/OR C.C.	.8139	5.3	27
455	21	MED	* OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE <70 W/O C.C.	.6121	3.5	22
456	22		** BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	2.0685	11.6	34
457	22		** EXTENSIVE BURNS	6.7918	12.6	35
458	22	SURG	** NON-EXTENSIVE BURNS WITH SKIN GRAFTS	2.8275	18.3	40
459	22	SURG	** NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT + OTHER O.R. PROC	2.7282	12.7	35
460	22	MED	** NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.4077	9.0	31
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.6335	8.0	30
462	23	MED	* REHABILITATION	1.8078	13.5	36
463	23	MED	SIGNS + SYMPTOMS WITH C.C.	.7622	6.3	28
464	23	MED	SIGNS + SYMPTOMS W/O C.C.	.7246	6.0	28
465	23	MED	** AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	.2049	1.5	4
466	23	MED	** AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	.6311	3.7	26
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.9697	6.1	28
468			UNRELATED OR PROCEDURE	2.0818	11.2	33
469			***PDX INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	0
470			***UNGROUPABLE	.0000	.0	0

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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 1984 and 1985, 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 1984 and 1985. 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. The costs of anesthetists services are also excluded for hospital cost reporting periods beginning in FY 1985.

For payments in FY 1985, we must take into consideration two situations that did not affect the determination of budget neutrality adjustments for payments in FY 1984. 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 1985 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 1985 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 1985. The first such factor will be applied in computing Federal regional rates for FY 1985. The second budget neutrality adjustment factor will be applied in computing Federal national rates for FY 1985. 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 1985.

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 or decrease 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 change in admissions beyond the level that would have occurred under prior law, we are making no adjustment for admission levels.

B. Assumptions 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 1984, and at 110 percent of the mean for cost reporting periods beginning in FY 1985. Further, although a hosptial that had allowable costs in excess of its rate of increase target amount could expect to be paid for 24 percent of those costs for a cost reporting period beginning in FY 1983 or 1984, it would be paid no more than its target amount per case for its cost reporting period beginning in FY 1985.

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 reimbusement 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 period 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 1985, most hospitals will have two separate hosptial-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 1985, not at the beginning of hospital cost-reporting periods, and is therefore constant throughout FY 1985.)

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 1985 (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 1985). 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. Further, for hospital cost reporting periods beginning in FY 1985, the costs of services of nonphysician anesthetists must be included in nonoperating costs under both Federal rate systems. 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) + anesthetists costs = TEFRA operating costs + Malpractice costs

Federal national rate × budget neutral factor + (kidney acquisition costs + capital costs + direct medical education costs + anesthetists 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 1983 limits, except that more recently available data (that is, 1981 cost report and billing data) are used, and the FY 1984 and 1985 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 1985, we would have discontinued payment of 25 percent of the excess costs over a hospital's target amount. The FY 1984 limits are computed using the same cost per discharge assumptions and market basket increase published on January 3, 1984. Since the FY 1984 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 regulations 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; 43 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 FYs 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 1984 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 1985, the factor was computed by adding the estimated 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 1984 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 1985 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 standarized 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 computed using each hospital's historical experience in the MEDPAR file. 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 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;
- Payment to hospitals located in MSAs that cross census division (regional) boundaries based on the regional rate of the region in which most of the hospitals in the affected MSA are located;
- Payment to hospitals reclassified from urban to rural by the EOMB MSA redesignation;
- The projected increased number of rural referral centers expected to meet the new criteria; and
- Increased nonoperating costs as result of paying for nonphysician anesthetist services on a cost basis.

To adjust for the latest case-mix data, we increased the estimated regional and national payment rates by 4.47 percent, which is the compounded combination of the 3.38 and 1.05 percent increases ($1.0338 \times 1.0105 = 1.0447$). The derivation of this factor is discussed earlier in this Addendum. Since the relative weight for each DRG was reduced by 1.05 percent, as described earlier in this Addendum, this 4.47 percent adjustment is actually

split between the 1.05 percent adjustment in the DRG relative weights, and the 3.38 percent case mix increase factor we developed for the FY 1984 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 change in payments to hospitals whose regional rates changed as a result of reclassification. 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 1985 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, we would pay, for cost reporting periods beginning in FY 1984, two-thirds of the difference between the applicable Federal urban and rural rates, and for cost reporting periods beginning in FY 1985, one-third of the difference between the applicable Federal urban and rural rates.

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 admissions and case-mix index values meeting the national and regional criteria for rural referral centers with less than 500 beds. For these hospitals, we substituted urban for rural adjusted average standardized amounts.

Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these costs will be paid for only once, we must remove them from prospective payments. For purposes of determining budget neutrality, we must include these costs in the nonoperating costs under both Federal rate systems.

