considered before final action is taken on the proposed rule; comments filed after this date will be considered to the extent practicable.

All comments received will be available for examination by interested persons at any time during regular business hours in Room 8201, Nassif Building, 400 Seventh Street SW., Washington, DC 20590.

In addition, FRA will hold a public hearing on this proposal in Washington, DC. The public hearing will be held beginning at 10:00 a.m. on October 24, 1985 in room 7200 of the Nassif Building, located at 400 Seventh Street SW, Washington, DC.

List of Subjects in 49 CFR Part 232

Railroad safety.

The Proposed Rule

In consideration of the foregoing, FRA proposes to amend § 232.13 of Part 232, Title 49, Code of Federal Regulations, as follows:

1. The authority citation for Part 232 continues to read as follows:

Authority: 72 Stat. 86, 45 U.S.C. 9; sec. 6(e), (f), 80 Stat. 939, 49 U.S.C. 1655; and § 1.49(c) of the regulations of the Office of the Secretary of Transportation, 49 CFR 1.49(c).

2. Section 232.13 is proposed to be amended by revising paragraphs (b), (c) and (d) (1) and (d) (2) (i), and by adding paragraphs (g) and (h) to read as follows:

§ 232.13 Road Train and intermediate terminal train air brake tests.

(a) * * *

(b) *Freight trains.* Before motive power is detached or angle cocks are closed on a freight train, brakes must be applied with not less than a 20-pound brake pipe reduction. After recoupling, and after angle cocks are opened, it must be known that brake pipe air pressure is being properly restored as indicated by a rear car gauge or device. In the absence of a rear car gauge or device, or in the event the rear car gauge or device is inoperative for any reason, an air brake test must be made to determine that the brakes apply and release on the last car.

(c) (1) At a point other than an initial terminal where a locomotive or caboose is changed, or where one or more consecutive cars are cut off from the rear end or head end of a train with the consist remaining otherwise intact, after the train brake system is charged to within 15 pounds of the feed valve setting on the locomotive, but not less than 60 pounds as indicated at the rear of a freight train and 70 pounds on a passenger train, a 20-pound brake pipe reducton must be made and it must be determined that brake pipe pressure is being reduced at the rear of the train as indicated by a rear car gauge or device. Before proeeding it must be known that brake pipe pressure as indicated at the rear of a freight train is being restored as indicated by a rear car gauge or device.

(2) On trains operating with electro-pneumatic brakes, with the brake system charged to not less than 70 pounds, a test must be made to determine that rear brakes apply and release properly from a minimum 20-pound electro-pneumatic brake application as indicated by the brake cylinder gauge.

(d) (1) At a point other than a terminal where one or more cars are added to a train, after the train brake sytem is charged to not less than 60 pounds as indicated by a gauge or device at the rear of a freight train and 70 pounds on a passenger train, a brake test must be made to determine that brake pipe leakage does not exceed five (5) pounds per minute as indicated by the brake pipe gauge after a 20-pound brake pipe reduction. After this test is completed, it must be known that the brakes on each of these cars and the rear car apply and release. Before proceeding it must be known that brake pipe pressure at the rear end of the train is being restored as indicated by a rear car gauge or device. In the event that the rear car gauge or device is inoperative for any reason, an air brake test mut be made to determine that the brakes apply and release on the last car. Cars added to a train that have not been inspected in accordance with § 232.12(c)–(j) must be so inspected and tested at the next terminal where facilities are availble for such attention.

(2) (i) At a terminal where a solid block of cars, which has been previously charged and tested as prescribed by § 232.12(c)–(j), is added to a train, after the train brake system is charged to within 15 pounds of the feed valve setting on the locomotive, but not less than 60 pounds as indicated at the rear of a freight train and 70 pounds on a passenger train, a 20-pound brake pipe reduction must be made and it must be determined that pressure is being reduced at the rear of the train as indicated by a rear car gauge or device. Before proceeding it must be known that the brake pipe pressure at the rear of the freight train is being restored and indicated by a rear car gauge or device. In the event the gauge or device is inoperative for any reason, an air brake test must be made to determine that the brakes apply and release on the last car.

(ii) * * *

(g) As used in this section, "device" means a device that—

(1) Accurately determines the brake pipe pressure on the rear car of a train on a continuous basis during train operations;

(2) Conveys the rear car brake pipe pressure on a continuous basis during train oprations in not more than one pound increments to the cab of the controlling locomotive; and

(3) Displays the quantitative value in a manner readily visible in daylight and darkness from the engineer's normal operating position.

(h) The accuracy of the device to be used to comply with the test procedures in this section shall be determined as part of the initial terminal air brake test. After charging the train, the rear car brake pipe pressure reading of the device shall be cross checked with the reading of a gauge at the rear of the train. The device may not be used if the difference between the two readings exceeds three pounds.

Issued in Washington, DC, on August 26, 1985.

John H. Riley,

Administrator.

[FR Doc. 85–20741 Filed 8–30–85; 8:45 am]

BILLING CODE 4910-06-M

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49 CFR Part 232

[Docket No. RSSI–85–1, Notice No. 1]

Special Safety Inquiry; Railroad Power Brakes

AGENCY: Federal Railroad Administration (FRA), DOT.

ACTION: Notice of Special Safety Inquiry.

SUMMARY: FRA is initiating a Special Safety Inquiry to obtain information from the public to assist in evaluating the impact of the changes in the power brake regulations made in August of 1983 in Docket PB–6. This information will be used in assessing whether further regulatory action to modify the 1982 power brake changes is appropriate.

DATES:

(1) A public hearing will begin at 10:00 a.m. on October 25, 1985.

(2) Prepared statements to be made at the hearing should be submitted to the Docket Clerk at least seven days before the hearing date.

(3) Persons desiring to participate at the hearing should notify the Docket Clerk at least seven days before the hearing.

(4) Persons desiring to submit written comments for inclusion in the safety inquiry docket should submit them by Ocober 18, 1985.

ADDRESSES:

(1) Hearing location—Room 7200, Nassif Building, 400 Seventh Street, S.W., Washington, D.C. 20590

(2) Docket Clerk, Office of Chief Counsel (RCC–30), Federal Railroad Administration, Washington, D.C. 20590. Telephone 202–426–8285.

FOR FURTHER INFORMATION CONTACT:

Principal Program Person: Philip Olekszyk, Deputy Associate Administrator for Safety, Federal Railroad Administration, Washington, D.C. 20590. Telephone 202–426–0897.

Principal Attorney: Michael E. Chase, Office of Chief Counsel, Federal Railroad Administration, Washington, D.C. 20590. Telephone 202–426–8285.

SUPPLEMENTARY INFORMATION: On August 23, 1982, FRA published a final rule (47 FR 36792–36795) amending the regulations relating to railroad power brakes (49 CFR Part 232). The changes included extension of the intermediate inspection interval in § 232.12 from 500 to 1,000 miles and extension of the maximum permissible piston travel limit in § 232.11 from 10 inches to 10½ inches.

These changes were responsive to a joint recommendation by rail labor and rail management contained in a letter to FRA dated November 6, 1981. The letter also requested that at the end of two years a review by made of relevant statistical data to determine if the elimination of a mileage requirement for the intermediate inspection is appropriate and if further extension of the piston travel limit is appropriate. In the preamble to the final rule, FRA committed itself to "closely monitor" the impact of the changes and to take action as warranted.

Now that two full calendar years (1983 and 1984) have elapsed since the rule changes became effective, years for which accident data has been obtained and published, FRA has concluded that all interested persons should be afforded an opportunity to assess the impact of the 1982 changes. Hence, FRA is holding a power brake safety inquiry to obtain information from the public to assist its evaluation of the impact of the 1982 revision of the power brake regulations. This information will be used in deciding whether further regulatory action to modify the 1982 changes is warranted.

Public Participation

FRA encourages all interested persons to participate in this Special Safety Inquiry. Persons desiring to participate may do so by submitting written comments for inclusion in the Safety Inquiry docket and by participating in the public hearing that will be held on October 25, 1985, in Washington, D.C.

Persons desiring to participate in the hearing should notify the Docket Clerk at least seven days before the hearing and indicate the amount of time they will need to present their views. Prepared statements also should be submitted at least seven days before the hearing date to the Docket Clerk.

Issued in Washington, D.C. on August 28, 1985.

(Secs. 202 and 209, Federal Railroad Safety Act of 1970 (45 U.S.C. 431 and 437), Sec. 1.49(n) of the regulations of the Office of the Secretary, 49 CFR 1.49(n))

John H. Riley,

Administrator.

[FR Doc. 85–20740 Filed 8–30–85; 8:45 am]

BILLING CODE 4910–06–M

federal register

Tuesday
September 3, 1985

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405 and 412

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1986 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 412

[BERC-315-F]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1986 Rates

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

ACTION: Final rule.

SUMMARY: We are modifying the Medicare inpatient hospital prospective payment system in order to implement necessary changes arising from experience with the system. In addition, this final rule sets forth our first adjustment of the diagnosis-related group weights and classifications as required under section 1886(d)(4)(C) of the Act.

Also, in the addendum to this final rule, we are describing changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. Changes to the Federal portion of the payment are applicable to discharges occurring on or after October 1, 1985.

Changes to the hospital-specific portion are effective with hospital cost reporting periods beginning on or after October 1, 1985. In effect, these changes apply to the final year of the three-year transition period for the hospital prospective payment system. The addendum also sets forth the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

EFFECTIVE DATE: With certain exceptions, this final rule is effective on October 1, 1985. We refer the reader to section VII.A. of this preamble for a detailed discussion of effective dates.

FOR FURTHER INFORMATION CONTACT:

Linda Magno (301) 594-9343—DRG Recalibration, Hospital Wage Index, New Hospital Exemption from Rate of Increase, Payment for Cost Outliers, Referral Centers, Indirect Medical Education, Transfer Policy, Prospective Payment Rates, Excluded Hospitals

Thomas Hoyer (301) 594-9446—DRG Reclassification, GROUPER Program, Alcohol/Drug Hospitals and Units, Review Activities

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary of the Implementation of the 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 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 currently contains 470 specific categories.

Section 1886(d)(1) 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 Federal rate per discharge. The Federal rate is based on regional average standardized hospital costs in the first year, and a blend of a regional and national rates per discharge in the second and third years. Beginning with the fourth year (that is, October 1, 1986), and continuing thereafter, the Federal portion of the payment for inpatient hospital services will be based entirely on national 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. Technical corrections for that rule were issued on October 19, 1983 (48 FR 48467). In that rule, we established criteria for determining—

- Which hospitals are included in or 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. Technical corrections for that rule were issued on June 1, 1984 (49 FR 23010).

As a result of our first year of experience with the prospective payment system and to accommodate changes resulting from the enactment of the Deficit Reduction Act of 1984 (Pub. L. 98-369) on July 18, 1984, we published a final rule on August 31, 1984 (49 FR 34728) that further revised the prospective payment regulations. In addition, in the addendum to that final rule, we described changes in the methods, amounts, and factors necessary to implement the second year of the payment transition period. Changes in the Federal rates were applicable to discharges occurring on or after October 1, 1984, while changes regarding the hospital-specific portion of the payment were effective with hospital cost reporting periods beginning on or after October 1, 1984. Technical corrections on that final rule were issued on October 15, 1984 (49 FR 40167).

On March 29, 1985, we published a final rule (50 FR 12740) that redesignated the prospective payment regulations under a new 42 CFR Part 412. These regulations were previously located in 42 CFR 405.470 through 405.477.

B. Summary of June 10, 1985, Proposed Rule

On June 10, 1985, we published a notice of proposed rulemaking (NPRM or proposed rule) in the **Federal Register** (50 FR 24366) to further amend the prospective payment system. We proposed to make the following changes:

- As required by section 1886(d)(4)(C) of the Act, we proposed to adjust the classifications and weighting factors for discharges beginning with Federal fiscal year (FY) 1986.
- We proposed to use a new wage index for purposes of adjusting for variations in area wage levels. The proposed new wage index is based on a HCFA survey of hospitals and would be used in standardizing hospital costs for purposes of determining the Federal rate, in standardizing hospital charges for purposes of recalibrating the DRG weights, and for adjusting the Federal rate for purposes of determining prospective payments for hospitals.
- We discussed several current provisions of the regulations in 42 CFR Parts 405 and 412 and set forth certain proposed changes concerning—

—Exemptions for new hospitals from the rate-of-increase limits;
—Payments for indirect costs of medical education;
—Limitations on charges to beneficiaries for hospitals paid under State reimbursement control systems or demonstration projects;
—Payment for cost outliers; and
—Referral center qualifying criteria.

We also proposed several conforming changes to the regulations.

• In the addendum to the proposed rule, we set forth proposed changes to methods, amounts and factors for determining the FY 1986 prospective payment rates. We also proposed new target rate percentages for determining the rate-of-increase limits for FY 1986 for hospitals excluded from the prospective payment system.

In addition, the proposed rule discussed in detail the recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(d)(4)(D) of the Act to make recommendations to the Secretary with respect to adjustments to the DRG classification and weighting factors and to report to Congress with respect to its evaluation of any adjustments made by the Secretary.

ProPAC is also directed, by the provisions of section 1886(e)(2) and (e)(3) of the Act, to make recommendations to the Secretary on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986. These recommendations are due to the Secretary no later than the April 1 preceding each Federal fiscal year. The statute requires that ProPAC, in making its recommendations, take into account changes in the hospital market basket, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services. As required under section 1886(e)(5) of the Act, we published the report of the recommendations from ProPAC as Appendix C to the proposed rule.

C. Number and Types of Public Comments

A total of 2,201 letters containing comments on the proposed regulations were received by the end of the comment period (July 10, 1985). Among the many issues addressed in the proposed rule, the following subjects received the majority of comments:

• The zero percent increase in the prospective payment rates.

• Proposed wage index based on the HCFA survey.

• Count of interns and residents for determining the indirect medical education payment.

• The recalibration of the DRG weights.

• Revision of the alcohol/drug DRGs and termination of the exclusion for alcohol/drug hospitals and units. (We received 2,025 form or nearly identical letters from individuals on this issue as well as several other comments.)

The contents of the proposed rule, the public comments, and our responses to the comments are discussed throughout this document in the appropriate sections. However, we are responding to a general comment here rather than in one of the more issue-specific areas below.

Comment: Several commenters objected that the 30-day comment period afforded them in the proposed rule was too short. They believe that this amount of time was inadequate to allow the hospital industry to evaluate thoroughly the complex issues included in that proposed rule. One commenter suggested that the September 1 final rule be published as an interim final rule with comment period in order to give the public additional time to evaluate the issues and submit further comments.

Response: When we issued the proposed rule, we recognized the importance of affording the public the fullest opportunity to analyze the many issues raised in the document and to express their views. In fact, in several places in the proposed rule, we specifically invited comments on particular issues. However, under section 1886(e)(5)(B) of the Act, we are required to publish final regulations and rates for FY 1986 by September 1, 1985. Since we could not publish the proposed rule until we had reviewed ProPAC's April 1, 1985 recommendations and taken them into account, there was insufficient time available for a public comment period of more than 30 days between the publication of the proposed rule and the required date of publication of the final rule. Under these constraints, we had no choice but to limit the comment period on the proposed rule to 30 days and to proceed with publication of the final regulations and rates for FY 1986 by September 1, 1985.

As to the comment that we should issue an interim final rule with comment period by September 1 instead of a final rule, we again refer to the specific language in section 1886(e)(5)(B) of the Act, which provides that:

> The Secretary shall cause to have published in the **Federal Register**, not later than . . . the September 1 before . . . [the next ensuing Federal] fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final determination . . .

The statute is implemented by regulations at 42 CFR 412.8(b)(3), which state that:

> HCFA will publish a **Federal Register** notice setting forth final . . . prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

The statutory language clearly anticipates that *final* prospective payment rates will be issued each year by September 1. Publication by that date is intended to give the industry a full 30 days in which to make whatever adjustments may be necessary to implement the provisions of the final rule by October 1 (the beginning of FY 1986).

If we were to issue an interim final rule with comment period, we would be obligated to consider whatever further public comments we receive. Conceivably, this could result in modifications based on the comments that might alter in some respect the finality of the FY 1986 prospective payment system rates. This in turn would undermine the certainty, so essential to the prospective payment system, that is gained by issuing a final rule by a specified date. Under section 1886(e)(5)(B) of the Act, we are required to establish clear payment policy and prospective payment rates in advance of the fiscal year to which the policy and rates will apply. Issuing an interim final rule with comment period instead of a final rule at this point would serve only to introduce uncertainty into the process and would also raise the prospect of retroactive adjustments that might be necessary to accommodate any later decisions arising from the interim rule.

II. Changes to DRG Classifications and Weighting Factors

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case (comprised of a hospital-specific portion and an urban or rural Federal portion adjusted for area wages) and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the national average resources consumed per case by the average hospital. Thus, cases in a DRG with a weigh of 2.0 would, on average, require twice as many resources as the average case for the average hospital.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. In addition, Congress provided the

Secretary with authority to reclassify services and procedures within the DRG system to take into account changes in medical technology and treatment patterns. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments are made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The intention of Congress was that we would make changes as often as needed to achieve the objectives of the prospective payment system, including the need to keep current with developments in the areas of coverage and medical technology. The DRG reclassifications and the recalibration for discharges occuring on or after October 1, 1985 are set forth below.

A. Basic Classification System

The method of classifying cases into DRGs for payment under the prospective payment system involves a number of steps. The intermediary enters medical and other information contained in each patient's bill into its claims system and subjects it to a series of automated screens called the Medicare Code Editor. These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the Medicare Code Editor and any further development of the claims, cases are classified by GROUPER into the appropriate DRG. The GROUPER software program was developed as a means of classifying each case into the appropriate DRG on the basis of the diagnosis and procedure codes and demographic information, that is, sex, age, and discharge status. It is used both to classify past cases in order to establish the DRG weights and to classify current cases for payment.

During the initial operating period of the prospective payment system, we learned that the use of the DRG method of classification posed some operational challenges that we needed to address further. In the NPRM, we proposed a number of improvements to the DRG classification system and included them in a revised GROUPER program that was used to develop the recalibrated DRG weights published in the addendum to the proposed rule (Table 5). The revised GROUPER program would be used to classify and assign cases to DRGs effective with discharges occurring on or after October 1, 1985.

We listed all the proposed changes made to GROUPER in Table 6 of the addendum to the NPRM. The following is a brief description of the general categories of proposed changes.

1. DRG Logic Issues and Technology Changes

We proposed that some GROUPER logic decisions be improved and others be corrected to reflect technological advances that have occurred since the development of the classification system. For example, as a method of solving a technology and coding problem, we proposed to move percutaneous transluminal coronary angioplasty from DRG 108 (Cardiothoracic Procedures, Except Valve and Coronary Bypass, With Pump) to DRG 112 (Vascular Procedures Except Major Reconstruction).

Comment: A few commenters suggested that percutaneous transluminal coronary angioplasty be assigned to DRG 109 (Cardiothoracic Procedure Without Pump), based on another view of the appropriate clinical placement of the procedure. Other commenters suggested that the change, as we described it, did not achieve our objective, because it failed to account for some cases that include open chest procedures. Many of the commenters agreed with the DRG 112 assignment.

Response: We are persuaded by our analysis and by ProPAC's recommendation that DRG 112 is the best assignment for percutaneous transluminal coronary angioplasty. Both DRGs 108 and 109 consist of major open cardiothoracic procedures with or without a cardiac bypass pump. Neither DRG is appropriate for percutaneous transluminal coronary angioplasty because, in order to perform the procedures listed in these DRGs, it is necessary to enter the chest surgically and expose the heart, as well as to perform surgery directly on the heart muscle or heart valves.

Percutaneous transluminal coronary angioplasty is not an operation that requires open chest surgery on the heart. Instead, a catheter is inserted in an artery in the arm or leg and is passed into the vessels that supply the heart muscle. Only a very small incision in the arm or leg is made and the chest is not opened. The procedure is carried out directly on the heart vessels but not on the heart muscle itself. This procedure is most closely related clinically to the procedures in DRG 112, which are procedures on the vessels of the body.

With respect to resource consumption, we believe DRG 112 is appropriate. Our data for FY 1984 indicate that the average charge for an uncomplicated percutaneous transluminal coronary angioplasty case was well within the range of charges for other cases that fall within DRG 112 and, in fact, is less resource intensive than many of the other cases within that DRG. Thus, we believe that the resource range required for this procedure fits within the DRG to which it is assigned.

We have, however, also noted comments on the NPRM that our proposed changes did not accomplish the result we desired because they do not permit those cases that entail use of a pump (code 39.61) to continue to be classified in DRG 108. We are correcting this omission in this document. We note that we published the changes as a proposal to elicit comments and corrections such as these.

We recognize that percutaneous transluminal coronary angioplasty is a significantly less invasive procedure than the one that it replaces and we are particularly concerned to assure that its placement in this DRG not create an incentive to continue to use more complex and invasive procedures. As we have noted, we believe that this assignment is appropriate from the standpoint of resource consumption and clinical coherence; however, as recommended by ProPAC, we will continue to monitor this issue to assure that placement of percutaneous transluminal coronary angioplasty cases in DRG 112 is appropriate from the perspective of both clinical characteristics and resource utilization.

2. Operating Room versus Non-Operating Room Assignment

The distinction between medical and surgical DRGs is meant to reflect the difference between cases that use operating rooms (a significant additional resource) and cases that do not. However, a few procedures that do not require the use of an operating room are recognized by GROUPER as operating room procedures. As we proposed, we are deleting these procedures from the list of procedures that could result in assignment to a surgical DRG in order to assure that the cases that included them as the only surgical procedure are classfied appropriately for payment purposes.

3. Complication and Comorbidity Membership

In some cases, DRGs are listed in pairs, one with and one without complications or comorbidities, with a higher weight generally assigned to the DRG that includes complication or comorbidity. We proposed to add a number of additional diagnostic and

procedural codes (mostly traumatic amputation codes) to the list of complications and comorbidities. The changes we are making will allow cases with these additional codes to be classified in DRGs that reflect the additional resources necessary to deal with complications or comorbidities.

4. Surgical Hierarchy Changes

An examination of length of stay and charge data has led us to reorder in the hierarchy of surgical procedures in a few cases, as we proposed in the NPRM.

5. DRG 468 (Unrelated OR Procedure) Issues

We proposed to modify a number of Major Diagnostic Categories (MDCs) and DRGs to include International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM) codes for surgical procedures that may be performed for diagnoses within them but that are not currently reflected in the GROUPER program that is used to assign cases to the particular MDC or DRG. Thus, with these changes, cases in which these procedures are performed will be recognized by GROUPER and properly classified in the appropriate DRG rather than DRG 468, where they are currently classified.

Comment: We received two comments on our list of operating room procedures that we proposed to add to the various DRGs so that assignment of cases to DRG 468 would be reduced. One commenter believes that the reassignment of some cases to DRGs 269 and 270 would reduce payments to the hospital for these procedures. Another commenter questioned whether the reassignment of these cases would mar the clinical homogeneity of the DRGs to which they will now group.

Response: Most of the procedures added to the various DRGs are relatively minor and were omitted from the original DRG system (and GROUPER software) through oversights. They are all clinically suited to the DRGs where they will now be grouped. Since the weights for all the DRGs that are set forth in Table 5 have been established using the revised GROUPER program, they accurately reflect the resources expended on all the cases that fall within them, including the cases that will be reassigned to them from DRG 468. Thus, the DRGs continue to be clinically homogeneous and any increase or decrease in payment for an individual case that previously would have grouped to DRG 468 will be an appropriate result of the changes.

In addition to these proposed revisions, we made a number of clarifying revisions in the documentation that describes how GROUPER works. Anyone interested in obtaining materials that reflect these changes may purchase revised GROUPER software and ICD–9–CM user manuals from:

Health Systems International, 100 Broadway, New Haven, Connecticut 06511.

As in the proposed rule, a listing of the changes appears in Table 6 of the addendum to this final rule.

B. Reclassification of DRGS

In addition to the generic types of changes discussed above, we also proposed to make changes in the DRG classification system for alcohol and drug abuse DRGs, certain major joint procedures, and kidney transplants for diabetic patients. We believed that the proposed changes would improve the accuracy of the classification system and, along with the use of FY 1984 claims data, would result in the establishment of more accurate weights. These changes should also strengthen the relationship between the consumption of resources in the cases whose assignments are affected by these changes and the payments made for these cases.

Set forth below are our responses to some general comments on DRG classification that we received. Comments related to our specific proposals are discussed later in this section.

Comment: A number of commenters made suggestions about DRG changes that reflected misconceptions as to the design of the system and manner in which the system works. A frequent comment was that one DRG or another should be given a higher weight to reflect the cost of caring for patients who may require more than the average intensity of services or to reflect the intensity of services associated with a particular clinical regimen favored by the commenter. Also, a number of comments dealt with cases in which a patient requires additional services unrelated to the principal diagnosis.

Response: We stress that the weights assigned to the various DRGs reflect the actual average intensity of services provided to patients whose cases fall within them. As we have noted, we used the FY 1984 Part A Tape Bill (PATBILL) file to establish the weights and are satisfied that they adequately reflect the intensity of services provided. We also note that both day and cost outlier payments are available for cases that are extraordinarily costly or for which the inpatient stay is prolonged. Finally, we noted that the geometric mean lengths of stay shown in the DRG listing (see Table 5) are not intended to be an expression of the typical length of stay for the DRG. Their main purpose is to serve as a benchmark for the computation of outlier payments. In fact, the arithmetic mean length of stay, which is typically longer, is the more common measure of the "average" stay for the DRGs. We have printed the arithmetic mean lengths of stay in Table 5 of the addendum to this final rule as a point of information for reviewers. We note that, with the exception of outlier cases, the weight assigned to a DRG reflects the average resource utilization for cases that fall within it even though some cases will require more or fewer resources. The system is designed so that, on balance, the aggregate Medicare payment to hospitals in a locality should be adequate for the aggregate Medicare utilization.

Comment: Various commenters suggested that the methodology by which reclassification issues were treated should be fully explained in connection with any proposed changes and that any difference in the payment for individual cases that may be moved from one DRG to another by such reclassifications should be fully discussed.

Response: As we have noted, we continue to employ the basic principles that were used for the original construction of the DRG system and that have been described in a variety of documents that are available to individuals who desire additional information. (See the September 1, 1983 interim final rule (48 FR 39761).)

Since the purpose of the system is to assure that cases are classified into DRGs that are both clinically coherent and that typically require a comparable range of resources, we do not believe that relative increases or decreases in payments for individual cases (so long as they fall within the general resource range) are relevant. We stress again that the classification system aims toward an aggregate payment that is appropriate for the sum of all cases, not payments that are based upon variations in resource consumption in individual cases. Thus, comments that are primarily anecdotal or that argue that payment should be based on a commenter's desired clinical practice (rather than actual resources used) have not been accepted.

Comment: A number of commenters suggested further changes in DRG classification or suggested further refinements of the changes we proposed.

Response: We have included in this final rule the changes we proposed (as revised on the basis of comments) as

well as certain other changes (for example, certain Grouper logic changes) that were suggested that we judged to be similar and complementary to the changes we discussed in the proposed rule. These changes are listed in Table 6 of the addendum. We have not discussed all these changes in detail in this document, but we have discussed briefly the changes in which we believe there was the most public interest. Other changes suggested by commenters will be dealt with in a separate notice, which we propose to publish early in 1986.

1. Alcohol and Drug Abuse DRGs

In the January 3, 1984 final rule, we excluded alcohol/drug treatment hospitals and units from the prospective payment system in response to criticism we received concerning the alcohol and drug abuse DRGs (49 FR 241). In that document, we specified that the exclusion would be permitted only until October 1, 1985, and that after that date we intended to include an adjustment to the DRG classification system that would permit prospective payment to be made appropriately for alcohol/drug treatment services. (See section IV of this preamble for a further discussion of the expiration date of this exclusion.)

In order to properly reclassify these DRGs, we consulted with medical experts of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health. The analysis we performed was explained in detail in the proposed rule (50 FR 24370). The following is the proposed reclassification of the substance abuse DRGs within MDC 20 (Substance Use and Substance Induced Organic Mental Disorders):

- DRG 433—Substance Use and Substance Induced Organic Mental Disorders, Left Against Medical Advice.
- DRG 434—Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence.
- DRG 435—Substance Dependence, Detoxification and/or other Symptomatic Treatment.
- DRG 436—Substance Dependence, Rehabilitation Therapy.
- DRG 437—Substance Dependence, Combined Rehabilitation and Detoxification Therapy.

The vast majority of letters we received were commenting on this proposal. The specific issues raised by those commenters are set forth below.

Comment: A number of commenters suggested that DRG 437 should be reweighted to allow payment for a mean length of stay of 16.9 days. The commenters argued that the course of rehabilitation for patients in DRG 437 requires a longer stay than the number of days shown as the geometric mean length of stay for this DRG (14.6).

Response: First of all, we wish to clarify that the length of stay data published along with the table of weights is neither prescriptive nor in any way intended to reflect limits on Medicare inpatient hospital benefits. Indeed, as long as an admission is medically necessary and the beneficiary has not exhausted his or her benefits, Medicare's payment to the hospital, except for outlier payments, is the same regardless of whether the patient remains hospitalized for one day or for one month. Each length-of-stay statistic represents the geometric mean of a distribution of hospital cases, some of which had lengths of stay considerably below the published mean and others that had lengths of stay considerably above the published means. In fact, although the geometric mean length of stay for DRG 437 is 14.6 days, the arithmetic mean length of stay, which is the measure of average length of stay for a DRG, is 18.9 days.

We have every reason to expect that the medical community will continue to concern itself with furnishing medically appropriate care to Medicare beneficiaries and that standards of care in particular cases will not be artificially constrained by published length of stay data that represent population means, not ranges.

We believe that these commenters may have misunderstood the principles upon which the DRG system is based. The recommendations we have received were apparently from commenters who added the separate geometric mean lengths of stay proposed for DRGs 435 and 436, and who have inferred that the lengths of stay and weights are based on a clinical assumption about the length of covered stay for both detoxification and rehabilitation. Our DRG system, however, is based on the actual medical practices of all hospitals that are subject to the prospective payment system and provide the services reflected in the DRG. The more than 38,000 claims we used to derive the weights of these DRGs came from nearly 4,500 different hospitals that submitted claims for these services in FY 1984. Since the DRG weights are based on the actual practice of the hospital furnishing care to the cases in question, it would not be appropriate to adjust the weights of one of them to reflect the views of a small group of providers with specific clinical preferences. We have therefore rejected this comment.

Comment: Some commenters noted that some drug-dependent or drug-intoxicated individuals who are dependent on multiple drugs may require a significantly longer period for detoxification and rehabilitation than is reflected in the DRGs. They question whether our proposed DRGs are adequate for these individuals.

Response: As we have noted before, the weight of any DRG is an approximate average of the cost of treating all Medicare cases that fall within it. We believe that the universe of claims we used to establish these weights was large enough to reflect some relatively long and short stay cases and that, on balance, the payments we make under these DRGs will adequately compensate hospitals treating the patients whose cases fall within them. For extremely long stay cases or extraordinarily expensive cases, of course, outlier payments are also available.

While it may be true, especially in a younger population, that the resources used in treating other drug problems may be greater than those used in treating alcohol alone, our data do not show that there is a difference of significant magnitude to warrant making this distinction between alcohol and drug problems in the Medicare beneficiary population. We do agree, however, that populations that include a significant number of younger patients (for example, Medicaid recipients) may have different overall characteristics and may require different DRG configurations. Moreover, we would expect the weights, not only for the substance abuse DRGs but for all DRGs, to vary substantially depending on the patient population on whose hospital experience the weights are based.

Comment: One commenter questioned whether the sample size of 5,577 cases used in studying the appropriateness of the proposed reconfiguration of the DRGs in MDC 20 was adequate, and whether the 1,112 providers in the sample were representative of the population of providers nationwide.

Response: It is important to note that the sample data were used solely to study the appropriateness of the proposed reconfiguration of the alcohol and drug abuse DRGs. These data were not used in deriving the relative weights reported in the proposed rule on June 10, 1985 (50 FR 24416). In order to treat the DRGs in MDC 20 consistently with the other DRGs, the larger recalibration data set was used in deriving the relative weights for the alcohol and drug abuse DRGs. However, statistical tests revealed that, with the exception of

DRG 433 (for which the sample did not contain a sufficient number of cases to generate a reliable estimate and which, in addition, was unaffected by the proposed reconfiguration of the DRGs), there were no significant differences between the mean charges for each DRG in the study sample and the mean charges in the larger recalibration data set.

The distribution by DRG of the 5,577 cases used in the study was as follows:

DRG 433—201
DRG 434—685
DRG 435—2,712
DRG 436—1,357
DRG 437—622

With the exception of DRG 433, the sample sizes were sufficiently large to conclude that our estimated mean charges for each DRG are within 10 percent of the true means with 95 percent confidence.

A chi-square test to determine how well the distribution of sample providers (that is, short-term general hospitals, alcohol and drug treatment hospitals, alcohol and drug units) matched the distribution of the population of providers with cases in the alcohol/drug DRGs revealed significant differences between the observed distribution of our sample of providers and the distribution of providers nationwide. In particular, alcohol and drug treatment hospitals and units of short-term general hospitals were overrepresented in our sample of providers, whereas short-term general hospitals without alcohol and drug treatment units were underrepresented in our sample. Despite these differences between the sample and the universe of hospitals, however, the means charges estimated from the sample were not significantly different from the mean charges obtained from the recalibration data set. Thus, there is no analytic basis for substituting weights derived from a sample for weights derived from essentially the universe of Medicare cases in these or any other DRGs.

Comment: Several commenters suggested that the revised alcohol/drug DRGs are overpaying for detoxification therapy relative to rehabilitation therapy.

Response: The relative weights of each DRG and the geometric mean lengths of stay are derived from actual consumption of resources as reflected in the 1984 Medicare PATBILL file and, thus, directly tracks the use of hospital resources to provide these services. In considering which services contributed to the weight derived for the DRG, it should be noted that many cases involve not only detoxification for drugs as well as alcohol but other symptomatic treatment as well. We note that if hospitals code cases inaccurately, here, as elsewhere, it could adversely affect payments and classifications in subsequent years, since we will continue to update the system based on the latest data available. While data submitted by hospitals is subject to review and correction, review activity is limited to samples. Therefore, we must view the bulk of the information furnished by hospitals as accurate and reflective of current hospital practices.

Comment: One commenter noted that patients with psychosis in alcohol dependence represented by ICD–9–CM codes 291.3, 291.8, 291.9 are not able to benefit from rehabilitative therapy while in a psychotic state and that their inclusion in DRGs 436 and 437 is inappropriate.

Response: We agree and are programming the GROUPER system so that these codes will group only to DRG 435 (Detoxification and Other Symptomatic Treatment).

Comment: One commenter noted that ICD–9–CM code 303.03 (Alcohol dependence syndrome in remission) presents ambiguities that suggest that every case may not be appropriate for inpatient rehabilitation.

Response: We agree and will institute prepayment review of cases that show this code as the principal diagnosis.

Comment: Several commenters noted that persons with an alcohol or drug problem with an ICD–9–CM code that does not indicate dependence may still have a medical need for detoxification.

Response: We agree and are revising the title of DRG 434 to read "Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence; Detoxification and/or Other Symptomatic Treatment."

Comment: One commenter indicated that most alcohol and drug abuse patients can be treated on an outpatient basis or in the home through the use of primarily medical and social treatment. It was suggested that increased payments for these DRGs was inappropriate.

Response: We agree that there are many settings in which both detoxification and rehabilitation may take place and that some of these settings are social and nonmedical. We believe, however, that some patients do require inpatient care for detoxification, rehabilitation, and other symptoms associated with alcohol and drug abuse. Our coverage rules explicitly indicate that inpatient care is only covered when it is medically necessary and, therefore, we would expect that inpatient hospital stays for those patients whose care could appropriately be provided in social and nonmedical settings would be denied as noncovered care.

Comment: One commenter suggested that the significantly higher weights assigned to DRGs that involve rehabilitation and combined detoxification and rehabilitation could create an incentive for misrepresenting cases in order to obtain increased payments.

Response: As we noted in the proposed rule, we believe that this potential problem can be solved by enhanced review by PROs. PROs will be asked to increase admission review of alcohol and drug abuse cases and also to increase attention to these cases during DRG validation. We believe that PRO review is adequate to prevent inappropriate payment.

2. Major Joint Procedures (DRG 209)

Hospitals, physicians, and professional societies allege that our current DRG 209 creates a disincentive for performing more than one medically-appropriate major joint procedure of the lower extremity during the same hospital stay. We have been told that some patients may be undergoing two separate hospitalizations when, in fact, the performance of both joint replacements during the same hospital stay might be more appropriate medically. This disincentive results from the high cost of each artificial joint prosthesis as well as the differing clinical course of patients who require this surgery and the nature of the postoperative rehabilitation process associated with lower extremity joint replacement.

Based on consultation with various professional organizations and individual physicians, including the American Academy of Orthopaedic Surgeons and the American College of Surgeons, and a review of all Medicare claims in our 1984 PATBILL file through September 1984 for DRG 209, we proposed to create a separate DRG for bilateral or multiple major joint procedures of the lower extremity.

We identified certain combinations of major joint procedures within DRG 209 that may both be performed during the same hospital stay. Each of these procedures requires the implantation of a separate prosthesis. We proposed that, if any two of the listed procedures are performed during the same hospital stay, they would be assigned to a new DRG that contains only those cases in which two major joint procedures, each requiring a separate prosthesis, were performed. Proposed DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) would contain the

following codes: 8141, 8148, 8151, 8159, 8161, 8162, 8163, and 8164.

The original composition of DRG 209 would remain unchanged except that all cases indicating the performance of two major joint procedures during the same admission would be moved to the new DRG 471 representing multiple major joint procedure of the lower extremity.

Comment: The majority of commenters were supportive of our decision to revise DRG 209 and to create two DRGs—one for single joint procedures and one for multiple joint procedures. One commenter indicated that such a split set an unfortunate precedent for other DRGs and should not be implemented.

Response: As we noted in the proposed rule, we believe that there are sound clinical reasons for making the split and we are adopting our proposed policy. However, we will continue to monitor cases in these two DRGs to determine whether further action is necessary. In our opinion, our decision to split DRG 209 does not create a presumption that we would split other DRGs that include both single and multiple procedures. Any decision such as that would only be made after an examination of available data and a conclusion that it is appropriate and is based on sound medical reasons.

3. Kidney Transplants for Diabetic Patients

We learned that an anomaly in the ICD–9–CM coding conventions leads to the classification into DRG 468 of diabetic patients with end stage renal disease (ESRD) who receive kidney transplants. Because these cases are clearly more clinically coherent with the services described for DRG 302 (Kidney Transplant), we proposed to change the GROUPER program so that diabetic ESRD patients who receive kidney transplants would be properly classified into DRG 302. We note, also, that the range of resources embraced in DRG 302 is more appropriate for the procedures performed.

Comment: Commenters generally agreed with the result we proposed; however, one commenter suggested that the best method of achieving that result within the context of the DRG system would be to transfer those ICD–9–CM codes of diabetes with a manifestation of disease in a different organ system to the MDC corresponding to the organ system in which the disease manifestations occur.

Response: We agree and are revising the assignment of the following codes that are currently grouped to MDC 10, which includes the endocrine system. We are moving ICD–9–CM codes 25040 and 25041 for diabetes with renal manifestations to MDC 11, Diseases and Disorders of the Kidney and Urinary Tract, DRGs 331, 332, and 333. We are moving codes 25060 and 25061 for diabetes with neurologic manifestations to MDC 1, Diseases and Disorders of the Nervous System, DRGs 18 and 19. We are moving ICD–9–CM codes 25070 and 25071, diabetes with circulatory manifestations, to MDC 5, Diseases and Disorders of the Circulatory System, DRGs 130 and 131. All surgical procedures performed for patients with these diagnoses will group to the appropriate surgical DRGs within the MDC to which they have been assigned. We believe that these changes strengthen the logic of the GROUPER program and enhance the clinical coherence of the DRG system in the manner intended by its designers. In fact, we note that codes 25050 and 25051 for diabetes with ophthalmic manifestation were already grouped in MDC 2, Diseases and Disorders of the Eye.

C. Recalibration of DRG Weights

The DRG weights currently used in the prospective payment system are based on operating cost information from hospitals' 1981 cost reports as well as patient characteristics, diagnoses, and charge data from the 1981 Medicare provider analysis and review (MEDPAR) file. The MEDPAR file contains inpatient hospital billing records, coded to indicate principal diagnosis, presence or absence of a secondary diagnosis, and one surgical procedure, for a 20-percent sample of Medicare beneficiaries.

One of the basic issues in recalibration is the choice of a data base that allows us to construct relative DRG weights that most accurately reflect current relative resource use. We considered continuing to develop cost-based weights using cost data or a combination of cost and charge data. Alternatively, we considered basing the relative weights solely on hospital charge information, adjusted or unadjusted for capital costs, teaching, and wage costs. Extensive and recent charge information is available from the FY 1984 PATBILL data set. Effective October 1, 1983, PATBILL is designed to contain fully coded inpatient hospital bills for 100 percent of Part A beneficiaries (MEDPAR is a 20 percent sample).

In order to determine if DRG relative weights based on charges can accurately reflect the relative resource consumption across DRGs, we conducted a study that compared relative DRG weights computed based on 1981 costs with those computed on 1981 charges. A description of this study was presented in the NPRM (50 FR 24372). Based on the results of the study, we proposed to recalibrate the DRGs based on charge data.

The recalibrated DRG relative weights set forth in the NPRM were constructed from FY 1984 PATBILL data received by HCFA through December 1984, which was about 90 percent complete and thus contained about 90 percent of all Medicare discharges occurring in FY 1984, the first year of the prospective payment system. Approximately 40 percent of these discharges were paid under the prospective payment system, and 60 percent under State demonstration waivers and on a reasonable cost basis under the rate of increase limits. The FY 1984 PATBILL file which now includes nearly 11 million Medicare discharges, is about 95 percent complete. Because it will eventually include all inpatient hospital bills of Medicare beneficiaries, it is referred to henceforth as a 100 percent file or the universe of FY 1984 Medicare hospital bills.

The methodology used to calculate the DRG weights is as follows:

- All the claims were reclassified using the proposed revised GROUPER program.
- The average charge per DRG was calculated by summing the total charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated from the calculation of the average charge per DRG.
- The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average charge per case for the average hospital to determine the weighting factor.
- No adjustments were made to the charges to remove capital-related and medical education costs. However, the charges were standardized for wage differences using the proposed survey-based wage index and for variations in teaching activity. The standardization for wage and teaching differences was done in essentially the same manner as it was in developing the initial set of DRG relative weights.
- Kidney acquisition costs continue to be paid on a reasonable cost basis, but, unlike other excluded costs, kidney acquisition costs are concentrated in a

single DRG (DRG 302, Kidney Transportation). For this reason, it was necessary to make an adjustment to prevent distortion of the relative weight for DRG 302. Kidney acquisition charges were subtracted from the total charges for each case in DRG 302 prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

The weights developed according to the methodology described above were normalized so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

When we established the current set of DRG relative weights, there were 109 DRGs that either contained no MEDPAR cases or had too few cases to provide a statistically reliable weighting factor. In order to construct a full set of relative weights, we supplemented the MEDPAR file with discharge records from Michigan and Maryland. The combined data sets were then used to calculate the weighting factors for the 109 low volume or empty DRGs.

By using the 1984 PATBILL data set, which represents substantially the entire universe of fully coded Medicare claims, rather than the MEDPAR file, which is a 20 percent sample of claims, the number of low volume and empty DRGs is reduced from 109 to 30 DRGs. In addition, sampling error is no longer a concern, which means that, in theory, a DRG weight could be constructed from a single case. In practice, however, we believe that some minimum number of cases is required to compute reasonable weights. In the NPRM, we proposed to use a minimum of 10 cases.

In computing weights for the 30 remaining low volume and empty DRGs, we decided to adjust the original weights of these DRGs by the percent change in the weight of the average case in the remaining DRGs. Therefore, we adjusted the original weights of the DRGs involved downward by approximately three percent. However, the renormalization of the entire set of relative weights involves adjusting the weights upward by approximately three percent. Therefore, the combined effect of these adjustments on the 30 low volume and empty DRGs was to leave their relative weights unchanged.

We received 46 pieces of correspondence on the DRG recalibration. Many of the commenters were pleased with our recalibration methodology. However, others voiced some concerns. Their comments and our responses are set forth below.

Comment: Commenters questioned the propriety of recalibrating the DRG relative weights using charge data from the PATBILL file instead of the cost data used in the current DRG relative weight computation. They believe that a decision to change the methodology should be made by Congress rather than the Secretary.

Response: We disagree with the commenters. We believe that the Secretary has the authority to make changes in the methodology for calculating the DRG relative weights. Section 1886(d)(4)(C) of the Act clearly directs the Secretary to recalibrate and adjust the DRG weighting factors at least every four years beginning with discharges occurring in FY 1986. In the absence of specific congressional action that instructs the Secretary to use a certain methodology and a specified set of data in accomplishing the recalibration that is required by law, it must be assumed that the Secretary has discretion within the law to select the data and develop the methodology to accomplish the task required.

As we stated in the proposed rule (50 FR 24372), the decision to use FY 1984 charge data for the recalibration was based on the following factors:

- Only if we use these data will be able to classify cases more accurately than was possible in constructing the current weights. The reason is that FY 1984 PATBILL data contain more detailed information on diagnoses, procedures, age, and discharge destination than does MEDPAR. Consequently, we will be able to use the same GROUPER program for recalibration as will be used for payment.
- Since FY 1984 PATBILL data are derived from nearly 100 percent of FY 1984 Medicare hospital discharges, the weights will be more reliable for all DRGs. Thus, we will be able to reduce significantly the number of low-volume and empty DRGs compared to what is possible using MEDPAR.
- FY 1984 PATBILL data are the most recent data, and therefore are more reflective to current treatment patterns than is MEDPAR.

We believe that these factors constitute a strong case in favor of using FY 1984 PATBILL data for the FY 1986 recalibration. In addition, we believe that this change in data allows us to be most responsive to the congressional mandate (section 1886(d)(4)(C) of the Act) that reclassification and recalibration reflect changes in treatment patterns, technology, and other factors that affect relative use of hospital resources.

Comment: One commenter was concerned that the recalibration methodology used charges and costs from two different periods. Citing the ProPAC study, the commenter stated that the Commission found a high correlation between 1981 costs and charges. The commenter doubted whether such high correlation exists between 1981 costs and 1984 charges.

Response: The commenter appears to be confused as to the methodology used in recalibrating the DRG weights. The weights were recalibrated entirely from the FY 1984 PATBILL file, which contains only charge data. No cost data were employed in the recalibration.

With respect to the comparison of 1981 costs and charges to which the commenters refer, both ProPAC's analysis and the analysis we performed compared the original cost-based DRG weights and a set of weights based on 1981 MEDPAR charges. Both comparisons arrived at very similar conclusions. There is a very high correlation between the 1981 cost-based weights and a set of charge-based weights drawn from the same discharge file for the same period. Our results and those of ProPAC agree entirely on these points. Moreover, with respect to the relationship between 1981 costs and 1984 charges, we also compared the recalibrated weights based on the 1984 PATBILL charges to the current weights based on 1981 costs, and again found a very high correlation between the two sets of weights. The Pearson correlation coefficient for the two sets of weights is .95.

Comment: One commenter objected to the use of charges in recalibrating the DRG relative weights because Congress mandated that payments to hospitals be made on a reasonable cost basis. The commenter argued that the use of charges makes it more difficult to determine whether payments approximate costs and, thus, whether we are violating the law.

Response: Under section 1886(d)(1)(A) of the Act (as added by Pub. L. 98-21), prospective payments determined under section 1886(d) of the Act for inpatient hospital services are to be computed notwithstanding the provisions of section 1814(b) of the Act. Therefore, the requirement to pay a prospective payment hospital its reasonable costs no longer applies. Current payment levels are derived from 1981 cost report data and rolled forward to later periods. However, under sections 1886(d)(4) (A) and (B) of the Act, we are obligated to construct a DRG classification system for classifying hospital discharges and for assigning an appropriate weighting factor that reflects the relative hospital resources consumed in treating each patient case assigned to a DRG. Thus, payment rates are no longer based on a

hospital's actual costs, but the relative weights do reflect relative hospital resource consumption as measured by bills for FY 1984 Medicare hospital discharges.

Section 1886(d)(4)(C) of the Act further directs the Secretary to adjust the discharge classification system and weights at least every four years beginning with discharges occurring in FY 1986 to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. By using charge data to recalibrate the DRG relative weights, we believe that we have maintained an appropriate index of relative hospital resources use across DRGs while, at the same time, complying with the legislative mandate to recalibrate the weights taking into account changes in treatment patterns, technology, and other factors affecting relative resources consumption.

Comment: One commenter argued that the high correlation reported in the proposed rule between DRG relative weights based on 1981 cost data and weights based on charge data for the same period is to be expected because of the use of charges in the original data base used to determine ancillary costs. To the extent that the cost to charge ratios have remained constant over the intervening years, the commenter believes that one could expect the same degree of correlation to persist. The commenter seemed to draw the conclusion that the PATBILL data used to recalibrate the DRG weights ". . . does not validate the weighing system . . . ." The commenter stated that a better system for measuring resource consumption must be utilized in order to validate the present system.

Response: The commenter appears to have misunderstood the reason for using charge data to recalibrate the DRG weights. We are using the charge-based weights because the charge data provided on the PATBILL is more detailed and current than the cost data available to us. Therefore, we consider the charge-based weights more valid than a comparable set of weights based on the available cost data. However, the charge-based weights are not intended to validate the cost based weights.

The fact that there is a high correlation between the two sets of weights permits us to use the 1984 charge-based weights with reasonable confidence that they reflect the relative resource use across DRGs as accurately as a set of cost-based weights do. As explained above, the use of the charge data in recalibrating the DRG weights affords us the advantages of using what we consider to be superior data than would be available were we to recalibrate the weights using cost data.

Comment: We received a comment inquiring whether the proposed revisions make the revised DRGs "better behaved" in a statistical sense and whether, for example, coefficients of variation are reduced.

Response: In general, the proposed grouper changes and reconfigurations of the DRGs were made on clinical rather than statistical grounds. Since the proposed changes do not alter the basic framework of the DRGs, we did not perform statistical tests such as those conducted by Yale University in establishing the DRGs.

Comment: We received a comment that we should recalibrate the DRG relative weights using only data for discharges paid under the prospective payment system to avoid distortions due to the previous cost-based payment system.

Response: Although in principle we agree with this comment, we think that the disadvantages of recalibrating using only the prospective payment system bills outweigh the advantages. All hospitals were required to begin coding 100 percent of their cases on the Uniform Institutional Provider Billing Form (UB–82) effective October 1, 1983. Since only 40 percent of the FY 1984 bills were paid under the prospective payment system, recalibrating using only the prospective payment system bills would significantly reduce the number of cases used to determine the relative weights. It also increases the number of low-volume DRGs. In addition, the FY 1984 prospective payment system cases are not representative of a full year's set of the prospective payment system cases because hospitals came on the prospective payment system at the start of their accounting year. For example, the hospital accounting year for many large teaching hospitals begins on July 1, so that their prospective payment system cases were limited to the fourth quarter of FY 1984. This phenomenon might also create seasonal effects that would not occur if data for a full year are used. Finally, differences between the prospective payment system and other cases may be lessened by the fact the law in effect before the prospective payment system was implemented also provided incentives for increased cost consciousness.

Comment: We received several comments about the use of charge data to recalibrate the DRG relative weights. Many commenters noted the high correlation between the cost and charge weights constructed from the 1981 data, but wondered about differences that might not be reflected by a measure as the correlation coefficient. A few commenters specifically questioned our statement that the two sets of weights differed by no more than five percent for most DRGs.

Response: The results reported in the proposed rule were based on an analysis of the 358 DRGs for which enough 1981 MEDPAR cases existed to construct reliable weights.[1] This study found a high degree of correspondence between the relative weights constructed according to our original methodology and those based solely on charge data. Both the Pearson and Spearman correlation coefficients were greater than .99. Further, the two sets of weights differed by less than 5 percent for 296 of the 358 DRGs, and these 296 DRGs accounted for 89.5 percent of the total cases. ProPAC's independent analysis of the 1981 MEDPAR data confirmed these results. ProPAC's cost and charge weights differed by less than 5 percent for 328 of the 358 DRGs (96.1 percent of the total cases). The greater similarity of ProPAC's cost and charge weights is attributable to the fact that they standardized the data for differences in indirect medical education costs; the internal HCFA study did not.

Comment: We received comments about two potential problems with our proposed use of charge data to recalibrate the DRG relative weights. Specifically identified were the common practice of setting different cost-to-charge ratios for different departments within a hospital and the lack of an adjustment for capital costs. Examples given included the effect on the charge weights of "undercharging" for intensive care and for expensive prostheses.

Response: Based on our study of the 1981 MEDPAR data, we concluded that neither of these factors creates major differences between the original set of weights and those based solely on charge data. The high degree of overall similarity between the cost and charge weights indicated that the effects of these factors were relatively small. The chief systematic difference between the two sets of weights was that the charge weights were slightly less compressed than the cost weights. That is, high-weight DRGs (low-weight DRGs) tend to have higher (lower) charge weights than cost weights.

[1] Philip Cotterill, Joel Bobula, and Rose Connerton, "A Comparison of Alternative DRG Relative Weights for the Medicare Prospective Payment System," HCFA Internal Working Paper, February 1985, available upon request.

The HCFA study recognized the issue raised in the comments regarding the effects of differences in cost-to-charge ratios among departments within the hospital. For example, if most hospitals cross-subsidize in the same manner, then DRGs with high proportions of cost in "undercharged" services might have lower charge weights than cost weights. Since "undercharged" services are typically thought to be relatively high cost services, cross-subsidization might be expected especially to affect high-weight DRGs with above average proportions of "undercharged" costs.

The HCFA study investigated this issue for the case of special care (which includes intensive care). The study found that among the 358 DRGs studied, there were 84 that had a relative weight greater than 1.0 and an above average proportion of special care costs (greater than 6 percent of total cost). Contrary to the hypothesized effect, the charge weights exceeded the cost weights for 77 of these 84 DRGs. The reason for this result is that there is a positive correlation between the proportions of cost in special care and in the ancillary categories with lower cost-to-charge ratios. In other words, a high proportion of special care costs does not generally compress the charge weight for a DRG because relatively high utilization of special care is accompanied by relatively high utilization of ancillaries, such as x-ray and laboratory services.

One commenter also mentioned DRGs 39 (lens procedures) and 209 (major joint procedures) as examples where "undercharging" for prostheses might be expected to yield charge weights that are lower than cost weights. A comparison of 1981 cost and charge weights from the HCFA study cited above did not yield this result. For both of these DRGs, the charge weight was about one percent higher than the cost weight.

Both the cases of special care and expensive prostheses suggest that the effects of cross-subsidization are more complicated than indicated by the reasoning set forth in the comments on this topic. Indeed, the effects may in many cases be largely offsetting.

Comment: One commenter stated that "HCFA readily admits problems in comparing the set of cost-based weights with the charge-based weights," and quotes our statement from the study of 1981 MEDPAR data that "Charge-based weights were not renormalized to accommodate 'external data' for the remaining 109 DRGs."

Response: Omission of the 109 "low volume" DRGs from the comparison of 1981 cost and charge weights does not significantly limit the comparisons that can be made between the two sets of weights. The point of the study was to compare weights constructed from Medicare data using alternative methods. The 109 DRGs omitted from the study accounted for less than 0.3 percent of Medicare inpatient hospital discharges in 1981. The sentence quoted in the comment was not indicative of a problem, but rather merely stated that the method of constructing the weights was consistent with the fact that the study was restricted to the 358 DRGs for which there were enough cases in the MEDPAR data to construct a reliable relative weight.

Comment: We received one comment that basing new weights on 1984 data suffers from the problem that claims processed and recorded by the fiscal intermediaries for that year are far from complete, and that the more complex and extraordinary cases may not be included in the recalibration process. The commenter also mentions that certain States may have larger backlogs than others and are, therefore, not fully represented in the recalibration data base.

Response: The data base used for recalibrating the relative weights for the proposed notice included all short-stay hospital bills for FY 1984 received as of December 28, 1984. The total number of bills used in the preliminary recalibration effort was 10.2 million, which represented approximately 90 percent of expected FY 1984 bills. The data base used for recalibrating the relative weights for this final rule included all short-stay bills for FY 1984 received through April 26, 1985. The total number of bills used in the final recalibration effort was 10.8 million, approximately 95 percent of all expected FY 1984 bills.

A comparison of average charges and lengths of stay between the preliminary data sets indicates that the earlier file may not have included all of the most costly and longer length of stay cases. In addition, some States were somewhat slower than others in bill processing, relative to the experience of prior years. However, the final recalibration data set, which included 95 percent of the expected total number of bills, conformed more closely with past experience. As a result, we believe that the concerns raised in this comment have been adequately addressed by the use of the final recalibration data set.

Comment: A commenter believes that it is inappropriate to adjust the data for the indirect costs of medical education when calculating the DRG relative weights. The commenter also noted that teaching hospitals account for a disproportionate number of cases in selected DRGs, so that the adjustment for indirect medical education costs will disproportionately reduce the relative weights for these DRGs. The commenter further noted that adjusting the relative weights for indirect medical education costs "alters the need" for an indirect medical education adjustment to payments and may redistribute payments among hospitals. The commenter concluded that it is critical that HCFA avoid building biases into the pricing system through the methods used to construct the relative weights and to set prices.

Response: We certainly agree that biases in the pricing system should be avoided, but we disagree that it is inappropriate to adjust the data for indirect medical education costs in calculating the relative weights. Our reasoning is precisely that noted in the comment: Teaching hospitals account for a disproportionate number of cases in selected DRGs.

Since the prospective payment system makes an additional payment for indirect medical education costs, the relative weights should be standardized to remove these costs in order to avoid overcompensating teaching hospitals for those DRGs. Further, we wish to note that the payment adjustment is twice that used in standardizing the data used to derive the relative weights. We believe that the appropriate policy would be to reduce the adjustment factor used in computing the additional payments to the same level as that used in standardizing the relative weights, not to alter the latter adjustment. The consistent treatment of indirect medical education costs in computing the relative weights and in adjusting payments would achieve the objective of avoiding biases in the pricing system.

Comment: A commenter was conserned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.

Response: This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the

means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to increase the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.

Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Comment: We received several comments on the topic of normalization of the relative weights; that is, the adjustment that was made to ensure that recalibration did not affect the aggregate level of payments. Some of these comments reflected confusion over the nature of this adjustment. One commenter referred to this adjustment as "restandardization," a term we use only for adjustments that influence relative payments among different hospitals. A second commenter misunderstood our normalization of the relative weights compared to the method recommended by ProPAC. Finally, several commenters requested evidence that our normalization would in fact have no effect on aggregate payments in FY 1986.

Response: In the regulatory impact analysis section of the proposed rule (Appendix A), we presented our estimate of the impact of recalibration on aggregate payments to all hospitals. Column one of the table at 50 FR 24438 showed a 0.11 percent increase in total payments due to recalibration. This estimate has been updated using more recent data than was available at the time the proposed rule was published and appears in the appendix to this document. In both cases, these estimates support our belief that recalibration of the relative weights was carried out in a manner that does not materially affect the aggregate level of payments to all hospitals in FY 1986.

Regarding the difference between our method of normalizing the relative weights and the method recommended by ProPAC, we note that the two methods are equivalent, except that we did not follow Pro PAC's recommendation that the weights be adjusted for any demonstrable changes in reported case mix occurring during FY 1985. ProPAC made this recommendation to "prevent these coding changes from being built into future prospective payment system payments." We have not penalized hospitals, as the commenter argues, by not adopting this ProPAC recommendation. We do not have sufficient data for FY 1985 to enable us to make this adjustment.

Comment: We received two comments about our use of the 1984 PATBILL data to determine the relative weight for a DRG as long as there were at least 10 cases for the DRG. One of these comments was quite critical, stating that the threshold of 10 cases is "without merit, unsupported and completely unjustified." The other comment did not oppose the proposed threshold but expressed concern that the affected DRGs be monitored to determine the appropriateness of their relative weights.

Response: The use of 1984 PATBILL data for recalibration permitted us to reduce the number of DRGs whose relative weight had to be based on non-Medicare data because the PATBILL data contains 100 percent of Medicare inpatient hospital discharges. (The MEDPAR data, in contrast, is only a 20 percent sample.) The use of the 100 percent data also changed the basis for deciding whether enough Medicare cases were available to establish a reliable relative weight for a DRG. Specifically, since the data are not from a sample but now represent the universe of Medicare beneficiaries' hospital experience, there is no explicit statistical criterion to be applied. As a result, we elected to set a relatively low threshold in order to maximize our use of Medicare data in determining the relative weights.

Our decision was based on the premise that relative weights based on Medicare data will yield more appropriate relative payment rates for Medicare beneficiaries than will some external data source. The aged or disabled nature of Medicare beneficiaries may make their medical care needs different from those of other population groups. We believe that a comparison of the original and proposed weights for the 79 affected DRGs supports our approach. In general, the relative weights of these DRGs increased as a result of replacing non-Medicare data with Medicare data. This result is explained by the fact that a majority of these DRGs are for persons under age 18 or for obstetrical patients; and Medicare beneficiaries in these groups are almost exclusively end stage renal disease patients or disabled beneficiaries. These groups clearly have special needs that may account for their relatively resource intensive hospital care.

There are fewer than 50 DRGs with fewer than 50 cases each. In total, these DRGs account for fewer than 500 cases out of the more than 10 million Medicare cases in FY 1984. Given the very small number of cases affected by the choice of a particular threshold, we do not believe that the affected DRGs require special monitoring.

Comment: We received inquiries during the comment period concerning the weights assigned to DRGs 385, 386, 389, 390, and 391 (which consist of diagnoses associated with newborns) and the fact that these DRGs are no longer low-volume DRGs. The commenters state that, with the exception of certain diagnoses codes for congenital anomalies not elsewhere classified or not otherwise specified (7597, 7598, and 7599), which could theoretically apply to adults and children beyond infancy, all other diagnoses resulting in assignment to MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period (that is DRGs 385 through 391), are specific to infants. Moreover, because Medicare entitlement for infants is statutorily limited to those infants suffering from end-stage renal disease, an extremely small population group, and because few adults should have principal diagnoses described by the above-mentioned codes, the commenters believe that there should be virtually no Medicare cases in this MDC. Therefore, the commenters do not understand why these DRGs were not designated as low-volume in Table 5 of the NPRM.

Response: As a result of these inquiries and our continuing analysis, we have determined that DRGs 385, 386, 389, 390, and 391 should continue to be treated as low-volume DRGs. In reviewing the diagnostic information associated with these cases in the PATBILL file used for recalibration, we have found that certain ICD-9-CM codes that are specific to infants, such as unspecified fetal and neonatal jaundice (code 7746), are being used for adult patients. It appears that these codes are being incorrectly assigned to similar conditions occurring in adult patients, and we are continuing to review these cases in order to evaluate the propriety of the coding.

In light of our concerns about the potentially faulty coding of these cases and the fact that there should be few, if any, Medicare cases assigned to the DRGs in MDC 15, we have decided to continue to treat DRGs 385, 386, 389, 390,

and 391 as low-volume DRGs. Accordingly, their weights as shown in Table 5 of this final rule are the same as those currently in use (see the proposed rule (50 FR 24373) for a full explanation of the assignment of weights to low-volume or empty DRG categories). Since there should be few Medicare cases appropriately grouped to this MDC, maintaining the weights currently in effect should have a negligible impact, if any, on a particular hospital's Medicare payment. We note that DRGs 387 and 388 were already classified as low-volume DRGs in the proposed rule, having not met the 10-case threshold that was set forth in that document. Therefore, there are now 35 low-volume or empty DRGs rather than 30, as was stated in the NPRM.

In addition to reviewing the particulars of the PATBILL cases that were grouped into MDC 15, we are also examining the possibility of modifying the DRG classification or the GROUPER in order to distinguish newborns from adult or nonnewborn pediatric patients with certain congenital anomalies. In keeping with our provisions on changes to the DRG classifications and the GROUPER, described in this section of the preamble, these changes would be subject to notice and comment. Also, to assure that cases assigned to MDC 15 are appropriately coded, we may institute age screens in the Medicare code editor.

Comment: Many of the commenters argued that they were prevented from submitting meaningful comments on many aspects of the proposed rule, including the DRG recalibration and the FY 1986 rates, because we did not release timely the date necessary for a thorough evaluation of these proposals. In particular, many commenters believe that our failure to disclose the PATBILL file prevented verification of the accuracy of the proposed recalibrated DRG weights, as well as a determination of the impact of the recalibration on specific hospitals. In addition, these commenters objected to the 30-day comment period allowed for the proposed rule because they claim that 30 days is not enough time to evaluate the proposals, especially since the data requested by these commenters were not released until July 2.

Response: As we indicated earlier, we understand the concerns expressed by the commenters regarding the length of the comment period, as well as concerns about public access to data that were used in determining the various weights, factors, and rates set forth in the proposed rule. However, because of the voluminous amount of data associated with the computation of the weights, factors, and rates and because of the limited interest that these data would have for the majority of readers, we do not as a matter of policy publish this material as an adjunct to our proposed rules. We believe that the methodology used to recalibrate the DRG weights was described in sufficient detail to allow informed public comment. In this regard, we believe we have complied with the Administrative Procedure Act (5 U.S.C. 553).

All disclosable data and information are available to the public upon request. While we do not guarantee that requested information will be furnished in the format desired by the requester, we have responded and will continue to respond promptly to all requests for material and provide all the available data to assist the hospital industry and other parties interested in the evaluation of our proposals for the prospective payment system.

In response to the specific request for the FY 1984 PATBILL data used in recalibrating the DRG weights, we made these data available at a July 2, 1985 meeting that was held specifically to present interested parties with a description of the data and methodology used to develop the proposed FY 1986 prospective payment rates. HCFA technical staff were available at the meeting to answer any questions concerning our methodology. While public meetings of this type may be helpful in the exchange of information and recommendations on regulatory matters, we still view the formal rulemaking process as the principal avenue for announcing changes in the Medicare program. The proposed rule was the formal instrument for disseminating our proposed policy concerning the payment rates, DRG weights, and other relevant factors for FY 1986.

As a part of the rulemaking process, we recognize our obligation to provide a reasonable period of time for interested parties to comment and make recommendations on our proposed policies. Yet, we do not believe that the fact that the PATBALL file was not disclosed at the time we published the proposed rule is a sufficiently strong argument to have extended the comment period and risk missing the September 1 publication deadline for the final rule mandated by section 1886(d)(6) of the Act. The PATBILL file is not necessary to comment on the significant issues related to the proposed methodology but is primarily useful only for the relatively minor purpose of checking the accuracy of our computations. We have not received any indication that we made computational errors. Section 1886(e)(5)(B) of the Act reiterates the requirement to publish the final rule timely for FY 1986. We believe that a 30-day comment period was justified considering our obligation to publish the new rates timely.

We would like to point out that in addition to disclosing the FY 1984 PATBILL file, we have readily provided, upon request, the hospital cost report file and the wage index raw data file. We believe that we have cooperated fully in furnishing information to the public, and we will continue to cooperate fully with proper requests for information.

Comment: One commenter recommended that we recalibrate the DRG relative weights annually.

Response: Section 1886(d)(4)(C) of the Act requires the Secretary to reclassify and recalibrate the DRG weighting factors for discharges occurring in FY 1986 and at least every four years thereafter. Under section 1886(d)(4)(D) of the Act, ProPAC is required to advise the Secretary on any adjustment of the DRG weights based on its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities.

Although the medical treatment of patients is evolving at a rapid pace, these changes do not automatically translate themselves into changes of the DRG weights. For example, changes in medical technology or practice patterns may result in the substitution of low risk procedures for high risk procedures, or procedure modifications within the same DRG may offset one another leaving resource consumption virtually unchanged. We believe that treatment changes in and of themselves do not necessarily alter resource consumption levels and often have no significant effect on the relative weights.

It is our opinion that recalibration should be performed periodically, as required by law, and when there is an indication that changes in practice patterns, technologies, or treatment modalities have significantly altered relative resource consumption patterns. We will also consider changes in the GROUPER Program that could alter relative consumption among DRGs. As a part of the process for considering when to recalibrate, we will review ProPAC's recommendations as well as comments from all interested parties. In essence, except for statutory requirements, we believe that a decision to recalibrate should be made when the accumulated evidence indicates a need for recalibration.

Comment: One commenter believes that the entire procedure currently in place for paying for discharges that include an unrelated operating room procedure (currently classified into DRG 468) should be reexamined. The commenter states that originally DRG 468 was intended to be used for cases that were ". . . truly different types of cases or were coding problems . . ." that were to be reviewed and reassigned to the DRG providing the fairest relative weight as indicated by the clinical circumstances. The commenter is concerned that the current method of payment for cases assigned to DRG 468 makes no sense clinically and can result in significant overpayments because of the high weight of DRG 468.

In lieu of the current procedure, the commenter proposed a procedure in which a Peer Review Organization (PRO) would review all DRG 468 cases to determine the necessity for admission, procedure, and length of stay. Payment for the discharge would be based on the average per diem amount of DRG 468 using the same procedure we currently use for day outliers. The commenter believes that this procedure would also solve the problem of patients who are assigned to DRG 468 because of complications that result from outpatient surgical procedures.

Response: We agree with the commenter that the present payment system may not provide the most appropriate payment amount for some cases that are assigned to DRG 468. Currently, payment for cases in DRG 468 is determined the same way payments for the other 467 DRGs are computed; however, DRG 468 is intended to represent a category of cases that cannot be logically assigned to any other DRG. Operationally, we have defined these cases as those in which all of the surgical procedures performed are unrelated to the patient's principal diagnosis. We have computed the relative weight of DRG 468 to reflect the relative resources consumed in the treatment of cases that are assigned to this DRG.

While the present system and method of payment may not be totally appropriate for the type of cases assigned to DRG 468, we believe that we are using the best method for determining this payment given the design of the prospective payment system. Currently, 100 percent of the cases assigned to DRG 468 are reviewed by a PRO for admission review and coding accuracy, and cases that are inappropriately coded are changed. This review process has served to substantially reduce the number of cases finally assigned to and paid under DRG 468.

In addition, as discussed in section II.A. of this preamble, we have revised the GROUPER program to include additional surgical procedures that could be associated with a particular MDC so that a discharge that includes one of these procedures will be assigned to the appropriate DRG rather than DRG 468. For example, procedure 7679 (open reduction of facial fracture, not elsewhere classified), commonly associated with principal diagnoses in MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissues), can now also be associated with principal diagnoses in MDC 2 (Diseases and Disorders of the Eye). Therefore, cases including a facial bone fracture in conjunction with a principal diagnosis of a disease or disorder of the eye will no longer be grouped into DRG 468.

Although we believe that these changes in the GROUPER program will further reduce the number of cases that could potentially be assigned to DRG 468, we recognize that these modifications do not address other problems of DRG assignment such as the one described by the commenter involving complications resulting from outpatient surgery. This issue requires further study.

Comment: One commenter objected to the recalibration methodology on the grounds that the DRG classification scheme fails to recognize and compensate for the severity of a patient's illness or condition within any given DRG. Citing a recent study on severity of illness,[2] the commenter argued that the current DRG-based payment system is inherently inequitable because it fails to account for the severity of illness differences among cases within DRGs.

Response: Without discussing here the specifics of the study cited by the commenter, the degree to which the current prospective payment system is creating distortions in the selection of patients for inpatient treatment is far from clear. However, the possibility of the failure of the DRG system to distinguish methodically among and account for resource use by severely ill patients is of deep concern to us. We clearly recognize our responsibility for constructing an economically neutral set of relative weights that will not systematically advantage hospitals that treat the relatively simple cases within a given DRG while denying treatment to other more severely ill patients because of the lack of appropriate economic incentives.

As a result of this concern for payment equity, we are anticipating conducting a research program to collect data and study the effects of severity of illness on hospital prospective payments. The study will also examine and test various competing measures of illness severity to determine which system or combination of systems affords us the best opportunity for improving the payment system with minimal disruption to the present system and minimal added implementation cost. If it is determined that severity of illness is a significant factor in resource use that is unaccounted for by the adjustments already made by the DRG system, we would certainly seek to recognize it appropriately through an equitable redistribution of payments.

Comment: One commenter suggested that because of the degree of variation between the previous set of DRG weights and the proposed set, the recalibrated weights should be phased in over a three-year period through a blending of the old and new weights. Based on an analysis of the recalibrated weights, the commenter believes that hospital revenues will be adversely affected. By having the new weights phased-in, the commenter hopes that the expected negative impact of the recalibration would be ameliorated.

Response: We disagree with the commenter's recommendation to phase in the new weights through a blending of the old and new weights for several reasons. First, by blending the two sets of weights, we perpetuate the use of outdated data in the payment formula. We believe that these data no longer reflect the current resource consumption patterns in either an absolute or relative sense. Nor do the previous weights reflect changes in practice patterns or technology that have occurred since 1981. We believe that retaining the old weights in the payment system through some form of blending would retain outdated data in the recalibrated weights, thus producing distortions in the payment amounts and diluting the effects of the recalibration.

In addition, if we recalibrate the weights annually by blending the previous year's weights with the recalibrated weights, we could create a situation in which old data were perpetually incorporated into the payment formula. We believe that the intent of Congress in including section

[2] Susan D. Horn, et al.: "Interhospital Differences in Severity of Illness: Problems for Prospective Payment Based on Diagnoses-Related Groups (DRGs), *New England Journal of Medicine*, Vo. 313, No. 1, 7/4/85, pp. 20–24.

1886(d)(4)(C) in the Act was to permit periodic updating of the relative weights to reflect the most current resource consumption patterns based on the most current data. Blended weights that are constructed using combined old and new data would defeat the purpose of this statutory requirement.

A further objection to the commenter's suggestion is that it only addresses the negative impact of recalibration on hospital revenues while ignoring any positive effects. Blending the weights that were in effect for FY 1985 with the recalibrated weights would only benefit those hospitals with discharges predominantly occurring in those DRGs whose recalibrated weights are lower than the FY 1985 weights. However, hospitals with discharges concentrated in those DRGs whose weights are increased by the recalibration would be disadvantaged if we adopted a blending recommendation.