To estimate the increase in nonoperating costs, we made use of data provided to us by the American Association of Nurse Anesthetists. From the data provided, we determined that there are about 20,000 nurse anesthetists, about one-half of whom are employed by hospitals for inpatient care. Their average 1982 salary was $36,775 in the direct patient care category. Twenty percent must be added for fringe benefits. We used these data and inflated them to FY 1985 using the labor component of the hospital input price index (market basket) to estimate an average FY 1985 total compensation level of $53,554. The average compensation level times one half of the of the 20,000 nurse anesthetists times the 40 percent Medicare share of inpatient days yields an estimated 1985 full year cost to Medicare of about $214 million. $214 million divided by the estimated FY 1985 Medicare operating costs for all hospitals (including hospitals not paid under the prospective payment system) yields the 0.5 percent adjustment factor. We applied the 0.5 percent factor the estimated costs for each hospital and added it to the nonoperating costs for each hospital.

For purposes of this methodology, we did not directly reduce the estimated operating reimbursements for FY 1985 under either Federal rate system because any required adjustment will be part of the budget neutrality factors to be applied to the national and regional standardized amounts.

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, thus indirectly increasing the national and regional adjusted standardized amounts for FYs 1984 and 1985. 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 10B 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 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.

We increased the nonoperating costs for each hospital by 0.5 percent of estimated operating costs in order to reflect the payment for costs of nonphysician anesthetists services on a cost basis. Since, to implement section 2312 of Pub. L. 98-369, each hospital's hospital-specific portion will be recomputed to carve out the costs of nonphysician anesthetists, we reduced the estimated hospital-specific rate for each hospital by the same amount that we added to the nonoperating costs.

For hospital cost reporting periods beginning in FY 1984, 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 in the January 3, 1984 final rule. For hospital cost reporting periods beginning in FY 1985, we increased each hospital's estimated hospital-specific rate by the most recently available market basket index values plus one-quarter of one percentage point. We then increased the resulting amount for each hospital by 4.47 percent to account for increases in reported case mix, divided by 1.0105 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 wavier States is not changed by the provisions of the prospective payment system.

The outlier criteria were calibrated 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 1985. 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 operatiang reimbursement per discharge (Federal blend weighted)	$1,362.86
TEFRA nonoperating cost per discharge (Federal blend weighted)	153.76
Weighted Federal regional rate standard payment per discharge	1,442.53
Weighted Federal nonoperating cost per discharge	145.56

Solve:
$1,442.53 × FRBN + $145.56=$1,362.86+153.76
FRBN=($1,362.86 + $153.76−$145.56) divided by $1,442.53=.950

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 disharge × 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)

Estimated values:	
TEFRA operating reimbursement per discharge	$1,362.86
TEFRA nonoperating cost per discharge	153.76
Federal national rate standard payment per discharge	1,436.73
Federal nonoperating cost per discharge	145.56

Solve:
$1,436.73 × FNBN + $145.56=$1,362.86+153.76
FNBN=($1,362.86 + $153.76−$145.56) divided by $1,436.73=.954

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 FY 1985. We cannot readjust a hospital's hospital-specific rate for its first cost reporting period under prospective payment (the period beginning in FY 1984). The first year hospital-specific rates have been calculated using an updating factor that is already adjusted for FY 1984 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 1984 and 1985 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 1985.

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

(HSP payment per discharge for cost reporting periods starting in FY 1985 × Fraction of discharges in FY 1985 for cost reporting periods starting in FY 1985 × 0.50 blending factor × hospital-specific budget neutrality adjustment factor (HSBN)) + (HSP payment per discharge for cost reporting periods starting in FY 1984 adjusted for FY 1984 budget neutrality adjustment factor × Fraction of discharges occurring in FY 1985 for cost reporting periods starting in FY 1984 × 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 1984 HSBN on discharges occurring in FY 1985 for cost reporting periods starting in FY 1984. The effect of the FY 1984 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 1985. This is done by dividing the result of the calculation described above by the FY 1984 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)	$2,112.45
TEFRA nonoperating cost per discharge (HSP blend weighted)	238.97
HSP payment per discharge for cost reporting periods beginning in FY 1985 × fraction of FY 1985 discharges × 0.50 blending factor	1,021.41
HSP payment per discharge for cost reporting periods × fraction of FY 1985 discharges beginning in FY 1984 × 0.75 blending factor × FY 1984 HSBN of 0.983	1,131.23
Weighted HSP nonoperating cost per discharge	223.45

Solve:
($1,021.41 × HSBN) + $1,131.23 + $223.45 = $2,112.45 + $238.97
HSBN = ($2,112.45 + $238.97 − $1,131.23 − $223.45) divided by $1,021.41 = .976
Then, to remove the effect of the FY 1984 HSBN: .976 divided by .983 = .993

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

[In percent]

Calendar year	Cost per admission	Hospital input price index
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	0.954	0.950	0.993

J. Summary of Changes from Proposed Methodology

As noted elsewhere, this final budget neutrality adjustment methodology incorporates some changes from the methodology as proposed on July 3, 1984. These changes are as follows:

- We incorporated an adjustment to reflect the cost-based reimbursement for non physician anesthetists.
- We modified the modeling of rural referral centers, hospitals redesignated from urban to rural, and MSAs that cross census divisions to be consistent with the provisions of this final rule.
- We reduced the updating of the hospital-specific rates and the Federal rates to market basket plus one quarter percent as specified by section 2310 of Pub. L. 98–364. Since that law did not amend section 1886(e)(1) of the Act, we continued to update the estimated TFRA limits and target amounts by the market basket rate plus one percentage point, in accordance with the law as in effect on April, 20, 1983. Since because of budget neutrality, the actual payment amounts are set by our estimated payments under TEFRA, this provision of Pub. L. 98–369 does not change the FY 1985 payment amounts under the prospective payment system.
- We decreased, from 2.4 percent to 1.05 percent, the factor (to be applied to the DRG weights) to take unanticipated increases in average case mix into account. We also applied this reduced case-mix increase factor to estimated Federal and hospital-specific payments.