In section J of the impact analysis, in the appendix to this final rule, we indicate that, in the aggregate, recalibration has an insignificant effect on hospital revenues. This lends support to our belief that the method used in recalibrating the weights, by itself, is neutral with respect to total hospital payments. (In fact, as indicated earlier in this section of the preamble, the recalibrated weights were normalized so that the average case weight using the recalibrated weights equals the average case weight using the weights in effect for FY 1985. Without this normalization, the average case weight using the recalibrated weights would have been lower.) It is the distribution of cases across hospitals that produces fluctuations in hospital revenues rather than the recalibration of the weights.

We point out that a decrease in a particular DRG's relative weight because of recalibration indicates that in FY 1985 we may have overpaid hospitals for discharges assigned to that DRG. Conversely, an increase in a particular DRG's weight indicates that hospitals were probably underpaid for discharges in that DRG for FY 1985. Blending the weights effective in FY 1985 and the recalibrated weights would merely maintain these inequities.

Finally, if the recalibrated weights represent the best available and most current measure of relative resource use, blending weights will potentially aggravate the cash flow problems of hospitals that have been experiencing losses because the current weights are based on out-of-date data. In effect, implementing blended weights would only create different categories of hospitals that are advantaged or disadvantaged; blending would not result in a technically superior set of weights. It is possible that an individual hospital could receive increased payments because of the recalibrated weights, just as another hospital may experience a decrease in payments.

D. Procedures for Making Changes During the Year

We stated in the proposed rule that we plan to make most of the changes we would want to make in the GROUPER program or the DRG classification system at the same time we publish the annual prospective payment rate notices required by § 412.8(b) in order to make the system as predictable as possible during the year. However, we believe that this interest may occasionally be overridden by the need to make certain changes on a more current basis to—

- Account for new items and procedures that become covered under Medicare during the course of the year; and
- Correct omissions or inequities that have a potentially substantial adverse impact on beneficiaries or a significant and unwarranted fiscal impact on the system.

We proposed to add a new § 412.10 to the regulations that would allow us to make these types of changes to the DRG classification system during the Federal fiscal year. We stated that these changes would be announced through HCFA's administrative issuance system. We also proposed that changes made under this provision of the regulations would be published for public comment in the next annual notice of prospective payment rates.

With one exception, which is described below, we did not made any significant DRG classification changes until now because we had not stated in previous documents that we would make changes outside of the overall recalibration and reclassification effort prescribed by section 1886(d)(4)(C) of the Act. However, we believe than when we identify cases that have a major fiscal impact, it is appropriate to deal with them as soon as possible after they are discovered so that appropriate levels of payment can be made.

In addition, Congress provided the Secretary with authority to reclassify services and procedures within the DRG system to take into account changes in medical technology and treatment patterns. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classification and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments are made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The intention of Congress was that we would make changes as often as needed to achieve the objectives of the prospective payment system, including the need to keep current with developments in the areas of coverage and medical technology.

We believe, however, that our decision to make limited changes in this way is consistent with the view of Congress, which exempted the establishment, methodology and weighting of DRGs from judicial review because of their complexity and ". . . the necessity of maintaining a workable payment system." (H.R. Rep. 25, 98th Cong., 1st Sess. 143 (1983).) In order to assure adequate public notice of these changes and an opportunity to comment on the coverage additions, we plan to publish an annual notice of classification changes for public comment, as described below.

The one change we have made already was to incorporate into the classification system two types of lithotripsy procedures so that Medicare beneficiaries could benefit from the procedures and hospitals could be paid for them once Medicare coverage was extended. In the case of these procedures, it was possible to incorporate them into the system by identifying the appropriate DRG and assigning an appropriate code. We included in the proposed rule (50 FR 24374) a full discussion of the process by which we determined how to make the lithotripsy change as an example of the approach we plan to take with interim changes. That change was subject to comment in the proposed rule along with the proposed procedures.

If the GROUPER program is not capable of assigning cases to the DRG that we have found to be appropriate, the Medicare Code Editor or manual claims review may be considered for use in the interim until GROUPER changes can be made.

Comment: Virtually all those who commented were disturbed by our proposal to make interim changes during the year by means of our administrative issuances system with all changes being subjected to public comment at the time of the first annual prospective payment update notice published after the changes were made. They all indicated the need for the opportunity for public comment before any changes are implemented. ProPAC, in its comment, pointed out that the law requires that we consult with it before making any changes.

Response: We recognize the basis for the concerns that were expressed by these commenters and have modified the approach we plan to take. We note, however, that the comments generally failed to take account of two important factors that affect the selection of procedures to use. First, as we noted several times in the proposed rule, we plan to implement very few changes other than during the annual notice of classification changes. We would make interim changes only to provide coverage of new items or services or to correct serious omissions or inequities. Our examples showed the type of rare situations of which we planned to take account.

The use of the full notice and comment process to make such interim changes would largely defeat the purpose of making them since that process can typically take from six to nine months to complete. We have, therefore, decided to establish two separate mechanisms for making interim changes apart from the annual notice of classification changes. Changes that are of the greatest importance are those that involve additions of coverage, and we still plan to implement these decisions by means of administrative issuances, since we do not believe that extensions of coverage should be delayed until the payment system can accommodate these changes in the most appropriate manner. Changes that involve omissions or inequities would be made formally, with a prospective effective date, through a **Federal Register** final notice with comment period, so that comments can be made by the public. Before either type of change takes effect, we will consider ProPac's comments. In order to assure adequate public notice and opportunity for comment, we will also include both types of changes in the annual classification notice discussed below. The coverage changes will be subject to formal comment; changes involving omissions or inequities already published in a **Federal Register** notice with comment period will be republished for purposes of providing complete information.

Comment: A number of commenters stated that any changes during the year would be disruptive because they would require modifications in hospital versions of the GROUPER program. They indicated that they needed a stable grouping and pricing mechanism during the year to conduct proper financial planning. They further suggested that all GROUPER changes (that is, classification changes) should be made before the annual updating process so that it would be available to them for analysis and for use in evaluating other changes. Some commenters suggested that software should be made available from Medicare without cost to the hospital.

Response: In part, we believe that the concern about disruptions is based on the mistaken belief that changes would be relatively numerous and would require reprogramming of software for grouping programs. We expect that these changes will be very infrequent and that hospitals will be able to make them manually until the next annual update of the GROUPER program. We do recognize that it would be more convenient for us, for ProPAC, and for the provider community to have annual GROUPER revisions completed before the annual prospective payment update notice and we have therefore decided to propose these changes separately. We will analyze all proposed changes in the classification system and the GROUPER program on a continuing basis and publish proposed changes in a separate notice early in the calendar year. (As noted above, this notice will also include for public comment all the interim changes made through administrative issuances during the previous year to accommodate coverage changes. Changes previously published that year in the **Federal Register** to correct omission and inequity problems will also be published as a matter of information but would not be subject to comment.) We will then analyze the comments and publish a final notice before or concurrently with the annual prospective payment update proposal. The changes will be effective beginning on the next October 1, at the same as the annual update on the prospective payment rates. Thus, both HCFA and the provider community will be able to evaluate the updating proposals by use of an updated GROUPER software package. Because it is not necessary for a provider to purchase such software in order to submit claims for Medicare payment, however, we did not accept the recommendations that Medicare provide the software without charge.

Although we are planning to publish future classification changes as discussed above, we have included in this regulation the classification changes proposed in the June 10 proposed rule as modified by the comments and suggestions we have received. We have also included some additional changes that we believe follow the principles discussed in the proposed rule or are similar to them. Future changes of this nature will, however, be published separately.

Some commenters will note that this preamble does not address certain GROUPER and classification issues they raised. This is because the suggestions either required indepth statistical analysis or a change in the ICD-9-CM coding system. All comments that fit these categories will be analyzed and reviewed during the next several months and actions on them will be published early in 1986.

In keeping with our commitment to review GROUPER and classification changes on an ongoing basis, any proposed GROUPER or classification changes should be made in writing. They should state succinctly the issue of concern. Any rationale for the change or supporting documentation should be included in the proposal and sent to the following address:

Health Care Financing Administration, Department of Health and Human Services, GROUPER Changes, P.O. Box 26681, Baltimore, Maryland 21207

An acknowledgment of receipt of the proposal will be sent.

Comment: We received several comments concerning the assignment of extracorporeal shock wave lithotripsy to the medical DRGs 323 and 324. The commenters believe that the resources consumed in the provision of this procedure are much greater than the resource consumption reflected in the weights for these two DRGs. They suggest that either the procedure be classified into DRGs 304 and 305 (surgical DRGs) or that a separate DRG be created.

Response: We appreciate the concern expressed by the commenters. However, based on the data available, we believe that DRGs 323 and 324 are the appropriate clinical classification for extracorporeal shock wave lithotripsy and that this classification will result in adequate reimbursement for efficiently operated, fully utilized lithotripsy centers.

We assigned extracorporeal shock wave lithotripsy to a medical DRG primarily because it is a noninvasive procedure and the clinical course of patients treated with lithotripsy, particularly length of stay, more closely resembles that of nonsurgical rather than surgical patients in the renal MDC. Measures of resource use for extracorporeal shock wave lithotripsy are currently limited because of the fact that the procedure was, until March 1985, considered experimental and, therefore, was not covered by Medicare. Consequently, the FY 1984 PATBILL file used for recalibration contains no extracorporeal shock wave cases.

However, we have reviewed limited charge data available from lithotripsy centers engaged in clinical trials, even though these data are from a different period from the remainder of bills used for recalibration, reflect low utilization, and, because clinical trials were underway, include the delivery of services that were furnished as an integral component of the research protocol (services that are not likely to be furnished to patients on a routine basis). In light of this analysis, we believe that the procedure does fit appropriately in the DRGs into which we have placed it. We will continue to monitor the resource intensity of this procedure to assure ourselves that this classification is appropriate and that payment is adequate.

III. Development of a New Hospital Wage Index

Section 1886(d)(2)(C)(ii) of the Act requires that we standardize the average cost per case of each hospital used to develop the separate urban and rural standardized amounts 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 the national rates be adjusted for hospital area wage levels as part of the methodology for determining the prospective payments to hospitals. To fulfill both requirements, we constructed a wage index to eliminate variations in the average cost per case.

We used calendar year 1981 hospital wage and employment data obtained from the Bureau of Labor Statistics (BLS's) ES 202 Employment, Wages and Contributions file for hospital workers to construct the wage index applied under both of the above provisions of the Act for computing prospective payments to hospitals during FY 1984 and FY 1985. The BLS ES 202 system compiles information on employment and total wages for workers covered by unemployment insurance.

We have been aware since the beginning of the prospective payment system of certain limitations of the BLS data, especially with regard to the lack of information on hours of employment or full-time equivalents. The BLS data provide information only on the number of workers employed at a hospital and their aggregate salaries. As a result, area wage indexes produced from these data do not distinguish between part-time and full-time employees. Although we recognized these shortcomings, we believed the disadvantages were outweighed by the advantage of being able to utilize the best national data available.

In an effort to overcome the limitation of the BLS data with regard to full time and part-time employment, we conducted a survey that we hoped would permit the analysis of options for the construction of an improved wage index. The survey provided for the extraction of specific hospital salary and fringe benefit data from the Medicare cost report for hospital fiscal years ending in calendar year 1982, and for the extraction from hospital records of data on paid hours worked. A complete description of the survey, as well as the survey results, can be found in the proposed rule published on July 3, 1984 (49 FR 27439), the final rule published on August 31, 1984 (49 FR 34764), and the June 10, 1985 proposed rule (50 FR 24375).

As we stated in the proposed rule, we computed two hospital wage indexes using the data from the 5,595 hospitals that were included in our survey data base. Both of these indexes were presented in our March 29, 1985 report to Congress on the HCFA wage index. One index is derived from gross hospital salaries; the second index is developed from adjusted gross hospital salaries. Adjusted gross salaries are defined as the net of wages for and hours worked by interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians.

The two indexes were developed from different categories of hospital workers. The index based on gross salaries and wages measures the difference from area to area in gross hospital wages; that is, the wages paid to all hospital employees, including interns and residents, provider-based physicians, and workers employed by the hospital but working in areas of the facility other than the hospital inpatient area. The other index is based on adjusted salaries and hours; that is, it eliminates the effect of interns and residents, provider-based physicians, and hospital workers in areas of the facility other than the hospital inpatient area.

Both indexes control for regional differences in part-time employment since each is based on the average hourly wage in each urban or rural area. However, because many hospitals have indicated that they had difficulty in determining the wages and salaries and hours worked for the excluded worker categories used to develop the adjusted gross wage index, that index is probably not as accurate as the gross wage index.

Therefore, we proposed to use the gross wage index, since we believe it is the better of the two wage indexes derived from the HCFA wage survey.

In the proposed rule (50 FR 24377), we set forth the method we used to compute the gross wage index as it appeared in that document. However, as is explained in detail in the comments and responses that appear below, we have incorporated corrected data into the survey data base. Therefore, the following is a corrected explanation of the method used to compute the gross wage index:

The method used to compute the gross wage index is as follows:

Step 1—Each of the 5,602 (5,595 in the NPRM) non-Federal acute care hospitals subject to the prospective payment system, for which a properly completed survey form has been received, is classified into its appropriate urban or rural area based on the Executive Office of Management and Budget's (EOMB's) metropolitan statistical area (MSA) definitions including the changes that were announced on June 27, 1985 and were effective June 30, 1985, (the NPRM used those definitions in effect as of June 10, 1985) and which would be recognized for prospective payment purposes beginning October 1, 1985.

Step 2—For each hospital, the total gross hospital salaries (item 4 on the survey report) are inflated from the end of the hospital's cost reporting year through the end of calendar 1982 using the annual 1982 rate of increase in the wages and salaries portion of the hospital market basket. The annual rate used was 11.0 percent. This is done to eliminate any distortion in the data caused by differing hospital cost reporting years.

Step 3—For each hospital, the inflated gross hospital salaries computed in step 2 are divided by the reported number of total paid hours worked (item 12 on the survey report) to yield an average hourly wage.

Step 4—Hospitals with an aberrant average hourly wage, which is defined as an average hourly wage either less than $3.35 (the minimum wage in 1982) or greater than $19.58 (2.5 times the 1982 national average hourly hospital wage as reported in BLS' *Employment and Earnings Bulletin* as of February 1984), are excluded. This results in the elimination of records from 63 (73 in the NPRM) hospitals.

Step 5—Within each urban or rural area, the result computed in step 2 is summed for all remaining hospitals to yield the total gross hospital salaries in each area.

Step 6—The total gross hospital salary result computed in step 5 is divided by the corresponding total number of paid hours worked to yield an average hourly wage for each urban or rural area.

Step 7—The arithmetic mean of the result in step 6 is computed across all urban and rural areas to obtain the national average hourly hospital wage based on gross salaries. The national average is $8.0253 ($8.03 in the NPRM).

Step 8—For each urban or rural area, the hospital wage index is calculated by dividing the average hourly wage computed in step 6 by $8.0253 ($8.03 in the NPRM), the national average.

On July 18, 1984, while we were conducting our survey, Congress enacted section 2316 of Pub. L. 98–369, which requires the Secretary to conduct a study to develop an appropriate wage index that specifically addresses the part-time employment problem. As mentioned above, this study was presented to Congress on March 29, 1985. In addition, section 2316(b) specifies that any changes made in the wage index under that provision of the law are to be retroactive to cost reporting periods beginning on or after October 1, 1983. We proposed to make the appropriate payment adjustments to overpaid and underpaid hospitals throughout FY 1986. The survey-based wage index used to determine the amount of a hospital's underpayment or overpayment would be based on the recognized urban/rural definitions in effect for the entire Federal fiscal year for which the payment adjustment determination is being made. We believe that spreading the payment adjustments over the course of one year, rather than requiring lump-sum payments, would minimize the negative impact on overpaid hospitals. Therefore, to accomplish these adjustments, we proposed that overpaid hospitals make 26 equal payments to us throughout FY 1986. Conversely, we would make 26 equal payments to underpaid hospitals over the same period of time.

We received 80 pieces of correspondence that contained comments on the proposed wage index. Reactions to our changes ranged from very positive to very negative; however, the majority of the commenters were in favor of the survey-based gross wage index. We have considered all of these comments quite carefully and have decided to proceed with implementation of the survey-based gross wage index as we proposed in the NPRM. Our reasons for doing so were set forth at length in the NPRM and are further explained in our responses to comments below.

Comment: Several commenters questioned the accuracy of the survey-based gross wage index, pointing out significant changes in the values of the index for specific locales that were perceived by the commenters as not being credible changes. Some commenters were highly critical of the way in which the survey was coordinated, characterizing the instuctions as ambiguous and citing the questionable nature of the preliminary survey results that led to the need for a follow-up effort to validate the accuracy of the initially reported records. We received several comments requesting that implementation of the gross wage index be delayed until we fully disclose all information that has a bearing on the validity and reliability of the survey and an opportunity for further public comment. Other commenters requested that hospitals be afforded an opportunity to submit corrected records if they can demonstrate that survey errors resulted in incorrect gross wage index values for their particular area.

Response: We wish to point out that the survey form and instructions for collecting hospital financial data in order to address the part-time employment limitation of BLS ES 202 records were reviewed and approved by a workgroup that included representatives from HCFA, the American Hospital Association, and State hospital associations from Connecticut, Ohio, Louisiana, Nebraska, and California. The survey instrument was designed with a view toward balancing the need to obtain comprehensive data by occupational category in order to correct all of the technical limitations of the BLS ES 202 data base with the desire to obtain data quickly in order to resolve the part-time employment problem in time for the FY 1985 update of the prospective payment rates.

For reasons that were discussed in detail in the July 3, 1984 proposed rule (49 FR 27439) and the August 31, 1984 final rule (49 FR 34764), the disappointing quality of the initial survey results precluded our adoption of a revised wage index effective October 1, 1984. Therefore, we subsequently afforded each hospital the opportunity to check the accuracy of the survey data reported for that facility. On July 2, 1984, we informed the Medicare fiscal intermediaries of this decision and directed them to send a letter to each hospital requesting that they check and, if necessary, correct the data reported. In our notification, we pointed out the sources of some of the more common errors in the survey reports, and hospitals were asked to review and ensure the accuracy of key data items.

In order to promote wide participation in the survey and ensure hospital cooperation in our validation effort, the various national and State hospital associations encouraged their respective memberships to complete the survey reports and return them to us promptly. Hospitals were furnished the name and telephone number of a contact in HCFA central office who could answer any questions concerning the proper completion of the survey report. In addition, HCFA staff attempted to resolve any discrepancies on validated survey reports by telephoning the hospital directly. In many instances, repeated contacts were made. Therefore, we must conclude that all hospitals wishing to participate in the wage index survey have been given sufficient opportunity to submit accurate wage and employment data.

With respect to the significant changes in the gross wage index compared to the 1981 BLS measures for certain locales, the HHS Office of the Inspector General (OIG) and our fiscal intermediaries audited key data items from the survey reports of 173 hospitals. Many of these hospitals were located in areas in which the Federal portion of the prospective payment rate, as computed by using the gross wage index, differed from that calculated by using the 1981 BLS index by more than 10 percent. Any corrections were incorporated in the survey data base. OIG concluded that, notwithstanding any differences between the reported and audited survey data for specific hospitals, their analysis indicated a very high degree of accuracy between the audited and reported data overall. Subsequent to the OIG's audit, additional corrected reports were added to the summary data base used to calculate the final gross wage index values that appear in Tables 4a and 4b of the addendum to this final rule. Some of these revised data were audtied, as indicated in the responses to comments below.

With respect to the comment that we should furnish an additional opportunity for public comment prior to implementing the revised wage index, we do not see how this would serve a useful purpose. Our report to Congress on the hospital wage index required by section 2316(a) of Pub. L. 98–369, OIG's report of its audit findings, as well as the data used to compute gross and adjusted gross wage indexes, have been available to the public both before and since the publication of the June 10, 1985 proposed rule.

We have expended considerable effort to provide hospitals with repeated opportunities to participate in the wage index survey and to submit corrected wage and employment records used to develop the gross wage index. Both HCFA and OIG have audited hospital records in areas in which implementation of the gross wage index

would significantly alter the Federal portion of the prospective payment rates to ensure the accuracy of the reported data. We have extended the deadlines for hospitals to submit their survey reports several times in order to obtain high quality records from as many hospitals as possible, which resulted in our delaying the issuance of the wage index report to Congress. Because we believe that hospitals have been provided ample opportunity to participate in the survey and to submit accurate records for purposes of constructing the gross wage index, we plan no further changes to the wage index values published in the addendum to this final rule.

Comment: Several commenters indicated concern about errors in the survey data that have been detected since the data collection was terminated (in order to allow HCFA to prepare the wage index report that was sent to Congress on March 29, 1985).

Response: We carefully reviewed any additional data received, as well as accompanying narrative, to determine the validity of altering the certified survey from data. The corrections received fell into four categories: corrections to the adjusted index data; minor changes to the gross wage index data; significant changes to the gross wage index data; and incorrect or inappropriate changes to survey data.

Many of the corrections to the survey data would have had an impact on only the adjusted wage index. Since we are not adopting the adjusted wage index, it is unnecessary to act on these corrections.

Each suggested change to the gross wage index data was reviewed for correctness and its impact on the area's wage index. If the reguested change had a significant impact in terms of average hourly wage amounts compared to the average hourly wage in the area or if the data submitted had not been certified by the hospital, we asked for further verification in the form of an audit. These audits were conducted by the Medicare fiscal intermediaries. Information contained in the audits was evaluated, and in most cases, the audited data have been incorporated in the final wage index values.

Information submitted suggesting that changes be made in recognition of events subsequent to the data collection year were not accepted as valid. These changes were not accepted because the survey was designed to extract uniform data covering the latest full cost reporting period in which audited data were expected to be available. Therefore, changes suggested as a result of subsequent events were not accepted. Subsequent events will be recognized in any later wage and employment data used to update the wage index.

In summary, we received additional data from 140 hospitals. Of these 140, we did not accept data from 40 for a number of reasons (for example, data from the wrong year). The data from 63 hospitals made no difference to the gross wage index because they either reflected no change to the data already on file or contained corrections to the data used in computing the adjusted wage index. Of the remaining 37, we accepted the changes from 13 hospitals without further review because the changes in the data had only a minimal effect on the hourly wage in the area, and we audited 24 hospitals. As a result of the audits, we accepted changes from 19 hospitals and did not accept changes from the remaining five. At this time, we anticipate that no further corrections will be made.

A number of hospitals also submitted revised data that they believe should have been included in the survey. A particular area of concern involved the use of contract labor by hospitals. While some hospitals may have included contract labor costs as salary costs on their Medicare cost reports, these costs are not generally considered salary costs. Therefore, in most cases, the wage data collected from the 1982 cost reports did not include contract labor. When the wage survey was initially designed, the workgroup members agreed that, in many cases, fees paid for contract labor may not be representative of area wages. Therefore, it was decided that no special attempt would be made to collect these data. (In fact, the survey form approved by the workgroup provided for the reporting of data that would allow for the removal of any contract labor costs that hospitals had happened to include in salary costs). The workgroup was also concerned that the survey impose as little additional reporting burden on hospitals as possible.

In light of the history of the development of the wage survey, we did not revise the data of any hospital that asked that its report be revised to include the costs of contract labor not reported as salaries on the Medicare cost report. While the question of whether a wage index should reflect these costs is a valid policy issue, it is an issue that is properly addressed on its own, and not in the context of corrections for the current survey wage data. Moreover, revising the data as these commenters indicated would have had the effect of raising the gross wage index for affected areas. This would have unfairly advantaged them compared to hospitals in other areas that would not have received the benefit of having their data similarly revised.

Comment: One commenter maintained that the proposed gross wage index did not differ materially from the BLS 1981 index currently in use, citing the reported .85 Pearson product-moment correlation between the two measures of hospital wage levels. The commenter suggested that our proposed adoption of the gross wage index on the basis of its similarity to an index that has been widely discredited is dubious at best.

Response: We have not cited the high correlation between the 1981 BLS and the survey-based gross wage indexes as evidence that supports that adoption of the latter measure. In our wage index report to Congress, we stated that this degree of correlation supports the position that despite the technical limitations of the BLS data, the use of aggregated data from all hospitals in each urban and rural area subject to indexing tends to mitigate the effect of any potential distortion for which no specific control was made. The correlation coefficient obtained, while statistically significant, only explains 72 percent of the variation in the BLS wage index associated with that of the gross index. While the BLS 1981 and gross wage index values are similar for many areas, there are also significant differences between the two values for other locales. We agree, however, with the commenter's implication that a very high degree of congruence between the BLS and either of the two survey based wage indexes (for example, as reflected in a perfect correlation coefficient of 1.0) would have been strong evidence in support of *not* revising the current index. Such a result would have indicated that the two survey-based wage indexes are equally as good at predicting differences in hospital wage levels as is the BLS wage index, and that replacing the BLS index with one of the others would not have yielded a superior wage index.

Comment: Several commenters pointed out that the gross wage index, while an improvement over the BLS measure, still fails to recognize the generally higher labor costs associated with hospitals within the more economically interdependent central counties of each urban area. These commenters recommended that we apply separate wage indexes to urban areas subdivided into "core" and "ring" (that is, inner city and suburban) counties.

Response: We have previously acknowledged that the current urban definitions that form the basis for constructing the area wage index may

not recognize the widely varying hospital labor conditions that can prevail within each locale. The implication of this comment, which is similar to ProPAC's recommendation 13 (see section V.B. of this preamble for a discussion of this recommendation), is that an alternative means for aggregating counties to obtain wage indexes more reflective of economically integrated areas needs to be investigated, not only for urban but for rural areas as well. Because of their greater specificity, the use of "core" and "ring" urban distinctions would, in principle, permit more precise urban wage index values. In practice, however, it is impossible to designate boundaries that will be completely satisfactory to all hospitals. Before any revised urban or rural definitions are adopted for the purpose of modifying the area wage index, we believe extensive research and analysis of potential impact will be necessary. Although we are examining other classification systems such as the Department of Commerce's Bureau of Economic Analysis economic areas, we intend to proceed carefully and must be certain that any alternative labor market definitions are an improvement over the current MSA/non-MSA classifications.

Comment: In the proposed rule (50 FR 24377), we explained that the denominator of each locale's gross wage index is the mean of the average hourly gross hospital wage computed for all urban and rural areas. The average hourly wage for each urban or rural area is weighted equally in determining the national average. One commenter maintained that using this method for computing the national average hourly hospital wage was upwardly biased and served to depress the wage index for areas in which hospital wage levels are lower. It was recommended that a more appropriate method would be to use a weighted national average in which each area's average hourly wage was weighted by the total number of paid hours worked in each locale.

Response: We believe that the current method of computing the national average hospital wage used as the base to develop the area wage index is logical and allows an understanding of interarea differences in wage levels. Each locale is weighted the same, regardless of the number of hospitals or size of the hospital labor force in the area. However, the choice of the base (that is, the national average wage level) used to index each area's average hourly hospital wage would have no effect on the Federal portion of a hospital's prospective payment, as long as the same wage index is used consistently to develop the labor-deflated regional and national rates and multiplied by the appropriate regional/national rate to derive the blended payment rates for the urban and rural locales. The following greatly simplified example (in which we assume that there are only two census divisions rather than the actual nine) demonstrates our point:

Urban areas A, B, C, D, and E each contain one hospital. Areas A and B are located in Census Division 1 while the remaining areas are in Census Division 2. Each hospital's labor cost per discharge, average hourly wage, area wage index, wage index deflated labor cost per discharge, and labor-related Federal portion of the prospective payment rate reflecting the FY 1986 regional/national blend are as follows:

Region	Area	Labor cost per discharge	Average hourly hospital wage	Wage index (WI)	Deflated labor cost per discharge
1	A	$4,000	$10.00	1.2500	$3,200
1	B	3,000	8.00	1.0000	3,000
2	C	2,625	7.00	.8750	3,000
2	D	2,250	9.00	1.1250	2,000
2	E	3,000	6.00	.7500	4,000

National Average Hourly Hospital Wage $8.00.
Region 1 Labor Deflated Standardized Amount $3,100.00.
Region 2 Labor Deflated Standardized Amount $3,000.00.
"National" Labor Deflated Standardized Amount $3,040.00.

CALCULATION OF LABOR-RELATED FEDERAL RATES

Region	Area	
1	A	.50 ($3,100.00×1.2500)+ .50 ($3,040.00×1.2500)=$3,837.50
1	B	.50 ($3,100.00×1.0000)+ .50 ($3,040.00×1.0000)=$3,070.00
2	C	.50 ($3,000.00×.8750)+ .50 ($3,040.00×.8750)=$2,642.50
2	D	.50 ($3,000.00×1.1250)+ .50 ($3,040.00×1.1250)=$3,397.50
2	E	.50 ($3,000.00×.7500)+ .50 ($3,040.00×.7500)=$2,265.00

In the example below, we perform the same calculations with the exception of computing the area wage index using an arbitrary national average hourly wage of $7.00. (This average need not be set arbitrarily. It could represent a case-weighted national average or average derived by weighting each area average using the total number of paid hours worked in each locale.)

Region	Area	Labor cost per discharge	Average hourly hospital wage	Wage index (WI)	WI deflated labor cost per discharge
1	A	$4,000	$10.00	1.4286	$2,799.94
1	B	3,000	8.00	1.1429	2,624.90
2	C	2,625	7.00	1.0000	2,625.00
2	D	2,250	9.00	1.2857	1,750.02
2	E	3,000	6.00	.8571	3,500.18

Arbitrary National Average $7.00.
Region 1 Labor Deflated Standardized Amount $2,712.42.
Region 2 Labor Deflated Standardized Amount $2,625.07.
"National" Labor Deflated Standardized Amount $2,600.01.

CALCULATION OF LABOR-RELATED FEDERAL RATES

Region	Area	
1	A	.50 ($2,712.42×1.4286)+ .50 ($2,660.01×1.4286)=$3,837.53
1	B	.50 ($2,712.42×1.1429)+ .50 ($2,660.01×1.1429)=$3,070.07
2	C	.50 ($2,625.07×1.0000)+ .50 ($2,660.01×1.0000)=$2,642.54
2	D	.50 ($2,625.07×1.2857)+ .50 ($2,660.01×1.2857)=$3,397.52
2	E	.50 ($2,625.07×.8571)+ .50 ($2,660.01×.8571)=$2,264.92

Except for slight differences due to rounding, the labor-related Federal amount in each area is the same regardless of whether the national average hospital wage used to develop the area wage index is area-weighted, hospital-weighted, or otherwise selected.

The following formula expresses the calculation of the labor-related portion of the standard payment amounts (regional or national):

$$Yj = \frac{1}{n} \sum_{i=1}^{n} \frac{Xi}{Wi/Z}$$

where Yj is the labor-related portion of the j^{th} standard payment amount, Xi is the labor cost per discharge of the i^{th} hospital, Wi is the average hourly wage in the area in which the i^{th} hospital is located, Z is the national average hourly wage weighted in any manner one chooses, and n is the number of the hospitals in the area of the j^{th} standard payment amount.

Since Z does not vary across hospitals in the summation, the equation above can be written:

$$Yj = \frac{1}{n} \left(Z\right)\left(\sum_{i=1}^{n} \frac{Xi}{Wi}\right)$$

The labor-related regional or national Federal payment (Pij) for the i^{th} hospital in the area of the j^{th} standardized payment amount is expressed as the product of the labor-related portion of j^{th} standardized payment amount and the wage index value applicable to the i^{th} hospital:

$$Pij = Yj\left(\frac{Wi}{Z}\right)$$

$$\text{or } Pij = \frac{1}{n}\left(Z\right)\left[\sum_{i=1}^{n} \frac{Xi}{Wi}\right]\frac{Wi}{Z} = \frac{1}{n}\left(\sum_{i=1}^{n} \frac{Xi}{Wi}\right) Wi$$

Since Z, the national average hourly wage, appears in the numerator and the denominator of this expression, it cancels out. Therefore, the method of weighting the average national wage has absolutely no effect on the labor-related Federal payment as long as the wage index is consistently applied in both standardization and payment.

Comment: Our commenter stated that the adoption of the gross wage index requires that the labor-related component of the cost per discharge values used to develop the regional and national standardized amounts be restandardized. It was alleged that the need to restandardize resulted from the method used to calculate the national average hourly hospital wage used as the base to compute each locale's index in which each urban and rural area is weighted equally. The commenter maintained that the need to restandardize could be avoided by reweighting the national average used as the denominator of the wage index to reflect the proportion of cases in each urban and rural area.

Response: We do not understand how reweighting the national average hospital wage would obviate the need for restandardizing the labor-related national and regional standardized amounts. As we discussed in the preceding comment and response, the choice of the national average hospital wage used as the base to calculate the wage index values is irrelevant as long as the resulting indexes are used consistently in developing the labor-deflated regional and national standardized amounts and multiplying these amounts by the area's applicable wage index. We restandardized the cost per discharge values used to derive the labor-deflated regional and national standardized amounts only because of the adoption of a new type of wage index.

We believe that revising the methodology for constructing the wage index does not avoid the need for restandardization but rather requires it, particularly since the survey-based gross wage index was explicitly designed to capture a different measure of area wage levels and, as a consequence, reflects different relative wage levels among areas. It is the effects of this difference that restandardization is intended to remove from the adjusted costs per case used to develop the standardized amounts.

Had we used a wage index developed from BLS ES 202 records for calendar year 1982 or 1983, we would in fact not have restandardized the labor-related national and regional standardized amounts. The reason is that the standardized payment amounts already have the effects of wage differences across areas removed from them, as such wage differences are measured by BLS. Any changes in BLS index values in subsequent years reflect different wage levels relative to an earlier time, not the effects of a different means of constructing an index. Those changes are precisely the kinds one would want the payment system to recognize. Restandardizing each year without new data potentially distorts the resultant payment rates, since it is based on the premise that variations across hospitals in a single year can be attributed repeatedly to subsequent years' events and relationships.

The point of standardizing for wages is to assure that each hospital's costs have been adjusted to what they would theoretically be if each hospital faced the same wage level as the national average. If this is successfully accomplished by whatever measure is

chosen for each hospital's wage levels relative to the national average, then it is never necessary to restandardize again as long as the type of index is not changed.

Comment: Several commenters endorsed the use of the adjusted gross wage index rather than the gross measure, pointing out that the adjusted gross index excludes salaries attributable to interns and residents, hospital-based physicians, contract labor, and employees working in nonhospital areas such as provider affiliated home health agencies and skilled nursing facilities. Because the adjusted gross wage index was constructed to control partially for differences in employment mix among hospitals by excluding salaries for physicians and employees engaged in hospital-based activities secondary to the provision of hospital services, these commenters believe that the adjusted gross index resulted in more comparable indexes among areas by reducing distortion due to area differences in occupational mix.

Response: Of the two survey-based wage indexes, we believe that the adjusted gross wage index is theoretically the better measure of hospital wage levels because of the greater uniformity of hospital occupational categories used in its construction. However, during the survey, many hospitals indicated they had difficulty in accurately determining the salaries and hours worked for the hospital worker categories excluded in developing the adjusted gross index. This is understandable since hospitals are not ordinarily required to record where employees are working at a level of detail that easily permits their classsification into separate categories. Therefore, the adjusted gross wage index is probably not as accurate as the gross wage index, a point that was clearly made in the wage index report to the Congress. Because the precision of the adjusted gross wage index is more problematic, we have addressed the part-time employment limitation of the current BLS index by implementing the gross wage index.

Comment: Several hospitals maintained that our use of the gross wage index rather than the adjusted gross wage index to develop the FY 1986 prospective payment rates unfairly penalizes those facilities whose gross wages did not include salaries for the worker categories excluded in deriving the adjusted gross measure. Compared to hospitals in the locales for which the gross wage index was constructed from survey data that includes salaries for the excluded categories, such as hospital-based physicians and contract labor, these hospitals pointed out that it is likely that their applicable gross wage index was understated. These commenters requested that either the adjusted gross wage index be used to develop the FY 1986 update of the prospective payment rates, or that hospitals be permitted to have their gross wage indexes recalculated to include the employee categories for which wages and salaries were not previously reported as gross salaries on the 1982 cost reports used for the wage index survey.

Response: We have not adopted the adjusted gross wage index for reasons explained in our response to the proceding comment. Compensation to hospital-based physicians and contract labor expenses are not supposed to be reported as salaries on the Medicare hospital cost report and ususally are not so reported. These expense categories, while they may include salaries for the affected physicians on the hospital's staff and wages for contracted workers, often include other remuneration and contract employer overhead expenses that should not be considered hospital wages. Therefore, these expenses are usually classified as "other" expenses on Worksheet A of the Medicare cost report and would not have been considered part of gross hospital salaries in completing the wage index survey report form.

If all hospitals had properly completed their 1982 cost reports that were used in the survey, both the gross and adjusted gross wage indexes would have excluded salaries for hospital-based physicians and contract labor. The survey instructions and July 2, 1985 letter requesting hospitals to verify the accuracy of the initially reported survey data (see Appendixes C and D of the March 29, 1984 wage index report to Congress) explicitly provided for the exclusion of salaries attributable to interns and residents, hospital-based physicians, contract labor, and employees working in nonhospital cost centers in reporting adjusted salaries and paid hours *only to the extent* that these figures were included as total gross salaries on Worksheet A of the hospital's cost report. We are not implementing the adjusted gross wage index. Therefore, hospitals that did not include contract labor expenses and salaries for provider-based physicians in reporting their gross salaries and total paid hours on their survey reports because their 1982 cost reports were completed correctly should not be permitted to have their gross wage indexes recalculated to include these figures.

Comment: In our proposed rule, we specifically solicited comments on how a survey-based wage index should be updated if we adopted such an index to develop the FY 1986 prospective payment rates. We received only a few comments in response to our solicitation. One commenter believes that if a survey-based wage index is implemented, we should establish a system for regularly updating the data used to complete the index. However, the preferred means for accomplishing this was not specified. Another commenter recommended use of the Medicare cost report as the appropriate instrument for obtaining the necessary wage and employment data to develop a more refined index. One industry association endorsed the use of a survey approach to obtain the required data, pointing out that the information necessary to compute the wage indexes should be more current than that contained in the cost reports.

Response: We believe that a method needs to be established in order to update the gross wage index, and we are committed to maintaining the quality and timeliness of this data. We are undecided as to how these goals could best be accomplished. In 1981, we proposed revising the cost report to obtain standardized wage and employment information to develop an improved wage index. However, at that time, certain segments of the industry opposed the use of the cost report for this purpose because of concerns over the disclosure of hospital-specific salary records and the additional reporting burden.

We believe that we can address these concerns while at the same time safeguarding the public's access to Medicare program data. Because the data elements that would need to be collected for obtaining more current and refined hospital wage and employment information will have a considerable bearing on selection of the appropriate reporting vehicle, we are deferring a final decision on how to update the gross hospital wage index. We believe further consultation with the industry is appropriate before proceeding any further on this issue.

Comment: One commenter suggested that the hospital industry be given access to the wage survey information in advance of its implementation so that it can validate its accuracy.

Response: We have worked with the hospital industry since the wage index survey began. The survey form itself was developed by a workgroup that was

comprised, in part, of several members of the hospital industry. In addition, each hospital was afforded the opportunity to validate the correctness and accuracy of the survey data. Over 92 percent of all hospitals subject to the prospective payment system submitted signed forms validating the completeness and accuracy of the data submitted. In addition, the data for a number of hospitals have been audited, and changes or corrections were made if appropriate.

In this connection, it should be noted that the Department's OIG, in a report submitted to the Undersecretary, stated that ". . . our analysis of these statistical data indicated a very high correlation of accuracy between the wage data reported to HCFA and the results of the audits. In fact, the correlation coefficient between the reported wages and hours and the wages and hours verified during the audits was .9999. This correlation coefficient is a statistical measurement of the strength of the relationship between the reported data and the verified data. Mathematically, the correlation coefficient cannot exceed +1 nor be less than −1. The closer a computed correlation coefficient is to one of these values, the stronger the relationship. A correlation coefficient of .9999 shows that providers generally reported accurate wage and hour data to HCFA."

Comment: Several commenters noted that while the gross wage index represented an improvement over the current BLS wage index because of its resolution of the part-time employment problem, the revised wage index still did not address the remaining technical limitations of BLS ES 202 records that prevent the construction of a more precise measure of area wage levels. These include the failure of the gross wage index to account for area variations in hospital fringe benefits, occupational/skill mix, and differences in labor markets not accounted for by the MSA/non-MSA definitions. Several of these commenters recommended that we undertake additional studies to further improve the gross wage index to account for these factors. Other commenters proposed that we make no change from the present BLS wage index until data can be obtained that would permit further analysis of these problems.

Response: We do not believe that the inability of the gross wage index to account for all of the factors that may be desirable in developing a very precise measure of area wage levels should present an obstacle to adopting an index that controls for local variation in the employment of part-time hospital personnel. Both the industry and Congress have advocated the adoption of a revised wage index that corrects the part-time employment deficiency of the index developed from BLS ES 202 hospital wage and employment data as soon as possible. Because this problem can now be addressed, we do not believe that delaying its resolution by deferring the implementation of a revised wage index would be appropriate.

Although the wage index survey solicited hospital employee health and welfare expenses (that is, fringe benefit costs), we did not compute wage indexes using the reported figures. The wide variability in the amount and scope of employee health and welfare expenses, coupled with the generally poor quality of the data reported, would have introduced a source of error in the development of a new hospital wage index that could have negated any increased precision due to correction of the part-time employment problem. However, further research is warranted on this issue to determine the degree to which hospitals in high and low wage areas weight their compensation between direct remuneration and additional fringe benefits. A potential future modification of the wage index to include a standard mix of fringe benefits has not been ruled out. For reasons explained in response to a previous comment, we did not adopt the adjusted gross wage index, which attempted to partially control for area differences in hospital occupational mix. Neither did we attempt to adjust the urban and rural definitions to better accommodate actual hospital labor markets. We believe further research and industry consultation are required before any legislative or regulatory proposals on these issues are recommended.

Comment: Although many commenters endorsed the use of the gross wage index because of its correction of the part-time employment limitation of the current BLS measure, several expressed strong concerns over its implementation retroactive to October 1, 1983. In several instances, affected hospitals estimated the adverse financial impact that retroactive implementation of the gross wage index would pose for facilities that would incur overpayments. Hospitals that perceived themselves to be particularly disadvantaged generally recommended the adoption of the gross wage index on a prospective basis only. Conversely, facilities that would receive additional payments if the gross wage index were adjusted retroactively generally favored its implementation effective October 1, 1983, and cited our obligation to comply with section 2316(b) of Pub. L. 98–369.

Response: We wish to point out that we have no administrative discretion not to comply with the provision. Section 2316(b) prescribes that any revised wage index that addresses the part-time employment limitation be implemented retroactively to October 1, 1983. Accordingly, we intend to meet our statutory obligation and make the appropriate payment adjustments to overpaid and underpaid hospitals based on the urban/rural definitions in effect for the Federal fiscal year for which the payment adjustment determinations must be made. Absent any Congressional action on this issue, we will begin making refunds to underpaid hospitals and collecting from overpaid hospitals after April 1, 1986. Detailed instructions to the Medicare fiscal intermediaries for accomplishing these adjustments will be issued as soon as possible.

Comment: Two comments were received endorsing the use of the survey-based gross wage index but recommending that its implementation by progressively phased-in over time by blending it with the 1981 BLS wage index so as to mitigate any adverse financial impact. One commenter supported a 50 percent blend between the 1981 BLS index and the gross wage index effective October 1, 1985. The gross wage index proportion would be increased to 75 percent of the blend beginning October 1, 1986 with full phase-in achieved in FY 1988. Other commenters recommended immediate implementation of the gross wage index retroactive to October 1, 1983, but suggested that any recoupment of overpayments be spread over two years rather than one year as originally proposed.

Response: We believe that phasing in the new wage index through a gradually increasing blend with the present BLS measure would only serve to perpetuate any existing distortion in the BLS index caused by its inability to account for local variation in hospital part-time employment. Therefore, we have not adopted this recommendation. However, we are concerned with mitigating any negative financial consequences for hospitals for which implementation of the new gross wage index would cause severe hardship. Therefore, as we proceed to develop methods of implementing the retroactivity provision, we will consider alternatives that would help reduce any adverse financial impact on these hospitals.

Comment: One commenter not only endorsed the use of the gross wage index retroactive to October 1, 1983, but also recommended its implementation for hospitals that exceeded their section 223 cost limits beginning in 1981. This commenter stated that hospitals that were disadvantaged by a lower wage index than would be justified compared to the gross wage index never received proper reimbursement from 1981 up to the present.

Response: Although adoption of the gross wage index requires its implementation retroactive to October 1, 1983 under section 2316(b) of Pub. L. 98–369, we will not go beyond the law by extending the application of the gross wage index to earlier reporting periods. The wage indexes used in connection with the annual updates of the cost limits prior to the establishment of the prospective payment system were based on the latest best available data consistent with a national hospital reimbursement system. We do not propose now to erode the prospective nature of the cost limits by retroactively applying a statutory provision only intended for the prospective payment system.

Comment: One commenter, citing the table that appeared in the impact analysis contained in the proposed rule (50 FR 24438), pointed out that the effect of implementing the gross wage index was a reduction in the payment of every bed-size class of rural hospitals. Thus, this commenter claims that the proposed wage index does not satisfy the original intent of either Congress or HCFA that a revised wage index correct the inadequacy of the prospective payment amounts to rural hospitals because of their greater utilization of part-time employees.

Response: We disagree with the commenter's premise. The purpose of adopting a revised wage index is not to assist a particular class of hospitals but to correct an acknowledged technical deficiency of the present BLS index; that is, its inability to account for local variation in hospital part-time employment. The fact that certain urban and rural hospitals may incur reductions in their total payment amounts as a result of the adoption of a more refined wage index is not an unexpected outcome of an improvement in the system. Whether particular hospitals as a class are disadvantaged or advantaged should have no bearing on our decision to replace the BLS wage index with an improved measure of area wage levels. However, we note that, while rural hospitals as a class do not benefit, many rural hospitals will receive increased payments.

Comment: One commenter pointed out that labor-related costs under the prospective payment system comprise approximately 80 percent of total inpatient operating costs. The commenter believes that hospital labor costs as a proportion of total inpatient costs have decreased over the past two years. The commenter recommends that we recognize this trend by applying the wage index to a smaller proportion of inpatient operating costs per discharge in developing updated prospective payment rates.

Response: Revisions in the market basket cost weights, including those that are considered labor-related for purposes of applying the hospital wage index, are presently under review as part of an overall rebasing and updating of the hospital input price index using later data. Once the necessary review and analyses are complete, revised market basket weights may be implemented in connection with further updates of the prospective payment rates. To the extend that the labor-related share of hospital inpatient operating costs is revised, the change will be recognized in the proportion of cost subject to adjustment by the area wage index in developing future prospective payment rates.

Comment: We received several comments that advocated that we adjust the nonlabor portion of the standardized amounts to account for geographic variation in nonlabor costs. One commenter maintained that a "labor" adjustment to these costs would not be inappropriate because a significant portion of nonlabor costs contains a labor component.

Response: We believe that the application of the hospital wage index to the average proportion of inpatient operating cost representing not only wages but also employee benefits, professional fees, costs of business services, and other miscellaneous expenses partially responds to this concern. In the final notice of the schedule of hospital cost limits for cost reporting periods beginning on or after July 1, 1980 published in the **Federal Register** on June 20, 1980 (45 FR 41868), we stated that the wage index, which is used to reflect area differences in wage levels that occur for a variety of reasons, also acts as a proxy for other variables affecting overall hospital costs that we have been unable to identify.

Now that we have adopted a revised wage index for use in the prospective payment system, the issue of whether we should modify the proportion of inpatient operating costs subject to adjustment by the gross wage index, or consider the development of a specific nonlabor index, will require further investigation and research. Revisions in the market basket cost weights, including those presently considered "nonlabor", are currently under review as part of an overall rebasing and updating of the hospital input price index.

In addition, section 2311(e) of Pub. L. 98–369 requires that we study the advisability and feasibility of varying by DRG the proportion of cost that is considered labor and nonlabor. These investigations will help us to determine whether explicit adjustments to the nonlabor share should be considered further.

IV. Other Changes to Current Regulations

A. Rate of Increase Limits (§ 405.463)

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248) added section 1886 to the Act in an attempt to restrain growth of hospital costs. Specifically, as originally enacted, section 1886(b) of the Act set forth a program of control on hospital cost increases. This provision required that we establish a target level for the allowable rate of increase of hospitals' inpatient operating costs per case. In addition, the statute provided for incentive payments for hospitals that keep their costs below the target, and penalties for hospitals that incur costs greater than the target.

This target rate system was expected to apply only to hospital cost reporting periods beginning before October 1, 1985 (section 1886(b)(2) of the Act). However, Pub. L. 98–21, which established the prospective payment system, also extended the target rate system indefinitely for all hospitals excluded from the prospective payment system by repealing section 1886(b)(2) of the Act.

1. Target Rate Percentage

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period, prorated based on calendar year target rate percentages. As set forth in section 1886(b)(3)(B) of the Act, as amended by section 601(b) of Pub. L. 98–21, the target rate percentage was the estimated hospital market basket increase factor plus one percentage point.

Section 2310 of Pub. L. 98–369 revised section 1886(b)(3)(B) of the Act to provide that, for cost reporting periods

beginning in FY 1985, the annual target rate percentage to be applied for updating the target rate is equal to the estimated hospital market basket increase factor plus one-quarter of one percentage point. Beginning in FY 1986 (cost reporting periods beginning on or after October 1, 1985), the target rate percentage will be equal to an update factor determined by the Secretary under section 1886(e)(4) of the Act, considering the recommendations of ProPAC under section 1886(e)(2) of the Act.

Currently, § 405.463(c)(3)(i) states that the target rate percentage is equal to the estimated increase in the market basket index plus one percentage point. We proposed to revise § 405.463(c)(3)(i) to reflect the changes made by Pub. L. 98-369. We received no comments on this issue.

2. Exemption for New Hospitals

When we published the regulations implementing section 101 of Pub. L. 97-248 on September 30, 1982 (47 FR 43282), we included a provision that exempted new hospitals from the target rate system (§ 405.463(f)(1)). We exempted new hospitals from the rate-of-increase limits to prevent the distortion inherent in a new hospital's operating cost per case from adversely affecting its target rate reimbursement. This exemption expired at the end of the earliest of—

- The first cost reporting period beginning at least two years after the hospital accepts its first patient; or
- The first cost reporting period beginning on or after October 1, 1985 (that is, the original statutory expiration date for the rate-of-increase limits).

However, when we revised the regulations at § 405.463 in the September 1, 1983 interim final rule, we inadvertently did not delete the October 1, 1985 date from § 405.463(f)(1). Since the reasons for providing a new hospital exemption remain as valid today as when the target rate system was first established, and since the statutory termination date of October 1, 1985 has been repealed, we proposed to revise § 405.463(f)(1) by deleting the October 1, 1985 expiration date for the exemption. We received no comments on this issue.

B. Exclusion of Alcohol/Drug Hospitals and Units (§§ 412.23 and 412.32)

In the January 3, 1984 final rule, we developed a set of criteria for the exclusion of hospitals and distinct part units that specialize in alcohol/drug dependency treatment. As provided in §§ 412.23(c) and 412.32, this exclusion terminates on October 1, 1985. However, if the exclusion expires on that date, all excluded alcohol/drug hospitals and units, regardless of their actual cost reporting period, would have to close their books and file cost reports as of September 30, 1985.

Since we originally intended these hospitals and units to be excluded from the prospective payment system for two full years, and because we believe it would be inappropriate to force excluded entities to close their cost reporting periods on September 30, 1985, we proposed to revise §§ 412.23(c) and 412.32. We proposed that the exclusion would expire at the end of the hospital's cost reporting period that began before October 1, 1985.

Comment: A large number of comments urged us to continue the exclusion of alcohol and drug treatment units and hospitals. They indicate that the newly reconstructed DRGs for alcohol and drug treatment are an improvement but that further refinements are necessary. The major refinement suggested is an increase in the payment for DRG 437 to reflect a mean length of stay of 16.9 days (instead of the 14.6 days reflected in the proposed rule). In addition, several letters were received from commenters who suggested that the exclusions should remain in place until further research has been done. Some of the letters cited statements in ProPAC's report to the effect that current research is proceeding and suggested that the results of that research be awaited.

Response: We note that the initial decision to create a temporary exclusion for alcohol and drug abuse treatment units and facilities was based on allegations by the treatment community and professional organizations that the grouping principles for the DRGs in question were inappropriate and that the resulting payments were generally inappropriate for the types of services clients typically were provided. During the past year, we have worked with our claims data and with NIAAA to develop groupings of cases that are consistent with the pattern in which the services are delivered. We have also made significant improvements in the coding of alcohol and drug cases. As a result, we have developed new DRGs that do follow the pattern in which services are generally provided.

We believe that these DRGs (see section II.B. of this preamble for a discussion of changes made in response to comments) are an appropriate expression of the clinical groupings of individuals who suffer from alcohol and drug abuse and who are in the Medicare age group. Because we have used the FY 1984 Medicare PATBILL file on alcohol and drug treatment cases in acute care general hospitals and excluded alcohol and drug treatment units and facilities to establish the weights, we know that they generally reflect the actual range of resources used during FY 1984 by Medicare hospitals for discharges falling into each new group.

We note that the HCFA research ProPAC refers to was conducted by us and described in the proposed rule (50 FR 24370). The research was concluded and resulted in the DRGs and weights contained in both the proposed rule and this final rule. Some commenters have suggested that the weights should be revised to reflect what they believe to be optimal clinical practice for the types of care they describe in their comments. We have noted in section II.B.1. of this preamble that the weights of the DRGs reflect actual clinical practice in hospitals that participate in Medicare.

We recognize, however, that further improvements in these DRGs are desirable to assure that the weights assigned to them capture the true range of resources used by currently excluded units and hospitals. Our analysis of alcohol and drug abuse claims leads us to conclude that coding practices for these cases need improvement. Although we issued an instruction to institute some improvements in coding, we believe further improvements are desirable and are undertaking them. Also, as noted in section II.B.1. of this preamble, in our discussion of the new alcohol and drug treatment DRGs, we have made some further refinements in the classification system. In order to assure that these DRGs are properly constituted and weighted, we have decided to continue the exclusion for another year for units and hospitals that are currently excluded and continue to be eligible for exclusion. During the next year, we will continue our efforts to improve coding practices and will continue to look at the new groupings we have developed. We believe that these actions will enable us to discontinue the exclusion, for cost reporting periods beginning on or after October 1, 1986.

In deciding to continue the exclusion, we decided to limit the extension to units and facilities that were excluded for their cost reporting period beginning in FY 1985. As noted above and by many of the commenters, our revised DRGs for these cases are greatly improved over the ones currently in effect. Thus, the appropriateness of payments to facilities and units not currently excluded will be improved when this final rule takes effect. Any hospital or unit that has not previously qualified for the alcohol/drug exclusion will be paid on the basis of the revised

DRGs set forth in this final rule. Since our overall objective is to eliminate reasonable cost reimbursement in short-term acute care hospitals, we do not believe it would be appropriate to temporarily exclude units and hospitals that have been operating under the prospective payment system at a time when the accuracy of our payment mechanism for these cases has measurably improved to a point at which the payment is fully adequate.

C. Review Activities

1. Responsibility for Medical Review (Subparts C and F of Part 412)

In the January 3, 1984 final rule, we used the term "medical review entity" to describe the various organizations that would be performing inpatient hospital medical review (49 FR 282). Now that the PROs are fully functioning, they have the responsibility for the medical review of hospital claims. Therefore, in Subparts C and F of 42 CFR Part 412, we proposed to replace all references to medical review entities, Professional Standard Review Organizations (PSROs), and to fiscal intermediaries as appropriate, with a reference only to PROs. We received no specific comments on this issue.

2. Limitations on charges to beneficiaries (§ 412.42)

In the January 3, 1984 final rule, we added § 405.472(b)(1)(iii) (since redesignated at § 412.42(c)) to allow prospective payment hospitals to charge beneficiaries for items and services excluded from coverage on the basis of § 405.310(g) (custodial care) or § 405.310(k) (medically unnecessary services) if certain conditions are met and the services are furnished by the hospital We provided this mechanism because the prospective payment system did not change Medicare's coverage rules and was not intended to prevent a hospital from charging a beneficiary for a noncovered service that he or she might choose to receive. In order to ensure that beneficiaries are protected from liability for noncovered services about which they had not been informed, we included § 412.42(c)(3), which requires that the written notice contain specific information.

Since implementation of the PRO program, we have received inquiries from some hospitals and hospital associations in States that either have a State reimbursement control system approved under section 1886(c) of the Act or participate in a demonstration project authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603), concerning the hospital's authority to charge beneficiaries for custodial or medically unnecessary care. Before the inception of the PRO program, many of these hospitals were delegated the PSRO review function; that is, they could review and deny services by issuing denial letters to beneficiaries. Under the PRO program, however, they no longer are delegated this authority.

Hospitals paid under a State reimbursement control system or demonstration project believe that they are at a disadvantage as opposed to prospective payment hospitals. They argue that they may be faced with situations in which they have to provide medically unnecessary or custodial care and there is no administrative mechanism that enables the hospitals to notify the beneficiary of noncoverage in a manner that the State will find provides a satisfactory basis for Medicaid payment for an ICF level of care in the hospital.

The hospitals can give notices of noncoverage under the waiver of liability regulation (§ 405.332). However, these notices, unlike the notices under the stricter requirements of § 412.42(c) applicable to prospective payment hospitals, can be given without the concurrence of either the attending physician or the PRO. Thus, the States operating under a State reimbursement control system or demonstration project are not prepared to accept these notices as a basis of Medicaid payment to the hospital for an ICF level of care. The hospital must wait for Medicaid payment until the PRO makes a retrospective determination regarding the level of care furnished.

We agreed that these hospitals are at a disadvantage and, therefore, we proposed to amend the regulations by adding a new § 405.308 to provide that the notice requirements of § 412.42(c) rather than § 405.332 would apply when a short-term acute care hospital (that is, a hospital that would be subject to the prospective payment system if it were not under a State reimbursement control system or demonstration project) receiving payment under a State reimbursement control system or demonstration project gives notice that a beneficiary who has been admitted for covered care no longer requires inpatient hospital services.

In the proposed rule, we stated that we had learned that some prospective payment hospitals have inappropriately implemented the notice process required by § 412.42(c), resulting in a detrimental effect on beneficiaries and inappropriate program payments. As we noted, we believe that these difficulties could be eliminated by increased oversight activity, and, therefore, we issued instructions to the PROs on this subject. The instructions (PRO Manual, Interim Manual Instruction, Transmittal No. 85–3) specify that the PROs are responsible for monitoring the notices used by hospitals and provide further guidance on the appropriate content of the notices.

We plan to continue to monitor this situation carefully to ensure that inappropriate notices are not issued. As we stated in the proposed rule (50 FR 24379), we will consider precluding hospitals from billing patients for any services if the situation does not improve. We do not believe that this step will be necessary, however, because our current authority provides a basis for a number of administrative actions to deal with individual hospitals that give inappropriate notices.

We note that the terms of Medicare provider agreements as expressed in 42 CFR Part 489 prohibit a hospital from billing a patient for services that are covered under Medicare. If a hospital does so (that is, if a hospital gives an inappropriate notice and then charges a beneficiary for care), Medicare may terminate its participation agreement. Thus, individual hospitals can suffer the loss of their provider status.

In addition, PROs have specific authority to make claims denials when a readmission is due to a premature discharge or when an unnecessary transfer is made. They also have the authority to recommend sanctions when inappropriate notices are given or when inappropriate care is given. PROs must also confirm any hospital notice of nonconverage with which the beneficiary or his or her physician disagrees. If a PRO finds that the notice is incorrect, a hospital may not bill the beneficiary.

Also, we proposed to revise §§ 412.42(c)(3)(iv) and 412.42(d)(4) to allow the attending physician as well as the hospital or the beneficiary to appeal a PRO's decision as to the validity of a hospital's finding that a beneficiary's stay is no longer covered care. We proposed to make a technical change in §§ 412.42(d) (3) and (4) to indicate that validation of a hospital's findings regarding coverage are made by the intermediary and the PRO (to the extent that there is a medical component to the decision).

We received several comments from hospitals, hospital systems, professional associations, unions, individual physicians, medical groups, and States

about the provisions on charges to beneficiaries. The major comments and issues raised are as follows:

Comment: One commenter expressed the view that allowing hospitals that receive payment under a State reimbursement control system or demonstration project to give notices and then charge beneficiaries for custodial or medically unnecessary care undermines Medicare's most basic protection and violates the law. The commenter believes that hospitals and physicians, not beneficiaries, should pay for decisions to keep patients in the hospital unnecessarily.

Response: Hospitals in States with a State reimbursement control system are already permitted to charge beneficiaries for medically unnecessary services, subject to the waiver of liability provisions of section 1879 of the Act. The provisions for payment for hospital services in these States do not prevent a hospital from charging a beneficiary for any noncovered services he or she may choose to receive. The new § 405.308 is designed to substitute for the waiver of liability rules governing charges for medically unnecessary continued hospitalization, the more stringent safeguards provided under the prospective payment regulations governing these charges. The rules for prospective payment hospitals, unlike the waiver of liability rules, require the concurrence of the attending physician or PRO before the hospital can give the notice of noncoverage.

It is desirable that hospitals be able to charge beneficiaries for a medically unnecessary continued hospitalization for two reasons. First, these charges are often required in order to induce the beneficiary to make the arrangements necessary to leave the hospital timely. Second, a continued hospitalization, while not medically necessary, may be desirable from the beneficiary's personal point of view. The regulations should not preclude a beneficiary from purchasing continued hospital care if he or she wants it.

Comment: One commenter noted that while the proposed regulations would govern the issuance of continued stay denials, other noncoverage letters (for example, at preadmission) are governed by Medicare's waiver of liability regulations. The commenter urged that all coverage denials should be subject to the same rules to ensure consistency and clarity.

Response: The waiver of liability regulations govern all notices regarding noncovered hospital admissions. The significance of these admissions does not differ appreciably whether the hospital is a prospective payment hospital, a State reimbursement control system hospital, or some other type of hospital. In the case of prospective payment hospitals, special safeguards on continued stay denials are necessary, however, and have been provided by the regulations. These safeguards are necessary because a finding that a continued stay is not medically necessary (permitting charges to the beneficiary) does not usually result in a corresponding reduction in Medicare payment to the hospital. Hospitals paid under a State reimbursement control system would ordinarily be subject to the waiver of liability rules with respect to continued stay denials, but many hospitals have requested that the more stringent prospective payment system rules apply to these continued stay denials in order to provide a firm basis for the State to pay under Medicaid in appropriate circumstances for the lower level of care provided after the denial.

Comment: Some commenters were critical of our statement that we may consider precluding hospitals from charging for medically unnecessary services and custodial care if the hospitals continue to fail to comply with the notice requirements of § 412.42(c) regarding continued stay denials. The commenters recommended that we continue to work with the hospital industry through the PROs to educate providers when necessary, and correct these deficiencies on an individual basis, rather than arbitrarily penalizing the entire industry. They suggest that we should not only issue clarifying instructions on the notice requirements to the PROs, as has been done, but also communicate these instructions to the hospitals in the Hospital Manual.

Response: We have no intention of dealing with this problem by generally eliminating, without cause, the right of hospitals to bill for medically unnecessary and custodial care. As we noted in the NPRM, we believe that steps we have already taken to eliminate this problem are adequate. Furthermore, we hope that the increased consciousness of the hospital community will render this issue moot. We already have the regulatory authority to terminate provider agreements with hospitals that charge beneficiaries for covered care and can move now to deal with individual hospitals that bill inappropriately. As we noted in the NPRM, however, we will monitor this matter closely to assure that beneficiaries generally are not being misinformed or disadvantaged by hospitals and will take any other appropriate action to prevent this behavior.

Comment: One commenter stated that certain PROs and intermediaries have taken inappropriate actions to discourage hospital determinations of noncoverage. Allegedly, PROs have warned hospitals that, if they make a determination of noncoverage and charge the beneficiary, the beneficiary will be totally ineligible for inpatient Part A coverage for a period of 60 days following the date of discharge regardless of the medical necessity of any subsequent services. Additionally, the PROs are reported to have stated that even if a PRO is consulted on a medical necessity issue and concurs with the hospital, it reserves the right to reverse its own decision.

Response: If a PRO or intermediary made the statement that a determination of noncoverage could restrict the eligibility of a beneficiary for future Part A coverage, it gave completely erroneous information. A PRO could reverse its original concurrence with respect to a hospital finding of noncoverage on review, but this should rarely happen and then only on a finding that the original concurrence was on the basis of misinformation or the receipt of new and material evidence. We will look into these allegations of questionable actions by PROs and intermediaries.

Comment: A number of physicians, primarily radiologists, commented on the change in § 412.42(d)(4) that permits an attending physician to be among the individuals entitled to appeal an intermediary or PRO decision that certain diagnostic or therapeutic services were medically unnecessary. The commenters suggested that they, too, as physicians performing diagnostic testing on a referral basis, should have the right to appeal these denials because they have an interest in receiving payment for their services.

Response: We understand the concerns of these physicians; however, we do not believe that the right to appeal these denials should be extended to them. The services with which we are dealing here are hospital services, not physicians' services. The purpose of an appeal is to permit the interested party to demonstrate that there was a medical basis for providing or ordering the service in question. The hospital is given the right to appeal the decision because it furnished the service; the attending physician is given the right to appeal because he or she ordered the services. A referral physician, by definition does not establish the medical need for his or her service: the order of the attending physician is accepted. Therefore, there

is nothing for the referral physician to appeal.

If the Medicare claim from a physician who provided a service ordered by another physician is denied, the physician may bill and collect from the beneficiary, subject to the terms of the Medicare assignment agreement. On the other hand, if the referral physician submits a claim to Medicare for his or her own services, and the claim is denied because the services are found to be not medically necessasry, the physician has the right to appeal that decision.

3. Admission Pattern Monitoring (§ 412.45)

We proposed to delete § 412.45, which concerns admissions pattern monitoring, from the regulations because our operating experience with this type of review has led us to begin developing procedures that are more efficient and that use more current data than the data referred to in § 412.45.

Comment: Some commenters suggested that the revised procedures that we are developing for admission pattern monitoring should be included in a regulation that is published in the **Federal Register** with an opportunity for public comment.

Response: We believe that the commenters may have misunderstood our intent in deleting the specific procedural requirements of admission pattern monitoring from the regulations. The provisions we are deleting were written at a time when we did not have enough operational experience with the PRO program to identify the types of review and the intensity of review that were appropriate. Our experience has led us to understand that the volume of claims and review procedures to which the regulations bound us were not cost effective and to seek other, more current and focused means of achieving the desired result.

We agree with the commenters that review activities should be planned so that there is a minimum of wasted effort—either by PROs of by the hospitals. We believe that this effect is most effectively achieved by avoiding general prescriptive regulatory review formulas and relying, instead, on approaches to admission pattern monitoring that are data oriented and hospital-specific. Therefore, we have deleted this section from the regulations.

4. Other Medical Review Issues

Although we proposed no changes in the physician attestation requirements contained at § 412.46, we received a number of comments on them and we believe it is appropriate to clarify the policy here.

Comment: One commenter noted that some hospitals have or are installing automated medical records systems that do not involve the use of many paper documents and asked if the signature required under the physician attestation requirement could be an "electronic" one; that is, a computer code or other physician identifier.

Response: As we noted in previous documents (most recently in the August 31, 1984 final rule (49 FR 34735)), an actual signature is required under § 412.46. An electronic code will not suffice. It is critical that the physician's actual signature be submitted since the payment made is based on the information provided by the physician and the physician is liable for the correctness of the information.

Comment: One commenter objected to requirements, which are imposed by PROs, that the physician attestation statement be dated. The commmenter noted that the regulations requiring this attestation do not require that it be dated.

Response: Although the language at § 412.46(a) does not require a date, the regulations do require that the attestation statement be completed before a claim is submitted. We believe that a dated attestation is the most sensible method of demonstrating that this requirement has been met.

D. Payment for Cost Outliers (§ 412.84)

Under the prospective payment system, an additional payment is made to hospitals for a typical case known as "outliers." These are cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG. A cost outlier case is a discharge that does not qualify as a day outlier case but in which covered charges adjusted to costs exceed the greater of a fixed dollar amount or a fixed multiple of the Federal prospective payment rate.

Currently, § 412.84 requires that, in the case of a cost outlier, the hospital must request medical review of all services furnished to the beneficiary. This medical review is performed before the additional amount requested by the hospital can be paid. Of course, if the medical review determines that some of the services are noncovered, the charges for those services will not be considered in determining if the claim meets the cost outlier threshold or the outlier payment amount.

We proposed to revise § 412.84 to provide that medical review prior to payment of cost outliers would not be required. However, if the PRO finds that a hospital has a pattern of inappropriately claiming these payments, the PRO could increase review of that hospital's claims, including review of all cost outlier cases for that hospital prior to payment. For cases in which payment is made for a cost outlier prior to medical review, the PRO would review a sample of these cases after payment. If the PRO determines that any services furnished in these cases are noncovered or inappropriately billed, the outlier payment for those services would be recovered from the hospital.

In addition to these changes, we would also revise § 412.84 to allow hospitals to request an outlier payment at the time they submit the bill for the discharge rather than waiting until they receive the intermediary's determination of the prospective payment rate for the discharge.

The majority of commenters were very much in favor of these proposed changes. However, the following issues were raised.

Comment: One commenter questioned whether the changes concerning review of cost outliers would revoke the intermediaries' current option of withholding the entire Medicare payment until the PRO has reviewed the claim.

Response: Under the revised regulations, intermediaries will no longer have an option for processing cost outlier cases. Except for claims from those hospitals placed on prepayment review by the PRO, the intermediary will process outlier claims just as it does any other claim under the prospective payment system. If cost outlier payment is requested with the initial submission of the bill, that payment will be included in the initial payment. The outlier portion of the payment is, of course, subject to recovery pending the outcome of any PRO review. If cost outlier payment is not requested in the hospital's initial submission of the bill, the basic DRG payment will be made and the hospital may request the additional outlier payment within 60 days.

Of course, if a hospital has demonstrated a pattern of inappropriate billing, the PRO may place the hospital under special review procedures. These procedures may include increased review of cost outlier cases or review of cases prior to payment. We expect that the need for prepayment review will occur infrequently.

Comment: One commenter believes that the new procedures would place a heavy burden on fiscal intermediaries

that may outweigh the benefits of such a change.

Response: We do not agree that the proposed changes would place a burden on the intermediaries. Day outlier payments prior to medical review have been authorized since January 1, 1984 (see the January 3, 1984 final rule (49 FR 311)). There has been little difficulty with this process and, therefore, we believe that there will be little difficulty in extending the policy to cost outliers. We will, however, continue to monitor the impact of this change closely in terms of administrative burden and program cost.

Comment: Commenters expressed concern that the sample level of cost outlier reviews currently prescribed in our administrative issuances is excessive in light of the low denial rate.

Response: The revised regulations deliberately do not define the sample size for review of cost outlier cases. They are intended to provide flexibility so that we may alter administratively the number of cases reviewed by the PRO as necessary. We have suggested that, at a minimum, 50 percent of cost outlier cases should be reviewed. However, PROs have the flexibility to review more claims from an individual hospital based on the hospital's past performance. We intend to continue to monitor denial rates in this area. If we believe it is appropriate to further reduce medical review of cost outliers, we will take action through our administrative issuance system.

E. Referral Centers (§ 412.96)

Hospitals may qualify as rural referral centers under three different approaches. Most hospitals qualify using the criteria set forth in § 412.96(c). One of the criteria that a hospital must meet under § 412.96(c) is that it has a case-mix index value that demonstrates the comparatively high degree of complexity of cases treated by the hospital. We believe a high case-mix index value helps to demonstrate the comparability of rural referral centers to urban hospitals in the same region. In the August 31, 1984 final rule, we set forth in § 405.476(g)(1)(iii)(A) (redesignated as § 412.96(c)(1)) four different case-mix index criteria, of which a hospital must meet at least one in order to qualify as a referral center for cost reporting periods beginning on or after October 1, 1984. These case-mix criteria are also factors against which a referral center is judged during its triennial review.

In the NPRM, we proposed to update the case-mix index values effective October 1, 1985 using the most current data we have available on case-mix. In addition, we proposed to revise § 412.96 so that, rather than state the actual criteria, it will describe the process we will use to calculate the case-mix indexes and will provide that we will publish the updated case-mix index values in the annual notices of prospective payment rates. These case-mix criteria would also be used during HCFA's triennial review to evaluate hospitals that are currently granted referral center status.

We proposed that, to qualify as a referral center for cost reporting periods beginning on or after October 1, 1985 under § 412.96(c)(1), a hospital's case-mix index during FY 1985 under the prospective payment system be at least—

- 1.1172; or
- Equal to the median urban case-mix index values calculated by HCFA for the census region in which the hospital is located as indicated in the table below.

Region	Adjusted median urban case mix
1	1.1443
2	1.1616
3	1.1226
4	1.1345
5	1.0955
6	1.1085
7	1.0542
8	1.1454
9	1.1638

For both the national case mix and median urban values, we multiplied the 1981 standards as published in the August 31, 1984 final rule (40 FR 34741) by 9.6 percent. This figure represented the percentage by which the average case-mix index value had increased from 1981 to bills processed through April 1985. The resulting figure was divided by 1.0105 to account for the reduction in the DRG relative weights for discharges occurring on or after October 1, 1984. (See the August 31, 1984 final rule (49 FR 34770) for a detailed discussion of this matter.) Thus, the proposed national case-mix criterion was computed as follows:

$$\frac{1.03 \times 1.096}{1.0105} = 1.1172$$

The same method was used to update the 1981 regional median urban case-mix index values.

In the NPRM, we also proposed to revise § 412.96(c)(2) to specify that we would publish the criteria for the number of discharges in each year's annual notice of prospective payment rates. However, we did not propose to update the number of discharges criteria applicable to cost reporting periods beginning in FY 1985 because we did not have current data available on total inpatient discharges for individual hospitals. Therefore, as proposed, the number of discharges criteria published in the August 31, 1984 final rule (49 FR 34741) would be used for FY 1986. In addition, we proposed to revise the title of § 412.96(b) (which provides alternative methods of qualifying for referral center status to those in § 412.96(c)) to indicate that these criteria apply to cost reporting periods that began on or after October 1, 1983, and that these criteria continue to apply in the future. We also made a technical change to § 412.96(f) to clarify the provisions of that paragraph.