K. Responses to Comments on the Proposed Methodology

We received a number of comments on the budget neutrality adjustment methodology as published in the addendum to the July 3, 1984 proposed rule. A summary of those comments and our responses to them follow. (See section II. C. of this Addendum for comments and responses on the reduction of the DRG weights to take into account the increase in average case mix.)

Comment—A number of commenters suggested that we should make adjustments to take the increase in average case mix into account only through the budget neutrality methodology amounts) rather than reducing DRG weights.

Response—We do not agree with these commenters. Our reasons are discussed at length in the sections on DRG weighting factors earlier in this Addendum.

Comment—Some commenters said that in the NPRM discussion of the budget neutrality adjustment methodology, we provided incomplete descriptions of the model used to develop estimates of cost per case under TEFRA; our assumptions, adjustments, and formulae; special studies, including the study of average case-mix increase that regulated in reduction of the DRG weights; and changes in the proposed methodology from that we had used for FY 1984 payments rates. It was suggested that we had not fully complied with section 1886(d)(6) of the Act, requiring us to publish a description of the methodology and data used in computing the prospective payment rates.

Response—We do not agree. We believe that our descriptions are adequate and that we have satisfied all legal requirements. We have released a substantial amount of data, as discussed above in regard to the reduction of DRG weights. Most commenters are satisfied with the level of description we have provided.

Comment—Some commenters suggested that the assumptions for cost per admission increases that we used in modeling TEFRA were too low because recent data partially reflected prospective payment system behavior.

Response—We explicitly adjusted our assumptions upward to remove the effects of prospective payment, especially the shorter lengths of stay. Even after these adjustments, our assumptions are higher than would be justified by recent experience.

Comment—Some commenters suggested that we should further adjust the FICA tax adjustment for those hospitals that first started paying FICA tax in 1983 to reflect the scheduled increase in the FICA tax rate for 1985.

Response—The FICA tax adjustment only makes the costs of hospitals that were not paying FICA tax in the past more comparable to the costs of the remaining hospitals. Any increases in the FICA tax rate are built into our cost per admission assumptions and the hospital input price index and adjusts for the FICA tax increases for all hospitals. Any further adjustment would be an over-adjustment.

Comment—Some commenters suggested that hospitals that are affected by the TEFRA limits would respond and reduce their costs. They suggested that we should assume such changes in behavior for purposes of modeling TEFRA.

Response—This comment makes sense, but we didn't have the time or resources to study hospital responses to the TEFRA reimbursement limits. However, we should point out that if we were to implement the suggestion, the estimated costs under TEFRA would likely be lower, and as a result the budget neutrality ratios would decline.

Comment—A commenter suggested that because we reduced the outlier pool from six percent to five percent, the outlier adjustment should be .952 to be consistent with the adjustment for the six percent outlier pool.

Response—The six percent outlier pool was six percent of Federal standard payments, which is less than six percent of total Federal payments. The five percent outlier pool is set at five percent of total Federal payments, pursuant to section 1886(d)(5)(A)(iv) of the Act, which requires that outlier payments be set at between five percent and six percent.

Comment—One commenter suggested that, in adjusting budget neutrality for rural referral centers, we should assume that only one-half of the hospitals that meet the mandatory requirements would meet any of the optional requirements.

Response—We believe that nearly all of these hospitals will be able to meet at least one of the optional requirements. Further, comments from potential referral centers did not indicate that they would have any problems meeting at least one of the optional requirements.

Comment—One commenter suggested that the hospital-specific rate used in the budget neutrality comparison is too low because of incorrect 1981 case-mix data.

Response—Since the case-mix in 1981 is more likely understated, using "corrected" higher 1981 data would further reduce the hospital-specific rate, since in calculating the hospital-specific rate, we divide by the 1981 case-mix index. It is more likely that the hospital-specific rate is too high.

Comment—One commenter suggested that it was too early in the implementation of the prospective payment system for us to have acquired sufficient experience to estimate regional and national Federal rate payments.

Response—Since prospective payment rates are set in advance, we only need to estimate the number of admissions and average case-mix level to estimate payment levels. We believe that our early experience actually may have understated the increase in average case mix, because the case-mix level has increased more with the accumulation of more experience. We believe that it is likely that our estimate has understated the increase in case-mix level that will actually occur by the end of FY 1985.

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