Comment: One commenter stated that the current § 412.96(c) (which sets forth the criteria for cost reporting periods beginning in FY 1985) must be retained in the regulations. The commenter believes that this is necessary to distinguish between the criteria for cost reporting periods beginning on or after October 1, 1984 and ending before October 1, 1985 and the criteria effective for cost reporting periods beginning on or after October 1, 1985.

Response: We do not believe that this is necessary. The August 31, 1984 final rule specified that the alternative criteria published at § 405.476(g)(iii) (redesignated as § 412.96(c)) were effective for cost reporting periods beginning on or after October 1, 1984. The revised criteria set forth in this final rule are effective with cost reporting periods beginning on or after October 1, 1985. Thus, we believe the distinction between the earlier and revised sets of criteria and the periods to which they are applicable is clear. It has always been true for the most part that when dealing with the criteria applicable to a particular period of time, one must return to the regulations in effect at that time. Thus, we do not believe the commenter's suggestion is valid.

Comment: One commenter pointed out that the current criteria for rural referral center status, such as patient origin distance (that is, a certain percentage of patients treated at the hospital live more than a certain number of miles from the hospital) and case-mix indexes, do not adequately define rural referral centers The commenter believes that the types of special programs developed at referral centers should be the key characteristic considered.

Response: We believe that if we change the criteria as the commenter wishes, we would then be relying on

subjective rather than objective and numerical standards. In a program as large and complex as the Medicare program, we believe that reliance on subjective standards should be avoided.

Standards such as the types of special programs developed at referral centers would be very difficult to develop because almost any hospital can claim that it performs some type of service better than any other hospital in its vicinity. Even if these standards could be developed, each hospital that applies would then have to be reviewed—probably onsite—by a team of intermediary or HCFA personnel and physicians. Such a review would be very time-consuming and expensive.

Establishing numeric standards such as case-mix index and number of discharges permits us to determine with relative ease whether a facility qualifies for a particular exemption. These standards can be measured exactly and applied uniformly to all hospitals. Furthermore, objective standards are fairest to hospitals because the hospitals know in advance how the standards are derived and applied. Thus, we believe that it continues to be appropriate to rely on the objective standards set forth in the regulations.

Comment: One commenter recommended that service-specific criteria for referral centers be developed rather than arbitrary criteria based on a hospital's case-mix index or number of discharges. The commenter believes that service-specific criteria would better recognize the differences that exist between referral centers and other hospitals.

Another commenter suggested that a scope of services criterion be substituted for the case-mix index criterion. The suggestion was that the scope of services in the rural hospital should be compared to that offered by hospitals of comparable bed size in the surrounding urban areas. This commenter believes that objective criteria could be developed using American Hospital Association (AHA) listing of services or the number of the MDCs in which the hospital had Medicare discharges. For example, if a rural hospital had discharges in at least 17 of the 23 MDCs, then the case-mix index criterion would not have to be met, although the other criteria (that is, number of discharges and medical staff specialists) would still have to be met. This same commenter also suggested that a rural facility be designated as a rural referral center if it meets the scope of services criterion and it is located in a county that is at least 95 percent surrounded by areas designated as urban, even though it does not meet the case-mix criterion.

Response: We do not agree with the commenters' suggestions. As noted in the discussion of scope of services contained in the August 31, 1984 final rule (49 FR 34742), we believe that the criterion in § 412.96(c)(3) that at least 50 percent of a referral center's medical staff are specialists and the establishment of a case-mix index standard adequately address the scope of services measurement suggested by Congress in section 1886(d)(5)(c)(i) of the Act. In particular, we note that a high case-mix index value results from treating some of the sickest patients or patients that require complex services, and a hospital's ability to treat these patients generally means that it can furnish certain diagnostic and therapeutic services that are not readily available in most community hospitals. Any other potential standards, such as the AHA's Facility Codes or the MDCs, as suggested by commenters, would not, in our opinion, be as exact a measure of a hospital's devotion to treatment of the most ill patients as is the case-mix index standard.

The AHA uses over 50 Facility Codes that describe services and facilities available within each hospital. Some of these codes, such as abortion services and obstetrics, represent services that are used relatively infrequently by Medicare beneficiaries. Other codes, such as hospital auxiliary, volunteer services, and health promotion, are not relevant to a hospital's treatment of the sickest patients.

Similarly, we do not believe that using MDCs would be appropriate. Because the MDCs are based on organ systems of the body, the number of MDCs into which a hospital's patients are classified is, at best, a measure of the number of organ systems a hospital is prepared to treat. Since there are, in general, relatively low-weight and high-weight DRGs in virtually all of the MDCs, such a measure would not necessarily indicate that a hospital treats difficult or complex cases within an MDC. On the contrary, it is quite possible that a hospital could treat patients in the entire range of the MDCs but only those DRGs with low weights within each MDC, transferring to other hospitals all patients who would fall in the higher-weighted DRGs precisely because the hospital is not prepared to handle complex cases. Finally, we note that using a criterion based on the number of MDCs could adversely affect the status of specialty hospitals that are organized to treat patients in a relatively small number of MDCs and that, in light of their high degree of specialization, do serve as regional or national referral centers.

Scope of services would also be far more difficult to monitor than use of the case-mix index, which is easily determined and also used for other purposes. Comparison of a rural hospital's scope of services to the scope of services offered by urban hospitals of comparable size could be particularly subjective.

Section 1886(d)(5)(C)(i) of the Act states that a referral center should demonstrate that its characteristics are "similar to those of a typical urban hospital located in the same census region." In defining the characteristics of a typical urban hospital, we determined that comparable bed size was less relevant to a hospital's serving as a referral center than other characteristics. Accordingly, we developed criteria that rely on case-mix index and volume of discharges, using urban median values of both as a measure of typicality within each census region. (See the August 31, 1984 final rule (49 FR 34741).) In determining what a typical urban hospital would be, we believe that comparable size is less relevant than these characteristics. In addition, since rural counties are bounded by urban counties to varying degrees, some rural hospitals would be compared to only a few urban hospitals while others would be compared to many hospitals.

A commenter suggested that a rural hospital should be designated as a rural referral center under § 412.96(c) if it meets the scope of services, discharge, and medical specialist criteria, and if it is located in an area which is 95 percent or more surrounded by areas designated as urban. We have determined that there are approximately 30 hospitals in 12 counties that are substantially surrounded by urban areas or by bodies of water. In addition to this particular group of hospitals, we note that hospitals in numerous other rural counties similarly argue that they are like a neighboring county's urban hospitals and, therefore, ought to be deemed rural referral centers in order to be paid the urban rate. In our opinion, to permit these facilities to become rural referral centers without consideration of their case-mix index values would be inappropriate. The underlying principle of section 1886(d)(5)(C)(i) of the Act is that the hospitals that wish to be designated as rural referral centers must be able to demonstrate that they resemble typical urban hospitals, not that their geographic location is like an urban location.

We believe that the case-mix index is an important measure in determining a rural referral center's status because it measures the complexity of a hospital's cases and differentiates a true referral center from other rural hospitals. To substitute characteristics such as the percentage of the counties' boundaries on urban areas would undermine this important element in determining which hospitals qualify as rural referral centers.

Comment: One commenter objected to the inclusion of a number of discharges criterion. The commenter pointed out that in many rural communities one hospital may meet all of the criteria to qualify as a rural referral center, while another hospital in the same community cannot meet the volume of discharges criterion and, thus, is severely disadvantaged financially. Instead of making the discharge criterion mandatory, the commenter suggested that we look at the volume of discharges in a community rather than on an individual hospital basis, that we make the discharge criterion optional, or that we drop the concept of rural referral centers altogether.

Response: At the time the original prospective payment legislation was passed, there was no existing definition of referral centers. We therefore relied heavily on Congressional reports for guidance in defining the criteria for qualification for the rural referral center adjustment. Throughout congressional discussions, there were references to "large" facilities that treat "patients who require an intensity of resources beyond the capabilities of general community hospitals." Congress also referred to such centers as "large, technologically sophisticated hospitals" (129 *Cong. Rec.* S3224 (daily ed. March 17, 1983)). Thus, we determined that we should include a criterion to measure size. We considered other measures of size, such as bed size, but ruled them out because they do not necessarily reflect the number of patients treated by the hospital. We believe volume of discharges is the fairest and most accurate measure of size, an element that Congress clearly intended us to consider.

While we understand the difficulties inherent in one facility qualifying for the adjustment while a neighboring facility does not, we do not believe that these difficulties justify extending the provision to a hospital that clearly does not meet the current criteria. Regarding the alternatives offered by the commenter, we do not believe any are acceptable. Defining a community would be very difficult. Regardless of how the boundaries were established, there would be some hospitals just outside them that would be faced with the same difficulties that this commenter now faces; that is, that nearby hospitals are granted an adjustment while they are not. Also, we do not believe a community concept is in keeping with congressional intent. The law refers to "referral centers" and "hospitals"—not to communities.

The community concept could also result in some very small hospitals acquiring the adjustment by virtue of their proximity to a large hospital, or a very large hospital that meets the criteria not receiving the adjustment because of its location in a community with several very small hospitals. For example, if the discharge criterion for a community that has two hospitals was set at 10,000 discharges, and one hospital has 9,000 discharges and the other has 1,000, then both would qualify as referral centers. However, if one hospital had 7,000 discharges and the other has 2,500, then neither would qualify.

Finally, with regard to the commenter's suggestion that the entire concept of referral centers be eliminated, we do not have authority to do this. Although the concept of an adjustment for referral centers was not included in our original presentation of the prospective payment system to Congress, Congress did enact this provision and, therefore, we must implement it.

Comment: One commenter pointed out what appears to be a discrepancy in the proposed rule between the language on number of discharges in the preamble and the language in the regulations text. The preamble language stated (50 FR 24381), "Therefore, the criteria published in the August 31, 1984 final rule (49 FR 34741) would be used for FY 1986." The commenter believes that this means that a hospital that had 6000 discharges in 1981 could still meet the discharge criterion. However, § 412.96(c)(2) as presented in the proposed rule (50 FR 24388) states that "For the hospital's most recently completed cost reporting period, its number of discharges (excluding discharges from subprovider units and newborn units) is at least 6,000 . . . ."

Response: We agree that the language in the preamble could cause confusion and that it should have read "the number of discharges published in the August 31, 1984 final rule would be used for FY 1986." As proposed, a hospital seeking to qualify as a referral center for cost reporting periods beginning on or after October 1, 1985 must have had at least 6,000 discharges in its most recently completed cost reporting period, not in 1981, the time period specified in the current regulations.

Comment: Several hospitals wrote to protest the fact that we retained the original volume of discharges criteria while they claim that admissions have declined since 1981. One commenter specifically wanted the 1981 alternative retained; that is, a hospital would meet the discharge criteria in the future if it had 6,000 discharges in 1981.

Response: The 1981 standard was included originally because it was the last year for which we could accurately determine the total number of discharges for hospitals. We do not believe that continuing to permit a hospital to qualify forever based on 1981 experience is appropriate. The 1981 data are not relevant to a hospital's qualification for rural referral center status five or more years later.

We agree with the commenters' observation that there has been an overall decline in the number of discharges since 1981. However, as noted in the proposed rule, current data are not available on total inpatient discharges for individual hospitals (50 FR 24381). While sample data from the AHA's National Hospital Panel Survey for 1984 indicate that admissions have declined by about four percent nationally from 1981 through 1984, we do not yet have complete data on the distribution of this decline by type of hospital. It appears that much of this decline is related to efforts to shift certain kinds of cases to outpatient departments and other less resource-intensive settings. We believe that hospitals serving as referral centers, because they are organized to treat the sickest patients and the most complex cases, would be less able to shift patients to outpatient and other ambulatory care settings. Therefore, we have not revised the number of discharges criteria. The criteria published in the August 31, 1984 final rule (49 FR 34741) will be used for FY 1986. The national discharge criterion is 6,000 discharges in the most recently completed cost reporting period. The regional median urban discharges are set forth in the table below.

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

Region	Urban discharges
8	9,928
9	5,564

Comment: One commenter suggested that data from hospitals that offer highly complex and sophisticated care be deleted in determining the median urban case-mix index criterion. The commenter's rationale was that the urban benchmark becomes skewed when it includes case-mix data for large teaching hospitals, national referral centers, research centers, and other hospitals of this type. This commenter also questioned some of the wording in our discussion of the triennial review for hospitals other than those that failed to continue to meet the criteria for referral center in the first two years; specifically questioned is the meaning of "other situations" and experience in the first two years. Finally, the commenter claimed that the regulations were silent on the methodology and criteria to be used to conduct the triennial review.

Response: We do not agree with the commenter's suggestion concerning the median urban case-mix index values. In the first place, identifying these types of hospitals would be very difficult. Certainly, we could identify teaching facilities, but delineating research centers would be far more difficult since, to our knowledge, there are no existing, widely accepted definitions of these facilities. Use of these classifications is often by self-designation.

In its discussions of referral centers during passage of the original prospective payment legislation, Congress intended referral centers to be "large" facilities which treat "patients who require an intensity of resources beyond the capabilities of general community hospitals." (129 *Cong Rec* S3224–3226 (daily ed. March 17, 1983).) Congress also referred to these centers as "large, technologically sophisticated hospitals which serve as regional and national referral centers and which are characterized by high case mix indices, diverse geographical patient origin, and numerous multidisciplinary medical education programs." Thus, to delete the case-mix data of urban facilities of this type would be to delete data on the very type of facility that Congress envisioned as a rural referral center.

In fact, we could justify increasing the case-mix index value criterion by the percentage change in urban hospitals' average case mix, which would have been higher than the national average case-mix index increase, since rural referral centers are supposed to have characteristics similar to those of "typical" urban hospitals. We chose to use the national average case-mix index increase because it would be less disadvantageous to rural hospitals.

However, we have made two changes in the case-mix index criterion. The first is to apply the case-mix index criterion on a Federal fiscal year basis instead of a hospitals' cost reporting year basis. This will eliminate the need to recompute case-mix index values from data spanning two fiscal years using weights applicable to only one. Computation of hospitals case-mix index values spanning two Federal fiscal years requires estimates based on quarterly case-mix index values, which may disadvantage some hospitals seeking referral center status. Therefore, we believe a case-mix index value based on discharges occurring in a single Federal fiscal year will permit more precise and uniform application of the case-mix criterion.

Because the case-mix index criterion, which is based on a Federal fiscal year, is calculated for an earlier period of time than hospitals' cost reporting periods beginning during that fiscal year (except for October 1–September 30 cost reporting periods), we have also decided to update the criterion by the total national average case-mix index increase for discharges through the midpoint of the Federal fiscal year instead of through as much of the fiscal year for which we have case-mix index data. On the basis of hospital bills received in HCFA through July 1985 (FY 1985 discharges through March 1985), we have determined that the national average case-mix index increased by 10.8 percent since 1981. Using the same methodology as described in the proposed notice, we calculated the national case-mix criterion as follows:

$$\frac{1.03 \times 1.108}{1.0105} = 1.1294$$

Using the same formula applied to the census region, urban median case mix yields the following regional criteria:

Region	Adjusted urban median case mix
1	1.1568
2	1.1743
3	1.1349
4	1.1469
5	1.1075
6	1.1206
7	1.0658
8	1.1579
9	1.1765

These national and regional criteria figures replace those we announced in the proposed rule.

We note that the percentage increase used here to update the case-mix index criteria is higher than that used in the proposed notice, although the time period that the 10.8 percent case-mix index increase reflects is limited to FY 1985 through March 1985. The reason for this is the time lags between discharge date and receipt of bills in HCFA. In addition, the increase used in the proposed rule was based on case-mix increases using FY 1984 and FY 1985 bills, since we did not have a sufficient number of FY 1985 bills at that time to calculate a reliable estimate of FY 1985 case-mix increases relative to 1981. We now have sufficient data on FY 1985 discharges to calculate a reliable measure of case-mix increases.

Regarding the commenter's views on our discussion of how the triennial review will be conducted, we note that this was discussed in detail in the August 31, 1984 final rule (49 FR 34746). A reading of this section should clarify many of the commenter's concerns. "Other situations" refers to instances in which a hospital has met the criteria for either one or both of the first two years of its existence as a referral center. "Experience in the first two years" refers to whether or not the referral center met the criteria applicable to the periods in which it was classified as a rural referral center. Finally, both the methodology and the criteria to be used to conduct the evaluation are adequately defined in the proposed rule (50 FR 24380). Once a hospital meets rural referral center criteria based on prior experience, it will be paid at the urban rate for three years. In order to retain that status after the three years, it must continue to demonstrate that it meets the criteria.

The purpose of the triennial review is to assure that a hospital, having met the qualifying criteria to achieve referral center status based on a prior period, continues to resemble a typical urban hospital during at least two of the three years after it qualifies. Meeting the qualifying criteria does not automatically mean that a hospital will meet the retention criteria in its first year as a referral center. In order to meet the retention criteria, it must meet the same criteria for the same period as

other rural hospitals must meet to qualify for referral center status initially.

For example, if a hospital acquired rural referral center status anytime on or after October 1, 1984 and before October 1, 1985, it did so on the basis of criteria applicable to an earlier time period, such as 1981 or FY 1984. In order to retain referral center status upon triennial review, it will have to meet in its first year as a referral center the case-mix index, volume of discharges, and one of the optional criteria that are published effective October 1, 1985; that is, those published in this final rule. For its second and third years as a referral center, it will have to meet the criteria published in the annual notice of prospective payment rates that will set forth the rates effective for October 1, 1986 and October 1, 1987, respectively.

The following table demonstrates under which timeframes hospitals qualify for and continue to meet rural referral center status.

Qualifying criteria	Period of referral center status—cost reporting period beginning in fiscal year	Mandatory retention criteria for triennial review
Criteria for cost reporting periods beginning in FY 1985 as published in the August 31, 1984 final rule.	1985	Case-mix index criteria for FY 1985 and discharges criteria for cost reporting periods beginning in FY 1985 as set forth in this final rule.
	1986	Case-mix index criteria for FY 1986 and discharges criteria for cost reporting periods beginning in FY 1986 as set forth in the final notice of prospective payment rates for FY 1987.
	1987	Case-mix index criteria for FY 1987 and discharges criteria for cost reporting periods beginning in FY 1987 as set forth in the final notice of prospective payment rates for 1988.
Criteria for cost reporting periods beginning in FY 1986 as set forth in this final rule.	1986	Case-mix index criteria for FY 1986 and discharges criteria for cost reporting periods beginning in FY 1986 as set forth in the final notice of prospective payment rates for FY 1987.
	1987	Case-mix index criteria for FY 1987 and discharges criteria for cost reporting periods beginning in FY 1987 as set forth in the final notice of prospective payment rates for 1988.
	1988	Case-mix index criteria for FY 1988 and discharges criteria for cost reporting periods beginning in FY 1988 as set forth in the final notice of prospective payment rates for FY 1989.

The following examples using two rural hospitals with cost reporting periods beginning on January 1 help explain the above table:

Example 1

Hospital A had a 1981 case-mix index value of 1.08 and a discharge level of 7,000 in 1981. Because Hospital A also met one of the optional criteria, it qualified for rural referral center status beginning in January 1985 under the criteria published in the August 31, 1984 final rule. During the FY 1985 cost reporting period (that is, January 1–December 31, 1985), the hospital's case-mix index value rose to 1.13 and its discharges declined to 6,500. Since both of these criteria are higher than the minimum needed for qualification for FY 1986 (as set forth in this final rule), Hospital A meets the retention criteria for case mix and discharges for its first year of referral center status (assuming it continues to meet one of the optional criteria). The hospital's continued status as a referral center depends essentially on whether it meets the criteria for at least one more year in the following two years.

Example 2

Hospital B had a 1981 case-mix index value of 1.08 and a discharge level of 5,900 in 1981. Since it did not meet the discharge criterion, it could not qualify for referral center status beginning in January 1985. During its FY 1985 cost reporting period, Hospital B's case-mix index value rose to 1.13 and its discharges rose to 6,050. Since it will qualify under the criteria set forth in this final rule, Hospital B will be given referral center status beginning January 1, 1986 if it meets one of the optional criteria. It will keep referral center status at least three years. Hospital B's status as a referral center after that will depend essentially on whether or not it meets the criteria applicable to two of those three years.

Comment: One commenter stated that while our existing regulations do authorize additional payment for rural referral centers, they fail to acknowledge that urban hospitals may also serve as referral centers. The commenter requests that we review urban hospitals against the criteria to determine whether the hospital qualifies.

Response: The criteria in §412.96(b)(2) do apply to urban as well as rural hospitals. To our knowledge, only one urban hospital has applied under this section and its application was approved. However, we have not provided for any adjustment for this referral center because we have no data to show that an adjustment is warranted or justified.

Comment: One commenter believes that the rural referral center concept has been commingled with that of national and regional referral centers. The commenter would prefer that these two concepts be separated, as it is unlikely that most rural referral centers are analogous to the types of institutions described in the legislative history as national and regional referral centers.

Response: The original legislation that created that prospective payment system (Pub. L. 98–21) provided in section 1886(d)(5)(C)(i) of the Act that the Secretary take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas). The accompanying conference Committee report contained little clarifying language beyond the reference to very large acute care hospitals in rural areas. In our September 1, 1983 interim final regulations, we made a special payment provision for rural hospitals with 500 or more beds. We did not believe that other hospitals would need relief in the first year of the system when hospitals were receiving 75 percent of their payment based on their historical cost. In the January 3, 1984 final rule, we provided additional criteria for referral centers that apply to either urban or rural hospitals. These criteria depend upon referrals to the hospital by other hospitals and by physicians not on the hospital's staff, as well as the length of distance its Medicare patients traveled to receive care and the percentage of services furnished to those patients. We believe that these criteria were acceptable to Congress because the changes made to section 1886(d)(5)(C)(i) of the Act by section 2311(a) of Pub. L. 98–369 applied only to rural hospitals and that legislation did not add any new requirements for national and regional

referral centers. Thus, we have separate criteria for rural hospitals, as well as criteria that apply to urban as well as rural hospitals.

Comment: One commenter requested that we conduct an assessment to determine whether any payment adjustment should be made for urban hospitals, given the existence of the kinds of institutions described in the legislative history, the commenter believes that the absence of any adjustment other than that for rural referral centers slights the intent of this statutory provision.

Response: Until we obtain and review the cost data of urban hospitals under the prospective payment system, we cannot determine whether or not urban hospitals that meet the criteria for referral centers should receive any payment adjustment.

Comment: One commenter suggested that our criteria be revised to permit rural osteopathic hospitals to qualify for the rural referral center adjustment by lowering the volume of discharges criterion to 3000 a year. The commenter pointed out that osteopathic hospitals tend to be small and complex and draw their patients from outlying areas.

Response: We do not believe it would be equitable to single out one category of hospitals for special treatment. This would be unfair to other hospitals seeking the adjustment. In addition, it should be noted that a hospital can qualify as a rural referral center without regard to its number of discharges. Volume of discharges is not a consideration under § 412.96(b), although drawing patients from outlying areas (to which the commenter refers) is a criterion under that section.

F. Indirect Medical Education (§ 412.118)

Section 1886(d)(5)(B) of the Act provides that hospitals subject to the prospective payment system receive an additional payment for the indirect costs of medical education. The amount of this payment is based on a hospital's ratio of full-time equivalent interns and residents to bed size. The regulations governing this provision are found at § 412.118.

In our August 31, 1984 final rule, we revised § 412.118 (then § 405.477) based on the amendment made to section 1886(d)(5)(B) of the Act by section 2307(b) of Pub. L. 98-369. The amendment requires that, in determining the additional payment amount for indirect medical education, we must count interns and residents on the basis of where they furnish services, regardless of which entity (for example, hospital, university, or medical school) employs them. However, no intern or resident is counted as more than one full-time employee for any cost reporting period. (See the August 31, 1984 final rule for a detailed discussion of this revision (49 FR 34747).)

In the NPRM, we proposed to revise § 412.118 to change the way interns and residents are counted for purposes of making payment for indirect medical education costs effective with cost reporting periods beginning on or after October 1, 1984. Currently, § 412.118(e) provides that interns and residents must work 35 hours or more per week to be counted as one full-time employee. All interns and residents who do not meet this criterion are counted as one-half of a full-time employee. At present, we determine the additional payment amount based on the number of interns and residents employed during the last week of a hospital's cost reporting period. Therefore, if an intern or resident works for a hospital at least 35 hours per week for only a few weeks at the end of its cost reporting period, that individual is counted as a full-time employee for the entire cost reporting period.

Section 412.118(d)(2) currently requires that hospitals must submit a quarterly report to their fiscal intermediaries that includes, among other information, the actual hours worked by each intern and resident during each month. However, we believe that the 35-hour threshold is not reflective of the normal work week of interns and residents. Furthermore, the use of hours as a measure of intern of resident time requires substantial recordkeeping, and, if interns and residents rotate among several hospitals, a method of apportionment that is not necessarily consistent with reporting and counting for an institution's or program's scheduling purposes. We received numerous suggestions from hospitals that the policy be made easier to administer and require less paperwork.

Therefore, we proposed that the additional payment for indirect medical education costs for a hospital cost reporting period would be based on the number of interns and residents assigned to the hospital on September 1 during the hospital's cost reporting period. We also proposed that this method of counting interns and residents be retroactively applied to all hospital cost reporting periods beginning on or after October 1, 1984 (the date on which we implemented the system of reporting quarterly on intern and resident time). If we were to make the changes effective with cost reporting periods beginning on or after October 1, 1985, and not retroactive, hospitals would be required to implement one procedure for counting interns and residents effective on October 1, 1984 and another on October 1, 1985. This is a burden that we avoided by proposing to apply this rule retroactively.

For hospitals with cost reporting periods beginning on July 1, the same date that their graduate medical education programs begin, there would be a relatively stable number of interns and residents throughout the cost reporting period. However, in any other hospital, the cost reporting period would span more than one academic year. Thus, there could be significant fluctuation between the two years in the number of interns and residents to be counted. In these cases, we proposed to prorate the intern and resident counts for the two academic years based on the number of months of each academic year that fell into the cost reporting period.

Prior to October 1, 1984, hospitals were not required to keep schedules of assigned time or logs of actual time on which to base the intern and resident count. Therefore, for cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985, we proposed to use April 15, 1985 instead of September 1, 1984 as the uniform reporting date.

Many interns and residents are assigned to freestanding family practice centers, hospital outpatient departments, and excluded units, such as psychiatric units. Currently, time spent in freestanding family practice centers and excluded units is not counted for purposes of the indirect medical education payment since these settings are not subject to the prospective payment system. Although we are currently counting time spent in outpatient departments, we proposed that time spent in these departments would not be counted for purposes of the indirect medical education payment because outpatient departments also are not subject to the prospective payment system and because the additional operating costs of outpatient departments associated with interns and residents are already recognized through reasonable cost reimbursement for hospital services furnished to outpatients.

Interns and residents assigned to areas of the hospital not subject to the prospective payment system would be counted based on where they are assigned on September 1. If an intern or resident is dividing his or her time on that day between these areas and the areas or units of a hospital subject to the

prospective payment system, the hospital would have to report to its intermediary the proportion of time spent in or assigned to both the included and excluded areas. The indirect medical education payment would be computed based on the proportion of time assigned to the areas of the hospital subject to the prospective payment system.

The additional payment for the indirect medical education costs is computed on the basis of the ratio of interns and residents to hospital bed size. Currently, for determining the intern and resident to bed ratio, as well as for classification purposes, a hospital's bed size has been determined based upon the total number of beds available on the first day of the pertinent cost reporting period. Since a hospital's bed size may increase or decrease, sometimes substantially, over the course of a cost reporting period, we proposed to base the number of beds on the number of available bed days (excluding beds assigned to newborns, custodial beds, and beds in excluded units) during the current cost reporting period divided by the number of days in the cost reporting period. We proposed that this change also be effective with cost reporting periods beginning on or after October 1, 1984.

We believe that a hospital's assignment of interns and residents on one day (September 1) would generally be representative of the academic year as a whole. However, it may be necessary for intermediaries to audit hospital records to verify the documentation of the September 1 assignments as reported to us and to verify that the September 1 count is representative of the count over the entire cost reporting period. Based on its review of the hospital's documentation, the intermediary may adjust the intern and resident to bed ratio for purposes of the final indirect medical education payment.

We received approximately 60 letters on this proposal from hospitals; hospital, physician, and other associations; a fiscal intermediary; and ProPAC. The commenters were generally in favor of the one-day count of interns, but were opposed to the exclusion from the count those interns and residents assigned to outpatient departments. The following are their specific concerns.

Comment: Some commenters have pointed out that in those years in which September 1 falls on a weekend or holiday, hospital staffing patterns may not be typical of their intern and resident assignments over the rest of the year. They suggest that we use the closest business day for the count in these years.

Response: We agree that in those years in which September 1 falls on a weekend or Labor Day, some hospitals may assign interns and residents in a different way than if September 1 were a typical business day. Therefore, we are revising the regulations to use a different date in these years. However, rather than use the closest business day, which in some cases will be at the end of August and at a time when hospitals may be changing their interns and resident assignments in preparation for the upcoming month, we will use the first business day following September 1.

Comment: One commenter gave an example of a residency program in which the count taken on September 1, 1985 would present a distorted picture of the distribution of interns and residents between two hospitals.

Response: Although we believe that for most hospitals, the September 1 date provides an accurate count of the intern and resident assignments throughout the year, we provided in the proposed rule that a hospital may provide additional information to the intermediary to demonstrate that the September 1 date is not representative. Similarly, intermediaries may audit hospital records to verify that September 1 represents the actual count of the assignments of interns and residents throughout the year. Based on the review, the intermediary may adjust the intern and resident to bed ratio.

Comment: One commenter stated that the proposal to count interns and residents as of September 1 each year will lead to distortions and uneconomic behavior on a given day of the year and lend the measurement to manipulation. The commenter suggested that since the 35-hour threshold did not reflect a normal work week of interns and residents, and since hospitals had to make quarterly reports to intermediaries anyway, it would be more appropriate to count as full-time each resident with 455 reported hours per quarter.

Response: We believe that this commenter misunderstood our proposal. The commenter's suggestion would continue to link payment to a 35-hour work week for interns and residents. Our proposal would revise our policy in which the count of interns and residents is made based on the number of hours in a work week. We believe that the one-day count is far superior to any methodology based on actual hours worked. Further, we believe that our proposal is less subject to manipulation than are the current procedures. There are a limited number of interns and residents during an academic year, and a one-day count should be reflective of the distribution of assignments through the year.

Comment: Commenters were concerned about the impact of using a single day approach to the counting of interns and residents for programs in which the number of these individuals varies widely from month to month. For example, two hospitals that share 20 residents who work approximately half the time in each hospital do not divide them on an equal basis each month. In one month there could be 15 at one hospital and 5 at the other. The commenters believe that this would lead to unequal payment to the hospitals if on September 1 the residents were not close to equally divided.

Response: Section 1886(d)(5)(B) of the Act requires that we establish a system of counting that does not distinguish on the basis of who employs an intern or resident and ensures that no intern or resident is counted as more than one full-time employee in any reporting period, regardless of the number of hospitals in which he or she works. We agree that the single day concept may not work in every possible situation. However, we do not believe that it is appropriate to impose substantial reporting requirements on all teaching hospitals, the majority of which appear satisfied with the single day count, in order to capture detailed data from the few for which a one day count is not representative. Therefore, we stated in the proposed rule (50 FR 24383) that hospitals could submit comprehensive data to show that the September 1 date is not typical of the entire cost reporting period.

We believe that the September 1 date meets the requirements of the law without skewing the results to the extent that there is a substantial adverse impact on any particualr facility. In previous years, we used September 30 as the single day for counting interns and residents (see the final notice of the schedule of limits on hospital per diem inpatient general routine operating costs published in the **Federal Register** on September 30, 1981 (46 FR 48010)), and it did not generate any adverse comment from the hospital industry. In considering a return to the single day approach, we worked with representatives of the hospital industry and took their comments and concerns into consideration.

Comment: One commenter indicated that the audit of hospital records to verify documentation of the September 1 assignments as to whether they are

representative of the entire cost reporting period defeats the purpose of the "single day" counting method; that is, to simplify recordkeeping while preserving the integrity of the count. The commenter suggests that examples should have been included to illustrate the nature of the intermediary's review. Finally, the commenter recommends that the proposal be dropped in favor of the current quarterly reporting system except that assigned time should be used instead of actual time in determining full-time equivalents. Other commenters indicated that the September 1 count might not be reflective of an individual's assignments over the course of the year, and that more documentation would be required such as residency program assignment schedules, intern and resident contracts, and payroll records.

Response: The "single day" approach to the counting of interns and residents is independent of the monitoring activity. We believe that in many cases, it will be clear that the count is accurate both for the date taken and for the year. This would be most apparent in the case of hospitals in which the number counted is less than the number of interns and residents who spend time in the facility, indicating that outpatient and excluded units assignments have been accounted for.

In the event the intermediary has reason to believe that the count of interns and residents is substantially in error for a particular facility, or if it is found upon audit that the facility may be counting interns and residents assigned to units reimbursed on a reasonable cost basis, the intermediary has the responsibility for reviewing hospital records and making any necessary changes in the count at the end of the cost reporting period. For purposes of the monitoring activity, hospitals are not being asked for any information not already in their records.

With respect to the inclusion in the preamble of examples to illustrate intermediary review activities, we believe that this information represents technical details that have an impact on implementation. Therefore, these examples should be included in policy guidelines issued through appropriate manual instructions for the purpose of implementing those regulations.

The August 31, 1984 final rule, which contained a provision for a quarterly reporting system, generally elicited negative reaction from the hospital industry. Many hospitals believe such a reporting system places an unnecessary recordkeeping burden on them. We agree with their stated concerns, and the regulations set forth in this document were written to simplify the recordkeeping activity accordingly. We believe that the new method for counting interns and residents takes into consideration individual rotations among hospitals and is consistent with reporting and counting for an institution's or program's scheduling purposes.

Comment: One commenter objected to the use of social security numbers as identifiers of interns and residents but did not object to the creation of another means of identifying interns and residents.

Response: The provision requiring the use of the social security number was contained in the regulations published in the August 31, 1984 final rule, and no negative comments were received. We do not believe that section 7 of the Privacy Act (U.S.C. 552a) is violated by withholding payment from hospitals that refuse to furnish social security numbers to intermediaries. No benefit is denied to an individual for failure to furnish the social security number. We would simply be denying an additional payment to a teaching hospital because it voluntarily decided not to furnish the information necessary to validate whether the payment is appropriate. We do not believe that the costs to Medicare involved in creating a whole new set of identifiers for interns and residents and the additional burden it would place on hospitals are justified.

Comment: Several commenters stated that the proposed rule did not clearly address how interns and residents are to be counted when they are assigned to ancillary departments, including operating rooms and radiology and laboratory departments. They pointed out that a percentage of the services provided in ancillary departments involve services for outpatients and inquired if the ancillary area's inpatient-outpatient allocation should be considered in the intern and resident count for adjustment purposes.

Response: Our position in the final rule is not to count interns and residents furnishing services to outpatients. Thus, interns and residents who treat outpatients or who furnish ancillary services to outpatients would not be counted for purposes of the indirect medical education adjustment.

Since the ancillary departments provide services to both outpatients and inpatients, we will determine the proportion of interns and residents who provide outpatient services on the basis of the ratio of outpatient charges to total charges in each ancillary department. While this approach does not necessarily reflect the precise way interns and residents spend their time in the ancillary departments, we believe it is a good approximation of the outpatient intern and resident count. This method also minimizes the recordkeeping activity of the hospital. If hospitals believe that the above methodology for apportioning interns and residents assigned to ancillary departments is inappropriate, they may provide additional information to their fiscal intermediary to document a more accurate apportionment.

Comment: One commenter asked how interns and residents who are on-call would be counted.

Response: Under the current regulations, the actual hours worked by interns and residents determined whether they were counted as full-time or one-half of a full-time employee. On-call time while an intern or resident was on the premises could make a difference in whether he or she was considered a part-time or a full-time equivalent. The new method of counting interns and residents based on their assignment to a hospital on September 1 eliminates the need to consider on-call time. If we were to count on-call time under the new rule, it would introduce a situation in which an intern or resident could be assigned to an excluded unit but on-call in another area of the hospital. Thus, he or she could be counted even if assigned to an excluded unit. To consider on-call time in situations such as this would defeat the intent of the regulations.

Comment: One commenter asked if dentistry and podiatry residents would be counted for purposes of the adjustment.

Response: At present, dentistry and podiatry residents are included in the count. However, we are reviewing this issue and, if we believe that a change in this policy should be made, we will propose that change in a future document published in the **Federal Register** for public comment.

Comment: One commenter believes that an intern or resident can account for more than one full-time equivalent. Also, the commenter questioned whether we have the authority to mandate the counting of interns and residents using one specific day in the reporting period.

Response: We believe it was Congress' intention, and our regulations at § 412.118 reflect that intent, that no intern or resident be counted as more than one full-time equivalent in any reporting period. This is true regardless of the number of hospitals in which he or she is providing services.

Previously, the "single day" approach was used for reporting the intern and resident count. Before publication of the

September 1, 1983 interim final rule, the single day for determining the count was September 30. The authority to establish the September 30 rule for counting interns and residents was never questioned by outside organizations or Congress.

Comment: Several commenters believe that we should count interns and residents in excluded units of the hospital, such as psychiatric and rehabilitation units, and in freestanding family practice centers outside the hospital setting.

Response: The indirect medical education adjustment recognizes that there are additional costs that teaching hospitals incur in connection with the presence of graduate medical education programs. Congress was concerned that teaching hospitals might be adversely affected by the implementation of the prospective payment system because these hidden costs would not be reflected in the prospective payment system payment rates as costs were standardized and the system moved toward a national payment rate applicable to all hospitals. Therefore, Congress authorized an additional payment representing those otherwise unidentified costs.

However, this rationale does not extend to excluded units or to freestanding family practice centers. Medicare continues to reimburse excluded units on a reasonable cost basis. The indirect costs of medical education are included in the overall costs of the unit upon which Medicare determines reasonable costs. Services furnished in freestanding clinics are payable on a Part B reasonable charge basis. The direct and indirect costs of operating the clinic are included in the charges made for services furnished there. In both cases, making an additional payment under the provisions of the indirect medical education adjustment to reflect the presence of interns and residents would be a duplicate payment.

Comment: One commenter indicated that it was inappropriate to reduce payment for indirect medical education costs without a careful analysis of the impact on availability of medical services in the communities that will be affected.

Response: We believe that the changes in the proposed regulation would have only a modest effect on the level of indirect payments to individual hospitals. Therefore, we do not think that our proposal would have a major impact on the availability of medical services in the affected communities.

Comment: Many commenters, in expressing concern over the proposal to exclude time that interns and residents spend in outpatient areas of hospitals in the calculation of the ratio of interns and residents to beds, pointed out that the proposal will be destructive to primary care specialty programs, which the Federal government has supported in the past. They also maintain that the proposal will encourage hospitals to assign interns and residents to inpatient areas of the hospital, that it will discourage the most cost-effective treatment of patients, and that it will remove an important source of funding for care furnished to uninsured patients.

Response: The additional payment to teaching hospitals for the indirect costs of graduate medical education programs was created because of the belief that these programs, by their very existence within institutions, increase the hospitals' costs in many ways. These indirect costs may include increased department overhead and the higher cost of treating patients due to a higher relative volume of laboratory tests and similar services.

In the September 1, 1983 interim final rule, the application of the indirect medical education payment was limited to hospitals that employed interns and residents who furnished services on their premises. Based on comments received, the rule was modified in the January 3, 1984 final rule to permit hospitals to count interns and residents employed by an organization with which the hospital had a longstanding relationship. The regulations were further modified in the August 31, 1984 final rule, based on enactment of section 2307 of Pub. L. 98–369, which precluded any consideration of who the employer of the interns and residents was in making these payments. Thus, this additional payment provision has been liberalized twice since the inception of the prospective payment system two years ago.

We believe that our proposal not to count interns and residents furnishing services to outpatients of the hospital is reasonable because outpatient services are not subject to the prospective payment system. Further, inclusion of interns and residents assigned to these areas is a misallocation of program resources since it means Medicare Part A funds are used to pay for services that are covered under Part B. Medicare continues to pay for outpatient services on a reasonable cost basis, and the indirect costs of the interns and residents providing these services are included in these payments. We believe that if this distinction is not made, Medicare will be making duplicate payments for indirect costs in the outpatient department.

We believe that the negative effects described by the commenters will not occur. It would be unfortunate if the decisions on whether to treat patients in the outpatient rather than inpatient setting were made strictly to promote the access of hospitals to additional Medicare payments. We continue to pay a great deal of the costs that hospitals that wish to promote primary care specialties incur for graduate medical education program.

Comment: Many commenters stated that we are required under section 1886(d)(5)(B) of the Act to count interns and residents furnishing services in outpatient settings because that section provides that the additional payment for the indirect costs of medical education be "computed in the same manner" as set forth in regulations in effect on January 1, 1983. They further argued that in the September 1, 1983 interim final rule we said that we would be counting interns and residents in hospital outpatient departments in order to avoid "altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factors and subsequently standardizing hospital costs based on that factor" (48 FR 39778). Some commenters said that if interns and residents assigned to outpatient areas of the hospital are not counted on September 1, a new adjustment factor should be developed using the revised method of counting. A few commenters do not believe that these changes should be made retroactively.

Some commenters indicated that the indirect medical education adjustment was designed as a proxy for many cost factors that are difficult to quantify but are known to exist, that the financing of graduate medical education is extremely complex, and that certain medical specialty programs would be unfairly disadvantaged by our revision.

Response: We continue to believe that interns and residents who are not furnishing services to hospital outpatients should not be counted in determining additional payment to teaching hospitals for indirect medical education. We understand the concern of the commenters for the need to train interns and residents in primary care specialties, and we do not believe that hospitals will drop these programs solely because Medicare will not be paying for them under the indirect medical education adjustment.

It is important to note that Medicare, in fact, continues to pay for outpatient services on a reasonable cost basis, and these costs include the indirect costs of

services performed by interns and residents treating outpatients. Continuing to pay for them under the indirect medical education adjustment, while simultaneously paying on a reasonable cost basis, would pay for their indirect costs twice. Furthermore, since many interns and residents will be assigned to the outpatient setting on September 1 for only part of the day, their time spent furnishing services to inpatients on that day still will be computed in the indirect medical education ratio.

The commenters made two main arguments against our position. They cited language from the preamble of the September 1, 1983 interim final rule, in which we stated that we would not exclude interns and residents in outpatient departments in applying the factor because we would be altering only one element of the regression analysis on which it was based, with the result being that the amount of the adjustment would be incorrect. They also pointed out that section 1886(d)(5)(B) of the Act requires that the indirect medical education adjustment be computed "in the same manner as the adjustment" in effect on January 1, 1983.

In response to these comments, we first note that we are computing the adjustment "in the same manner" as previously, because we are basing it on the ratio of interns and residents to bed size. However, we do not believe that Congress intended that we ignore the fact that the stated rationale for the adjustment does not apply to outpatient services. There were no specific regulations in effect on January 1, 1983, although there was a description of the methodology to be used that was published in the final notice of the schedule of hospital cost limits for cost reporting periods beginning on or after October 1, 1982 that was published in the Federal Register on September 30, 1982 (47 FR 43310). We believe that Congress, in enacting the prospective payment system, intended that the methodology in effect be adopted rather than the entire description published in that notice. We also point out that in both the January 3, 1984 and August 31, 1984 final rules (the latter in response to the Congressional mandate in Pub. L. 98-369), we revised the methodology for counting interns and residents to adapt the previous system to the prospective payment system more effectively, yet we did not decrease the indirect medical education adjustment to reflect the larger number of interns and residents that hospitals were permitted to count. Therefore, the current adjustment itself is no longer entirely consistent with the original factor.

If the deletion of time furnishing services to outpatients, which decreases the count of interns and residents, invalidates the indirect medical education adjustment, it should follow that the expansion of programs that took place since the current factor was developed also should have invalidated the adjustment. However, especially since Congress did not mandate that the factor be recalculated, we believe that if there are, as here, overriding concerns, then revision to the method of counting interns and residents is justified. While a new regression analysis that takes into account the changes that have arisen since 1981 would be worthwhile, the cost data on which to base this are not yet available.

In the meantime, it has become apparent, since publication of the September 1, 1983 interim final rule, that even if it may cause some inconsistency with the regression analysis on which the current factor is based, exclusion of interns and residents furnishing services to outpatients is justified in light of the double counting that results from including these interns and residents. Moreover, since the ratio of intern and residents to beds has risen in most hospitals since 1981, even before the change in the August 31, 1984 final rule was fully implemented, we believe that the current adjustment, even without the adjustment factor being doubled, pays hospitals more than their actual indirect costs.

Finally, prior to the proposed rule, we defined a full-time employee as an intern or resident who worked 35 hours a week or more. Since most residents frequently work far more than this amount, the previous policy may have been justifiable as residents could have worked 35 hours or more treating patients in each of the settings, inpatient and outpatient. With the change to the one-day count, that policy no longer is appropriate.

However, we are going to make one change in response to the comments. We agree that it is inappropriate and contrary to what we said in the January 3, 1984 interim final rule (49 FR 268) to exclude interns and residents retroactively. Therefore, we are changing the proposed revision to § 412.118 to make the exclusion for interns and residents furnishing services to hospital outpatients effective with cost reporting periods beginning on or after October 1, 1985. By making this a prospective change, it will give teaching hospitals some time to plan for the impact of the change on their operations.

Comment: One commenter asked if interns' and residents' time spent in the outpatient department furnishing services to individuals admitted as inpatients before midnight of the next day could be included in the count. These individuals are considered hospital inpatients as of the day on which they are formally admitted as inpatients.

Response: If an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the next day, the outpatient hospital services furnished to him or her are treated as inpatient services unless the patient does not have Part A coverage. Generally, for purposes of the indirect medical education adjustment, the time spent by interns and residents in the outpatient department is not counted regardless of the patient's status subsequent to treatment in the outpatient department. Consequently, there will generally be no allocation of interns' and residents' time to areas of the hospital covered under the prospective payment system due to this rule. However, if a hospital is able to furnish adequate documentation to its fascal intermediary concerning the percentage of Medicare beneficiaries treated in the outpatient department who are subsequently admitted to an inpatient area subject to prospective payment under this rule, the intermediary will use that percentage to apportion interns and residents assigned to the outpatient department back to the inpatient setting for purposes of the intern and resident-to-bed ratio.

Comment: One commenter indicated that time spent by interns and residents in outpatient departments is not comparable to time spent in freestanding centers or excluded units. The commenter pointed out that time in freestanding centers was excluded because they are not subject to Part A reimbursement, and that the time spent by interns and residents in excluded units must be excluded from the caluclation since the indirect costs are reimbursable on a cost basis. This policy would avoid duplicate payment of some of the costs. On the other hand, the indirect costs associated with time spent in outpatient departments were historically subject to cost reimbursement under Part A, and unlike the revised calculation resulting from excluded units, only residents' time, and not beds, would be removed from the calculation with a resultant distortion.

Response: We do not agree with the commenter. The situation regarding outpatient services is largely the same as that for excluded units. Both continue to be reimbursed on a reasonable cost basis (or charge basis in the case of freestanding centers), and these costs include indirect costs. The only difference between the two is that the removal of the excluded units from the adjustment affected bed size as well as the count of interns and residents. Bed size cannot change based on a different treatment of outpatient services since the historical Medicare definition of bed size is that it consists of beds (other than new born) maintained for inpatient use.

The indirect costs of graduate medical education activities associated with outpatient care are reimbursed on a reasonable cost basis under Part B. Including a count of interns and residents furnishing such care in the ratio of interns and residents to beds results in a duplication of payment of the indirect costs of the outpatient department.

Comment: One commenter believes that our proposal not to count interns and residents assigned to outpatient departments means that we are proposing to eliminate reimbursement for their services.

Response: The proposal applies only to the payment of an additional amount for the indirect costs of graduate medical education programs. The direct and indirect costs of operating these programs associated with the care of hospital outpatients will continue to be reimbursed on a reasonable cost basis. What we are proposing to eliminate is the duplicate payment for the indirect costs associated with interns and residents furnishing services to outpatients since these costs are included in the total cost for outpatient services.

Comment: One commenter requested a more precise definition of the term "available bed days."

Response: For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

Comment: One commenter suggested a change in the method of calculating the indirect medical education adjustment. Instead of using the ratio of interns and residents to beds, the commenter recommended that patient days would be used in lieu of available beds. The commenter believes that the use of patient days would not require an additional calculation, the data are readily available, and recommended a legislative change.

Response: As the commenter points out, this change would require legislation. Thus, we cannot change the regulations to meet this suggestion. However, as we obtain more data, we will consider this approach and others. If our analysis indicates that a change is necessary, we will propose a legislative amendment.

G. Transfer Policy (§ 412.4)

Our current policy concerning transfers between prospective payment hospitals provides for transferring hospitals to receive payment on a per diem basis. The discharging hospital receives the full DRG payment. Transferring hospitals may also receive an additional payment for extraordinarily high-cost cases that meet the cost outlier criteria in §§ 412.80 and 412.84; they are not eligible for day outlier payments.

As we have stated in previous prospective payment documents (most recently in the August 31, 1984 final rule (49 FR 34730)), our ultimate goal is to make one payment for the entire course of treatment. Because of the complexities of this issue, we did not propose any changes in the regulations that would implement a new transfer policy. However, we noted in the proposed rule that we are continuing to study this problem and to collect relevant data so that we can implement a single payment for transfers in the future.

Several commenters wrote to voice their opposition to the prospect of a single payment for transfer situations. Their specific objections are set forth below.

Comment: One commenter believes that a single payment policy would result in inequitable payments and operational problems.

Response: The prospective payment system is intended to provide full payment less applicable deductibles and coinsurance for all inpatient services associated with a particular episode of hospitalization. As we have previously stated on several occasions, our current transfer policy is an interim policy to be used until we restructure the payment methodology for making one payment to a hospital for the entire course of treatment. The single payment methodology will be developed only after we conduct a thorough review of the PATBILL file to evaluate the distribution of costs in a transfer situation. This review will enable us to develop a transfer payment policy that will be designed to result in equitable payments among hospitals and to limit administrative difficulties.

Comment: One commenter proposed that in transfer situations either full payment should be made to each hospital or the per diem method of payment should be continued. The commenter's greatest concern was that in no case should the transferring hospital or the discharging hospital be placed at risk for services furnished outside of its institution.

Response: We do not believe that full payment to the transferring hospital is appropriate in the majority of transfer situations. In multiple transfer situations in which the initial admitting hospital is also the ultimate discharging hospital, that hospital would receive two full payments—one for stabilizing the patient before transfer to the treatment facility and one for providing recuperative care before the patient is discharged. We agree that we should develop a methodology that allows the most appropriate payment to be made to hospitals for the medically necessary care furnished by each hospital in transfer situations. However, we do not believe that the solution lies in overpaying all hospitals involved to guarantee an adequate payment to the hospital that furnishes the bulk of a patient's care.

V. Other ProPAC Recommendations

As required by law, we reviewed the April 1, 1985 report submitted by ProPAC and gave its recommendations careful consideration in conjunction with the formulation of the proposals set forth in the NPRM. We received many comments on our treatment of the ProPAC recommendations. We have included these comments in our discussion of the issues to which they relate as they are set forth in the preamble and addendum to this final rule. Set forth below are the remaining ProPAC recommendations and the comments we received on them.

A. Hospital Market Basket (Recommendations 2, 4 through 6, and 9)

1. The Number of Market Baskets (Recommendation 2)

For FY 1986, ProPAC recommended using a single market basket for prospective payment system hospitals. However, it plans to study the

appropriateness of developing multiple market baskets by region and class of hospital.

We believe that this is an area that warrants further study and we support ProPAC's research. In the past, we have studied variations in regional market baskets and we plan to continue our research concerning multiple market baskets by region and class of hospital.

2. Market Basket Wage Component—Occupational Groups (Recommendation 4)

ProPAC recommended that separate wage categories by occupational groups should be created to take into account the broad changes in skill mix among managers, professionals, and other hospital workers. ProPAC suggested that changes in wages for these categories should be measured using a combination of internal and external proxy measures as follows:

- Managers and Administrators: The Employment Cost Index (ECI) for Managers and Administrators.
- Professionals and Technicians: A 50–50 blend of the Average Hourly Earnings (AHE) for the hospital industry and the ECI for Professionals and Technicians.
- Other Hospital Workers: A 50–50 blend of the AHE for the hospital industry and the ECI for all private industry.

The issue of whether to use only internal proxies as we do in formulating the current single wage component or a combination of internal and external (that is, hospital and nonhospital) proxy measures as ProPAC recommends has been debated for some time. We have opted to use internal proxies, since that position is consistent with our treatment of the wage index, which is also based on internal wage measures. Moreover, as ProPAC noted, the various external measures that might be used (including the ECI) also have certain drawbacks that we believe warrant further examination. We are studying this issue further and plan to develop various market basket models using internal and external proxies, as well as weighted occupational categories, for further consideration.

3. Employment Cost Index Feasibility Study (Recommendation 5)

ProPAC recommended that the Secretary should work with BLS to study the advantages and feasibility of developing an ECI for the hospital industry that includes both public and private hospitals and covers increases in both wages and fringe benefits.

The basic difference between an ECI and the AHE we currently use to measure increases in hospital workers' salaries is that the ECI controls for occupational mix. Therefore, the ECI would maintain the relative hospital worker skill mix constant over time and would preclude skill mix from affecting the amount of the increase in the hospital wage measure. We agree that this is an area that warrants further study and we plan to examine the merits of establishing an ECI for hospital workers as part of our ongoing analysis of the market basket.

4. Study Effects of Changes in the Minimum Wage Law on Hospital Workers (Recommendation 6)

ProPAC plans to study the extent to which hospital workers would be affected by changes in the Federal minimum wage law. The intent of the study is to detect whether, under the prospective payment system, workers who earn more than the minimum wages are differentially affected by statutory increases in the minimum wage compared with workers in other industries.

Since it is our desire that the prospective payment system be equitable, we would certainly want to know about any dimension of the system that is found to be unfair. However, we point out that the purpose of the prospective payment system is to develop prices for individuals DRGs. In accomplishing this, we have referred not only to wages paid to hospital workers, but to the entire spectrum of resources expended by hospitals in producing health care.

5. *Rebasing of Market Basket Weights (Recommendation 9)*

ProPAC suggested that the market basket weights should be rebased at least every five years or more frequently if significant changes in the weights occur. We agree that it is appropriate to periodically rebase the market basket weights in order to reflect more current data, especially if significant changes in the mix of inputs used by hospitals occur. We are currently in the process of developing rebased market basket weights. We also recognize that the market basket weights may require further revision to account for payment changes that might occur if additional costs, such as capital-related costs, are included in the prospective payment system.

B. Hospital Labor Market Areas—Area Wage Index: Improvement of Labor Market Area Definitions (Recommendation 13)

The current area wage index used to adjust payments for interarea wage differences does not distinguish separate labor markets within MSAs. ProPAC recommended that the prospective payment rates be adjusted to take into account variations in wages paid within a metropolitan area and in different rural locations within a State. ProPAC noted that several studies have shown that there is substantial variation in the wages paid in the inner city as compared with suburban areas (that is, "core" areas and "ring" areas) within the same MSA and that similar concern has been expressed regarding rural areas within a State.

ProPAC recommended that these differences in hospital labor markets be reflected in the application of the area wage index used to adjust the prospective payment rates for actual variation in area wage levels. While ProPAC recommended that labor market area definitions be improved to better reflect hospital labor market areas, the report did not discuss how specific alternatives to the current MSA/non-MSA definitions might be established.

We have previously acknowledged in various Federal Register documents that the current MSA/non-MSA definitions may not adequately recognize widely varying hospital labor market conditions, especially among counties classified as rural. We have been looking into possible alternative classification systems that would better define hospital labor markets. The core-ring concept for splitting MSAs that is addressed in ProPAC's recommendation is one alternative that we have previously considered (see the January 3, 1984 final rule (49 FR 254)). In addition, we are studing other classification systems such as the Department of Commerce's Bureau of Economic Analysis (BEA) economic areas that are defined based on area ties to economic centers.

However, we believe that extensive research and study will be required before alternative labor market definitions are adopted. As with any classification system in which boundaries must be established, it is impossible to designate boundaries that will be completely satisfactory to all concerned. Therefore, we must be certain that any new classification system is based on objective criteria that will provide more equitable labor market area definitions than the current MSA/non-MSA classifications.

Comment: One commenter was in favor of our using the BEA economic areas to establish whether a hospital is located in an urban or rural area.

Response: Section 1886(d)(2)(D) of the Act defines an urban area as an area

within an MSA as designated by EOMB or within a similar area, as we recognized under the regulations (§ 405.460) establishing limits on total inpatient operating costs under section 1886(b) of the Act. We have begun preliminary analysis of the suitability of using BEA economic areas for area wage index classification purposes. However, more thorough analysis will have to be performed to determine whether these areas are more or less appropriate than MSAs for defining hospitals' labor market areas.

As we move closer to a national standardized amount for the prospective payment system, we are continuing to evaluate the necessity of establishing separate national urban and rural rates. In addition, Congress has requested a study on the feasibility and impact of eliminating or phasing out separate urban and rural classifications.

Comment: Commenters requested that an adjustment be provided for hospitals located in rural areas where the residents commute to more than one nearby MSA. Under current EOMB guidelines, a county is included in an MSA if a certain percentage of the county's resident population commutes to the MSA. However, the commenters point out that if the same percentage of residents of a county commute to more than one MSA, the county is not included in any MSA. The commenters believe that a county such as this should be designated as an urban county rather than rural and the wage index value assigned to it should be the value of the MSA to which the greatest number of persons commutes.

Response: As we noted above, for purposes of the prospective payment system, section 1886(d)(2)(D) of the Act defines an urban area as an area within an MSA as designated by EOMB or within a similar area, as recognized under the regulations (§ 405.460) establishing limits on total inpatient operating costs under section 1886(a) of the Act. The designation of a county as urban or rural is based on whether or not a particular location qualifies as an MSA or New England County Metropolitan Area (NECMA). The criteria for MSA or NECMA status are not within our control. EOMB determines which areas qualify as MSAs or NECMAs and the effective date of their qualification based on standards prepared by the Federal Committee on MSAs, which advises EOMB on metropolitan area definitions.

We are not aware of any criteria that are as objective as the MSA criteria are for use in determining whether a hospital is located in an urban or rural area. We do not believe it would be appropriate to establish criteria in our regulations that have been derived solely to allow a targeted hospital or group of hospitals to be classified as urban. On the contrary, we believe that the criteria we establish should have broad applicability and serve to delineate common characteristics that objectively define urban and rural areas.

Comment: A commenter indicated that hospitals located in the same MSA but not the same census division should all be assigned to the same census division.

Response: We addressed this situation in the August 31, 1984 final rule (49 FR 39738). Section 1886(d)(2) of the Act authorizes us 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 a hospital in an MSA or NECMA that crosses two or more census divisions to the census division in which most of the MSA's or NECMA's hospitals are located (§ 412.62(f)(2)). These regulations were effective for cost reporting periods beginning on or after October 1, 1983. We believe that the current regulations address the problem of hospitals in the same MSA that are located in different census regions and do not plan to revise them.

C. Hospitals Serving Disproportionate Shares of Low Income or Medicare Patients (Recommendations 14 and 15)

ProPAC recommends that an adjustment be established for FY 1986 rates for hospitals that serve a disproportionate share of low income or Medicare patients or both and that a definition of these hospitals be established based on a broader concept of low income than simply percentage of Medicaid patients. However, ProPAC made no specific recommendation as to the basis for such an adjustment.

As required by section 2315(h) of Pub. L. 98-369, we have been working on the development of the definition. However, as discussed more thoroughly in the proposed rule (50 FR 24384), our research efforts have been hampered by the lack of data of sufficient quality to permit us to develop a definition with any degree of confidence.

Once we obtain accurate data, we will be able to turn our attention to analyzing whether, in fact, hospitals serving a significantly disproportionate number of low income or Part A Medicare patients experience higher Medicare costs per case due to the provision of care to these patients or whether these additional costs are accounted for by severity, inefficiency, or other factors. We will then determine whether these costs are already appropriately recognized in the prospective payment system or if additional payment adjustments should be made.

Comment: Numerous commenters expressed their belief that an adjustment should be provided to hospitals serving a disproportionate share of low income or Medicare Part A patients.

Response: As we explained in the proposed rule, we do not have conclusive evidence to date that warrants an adjustment for hospitals serving a significantly disproportionate share of low income or Medicare Part A patients. A disproportionate share adjustment must be firmly rooted in an analytical research model that accurately depicts the relationship between high proportion of low income patients and a hospital's average Medicare costs. Currently, no model exists.

The present methodology assumes that all hospitals serve an average proportion of low-income or Medicare Part A patients. Implementing a national adjustment would arbitrarily select one definition of a disproportionate share hospital and reward only those hospitals that conform to the arbitrary definition. The selection of hospitals and the magnitude of any adjustment are critical because the funds to pay for the significantly disproportionate share adjustment would likely come from lowering the standardized Federal rates to exclude from the base those costs associated with treating a disproportionate share of low income or Medicare Part A patients. If an analysis shows that hospitals with a high percentage of low-income or Medicare Part A patients are being underpaid, then hospitals with low levels of these types of patients must be overpaid. An arbitrary national adjustment would only create a new set of payment inequities among hospitals.

As mentioned in the proposed rule, we are continuing to review the feasibility of using Medicare patient origin data and census data on the aged with income below the poverty level to assess the impact of low-income Medicare patients on hospital costs. We are also continuing to investigate an alternative proxy for low income other than "percent Medicaid" that will be more reliable than the data we obtained from the Office of Civil Rights (OCR) survey. At this time, the relationship between Medicare costs and low income patients is not well understood even though research done by the Congressional Budget Office, ProPAC,

and HCFA indicates that hospitals with a high percentage of Medicaid patients tend to have higher average Medicare costs.

Recently, we have obtained survey data from the AHA on hospitals' Medicare and Medicaid utilization information. The AHA data base is also somewhat flawed because the data are self-reported on a voluntary basis and unaudited. In addition, data are missing for about 20 percent of the hospitals. Through analysis of this information on Medicare and Medicaid utilization, we will try to determine if hospitals that serve a significantly disproportionate share of low-income patients or Medicare Part A patients have different average Medicare inpatient costs due to the provision of care to these patients or if these additional costs are accounted for by severity, inefficiency, or other factors.

In addition, ProPAC recently compiled information that demonstrated the range of Medicaid coverage of the population below the poverty level in 1979. The data ranged from a high of 143 percent in Massachusetts to a low of 25 percent in Texas. These results lead us to question the assumption that percent of Medicaid utilization has a consistent relationship to low income. We recognize the importance of this issue and are committed to continuing the search for realistic policy options. Only with some further analysis will we be able to determine if inpatient costs associated with the treatment of low income patients are already appropriately recognized in the prospective payment system or if additional payment adjustments should be made.

VI. 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. Rate of Increase Limits

We are revising § 405.463 to—

- Provide that the applicable target rate percentage is the prospectively determined percentage, published by HCFA, based on the estimated market basket index for the calendar year adjusted by other factors as determined by the Secretary: and
- Delete the October 1, 1985 expiration date for the exemption from the rate of increase limit that is available to new hospitals.

B. Changes in the DRG Classification System

We are adding a new § 412.10 that describes the procedures we will use to revise the DRG classification system both annually and, on a very limited basis, during the Federal fiscal year.

In response to comments, we have revised our proposed § 412.10 to provide that any interim changes made because of a serious omission or inequity in the DRG classification system will be published as a final notice with comment period in the Federal Register. Changes made to incorporate a newly covered service or item will be issued through our administrative issuance system as we proposed. Both of these changes will be included in the next annual notice of changes to the DRG classification system, which we hope to publish early each year. We also added a provision describing ProPAC review of interim changes.

C. Exclusion of Alcohol/Drug Hospitals and Units

In §§ 421.23(c) and 412.32, we are changing the expiration of the qualifying date of the exclusion for alcohol/drug hospitals and units from October 1, 1985 to the end of the hospital's cost reporting period beginning before October 1, 1985. In response to comments, we have decided to extend the exclusion for one more year for those units and hospitals who currently qualify for an exclusion.

D. Review Activities

We are making changes in Subparts C and F of 42 CFR Part 412 to replace all references to PSROs and medical review entities with references to PROs because the PROs are now fully operational. In addition, we are deleting § 412.45, which describes how we monitor discharge rates under the prospective payment system.

E. Charges to Beneficiaries

We are adding a new § 405.308 that allows hospitals excluded from the prospective payment system because of their participation in a State reimbursement control system or demonstration project to change beneficiaries for custodial or medically unnecessary care after issuing the proper notices that are currently required in § 412.42(c) for prospective payment hospitals.

F. Payment for Cost Outliers

We are revising § 412.84 to delete the requirement that all cost outlier cases must be reviewed by the PRO before payment. However, these cases could be subject to prepayment review if the hospital demonstrates a pattern of inappropriate billing. The PRO will also review a sample of the claims that were not reviewed prior to payment. If, as a result of its postpayment review, the PRO determines that any services were noncovered, the outlier payment will be recovered from the hospital. We are also revising § 412.84 to allow hospitals to request cost outlier payment at the time they submit bills for payment, rather than waiting until after the intermediary has notified them of its determination on payment for the discharge.

G. Referral Centers

We have revised § 412.96 as follows:

- The title of pargraph (b) is changed to indicate that this paragraph is effective for cost reporting periods beginning on or after October 1, 1983.
- Paragraphs (c)(1) and (c)(2) are revised to provide that the criteria related to case-mix index and discharges for referral centers will be published in the proposed and final annual prospective payment rate notices.
- We added a new paragraph to describe the method we will use to calculate updated case-mix indexes each year.

H. Indirect Medical Education

We are revising § 412.118 effective for cost reporting periods beginning on or after October 1, 1984 as follows:

- Change the method used to determine the number of beds in a hospital for purposes of counting interns and residents.
- Delete the requirement of a quarterly report from hospitals on numbers of interns and residents and replace it with an annual report that counts by specialty the number of interns and residents on September 1 (with an additional count on April 15, 1985 for hospitals with cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985). In response to comments, we added a provision that requires the count to be made on the next business day after September 1 when that day falls on a weekend or Federal holiday.
- Delete the requirement of counting hours of interns and residents to determine full-time equivalents. Instead, all interns and residents assigned to the hospital on September 1 (or April 15, 1985, if applicable) will be counted as full-time except for those individuals splitting their time between prospective payment areas and one or more areas excluded from the prospective payment system or spending all their time in the excluded areas. In response to

comments, we have delayed until cost reporting periods beginning on or after October 1, 1985 implementation of our decision to no longer count interns and residents furnishing services to outpatients as full-time.

• Provide for intermediary review of hospital documentation to verify the hospital's intern and resident-to-bed ratio.

VII. Other Required Information

A. Effective Dates

The effective date of the final rule (including the addendum and appendix) is October 1, 1985. Changes to the regulations are effective as follows:

October 1, 1985

§§ 405.301 and 405.308—Charges to beneficiaries.

§ 405.463—Rate of increase limits.

§ 412.10—Changes to the DRG classification system.

§§ 412.23 and 412.32—Exclusion of alcohol/drug hospitals and units.

§§ 412.42, 412.44, 412.45, and 412.48—PRO medical review.

Effective With Discharges Occurring on or After October 1, 1985

§ 412.84—Payment for cost outliers.

Effective With Cost Reporting Periods Beginning on or After October 1, 1984

§ 412.118—The changes affecting the indirect medical education adjustment factor are all effective with cost reporting periods beginning on or after October 1, 1984 except that the provision under which interns' and residents' services to outpatients will no longer be counted for purposes of the adjustment factor is effective with cost reporting periods beginning on or after October 1, 1985.

Effective With Cost Reporting Periods Beginning on or After October 1, 1985

§ 412.76—Referral centers.

§ 412.118—Count of interns' and residents' services to outpatients.

B. Paperwork Reduction Act

Section 412.118 of this final rule contains information collection requirements that are subject to review by EOMB under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3511). A notice will be published in the **Federal Register** when approval is obtained. Organizations and individuals who wish to submit comments on the information collection requirements should direct those comments to the agency official whose name appears in the preamble and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building (Room 3208), Washington, DC, 20503, Attention: Fay Iudicello.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Cancer hospitals, Christian Science Sanatoria, Discharges and transfers, Inpatient hospital services, Medicare, Outlier cases, Prospective payment, Referral centers, Renal transplantation centers, Sole community hospitals.

C. Impact Analyses

The appendix to this final rule, which is printed immediately following the addendum to this final rule, sets forth our analyses of the projected impact and effect on small businesses of the changes that are set forth in this document.

42 CFR Chapter IV, Subchapter B is amended as set forth below:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B—MEDICARE PROGRAMS

I. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Subpart C is amended as follows:

Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment

1. The authority citation for Subpart C continues to read as follows:

Authority: Secs. 1102, 1154(a)(2)(B), 1815, 1833, 1842, 1862, 1866, 1870, 1871, and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c–3(a)(2)(B), 1395g, 1395l, 1395u, 1395y, 1395cc, 1395gg, 1395hh, 1395pp), and 31 U.S.C. 3711.

2. The table of contents of Subpart C is amended by adding the title of a new § 405.308 to read as follows:

Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment

* * * * *

Sec.

405.308 Limitations on charges to beneficiaries.

* * * * *

§ 405.301 [Amended].

3. Section 405.301 is amended by revising the citation "405.310" to read "405.308".

4. A new § 405.308 is added to read as follows:

§ 405.308 Limitation on charges to beneficiaries.

(a) *Prospective payment hospitals.* A hospital receiving payment under the prospective payment system for a covered hospital stay may charge a beneficiary for items and services excluded from coverage only as described in § 412.42 of this chapter.

(b) *Hospitals participating in State reimbursement control systems or demonstration projects.* A hospital receiving payment for a covered hospital stay under either a State reimbursement control system approved under 1886(c) of the Act or a demonstration project authorized under section 402(a) of Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1 (note)) and that would otherwise be subject to the prospective payment system may charge a beneficiary for noncovered services as follows:

(1) For the custodial care and medically unnecessary services described in § 412.42(c) of this chapter, after the conditions of § 412.42 (c)(1) through (c)(4) are met; and

(2) For all other services in accordance with the applicable rules described in Part 489 of this chapter.

B. Subpart D is amended as follows:

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

1. The authority citation for Subpart D continues to read 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), 1935x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

2. Section 405.463 is amended by revising paragraphs (c)(3)(i) and (f)(1) to read as follows

§ 405.463 Ceiling on rate of hospital cost increases.

* * * * *

(c) *Procedure for establishing the ceiling (target amount).* * * *

(3) *Target rate percentage.* (i) The applicable target rate percentage will be the prospectively determined percentage, published by HCFA, based on the estimated increase in the market basket index for the calendar year

adjusted by other factors as determined by the Secretary.

* * * * *

(f) *Exemptions*—(1) *New hospitals.* New hospitals that request and receive an exemption from HCFA are not subject to the rate of increase ceiling imposed under this section. For purposes of this section, a new hospital is a provider of inpatient hospital services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years. This exemption expires at the end of the first cost reporting period beginning at least two years after the hospital accepts its first patient.

* * * * *

II. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395hh, 1395ww).

B. The table of contents of Part 412 is amended by adding the title of a new § 412.10 to Subpart A and deleting the title of § 412.45 from Subpart C to read as follows:

Subpart A—General Provisions

Sec.

* * * * *

412.10 Changes in the DRG classification system.

* * * * *

C. A new § 412.10 is added to Subpart A to read as follows:

Subpart A—General Provisions

§ 412.10 Changes in the DRG classification system.

(a) *General rule.* HCFA issues changes in the DRG classification system in an annual notice. Except as specified in paragraphs (c) and (d) of this section, the DRG changes will be effective prospectively with discharges occurring on or after the same date the payment rates are effective.

(b) *Basis for changes in the DRG classification system.* All changes in the DRG classification system are made using the principles established for the DRG system. This means that cases are classified so each DRG is—

(1) Clinically coherent; and

(2) Embraces an acceptable range of resource consumption.

(c) *Interim coverage changes*—(1) *Criteria.* HCFA makes interim changes to the DRG classification system during the Federal fiscal year to incorporate items and services newly covered under Medicare.

(2) *Implementation and effective date.* HCFA issues interim coverage changes through its administrative issuance system and makes the change effective as soon as is administratively feasible.

(3) *Publication for comment.* HCFA publishes any change made under paragraph (c)(1) of this section in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(d) *Interim changes to correct omissions and inequities*—(1) *Criteria.* HCFA makes interim changes to the DRG classification system to correct a serious omission or inequity in the system only if failure to make the changes would have—

(i) A potentially substantial adverse impact on the health and safety of beneficiaries; or

(ii) A significant and unwarranted fiscal impact on hospitals or the Medicare program.

(2) *Publication and effective date.* HCFA publishes these changes in the **Federal Register** in a final notice with comment period with a prospective effective date. The change is also published for public information in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(e) *Review by ProPac.* Changes published annually in accordance with paragraph (a) of this section are subject to review and comment by ProPac upon publication. Interim changes to the DRG classification system that are made in accordance with paragraphs (c) and (d) of this section are subject to review by ProPac before implementation.

D. Subpart B is amended as follows:

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment System

1. In § 412.23, the introductory language in paragraph (c) is revised to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(c) *Alcohol/drug hospitals.* If an alcohol/drug hospital meets the following requirements, it is excluded from the prospective payment system for its cost reporting periods beginning before October 1, 1986, but no hospital is excluded for its cost reporting period beginning during Federal fiscal year 1986 unless it was excluded for its cost reporting period beginning during Federal fiscal year 1985:

* * * * *

2. In § 412.32, the introductory language is revised to read as follows:

§ 412.32 Distinct part alcohol/drug units: Additional requirements.

If a distinct part alcohol/drug unit meets the following requirements, it is excluded from the prospective payment system for its cost reporting periods beginning before October 1, 1986, but no unit is excluded for its cost reporting period beginning during Federal fiscal year 1986 unless it was excluded for its cost reporting period beginning in Federal fiscal year 1985:

* * * * *

E. Subpart C is amended as follows:

Subpart C—Conditions for Payment Under the Prospective Payment System

1. In Subpart C, all occurrences of the phrase "medical review entity" are revised to read "PRO".

2. In § 412.42, the introductory language of paragraphs (c) and (c)(3) is reprinted for the convenience of the reader; paragraphs (c)(2) and (c)(3)(iv) are revised; the introductory language of paragraph (d) is reprinted for the convenience of the reader; and paragraphs (d)(3) and (d)(4) are revised to read as follows:

§ 412.42 Limitations on charges to beneficiaries.

* * * * *

(c) *Custodial care and medically unnecessary inpatient hospital care.* A hospital may charge a beneficiary for services excluded from coverage on the basis of § 405.310(g) of this chapter (custodial care) or § 405.310(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

* * * * *

(2) The attending physician agrees with the hospital's determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not require inpatient hospital care but is unable to obtain the agreement of the physician, it may request an immediate review of the case by the PRO. Concurrence by the PRO in the hospital's determination will serve in lieu of the physician's agreement.

(3) The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or person acting on his or her behalf) in writing that—

* * * * *

(iv) The determination of the PRO made after the beneficiary received the purportedly noncovered services will be appealable by the hospital, the attending physician, or the beneficiary under the appeals procedures that apply to PRO determinations affecting Medicare part A payment; and

* * * * *

(d) *Medically unnecessary diagnostic and therapeutic services.* A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (for example, experimental procedures) that are excluded from coverage under § 405.310(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

* * * * *

(3) If the beneficiary receives the services, a formal determination on the validity of the hospital's finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the PRO.

(4) The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to determinations affecting Medicare Part A payment.

* * * * *

3. In § 412.44, the introductory language is revised to read as follows:

§ 412.44 Medical review requirements: Admissions and quality review.

Beginning on November 15, 1984, a hospital must have an agreement with a PRO to have the PRO review, on an ongoing basis, the following:

* * * * *

§ 412.45 [Removed]

4. Section 412.45 is removed.

5. Section 412.48(b) is revised to read as follows:

§ 412.48 Denial of payment as a result of admissions and quality review.

* * * * *

(b) When payment with respect to admission of an individual patient is denied by a PRO under paragraph (a)(1) of this section, and liability is not waived in accordance with §§ 405.330 through 405.332 of this chapter, notice and appeals are provided under procedures established by HCFA to implement the provisions of section 1155 of the Act. Right to Hearing and Judicial Review.

* * * * *

F. Subpart F is amended as follows:

Subpart F—Payment for Outlier Cases

1. In § 412.82, the introductory language of paragraph (b) is revised to read as follows:

§ 412.82 Payment for extended length of stay cases (day outliers).

* * * * *

(b) The PRO must review and approve to the extent required by HCFA—

* * * * *

2. Section 412.84 is amended by revising paragraph (b); redesignating current paragraphs (c), (d), (e), and (f) as paragraphs (f), (g), (h), and (i) respectively; adding new paragraphs (c), (d), and (e); revising the introductory language of newly redesignated paragraph (f); and revising newly redesignated paragraph (i) as follows:

§ 412.84 Payment for extraordinarily high cost cases (cost outliers).

* * * * *

(b) The hospital must request additional payment—

(1) With initial submission of the bill; or

(2) Within 60 days of receipt of the intermediary's initial determination.

(c) Except as specified in paragraph (e) of this section, an additional payment for a cost outlier case is made prior to medical review.

(d) As described in paragraph (f) of this section, the PRO reviews a sample of cost outlier cases after payment. The charges for any services identified as noncovered through this review will be denied and any outlier payment made for these services will be recovered, as appropriate, after a determination as to the provider's liability has been made.

(e) If the PRO finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the PRO determines that appropriate corrective actions have been taken.

(f) The PRO reviews the cost outlier cases, using the medical records and itemized charges, to verify the following:

* * * * *

(i) The additional payment amount will be derived by first taking 60 percent of the difference between the hospital's adjusted cost for the discharge (as determined under paragraph (g) of this section) and the threshold criteria established under § 412.80(a)(2). The resulting amount will then be multiplied by the applicable Federal portion of the blend as indicated in § 412.82(c).

G. In Subpart G § 412.96 is amended by revising the title of paragraph (b), the title and the introductory language of paragraph (c), paragraphs (c)(1), (c)(2), and (f), and adding a new paragraph (g) to read as follows:

Subpart G—Special Treatment of Certain Facilities

§ 412.96 Special treatment: Referral centers.

* * * * *

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.*

* * * * *

(c) *Alternative criteria for cost reporting periods beginning on or after October 1, 1985.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in § 412.62(f)) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) *Case-mix index.* The hospital's case-mix index for the Federal fiscal year that ended prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to the national or median urban regional case-mix index value set forth in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (g) of this section.

(2) *Number of discharges.* For the hospital's most recently completed cost reporting period, its number of discharges (excluding discharges from subprovider and newborn units) is at least equal to the number of discharges under one of the two criteria set forth in each year's annual notice of prospective payment rates published under § 412.8(b).

* * * * *

(f) *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 continues to meet the criteria set forth in paragraphs (b) or (c)

of this section. If the determination is to the effect that the hospital no longer qualifies for a referral center adjustment, HCFA will discontinue the adjustment beginning on the first day of the hospital's next cost reporting period.

(g) *Methodology for calculating case-mix index criteria.* HCFA calculates the national and regional case-mix index value criteria as described in paragraph (g)(1) through (g)(5) of this section.

(1) *National criterion.* HCFA calculates a national case-mix index value for all hospitals subject to the prospective payment system and compares it to the 1981 national average case-mix index value of 1.00. The percentage of change between those two figures is used to update the 1981 national case-mix index criterion of 1.03.

(2) *Regional criterion.* HCFA calculates the median urban case-mix index values for each census region by updating the 1981 regional criterion using the percentage of change that is calculated under paragraph (g)(1) of this section.

(3) *Source of data.* In making the calculations described in paragraphs (g)(1) and (g)(2) of this section, HCFA uses all inpatient hospital bills received for discharges through the midpoint of the Federal fiscal year before the year in which the criteria will be effective.

(4) *Effective date.* HCFA sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are used to determine if a hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(5) *Applicability of criteria to HCFA review of referral center status.* For purposes of the triennial HCFA review of a referral center's status as described in paragraph (f) of this section, the referral center's case-mix index value for Federal fiscal year is evaluated using the updated case-mix value criteria published in the subsequent Federal fiscal year's notice of prospective payment rates.

H. In Subpart H, § 412.118, the introductory language of the section is revised; the introductory language of paragraph (a) is reprinted for the convenience of the reader; paragraph (a)(1) is revised; current paragraphs (b) through (e) are redesignated as paragraphs (c) through (f) respectively; a new paragraph (b) is added; the introductory language of newly redesignated paragraphs (d) and (e) is reprinted for the convenience of the reader; newly redesignated paragraphs (d)(3), (e)(2), (e)(3), (e)(4), and (f) are revised; and a new paragraph (g) is added to read as follows:

Subpart H—Payments to Hospitals under the Prospective Payment System

§ 412.118 Determination of indirect medical education costs.

For cost reporting periods beginning on or after October 1, 1984, to determine the indirect medical education costs, HCFA uses the following procedures:

(a) *Basic data.* HCFA determines for each hospital its—

(1) Ratio of full-time equivalent interns and residents to number of beds (as determined in paragraph (b) of this section), excluding those interns and residents in anesthesiology who are employed to replace anesthetists; and

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

* * * * *

(d) *Determination of payment amount.* Each hospital's indirect medical education payment will be determined by multiplying the following three factors:

* * * * *

(3) The education adjustment factor determined under paragraph (c) of this section.

(e) *Count of interns and residents.* In order to have interns and residents included in the count under paragraph (a)(1) of this section, the following requirements must be met:

* * * * *

(2) The hospital must submit an annual report to its fiscal intermediary. The report must include the following information:

(i) A listing, by specialty, of all interns and residents assigned to the hospital and providing services to the hospital on September 1 of that year. If September 1 falls on a weekend or a Federal holiday, the next business day is used for purposes of the count of interns and residents. For cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985, the hospital must also report this information for April 15, 1985.

(ii) The social security number of each intern and resident.

(iii) The hospital unit or department to which each intern and resident is assigned on the day of the count.

(3) No intern or resident will be counted as more than one full-time employee on the date counted, regardless of the number of hospitals in which he or she is providing services.

(4) Fiscal intermediaries must verify the correct count of interns and residents and may review the hospital's entire cost reporting period.

(f) *Limits on count of interns and residents.* (1) Interns and residents who are assigned to a freestanding family practice center or an excluded distinct part hospital unit on the day that the count of interns and residents (as described in paragraph (e)(2)(i)) is made are not counted as full-time equivalents. Only the percentage of time that these interns and residents spend in the portion of the hospital subject to the prospective payment system on the day the count is made is used to determine the indirect medical education adjustment.

(2) For cost reporting periods beginning on or after October 1, 1985, interns and residents who are assigned to the outpatient department of the hospital on the day the count is made are subject to the provisions of paragraph (f)(1) of this section.

(3) For cost reporting periods beginning on or after October 1, 1985, the number of interns and residents assigned to ancillary departments of the hospital will be apportioned between inpatient and outpatient settings based on the ratio of each ancillary department's inpatient and outpatient charges to total department charges, respectively. In determining the indirect medical education adjustment, only that percentage attributable to furnishing inpatient services will be included in the computation of the intern and resident-to-bed ratio.

(g) *Intermediary review.* Based on its review of a hospital's documentation concerning the hospital's count of interns and residents under this section, the intermediary may adjust the intern and resident-to-bed ratio for purposes of the final indirect medical education payment.

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

Dated: August 2, 1985.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 27, 1985.

Margaret M. Heckler,

Secretary.

Editorial Note: The following addendum and appendix will not appear in the Code of Federal Regulations.

ADDENDUM—SCHEDULE OF STANDARDIZED AMOUNTS EFFECTIVE WITH DISCHARGES ON OR AFTER OCTOBER 1, 1985, AND UPDATE FACTORS AND TARGET RATE PERCENTAGES EFFECTIVE WITH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1985

I. Summary and Background

In this addendum to the final rule we are making changes in the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services during the third and final year of the transition period of the prospective payment system. In addition, the addendum sets forth new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

Under the prospective payment system, for hospital cost reporting periods beginning October 1, 1985 through September 30, 1986, except for sole community hospitals, each hospital's payment per discharge will be the sum of a Federal portion that is 75 percent of the Federal rate and a hospital-specific portion that is 25 percent of the hospital-specific rate (section 1886(d)(1)(C) of the Social Security Act (the Act)). Sole community hospitals will continue to be paid on the basis of a rate per discharge composed of 75 percent of the hospital-specific rate and 25 percent of the applicable Federal regional rate. 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 FY 1986, the Federal rates will be comprised of a blend of 50 percent of the national rate and 50 percent of the appropriate regional rate, as required by section 1886(d)(1)(D) of the Act. During the first year of the transition period (that is, FY 1984), the Federal rates were comprised solely of the regional rate. During the second year, FY 1985, the Federal rates are comprised of a blend of 25 percent of the national rate and 75 percent of the regional rate.

As discussed in section II below, we are making changes (proposed on June 10, 1985, 50 FR 24366) in the determination of the prospective payment rates. The method for determining these rates was published in an interim final rule on September 1, 1983 (48 FR 39752) and modified in final rules published on January 3, 1984 (49 FR 234) and August 31, 1984 (49 FR 34723). The changes, to be applied prospectively, affect the calculation of both the Federal rates (adjusted standardized amounts) and the hospital-specific rates that are used to determine transition period prospective payment rates. As part of these changes, we are incorporating adjustments for the updated market basket index and additional adjustments as authorized under section 1886(e)(4) of the Act.

We are also including in the discussion below a summary of the comments we received on the addendum of the June 10, 1985 notice of proposed rulemaking (NPRM or proposed rule) and our responses to the comments.

Section III, below, sets forth our changes in determining the rate-of-increase limits for hospitals excluded from the prospective payment system. Section IV contains the tables referred to throughout the preamble to the final rule and in this addendum.

II. Changes To Prospective Payment Rates and DRG Weighting Factors for FY 1986

The basic methodology for determining Federal regional and national prospective payment rates is set forth at § 412.63, and for hospital-specific rates is set forth in § 412.73. Below, we discuss the manner in which we are making changes to some of the factors and methodology used for determining the prospective payment rates. The Federal rate changes, the revised wage index, and the DRG weights will be effective with discharges occurring on or after October 1, 1985. Updated hospital-specific rates will be effective for hospital cost reporting periods beginning on or after October 1, 1985.

In summary, we are establishing the FY 1986 Federal rates (that is, the standardized amounts set forth in Table 1, below) by:

- Restandardizing the base year cost data to reflect adoption of the survey-based gross wage index (described in section II.A.1.);
- Grouping the standardized amounts by urban/rural averages for the nine census regions and the nation, reflecting the most recent geographic designations (described in section II.A.2.);
- Updating the standardized amounts by zero percent, after considering—
  - —Certain factors that resulted in payment rates for FY 1985 that were overstated by 7.5 percent;
  - —The forecasted FY 1986 market basket increase of +4.27 percent; and
  - —A policy target adjustment factor of −1.5 percent (described in section II.A.3.);
  - —The adjustment factor (+.31 percent) for Part B costs and FICA taxes (described in section II.A.4.); and
- Applying the same adjustment factors for nonphysician anesthetist costs and outlier payments as were used for FY 1985 (described in section II.A.4.).

Further, for cost reporting periods beginning in FY 1986, we are not increasing either the hospital-specific rates for hospitals under the prospective payment system, or the rate-of-increase limits for hospitals excluded from the prospective payment system.

Although we believe the standardized amounts for FY 1985 were so overstated that a significant reduction could be justified, we are not reducing them for FY 1986. Rather, we are maintaining them at the same level as the FY 1985 payment rates. Thus, the amounts in Table 1 differ from the FY 1985 standardized amounts only as a result of restandardization to reflect the new wage index, as well as changes in MSA area designations announced by EOMB since September 30, 1984. In section II.A.3. below, we discuss our reasons for maintaining the FY 1986 Federal rates at the FY 1985 level.

The new DRG weights and outlier criteria are included in Table 5 of section IV, below.

Comment: Several commenters requested that special adjustments be made to the average standardized amounts for the costs of uncompensated care, labor room days, and malpractice insurance.

Response: Section 1886(d) of the Act requires that the prospective payment rates serve as total Medicare payment for inpatient operating costs of each discharge for all items and services furnished other than physicians' services. Operating costs are defined as all routine operating costs, ancillary service operating costs, and special care unit costs. Uncompensated care represents a loss of revenue and is not an operating cost. However, the operating costs associated with uncompensated care, labor room days, and malpractice insurance that are attributable to services furnished to Medicare patients, are already a part of inpatient operating costs and an

appropriate payment is already made for these costs under the prospective payment system.

A. Calculation of Adjusted Standardized Amounts

1. Standardization and Restandardization of Base Year Costs Per Case Used in Calculation of Federal Rates

Section 1886(d)(2)(A) of the Act requires the establishment of base year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the interim final rule, published September 1, 1983 (48 FR 39763), contains a detailed explanation of how base year cost data are established and how they are used in computing the Federal rates.

Section 1886(d)(2)(C) of the Act requires that the updated base year per discharge costs be standardized in order to remove from the cost data the effects of certain causes of variation in cost among hospitals. These include case-mix, wage levels, cost of living, and indirect medical education costs. We have decided to restandardize the base year costs to reflect the survey-based wage index.

As stated in the proposed rule (50 FR 24390), we do not believe that section 1886(d) of the Act contemplates rebasing the standardized amounts. Rather, it directs that the rates be updated annually. However, there has been much discussion concerning the desirability of rebasing the standardized amounts so that they are more reflective of hospital behavior under the prospective payment system. There has been concern that changes in hospital behavior, such as shorter lengths of stay and shifts of services to the outpatient setting, are difficult to quantify as part of the annual update because of the limited amount of data available to estimate the effects of these factors. Since rebasing the standardized amounts would automatically reflect changes in hospital behavior under the prospective payment system, it may be appropriate to consider such rebasing in the future.

a. *Adjustments for Variation in Hospital Wage Levels.* Section 1886(d)(2)(C)(ii) of the Act requires that the updated amounts be standardized by adjusting for variations among hospitals in the average area hospital wage level. Therefore, the updated average cost per discharge is divided into labor-related and nonlabor-related portions. We established labor and nonlabor portions, based on the labor and nonlabor components of the hospital market basket, and standardized the labor portion of the FY 1984 and FY 1985 standardized amounts using the Bureau of Labor Statistics' (BLS) area wage index. However, adoption of a new wage index (discussed in section III of the preamble of this final rule) requires us to restandardize the base year costs used to calculate the standardized amounts. Therefore, we have removed the effect of the previous standardization for each hospital's BLS wage index by multiplying each hospital's average cost per discharge value by the old index and by restandardizing the amounts by dividing that result by the survey-based gross wage index.

The comments and responses on the adoption of a new wage index are located in section III of the preamble to this final rule.

b. *Variations in Case Mix Among Hospitals.* Section 1886(d)(2)(C)(iii) of the Act requires that the updated amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768–39771). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3a, section VII of the addendum to the September 1, 1983 interim final rule (48 FR 39847–39870), contains the case-mix index values used for this purpose for the FYs 1984 and 1985 rates.

Because we are using new charge-based DRG weights for discharges occurring in FY 1986, we considered calculating new case-mix indexes based on 1981 charge data, and using these indexes to restandardize the base year costs used to determine the prospective payment rates. This would be technically the most accurate method for restandardizing the 1981 cost data. However, we found that restandardizing with 1981 charge-based case-mix index values would have a negligible effect on the standardized amounts. Therefore, we are continuing to standardize for case mix using 1981 cost data, and we have decided not to restandardize with 1981 charge-based data.

Comment: One commenter suggested that we consider restandardizing the Federal payment rates using 1981 charge-based (rather than cost-based) case-mix indexes. Because the charge data are slightly less compressed than the cost data, the commenter argued that failure to restandardize could have the potential outcome of paying hospitals with high case-mix indexes too much and hospitals with low case-mix indexes too little.

Response: We recognized this point in the NPRM (50 FR 24391), but argued that the differences in the Federal payment rates are small and the resulting payment differences are negligible. We would like to note further that there are technical disadvantages to restandardizing the rates for the use of charge-based relative weights. In particular, the charge-based case-mix indexes would incorporate all the limitations of the MEDPAR data that are inherent in the cost-based case-mix indexes currently used in the standardization. In addition, the charge-based case-mix indexes that we have calculated are based on only the 358 DRGs for which the 1981 MEDPAR data contain enough cases to calculate a reliable relative weight. We do not have charge-based weights for the original set of 109 low volume DRGs. Finally, restandardization of the rates with charge-based case-mix indexes may reduce total payments because hospitals with high case-mix indexes account for a disproportionately large percentage of total Medicare cases.

c. *Indirect Medical Education Costs.*—Section 1886(d)(2)(C)(i) of the Act requires that the updated amounts be standardized for indirect medical education costs. Therefore, in establishing the standardized amounts used to determine the FY 1984 and FY 1985 prospective payment rates, after adjusting each hospital's inpatient operating cost per discharge for inflation and case-mix, we divided each cost by 1.0 plus the product of double the education adjustment factor (5.795 percent, which, when doubled, yields 11.59 percent) and the individual hospital's adjusted intern and resident-to-bed ratio. We determined that adjusted ratio by dividing the hospital's number of full-time equivalent interns and residents for the cost reporting period by the hospital's bed size determined at the beginning of the data base period to obtain the hospital's intern and resident-to-bed ratio, and dividing that ratio by 0.1.

We are not revising the education factor, because we do not have the latest intern and resident counts needed to rerun the regression. Therefore, we cannot restandardize the updated amounts to reflect the latest intern and resident-to-bed ratios. In addition, we do not believe that the indirect medical education factor would necessarily

change even if the data were available. That factor is based on considering interns and residents that work 35 or more hours per week as full-time, and those that work less than 35 hours as half-time. Even if certain interns and residents worked some hours furnishing services to out outpatients, they probably would have still spent 35 or more hours furnishing services to inpatients. Therefore, since the count of interns and residents in 1981 almost certainly would not have changed significantly had outpatient time been eliminated, the indirect medical education factor is unlikely to have changed. We will, however, reestimate the relationship between costs and teaching activity in the future once data become available.

The comments and responses on the calculation of indirect medical education costs are located in section IV.F. of the preamble to this final rule.

d. *Cost-of-Living Factor for Alaska and Hawaii.* Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation. The higher cost of labor is accounted for in the wage index adjustments discussed above. However, the higher cost-of-living in these States also affects the cost of nonlabor items (for example, supplies and equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (that is, for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor. The factors used for this adjustment have not changed from FY 1985; therefore, we are not restandardizing the base-year cost data for cost-of-living adjustments. We note that some of the adjustment factors were incorrect in the NPRM. The table below presents the most recent (FY 1985) cost-of-living adjustment factors.

We received no comments on this issue.

Table of 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.)

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 1986 the Federal rates will be comprised of 50 percent of the national rate and 50 percent of the regional rate (section 1886(d)(1)(D) of the Act). Therefore, Table 1 contains 20 standardized amounts (ten urban amounts and ten rural amounts further divided into labor-related and nonlabor-related portions). The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that the national urban and rural groups include hospitals from all urban or rural geographic areas, respectively.

On June 27, 1985, EOMB announced, effective June 30, 1985, revised listings of the Metropolitan Statistical Area (MSA) designations that are used in calculating the standardized amounts. We note that under the law *Making Continuing Appropriations for FY 1985,* (Title I of Pub. L. 98–473), enacted October 12, 1984, the designation of the St. Louis MSA was also changed. As stated in the January 3, 1984 final rule (49 FR 253), such changes in designation will not be recognized in the prospective payment rates until the beginning of each new Federal fiscal year following the announced changes. The revised wage index (as well as the standardized amounts) included in this final rule incorporates this change, as well as those effective June 30, 1985, which will be effective October 1, 1985 for prospective payment purposes. Note that such changes in the MSA designations account for modest changes in the nonlabor portions, as well as the labor portions, of the standardized amounts.

3. Updating the Average Standardized Amounts

a. *Legal Requirements.* In accordance with section 1886(d)(3)(A) of the Act, we are adjusting the urban and rural average standardized amounts using the applicable percentage as determined by the Secretary in accordance with section 1886(e)(4) of the Act. That section reads as follows:

(4) Taking into consideration the recommendations of the Commission [that is, the Prospective Payment Assessment Commission, or ProPAC], the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

As prescribed by section 1886(e)(2) of the Act, the Commission, in making its recommendations to the Secretary:

shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

Section 1886(b) of the Act sets forth the requirements under which a rate of increase limit is established for the inpatient operating costs of hospitals excluded from the prospective payment system. Under this section, a target amount is determined annually for each hospital cost reporting period, based on each hospital's base year cost per case, updated by an "applicable percentage increase."

This "applicable percentage increase" is defined in section 1886(b)(3)(B) as:

one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

We have used the hospital market basket index as the measure of the cost of goods and services for determining both prospective payment rates and the target amounts applicable to hospitals and units excluded from the prospective payment system. For FY 1986 and subsequent fiscal years, section 1886(e)(4) of the Act requires that the

determination of a percentage change, considering at least the factors set forth in that section and section 1886(e)(2) of the Act, *will substitute for* the "applicable percentage increase" that would otherwise apply as it did in FY 1984 and FY 1985. However, section 1886(b)(3)(B) of the Act specifies that for FY 1986, the percentage determined under section 1886(e)(4) may not exceed the applicable percentage increase that would otherwise be determined for that period. (Note that, under the statute, from FY 1986 on, the percentage determined by the Secretary under section 1886(e)(4) will be applied to *both* the prospective payment rates and the rate-of-increase limits applicable to hospitals and units excluded from the prospective payment system. Although the statute is not explicit on using the same percentage, we believe that the update factor is to be the same for both classes of hospitals. Section 1886(e)(2) of the Act requires ProPAC to make recommendations on the "appropriate percentage change [singular] which should be affected for hospital inpatient discharges under subsections (b) [non-prospective payment system hospitals] and (d) [prospective payment system hospitals] . . . ." Similarly, section 1886(e)(3) of the Act refers to "an" appropriate change factor and section 1886(e)(4) of the Act to "the percentage change.")

Comment: Many commenters stated that we are overstepping our authority by providing for a zero percent increase in the FY 1986 prospective payment rates from the FY 1985 levels. They stated that we have circumvented the legislative prerogatives of Congress by administratively setting Medicare prospective payments for FY 1986 at the FY 1985 levels in order to reduce the Federal budget deficit, and that we do not have the authority to make those budget decisions.

Response: We believe that our proposal to hold the FY 1986 prospective payment rates at FY 1985 levels is not only analytically defensible and supportable, but also fully complies with statutory requirements. Our decision not to inflate the FY 1986 prospective payment rates was made with explicit regard to the law.

Sections 1886(e) (2) and (4) of the Act specify the factors that ProPAC and the Secretary must consider in making an appropriate update determination. These factors include, but are not limited to, the following:

- Changes in the cost of goods and services that hospitals purchase (that is, market basket inflation or deflation).
- Hospital productivity.
- Technological and scientific advances.
- Quality of health care provided in hospitals.
- Long-term cost effectiveness in the provision of inpatient services.

Each of these factors, together with ProPAC's recommendations, was given careful consideration in the development of the proposed rule and this final rule as required under sections 1886(e) (2) and (4) of the Act.

In addition, section 1886(b)(3)(B) of the Act provides the Secretary authority to establish a rate of increase not to exceed the annual rate of increase in the hospital market basket plus one-quarter of one percentage point. While the law specifies the upper limit that could be used to establish the prospective payment rates, it neither requires that the ceiling rate be implemented nor prohibits the establishment of lower rates.

We considered the ramifications of not inflating the FY 1985 prospective payment rates. As explained below, we could have justified a reduction of 4.42 percent. We believe that sections 1886(e) (2) and (4) of the Act provide the Secretary sufficient authority to maintain FY 1986 prospective payment rates at the FY 1985 levels. According to section 1886(e)(4), the Secretary has the discretionary authority to determine the appropriate "percentage change" in the payment rates beginning with FY 1986. As part of this authority, the Department is responsible for ensuring that the Medicare Trust Funds are not overpaying for services provided to Medicare beneficiaries. Therefore, as further justified below, a zero percent increase in the prospective payment rates for FY 1986 is appropriate.

Comment: A number of commenters stated that nothing in the statute authorizes the Secretary to adjust the prior year's rates. They stated that the law authorizes the Secretary to "update previous standardized amounts," not to recalculate them.

Response: We believe that section 1886(d)(3)(A) of the Act gives the Secretary authority to consider the appropriateness of the prior year's standardized amounts as part of the update of the FY 1986 payment rates. This section states that the standardized amounts for fiscal years subsequent to FY 1985 are to be "adjusted in accordance with" the Secretary's final determination of the "percentage change" under section 1886(e)(4) of the Act. In addition, section 1886(d)(3)(A) of the Act specifically authorizes the Secretary to adjust the standardized amounts to reflect the latest case-mix data.

We believe that, in providing discretionary authority to adjust the standardized amounts, Congress intended that, rather than merely to update the rates mechanically, we should evaluate the appropriateness of the current payment levels. If we were to update the previous standardized amounts without consideration for how much they are overstated, as the commenters suggest, this would guarantee a windfall to hospitals that clearly Congress could not have intended as meeting the "amounts necessary for the efficient and effective delivery" of medically needed health care. In this connection, Congress also prescribed specific factors to be considered by ProPAC in making its recommendation on the "percentage change" for FY 1986 and beyond. In commenting on the proposed rule, ProPAC agreed that it was reasonable to consider the appropriateness of current payment levels in developing an update factor. While ProPAC may have disagreed with the extent of our adjustments to the prior years' rates, it supported the nature of these adjustments. A discussion of ProPAC's comments concerning the update factor is included elsewhere in this section.

Comment: A few commenters stated that we are required by law to increase the payment rates for FY 1986. They state that sections 1886(d)(3)(A) and 1886(e)(4) of the Act, which address the update of the previous years' standardized amounts, specifically refer to the "percentage increase" and, therefore, preclude us from not increasing the payment rates.

Response: We disagree with this interpretation. Section 1886(d)(3)(A) of the Act, in referring to the "percentage increase", is addressing the FY 1985 update and not subsequent updates. In addition, for FY 1986 and subsequent fiscal years, section 1886(e)(4) of the Act requires that the determination of a percentage change, considering at least the factors set forth in that section and section 1886(e)(2) of the Act, *will substitute for* the "applicable percentage increase" that would otherwise apply as it did in FY 1984 and FY 1985. We believe that this change in terminology clearly implies that a factor other than an increase may be applied for updates beginning with FY 1986.

b. *Factors Considered in Determining the Proposed FY 1986 Update.* Based on the legal requirements for establishing the FY 1986 update factor, we had to consider at least the following factors in addition to the hospital market basket index: hospital productivity, technological and scientific advances,

quality of care, cost-effectiveness, and case-mix data. In addition, we considered prior years' experience with the prospective payment system.

Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. We believe that it is necessary, each year, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, the FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be neither more nor less than we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section II.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals −7.5 percent.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. We have combined these values into a composite policy target adjustment factor, as discussed in section II.A.3.e., below. For FY 1986, this factor equals −1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." Establishing FY 1986 prospective payment rates based on FY 1985 rates that have been demonstrated to be overstated, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a −4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase	+4.27
Part B costs and FICA taxes	+.31
Composite correction factor	−7.5
Composite policy target adjustment factor	−1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.

Comment: Many commenters stated that our framework for determining the update factor is not justified and is contrary to the recommendations of ProPAC. Other commenters stated that we had completely ignored ProPAC's recommendations.

Response: We disagree with these commenters. Our framework for developing an update factor is very similar to ProPAC's. For example, ProPAC recommended similar adjustments for case-mix increases and market basket forecast errors. While the extent of these adjustments and our methodology for making them may have differed somewhat from those recommended by ProPAC, the nature of the adjustments is very similar. In fact, in commenting on the proposed rule and notice of rates, ProPAC stated its belief that we had constructively considered its recommendations. Along with its comments, ProPAC submitted the following table comparing the components of our updating factor for the FY 1986 rates with its recommendations. We have added a third column to reflect our most recent information. We believe this table demonstrates that, in principle, our framework for updating the FY 1986 rates is very similar to ProPAC's.

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ESTIMATED INCREASE IN PROSPECTIVE PAYMENT AMOUNTS FOR FY 1986: COMPARISON OF NPRM TO PROPAC RECOMMENDATION (percentage change)

	NPRM	ProPAC	Final Rule
FY 1986 market basket increase	4.85	4.85	4.27
Previous market basket forecast errors	-1.30	-0.57[a]	-1.20
Policy Target Adjustment Factor or Discretionary Adjustment Factor	-1.50	-1.00	-1.50
Components:			
Productivity	-1.0	-1.5 to -2.0	-1.0
Cost-effective technologies	1.5	1.5 to 2.0	1.5
Product change		-1.0	
Cost-ineffective practice patterns	-2.0		-2.0
SUBTOTAL (market basket plus adjustment factor)	2.05	3.28	1.57
Observed change in case mix	-4.90 (1981-1985)	-2.00[b] (1985 only)	-6.30 (1981-1985)
Part B costs and FICA taxes	0	0	.31
Case-mix changes within DRGs during FY 1985	0	0.80[c]	0
TOTAL	-2.85	2.08	-4.42
PROPOSED INCREASE	0	2.08	0

[a] The Commission recommended that errors in forecasting internal price proxies (the wage component of the market basket) should not be corrected. The estimate of -0.57% (44% of -1.3%) assumes that the magnitude of the forecast errors was about the same for wages as for other price change measures.

[b] ProPAC estimate based on the findings of the Rand study cited in the proposed rule. The 2% increase in observed case mix for fiscal year 1985 is based on RAND's estimate of a 0.5% quarterly increase in case mix after hospitals have switched to the prospective payment system.

[c] The 0.8% increase estimated here for fiscal year 1985 takes into account historical trends in real case-mix change, recent shifts to outpatient treatment, and within-DRG case-mix changes that would not show up in the case-mix index.

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The extent of the case-mix adjustment continues to be the most significant area of difference. ProPAC believes we should adjust only for case-mix increases occurring in FY 1985. As explained in the NPRM (50 FR 24393), we believe the adjustment should also reflect previously unaccounted for changes in case mix prior to FY 1985. Otherwise, the standardized amounts, which serve as the basis for determining future prospective payment rates, would be overstated. The basis for ProPAC's recommendation is unclear since failure to also adjust for case-mix increases prior to FY 1985 would result in perpetuating overstated standardized amounts. In order to ensure an appropriate payment base for updating future rates, we believe it is essential to adjust for the entire overstated amount.

ProPAC's comments on other components of the update factor, such as adjusting for real case-mix increases, are discussed along with other comments received on these issues.

Comment: Several commenters maintained that our proposed 4.9 percent reduction in the FY 1986 standardized payment rates to correct for the understatement in the FY 1984 and FY 1985 budget neutrality adjustments attributable to case-mix increases beyond those recognized in the 1981 MEDPAR file was in violation of section 1886(e)(1) of the Act. These commenters pointed out that the budget neutrality provisions in section 1886(e)(1) only apply to the determination of the FY 1984 and FY 1985 prospective payment rates. None of the factors set forth in the law explicitly provide for computing the FY 1986 standardized amounts to include budget neutrality. Therefore, these commenters claimed that applying the proposed 4.9 percent reduction to correct the amount of the budget neutrality offsets for FY 1984 and FY 1985 due to an underestimation of the rate of increase in case mix is inappropriate. The commenters argued that the FY 1986 prospective payment rates should be calculated based on the FY 1984 and FY 1985 standardized amounts *prior* to the adjustment of these amounts for budget neutrality.

Response: Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the limits enacted under the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248) during FYs 1984 and 1985. That is, for FY 1984 and FY 1985, the prospective payment system should be "budget neutral." Section 1886(e)(1)(A) states in part, "The Secretary shall provide for such proportional adjustment . . . as may be necessary to assure that—

(i) The aggregate payment amounts otherwise provided . . . for that fiscal year . . . are not greater or less than—

(ii) The target percentage . . . of the payment amounts which would have been payable . . . for that fiscal year . . . under the law as in effect before the date of enactment of the Social Security Amendments of 1983."

In order that total estimated payments under the prospective payment system would equal "what would have been payable" under prior law, we applied an adjustment factor to both the Federal and hospital-specific portion of each hospital's blended prospective payment rate at the time the rate was determined. The budget neutrality adjustments for both FY 1984 and FY 1985 were both offsets, although an add-on could have been required to ensure compliance with law. Our preliminary determination of the case-mix adjustment for FY 1984 was 3.38 percent. We used an additional 1.05 percent for the FY 1985 rates. The portions of the budget neutrality offsets for these Federal fiscal years solely attributable to the estimated rate of increase in case mix were 3.38 percent and 1.05 percent, respectively.

The commenter's position is that a literal reading of the law precludes *any* reconsideration of the budget neutrality adjustment factors incorporated in the FY 1984 and FY 1985 standardized amounts in establishing payment rates for FY 1986. We disagree. The estimate of the rate of change in case mix affects the accuracy of the initially computed budget neutrality adjustments. Since our latest measure is more accurate than the earlier measurements used to compute the previously published factors because of the availability of more complete and later data, its use should result in a more precise approximation of the amounts that should have been paid in FY 1984 and FY 1985, if we had been able to achieve budget neutrality accurately. There is no reason to believe that Congress would have intended that the hospital industry receive a windfall as a result of these misestimations. Because the creation of overpayments and underpayments for FY 1984 and FY 1985 through retroactive implementation of revised budget neutrality adjustments would not comport with the basic principle of prospectivity of the prospective payment system, we have not applied these adjustments retroactively, but have converted these factors prospectively by adjusting the FY 1986 rates accordingly.

We have also considered the commenter's position that FY 1984 and FY 1985 standardized rates be recalculated to remove the entire effect of budget neutrality prior to developing the FY 1986 payment rates. We do not agree that the prior years' standardized rates before budget neutrality should serve as the basis for updating the FY 1986 rates. Since the budget-neutralized standardized amounts represent the actual payment rates used to pay hospitals in FY 1985, we believe the "percentage change" for FY 1986 should be applied to these amounts. In addition, section 1886(d)(3)(A) and (C) of the Act does not explicitly require that the update factor apply to the FY 1985 payment rates prior to the adjustments for budget neutrality in FY 1985.

However, absent the budget neutrality requirement applicable to FY 1984 and FY 1985 payment rates, we believe an adjustment to remove the effects of coding-related case-mix index increases from the standardized amounts would still be necessary. Since our analysis and RAND's study indicate that by far the greatest portion of the observed increase in case mix measures is due to coding changes, we would be overpaying on a prospective basis, because the case-mix increase would not reflect real changes in resource use, but only improve coding. These case-mix increases should not be reflected in the standardized amounts because they are unrelated to actual increases in costs per case. In addition, we believe the language in section 1886(d)(3)(A) of the Act requires that the standardized rates for fiscal years subsequent to FY 1985 be adjusted (that is, deflated) to reflect the most recent case-mix data available. Even if we were to accept the commenters' premise that the update factor should be applied to FY 1985 standardized amounts prior to budget neutrality, the result would be the same (that is, a zero percent update for FY 1986). The following table illustrates the adjustments that would apply to the FY 1986 update if the budget neutrality adjustment was eliminated. We recomputed the applicable overall rate of increase in the FY 1986 rates to remove the budget neutrality offset and case-mix rates of increase previously recognized in FY 1984 and FY 1985.

	Percent
Forecasted market basket increase for FY 1986	+4.27
Change due to elimination of budget neutrality [1]	[2] +5.26 [3] +4.82

	Percent
Change due to elimination of case-mix increases previously recognized in FY 1984 and FY 1985 [4]	+1.05
Reduction in rates due to case-mix increase CY 1981–FY 1985 (as of June 1985) [5]	−8.19
Change due to market basket forecasting error [6]	−1.5
Policy target adjustment factor	−1.5
Productivity	−1.0
Cost effective technologies	+1.5
Cost ineffective practice patterns	−2.0
Total	[2] −0.61
	[3] −1.05

The combined effect is still a reduction in the standardized amounts for FY 1986 compared to those for FY 1985

[1] 1.950 (Regional budget neutrality adjustment factor)=1.0528, 1.954 (National budget neutrality adjustment factor)=1.0492
[2] Regional.
[3] National.
[4] The 3.38 percent case-mix adjustment, and the .31 percent adjustment for Part B costs and FICA taxes, are included as part of the above budget neutrality adjustments.
[5] This factor represents the nominal increase in case mix from the 1981 MEDPAR file to FY 1985, and does not include any "real" case-mix increase. This figure was derived using the results of the RAND study, which found that 2.2 percentage points (or 26.2 percent) of the 8.4 percent observed case-mix increase for 1984 was related to "real" increases in case mix. Therefore, 73.8 percent (or 6.19 percentage points) of the 11.1 percent increase in average case-mix index through FY 1985 is nominal.
[6] This factor is the compounded difference between the latest FY 1984 and FY 1985 projections, and the FY 1984 and FY 1985 projections provided in the addendum to the August 31, 1984 final rule (49 FR 34767).

Comment: Many commenters stated that the actual Medicare outlay experience was far below the estimated outlays for the budget neutral period (FYs 1984 and 1985), and, therefore, hospitals were underpaid. Other commenters suggested that we should compare estimated payments for budget neutrality with actual outlays rather than incurred payments.

Response: Actual Medicare outlays are lower than estimated outlays because of a slow-down in the speed with which hospitals process bills and because of a decline in admissions. Although both factors affect estimated outlays, neither factor affects the determination of budget neutrality.

Budget neutrality, as provided for under section 1886(e)(1) of the Act, requires that outlays be the same under the prospective payment system as they would have been under the limits enacted under Pub. L. 97–248, that is, the law in effect prior to Pub. L. 98–21.

Budget neutral outlays should not necessarily equal the estimated outlays that appear in the budget for planning purposes. Thus, if actual outlays under budget neutrality are lower than estimated, they also would have been lower under the limits enacted by Pub. L. 97–248. Comparing estimated outlays with actual outlays provides absolutely no measure of the performance of budget neutrality.

In addition, we stated our intent in the addendum of the September 1, 1983 interim final rule (48 FR 39887) to determine budget neutrality on an incurred payment basis rather than a cash basis, and to assume that admission rates would be the same under the prospective payment system as under Pub. L. 97–248. We received no adverse comments on these provisions.

Comment: We received comments that our model does not reflect full experience under the prospective payment system and that we need cost report information to make these adjustments.

Response: It would be impractical to determine payments under the prospective payment system using current year cost reports, especially since we must set these rates before the cost report accounting years begin. Thus, we have used the best data and most recent information available to us in determining the payment rates.

Comment: We received comments stating that a shorter length of stay does not imply lower costs.

Response: Although this may be true in isolated instances, it is generally not the case. If such were the case, then there would be a zero marginal cost associated with longer stays, implying that our day outlier payment is excessive. Most hospitals see a financial advantage to a shorter length of stay, and are working to reduce length of stay in order to reduce costs.

c. *Corrections for Prior Years' Experience.*—(1) *Case mix.* In the proposed rule, the timeframes for the observed case-mix increase of 9.6 percent were based on prospective payment billing experience received through April 1985 for both FYs 1984 and 1985 combined. Using patient bill data received through July 1985, and using the FY 1984 relative DRG weights, we have determined that the average case-mix index for hospitals under the prospective payment system has increased 11.1 percent over the 1981 MEDPAR level. Relative to 1981, the average case mix increased 9.0 percent through FY 1984, and 11.1 percent through FY 1985. Since we now have significant experience for FY 1985 (4.7 million discharges), it would be more appropriate to use the FY 1985 experience than the combined experience, especially since FY 1985 is the basis for the prospective payment system in future years. We have previously taken 4.47 percent of this case-mix increase into account by adjusting the original FY 1984 standardized amounts by 3.38 percent and reducing the FY 1985 DRG weights by 1.05 percent. (The relationship of these percent changes is multiplicative, rather than additive; that is $1.0338 \times 1.0105 = 1.0447$.) Thus, the observed case-mix increase to date is 6.3 percent greater than the total prior adjustment (1.111 divided by $1.0447 = 1.063$).

Comment: Several commenters pointed out that the proposed rates make no allowance for real changes in case mix from 1981 through FY 1985, despite ProPAC's recommendation that an allowance for real increases in case mix that occurred during FY 1985 be incorporated in the FY 1986 rates.

Response: We disagree with the commenters' allegation for the following reasons. In FYs 1981 through 1983, prior to implementation of the prospective payment system, hospitals were reimbursed on a reasonable-cost basis which automatically made allowances for real changes in case-mix severity. Under the prospective payment system, for changes in real case mix that have occurred in FYs 1984 and 1985, as compared to 1981, we believe that an explicit add-on to the standardized payment rates would, in effect, result in the Medicare program paying for higher-cost, more resource intensive cases twice; first, by means of the specific add-on, and secondly, through the classification of the case in a higher-weighted DRG. To the extent that a hospital's case mix has changed because a greater proportion of cases are assigned to DRGs with higher weights, the provider has and will continue to receive increased prospective payments that reflect its real case mix. Therefore, a separate add-on to the standardized payment rates for real changes in case mix would not be appropriate.

In addition, we point out that under the budget neutrality provisions applicable for FY 1984 and FY 1985, any increases in case mix, whether "real" or attributable to changes in medical coding practices, should not have been recognized in increased prospective payments to hospitals. In the addendum to the proposed rule (50 FR 24393), we stated that, based on bills received through April 1985, the average case-mix index for hospitals under the prospective payment system increased 9.6 percent over the 1981 MEDPAR level. We now have data through July 1985, and the average case-mix index increased by 11.1 percent. Of this overall increase, only 4.47 percent was accounted for in budget neutrality reductions to the FY 1984 and FY 1985 prospective payment rates. Because budget neutrality is required by law and in view of the understatement of the FY

1984 and FY 1985 budget neutrality adjustments, a further 6.3 percent reduction in the standardized amounts of the prospective payment rates for FY 1986 is necessary to ensure that the first post-budget-neutrality payment rates are established on an appropriate basis. We reiterate, however, that even absent budget neutrality, we would want to make some adjustments for case mix in order to avoid overpaying for services.

Comment: Many commenters stated that we should not make any downward adjustments for increases in case mix that occurred in FY 1985 because increases in case mix would have been passed through under the Pub. L. 97–248 limits. They believe that any increases in real case mix would also been passed through under these limits.

Response: We agree that the limits under Pub. L. 97–248 would have passed through and did pass through a portion of the increase in real case mix. We will recognize increases in real case mix under the prospective payment system that occur in FY 1986 and later. To the extent that cases are falling into the higher-weighted DRGs, real case-mix increases will be automatically recognized and paid for under the prospective payment system. In addition, because the limits under Pub. L. 97–248 constituted a cost-based reimbursement system, increases in real case mix would have resulted in increased costs that would have been reimbursed subject to both the regulations describing the reasonable cost limits (§ 405.460) and the rate of increase limits (§ 405.463).

In modeling the limits under Pub. L. 97–248, we used cost-per-case increase assumptions that had a more than adequate margin for case-mix increases. Furthermore, we were careful to ensure that the cost-per-case increase assumptions did not reflect any of the incentives of the prospective payment system, such as a shorter length of stay. In fact, as described in the addendum to the June 10, 1985 proposed rule (50 FR 24393), we determined that the cost-per-case increase assumptions that we used in calculating budget neutrality in FYs 1984 and 1985 were too high. Thus, there was a liberal margin to allow for real case-mix increases under Pub. L. 97–248.

Comment: Some commenters stated that we removed all case-mix increases from 1981 through 1985, and that we are not allowing any real case-mix increases for 1981 through 1986. Other commenters requested that we remove all case-mix adjustments made in prior years.

Response: The model we used for determining budget neutrality under Pub. L. 97–248 implicitly allowed for all real case-mix changes that would have been allowed under Pub. L. 97–248 in FYs 1984 and 1985 as compared to the 1981 MEDPAR data. If we had not adjusted for the reported increases in case mix during the budget neutrality period, we would have paid double for increases in case mix (that is, first by means of overpaying for changes in case-mix due to improved medical coding, and secondly through classification of cases into higher-weighted DRGs). For this reason, and the reasons discussed in the previous comment, we cannot remove case-mix adjustments that we have already made (or we would be making excessive payments). We agree that real case-mix increases that occur during FY 1986 should be paid in full through classification of cases into higher-weighted DRGs, and we are not preventing increases in payments for real case-mix increases in FY 1986.

Comment: One commenter stated that our staff had acknowledged that unexpected case-mix increases would have been payable under Pub. L. 97–248.

Response: Unexpected real case-mix increases would have been partially recognized under Pub. L. 97–248, to the extent that case-mix increases resulted in increased costs per admission. An adequate margin for "real" case-mix increase was incorporated in the cost-per-case assumptions used in the determination of budget neutrality. Thus, if we were not to make a full adjustment for reported case-mix increases under the prospective payment system, we would, in effect, be paying double for increases in case mix.

Comment: Some commenters stated that the limits under Pub. L. 97–248 were adjusted for case mix and that exceptions were available.

Response: Sections 405.460 and 405.463 permit the granting of exceptions to the Pub. L. 97–248 cost limits and rate of increase limits 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 Pub. L. 97–248 would have little effect on total cash outlays since only a comparatively few hospitals will be granted increases in their Pub. L. 97–248 cost limits or rate of increase limits. 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 the Pub. L. 97–248 limits since hospital payments are not dependent on the DRG to which a case is assigned.

Comment: Many commenters stated that we had abandoned the policy set forth in the addendum of the August 31, 1984 final rule (49 FR 34770) for allowing increases in real case mix. The commenters believe that the FY 1985 adjustment was binding in future years.

Response: As discussed previously, we have more than allowed for increases in real case mix even after we made adjustments for coding changes. The FY 1985 case-mix adjustment represented a discretionary policy decision that was made for FY 1985 pending further studies of case-mix data. This decision, made in consultation with the hospital industry, represented a delay to the full reduction for nominal (improved medical coding) case mix until a study of the nature of the case-mix increases was completed. This study, now completed by the Rand Corporation, supports a full reduction for nominal case-mix increase that occurred prior to publication of the FY 1986 prospective payment rates. This study found that, since 1981, only a small portion of the reported case-mix increases are "real". As discussed previously in this section, the cost-per-case assumptions, used in developing the budget neutrality adjustments in prior years, provided an adequate margin for "real" case-mix increases.

Comment: Many commenters objected to the adjustments we made to refine the FY 1985 base, such as adjustments for case mix and market basket forecasts. As well, many commenters objected to what they referred to as the retroactive nature of the adjustments, and to our using budget neutrality to adjust for case mix. Other commenters stated that we had destroyed the prospective nature of the prospective payment system. Quoting section 1886(e)(4) of the Act,

> Taking into consideration the recommendations of the Commission, the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

these commenters claimed that we violated this section of the law.

Response: In order to comply with section 1886(e)(4) of the Act, we adjusted the prospective payment change factor to compensate for FY 1985 payments being excessive. Though this adjustment, in the sense of looking back, may have been retrospective, it certainly was not retroactive. We have not

destroyed the concept of prospectivity since we are not recovering overpayments or refunding underpayments nor have we reduced rates so as to effect recovery of overpayments during FY 1986. Rather, we are ensuring that payment levels for FY 1986 will be adequate for the appropriate and necessary care of Medicare beneficiaries. There is no statutory requirement to establish rates so as to perpetuate estimating errors, whether upward or downward, indefinitely into the future. Also, there is no statutory provision prohibiting us from correcting past estimating errors. We made reference to budget neutrality in adjusting for case mix because budget neutrality applied in FY 1985, and FY 1985 is the basis for all future prospective payments. We have not received any evidence or studies suggesting that the prospective payment rates are inadequate so as to preclude the hospital industry from providing Medicare beneficiaries with high quality, medically appropriate care. In addition, as we have already noted, we would have had to make these adjustments even in the absence of budget neutrality in order to comply with section 1886(e)(4) of the Act.

Comment: We received comments stating that we should separate the FY 1985 case-mix increase into real increases and coding increases. Other comments suggested that we had acknowledged that we were unable to separate the reasons for case-mix increases.

Response: A study performed by RAND provided this analysis for us. For purposes of FY 1985, in which budget neutrality applied, separating real case-mix increases from increases resulting from improved coding is unnecessary since the limits enacted by Pub. L. 97-248 did not pass through increases in reported case mix, and since the cost-per-case assumptions used to determine budget neutrality more than allowed for real increases in case mix.

Comment: Several commenters were critical of the study conducted by the Rand Corporation to determine the reasons for the increase in the Medicare case-mix index since 1981. That study concluded that, of the 8.4 percent increase in the case-mix index observed from calendar year 1981 through FY 1984, 6.2 percentage points, or almost three-quarters of the increase, were due to documentation and coding changes. (Subsequent to the completion of this study, RAND has revised the 8.4 percent figure to 11.3 percent based on bills received through April 1985.) The study concluded that since coding changes were responsible for a large portion of the case-mix increase experienced to date, these changes should be reflected in an adjustment (that is, an offset) to eliminate the effect of nominal (improved coding) case-mix increases (as opposed to "real" changes) in the determination of the prospective payment rates. One commenter stated that the Rand study did not use an appropriate time series design and that the only experimental design that would have permitted an assessment of the effects of real changes in case mix from changes in coding would have been a reabstracting study. We received other comments that the study failed to address the issue of whether the sharp increase in the case-mix index could have been at least partially attributed to the significant decline in Medicare admissions since the beginning of the prospective payment system. The implication is that those DRGs with a low weight may have had a disproportionate share of the decline in admissions due to the furnishing of care on an outpatient or other basis. The impact of such an effect would be an understatement of approximately 25 percent of the observed 8.4 percent increase in case mix considered "real."

Response: As we stated previously in this section, any increases in case mix prior to FY 1986, whether "real" or not, should not be recognized in increased FY 1986 prospective payments because of the budget neutrality requirement that applies through FY 1985. Furthermore, we disagree with the statement that the only experimental design that would have allowed an accurate determination of the reasons for the substantial increase in the case-mix index is a reabstraction study. Because RAND examined the increase in hospital case mix for facilities with different reporting periods from calendar year 1981 through FY 1984, a time series analysis was reflected in the experimental design. We point out that a time series analysis of data from the Commission on Professional and Hospital Activities was performed by RAND. This design enabled RAND to distinguish coding improvements from the estimated effects due to "real" increase in the case-mix index. Therefore, a reabstraction study is not essential in distinguishing real from nominal increases in case mix.

Furthermore, a reabstracting study would not capture the effect of improved documentation of diagnoses and procedures by physicians. Thus, reabstracting is unnecessary, and, if done, would not be definitive.

An examination of case-mix changes that have occurred in the four waiver States (New York, New Jersey, Maryland, and Massachusetts) provides further evidence that a significant portion of the increase in the case-mix index reflects prospective payment system-induced changes in coding and medical practice. Since the four waiver States either do not use DRGs for reimbursement, or place less emphasis on them than the prospective payment system, comparing their case-mix index rate of change to that of hospitals in the non-waiver States over the same period of time would provide a rough measure of the magnitude of prospective payment system-induced coding improvements. Also, because the waiver States are subject to the same changes in medical technology and the impact of changes in the patient population as the rest of the country, such a comparison should reveal the extent to which the prospective payment system has affected nominal changes in case mix. At our request, the Rand Corporation performed such an analysis. As the table below reveals, Medicare data show an 8.4 percent increase in case mix in the non-waiver States from calendar year 1981 to FY 1984, while the corresponding increase for the waiver States was only 2.0 percent. A similar analysis was performed on the Professional Activity Study (PAS) data (discharge abstract data collected by the Commission on Professional and Hospital Activities) from the fourth quarter of 1981 to the fourth quarter of 1984. This analysis revealed the case-mix index increased by 5.9 percent in the non-waiver states but only 0.3 percent in the waiver States. These comparisons provide further evidence that much of the observed case-mix index increase reflects prospective payment system-induced changes in coding.

CASE-MIX INCREASE IN WAIVER STATES

	Percent change, 1981-1984	
	Non-waiver	Waiver
Medicare data [1]	8.4	2.0
PAS data [2]	5.9	0.3

[1] Calendar Year 1981 to Fiscal Year 1984.
[2] Fourth Quarter of Calendar Year 1981 to Fourth Quarter Calendar Year 1984.

We also asked RAND to investigate whether the sharp decline in Medicare admissions from 1983 to 1984 may have contributed to the increase in the case-mix index (although, as we note elsewhere in this section of the addendum, Medicare admissions did *not* decline during the period 1981 through 1984). A reduced demand for hospital services at the same time the

prospective payment system was being implemented could have led to an understatement of the rate of increase in case mix that was real if it led to an increase in the complexity of the admissions that occurred. A regression model that explicitly included volume changes was performed on the Professional Activity Study data. RAND found that the magnitude of the volume effect was very small. For example, a four percent decline in admissions is estimated to have increased case mix by only 0.2 percent in FY 1984. Therefore, controlling for volume changes did not alter the significance of the conclusion that most of the observed change in case mix is due to changes in medical coding.

Finally, in response to the assertion that a significant portion of the 8.4 percent increase in case mix that RAND observed may be attributed to a shift in the proportion of cases falling in DRGs with relatively low weights from an inpatient to an outpatient setting, RAND selected 37 DRGs having a significant potential for outpatient substitution to determine their contribution to the increase in the case-mix index. The 37 DRGs accounted for only 0.7 percent of the 8.4 percent increase, and virtually all of that 0.7 percent was accounted for by DRG 39 (lens procedures). In response to further comments that several DRGs with a high potential for outpatient substitution were not included in the analysis, 3 DRGs were added to the original 37 initially selected. They are DRGs 364, 410, and 412. The three were dominated by category 410 (chemotherapy), which *increased* as a proportion of Medicare discharges under the prospective payment system. Because DRG 410 has a relatively low weight, the increased proportion of Medicare discharges tended to lower the case-mix index. Thus, with an expanded list of outpatient DRGs, the portion of the case-mix index increase attributed to a shift in cases to outpatient settings (that is, the portion that reflects "real" increase in the case-mix index) was somewhat reduced. This result further supports the finding that most of the increase in the case-mix index that RAND observed reflected changes in medical coding practices.

Comment: Many commenters stated that reduced admissions and the movement of certain cases to an outpatient setting would increase case mix leaving hospitals with more severely ill patients. One commenter supplied evidence purporting to show that patients are more severely ill because fewer patients can get out of bed unassisted and because hospitals have increased the number of employees per bed on their staffs. One commenter suggested that shortening the length of stay did not reduce the cost per admission. We also received comments that the prospective payment system was the cause for fewer admissions.

Response: We agree that a reduction in admissions could increase case mix. The RAND study measured the increase in case mix due to the shifting of cases to the outpatient setting. The cost-per-case assumptions used in the determination of budget neutrality more than compensated for these increases in case mix. It is not surprising that a higher percentage of patients are unable to get out of bed unassisted. Shortening the length of stay can lead to this situation, since the days removed from the stay are the latter days, when the patient is more mobile. This does not imply that such shortened admissions are more costly. The staffing level in a hospital has not been shown to be a reliable indication of the severity of illness of the patients. As one commenter stated, "physicians, not hospitals, admit patients and hospitals do not determine the location of treatment." We agree, therefore, that the prospective payment system does not appear to have an impact on the number of admissions.

We refer the reader to the discussion in the previous comment and response of the RAND regression analysis, which included volume changes. The results of this analysis showed that volume changes had little impact on case mix.

Comment: We received comments that admissions have declined substantially since 1981. One commenter supplied evidence showing that admissions declined since 1983.

Response: Panel Survey Data published by the American Hospital Association do not show Medicare admissions declining during the period 1981 through 1984. Admissions declined from 1983 to 1984 because 1983 was a year with an unusually high Medicare admission level. However, Medicare admissions still increased substantially during the period 1981 through 1984.

Comment: Some commenters suggested that we simply dismissed the effect of aging on average case mix, and that costs within a DRG increase with age.

Response: The DRG. system considers age when assigning a DRG. Consequently, the aging of the population should have minimal impact on costs within a DRG. In addition, the RAND study estimated the effect of the aging of the inpatient population through calculating case-mix indexes by age group and by the proportion of Medicare discharges in each age group in 1981 and 1984. As a check, RAND calculated the case-mix indexes by age group using both 1981 and 1984 data.

As shown in the table below, aging did not affect the case-mix index. Calculating the case-mix indexes by age group from 1981 data, the 1984 age distribution would have resulted in a 1981 case-mix index of 1.0490, which is close to the actual 1981 case-mix index of 1.0486. Similarly, the 1981 age distribution would have resulted in a 1984 case-mix index of 1.1183, which is close to the actual 1984 case-mix index of 1.1181. Therefore, the aging of the Medicare population has had a negligible impact on the observed increase in case mix.

AGE OF MEDICARE INPATIENTS AND THE CASE-MIX INDEX (CMI)

Age group	1981		1984	
	Percent	CMI	Percent	CMI
<65	11.91	1.0356	11.30	1.1063
65 to 69	22.45	1.0386	21.17	1.1233
70 to 74	21.61	1.0633	21.05	1.1404
75 to 79	18.55	1.0511	19.41	1.1176
80 to 84	13.89	1.0444	14.43	1.0972
85 +	11.78	1.0555	12.65	1.1065
Total	100.00	1.0486[1]	100.00	1.1181

Source: Medicare data, nonwaiver states.

[1] The Medicare case-mix index, which was based on MEDPAR data for calendar year 1981, was 1.046. The slight difference between the value of this case-mix index, and that appearing in the above table, is due to cases with missing DRGs.

Moreover, both our studies and the RAND study have determined that the aging of the Medicare population has had negligible impact on the increase in case mix.

Comment: A commenter suggested that we should use RAND's 8.4 percent case-mix increase instead of our proposed 9.6 percent increase.

Response: As explained in the addendum to the proposed rule (50 FR 24393), we used the 9.6 percent increase because it was based on more recent data and included not only FY 1984

data, but also FY 1985 data. Additional data received since the NPRM was issued show that case mix has now increased by 11.1 percent.

When RAND updated its data to include FY 1984 claims that were received well into FY 1985, they concluded that the case-mix index for FY 1984 increased 9.2 percent. Similarly updated RAND data project that the case-mix index for FY 1985, for claims received through April 1985, increased 11.3 percent.

Comment: Many commenters complained that we did not describe the methodology used to calculate the case-mix increases, and that we did not specify the timeframe to which these increases applied.

Response: The methodology used to compute the case-mix increase is the same methodology used and fully described in the July 3, 1984 proposed rule (49 FR 27442) and in the August 31, 1984 final rule (49 FR 34770). To summarize, for each hospital, and for each month, the case-mix level in the 1981 MEDPAR file for the corresponding month is weighted by the prospective payment system discharges for the month. Then, all months of the 1981 MEDPAR file are weighted together. This is divided into the average case-mix under the prospective payment system to compute the case-mix increase. This method automatically adjusts for seasonal variations in case-mix, for the different rates at which hospitals submit bills, and for the phasing in of hospitals to the prospective payment system by accounting year. In the proposed rule, the timeframe for the case-mix increase was the total prospective payment system experience, including bills we received through April 1985, for both FYs 1984 and 1985. Looking at the experience as reflected through bills received through July 1985, we now have prospective payment system case-mix experience on 5.8 million discharges in FY 1984 and 4.7 million discharges in FY 1985. Relative to 1981, the average case-mix index increased 9.0 percent through FY 1984, and 11.1 percent through FY 1985. Since we now have significant experience for FY 1985, it would be more appropriate to use the FY 1985 experience than the combined experience, especially since FY 1985 is the basis for the prospective payment system in future years.

Comment: One commenter alleged that we cut reimbursement upon observing that the average case weight had increased to a level in excess of 1.000.

Response: We disagree with the commenter's allegation and note that the average case weight in the MEDPAR file was on a discharge-weighted basis of about 1.05.

Comment: Many commenters stated that the law requires us to consider the most recent case-mix data available.

Response: We agree with the commenters. We have considered the most recent case-mix data available and have determined that corrections need to be applied. Further, we have made every effort to acquire and analyze the latest possible case-mix data.

Comment: We received comments that stated that we must consider case-mix changes when recalibrating the relative DRG weights.

Response: In fact, we were careful to ensure that average case weight using both the old set of weights and the new set of weights is the same. This "normalization" of the recalibrated weights had the effect of increasing all the recalibrated weights by three percent. Therefore, had we not taken care to provide for normalization, all the recalibrated weights would be lower. We did not use the recalibration to adjust for changes in case mix.

Summary of Case Mix Discussion

Many comments reflect confusion over whether and to what extent increases in case mix would have been recognized and paid for under Pub. L. 97-248. Because the case-mix index is, by definition, a measure of a hospital's average cost per case relative to the average of all hospitals' average costs per case (as described in the September 1, 1983 interim final rule (48 FR 39764)), the only changes in case mix that would have been recognized under Pub. L. 97-248 are "real" changes in case mix, since it is only real changes in case mix that affect a hospital's average cost per case.

Because aggregate outlays under the prospective payment system were required to be neither greater nor less than what outlays would have been under the Pub. L. 97-248 limits, it was necessary to estimate expected reimbursement levels under both Pub. L. 97-248 and the prospective payment system, and to set the prospective payment rates at a level that would result in equality between outlays under Pub. L. 97-248 and the prospective payment system.

Hence, for purposes of budget neutrality, it was assumed that under Pub. L. 97-248, Medicare costs per case would have increased at the following rates:

Estimates used to set fiscal year 1984 and fiscal year 1985 rates

	Percent
1983	10.9
1984	9.8
1985	9.8

(See the August 31, 1984 final rule at 49 FR 34798 and the June 10, 1985 NPRM at 50 FR 24395.)

These assumptions implicitly incorporated increases in hospital input prices, changes in technology, increases in the intensity of services provided to hospital inpatients, increases in real case mix (which, by definition, result in increases in costs), and other factors.

One can remove the effects on cost per case of inflation by use of the most recent market basket factors, which are:

	Percent
1983	6.3
1984	5.7
1985	4.8

Thus, the extent to which cost-per-case estimates exceeded hospital industry inflation is:

1983	4.3%	(1.109÷1.063=1.043)
1984	3.9%	(1.098÷1.057=1.039)
1985	4.8%	(1.098÷1.048=1.048)

These increases in the cost per case (over and above inflation adjustments) that we estimate would have occurred under Pub. L. 97-248 are, we believe, more than ample allowances for increases in real case mix and changes in technology, intensity, and utilization of inpatient services. Indeed, as noted elsewhere, we conclude, on the basis of actuarial estimates, that the cost-per-case assumptions used in setting the prospective payment rates to date have resulted in an overstatement of the FY 1985 rates of approximately 1.2 percent. Nevertheless, we are not including an offset for this overstatement in our composite correction factor. However, because we believe that the FY 1985 rates already include a generous margin for changes in real case mix, we believe it is wholly appropriate to include in our composite correction factor a full adjustment for reported case-mix increases not previously accounted for.

In summary, we believe it is essential to adjust the FY 1985 standardized amounts to remove the effects of all previously unaccounted for increases in case mix, whether "real" or coding-related, for the following reasons:

• Unaccounted for increases in case mix resulted in FY 1985 standardized rates that were overstated. Under budget neutrality, these increases in case mix should not have increased payments to hospitals.

• As described in the August 31, 1984 final rule (49 FR 34773) and the June 10, 1985 proposed rule (50 FR 24393), our estimates of cost-per-case increases for budget neutrality purposes that would have occurred during FYs 1984 and 1985 under Pub. L. 97–248 incorporated an implicit recognition of case-mix increases that would have occurred regardless of implementation of the prospective payment system. (This included recognition that the Pub. L. 97–248 cost-per-case group limits were also case-mix adjusted, so that increases in case mix would have been reflected in those limits to the extent they had an impact on hospital costs.) Since the same incentives to improve coding would not exist under Pub. L. 97–248, this margin would essentially represent potential real case-mix increases as opposed to coding-related increases.

• Therefore, since a margin for real case-mix increases has already been incorporated in the standardized amounts through the cost-per-case assumptions used in determining the budget neutrality adjustment for FY 1984 and FY 1985, we would be recognizing real case-mix increase twice in the prospective payment rates if we failed to make adjustments for all reported case-mix increases.

• Hospitals have already received the benefit of both real case-mix increases as well as coding improvements. To the extent that future case-mix increases are real, these will be paid through assignment of cases to the higher weighted, more resource-intensive DRGs.

• The results of the RAND study demonstrated that much of the observed increase in case mix was due to prospective payment system-induced coding improvements. Since the cost-per-case assumptions used to determine budget neutrality in FY 1984 and 1985 already more than allowed for those increases in case mix which are real to be incorporated in the prospective payment rates, it is appropriate to adjust for all reported increases in case mix whether "real" or coding-related.

(2) *Market basket.* The forecasted hospital market basket increase factors used to calculate the FY 1985 standardized amounts were 6.2 percent for 1983, 6.0 percent for 1984, and 6.5 percent for 1985. Our latest hospital market basket factors, as of July 1985, reflect more actual experience than those available at the time the FY 1985 rates were published. The most recent factors are 6.3 percent for 1983, 5.7 percent for 1984, and 4.8 percent for 1985. Substituting these latest market basket factors into our budget neutrality model for correction of the standardized amounts reduces them by 1.2 percent.

We are not making retroactive adjustments. We believe that there is ample statutory authority to correct previous market basket forecasting errors *prospectively.*

Comment: Many commenters stated that we had promised not to revise the market basket for projection errors. Some commenters opposed any revisions in the market basket while others supported the concept of revisions in the market basket projections. ProPAC suggested that, because only the third quarter of the fiscal year would have elapsed when the market basket projection was determined in this addendum, we wait another year, or that we make corrections for the first three quarters of the fiscal year and then correct the fourth quarter in the following year.

Response: To maintain the integrity of the prospective payment system, we must have an appropriate base upon which payment levels are set. Since FY 1985 is the basis for future year payment rates, any market basket projection errors in FY 1985 would be carried forward into all future years. Therefore, based on the recommendation of ProPAC and other commenters, we decided to use a more recent update (the latest data available) of the market basket to develop a more accurate payment basis. We are revising the market basket estimate only for forecast changes and are not making any changes in the market basket itself.

If we were to revise the market basket estimates to reflect only actual experience through June 1985, and not to reflect the most recent estimates available, we could be forced to make even larger changes in the market basket update factor in next year's prospective payment rate notice. We believe that it is in the best interests of the hospital industry, therefore, to reflect changes in the market basket estimates using the latest estimates available at the time we issue the annual prospective payment notice.

Comment: Several commenters stated that we should adjust the market basket, but that the changes should not be applied retroactively.

Response: We agree that the market basket forecast changes should not be applied retroactively. Hence, we are not making any recoveries for overpayments for FYs 1984 and 1985.

Comment: Many commenters stated that we should acknowledge that FY 1986 is not a budget neutral year.

Response: We agree that FY 1986 is not a budget neutral year. However, budget neutrality is a consideration because FY 1985 is the base year for future prospective payment system payments, and because budget neutrality applied in FY 1985. Because payments in FY 1985 were higher than they should be under budget neutrality, we are correcting the update factor for FY 1986 to ensure that payment levels are not distorted in all future years.

Comment: Many commenters wanted documentation on the 1.3 percent difference in the forecasted market basket projections.

Response: The 1.3 percent difference represents the difference between the standardized amounts, holding the budget neutrality adjustment factor constant, by comparing the FY 1985 market basket forecast with our revised market basket forecast as discussed in the addendum to the proposed rule (50 FR 24394). The actual difference in the market basket updates (as documented at the beginning of this section) is actually greater than 1.3 percent. However, because actual costs are a factor in budget neutrality, only part of the difference in the updated market basket is reflected in the impact on budget neutrality. The latest market basket update for FY 1985 increased 0.1 percent since the February update, and consequently, we revised the adjustment to −1.2 percent.

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial

estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital-specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals' total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs. GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided at this time not to correct the standardized amounts for these factors.

We received no comments on this issue.

(4) *Composite Correction Factor.* We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

	Percent
Case mix	−6.3
Market basket	−1.2
Composite correction factor	−7.5

d. *Forecast Market Basket Increase.* We considered forecasted market basket index increases in determining the percentage increase for both prospective payment rates and rate-of-increase limits for FY 1986 and subsequent fiscal years. However, the percentage change determined under section 1886(e)(4) of the Act does not have to equal the market basket index plus one quarter of one percentage point, although section 1886(b)(3)(B) of the Act does specify that for FY 1986 the percentage determined under section 1886(e)(4) of the Act *may not exceed* the applicable percentage increase that would otherwise be determined for that period.

FORECASTED MARKET BASKET (MB) PERCENT INCREASE PLUS ONE-QUARTER OF 1 PERCENTAGE POINT

Calendar year	MB percentage	MB + ¼ percentage
1985	4.8	5.05
1986	4.1	4.35
1987	4.8	5.05

Based on these calendar year factors, we project a hospital market basket increase factor for FY 1986 (that is, October 1, 1985 through September 30, 1986) of 4.27 percent. Thus, the maximum update factor we could use in updating the FY 1986 standardized amounts (that is, the market basket plus one-quarter of one percentage point) would be 4.52 percent.

Comment: One commenter suggested that HCFA should not use the most current Data Resources, Inc. forecast of the market basket, because it incorporates the assumption that an update of zero percent of the prospective payment rates may take place in FY 1986. In particular, the commenters believe that the zero percent update could influence the pattern of hospital wage setting, and that Data Resources, Inc. may incorporate such changes in patterns of wage setting in its forecasts.

Response: The market basket forecast (4.85 percent) stated in the NPRM did not incorporate as an assumption that we were proposing a zero percent increase to the prospective payment rates. However, the most recent market basket forecast (4.27 percent) does incorporate changes resulting from the prospective payment system.

In addition, for the reasons stated below, we believe that incorporating these changes is appropriate. A primary objective of the prospective payment system is to alter the incentives of Medicare payment to encourage efficiency and effectiveness. Improvements in the processes of hospital purchasing, operations, quality control, practice patterns, etc., were desired and anticipated by Congress. The intent is to adjust the prospective payment rates to reflect these changes in behavior under the prospective payment system. For instance, the congressionally mandated recalibration of individual DRG rates is a demonstration of the intent to adjust for behavioral changes associated with the prospective payment system.

To most accurately capture the unique labor market characteristics of the hospital industry, and to be consistent with the use of the area wage index to adjust the standardized amounts for geographic area wage cost differentials, we use a hospital industry wage rate in our market basket.

During the last four calendar years, average hourly earnings in the hospital industry have increased at rates substantially in excess of economy-wide wage increases (see table below). The hospital wage rate we use captures the effects of skill-mix and occupation-mix shifts in the hospital industry, because it is measured by payroll expenses divided by hours of work. If case mix becomes more severe as a result of behavioral changes associated with the prospective payment system, and it becomes medically appropriate to shift to a higher quality and skill level of employees, the hospital wage variable we use captures observed behavioral changes to upgrade the skill-mix of employees. Likewise, if hospitals respond to a decrease in hospital admissions and lengths of stay, laying off workers with less seniority and associated lower wages, the hospital wage variable we use captures the upward pressure on average hourly earnings.

CALENDAR YEAR (PERCENTAGES)

	1981	1982	1983	1984
Hospital industry wage rate increases used in the prospective payment market basket	12.3	11.2	7.4	5.5
Economy-wide wage rate increases (Index of Hourly Earnings of Production Workers—total private nonfarm), Bureau of Labor Statistics	9.1	6.9	4.6	3.4

An intended effect of the prospective payment system is to encourage hospitals to be prudent buyers of labor using state-of-the-art wage and salary administration procedures used in other sectors of the economy.

Forecasts of hospital wage increases, and other components of the hospital market basket, as provided by the private consulting firm of Data Resources, Inc. include their best estimates of the combined forces expected over the period 1985 to 1987. Since forecasting is inherently difficult and subject to error, we will prospectively correct for forecast errors.

In summary, we feel our treatment of hospital wages in the market basket is appropriate and makes specific allowance for quality and skill level of employees as shifts are made in response to prospective payment system incentives.

Comment: One commenter stated that we did not supply any of the supporting information on which the FY 1986 hospital market basket projections were based.

Response: The market basket components, relative weights as well as the data source for each component measure, are listed in the September 1, 1983 interim final rule (48 FR 39845). Also, referenced in the rule as a source for further background on the development of the market basket index is an article by Freeland, Anderson and Schendler, "National Hospital Input Price Index," *Health Care Financing Review*, Summer 1979. In addition, Data Resources, Inc., which is the forecaster of the market basket increases, is specifically identified. The addresses for Data Resources, Inc. are also provided in the September 1, 1983 document for anyone interested in obtaining additional information on these forecasts. Upon request, Data Resources, Inc. will provide in writing a description of the general methodology as well as a discussion of the variables considered in developing the market basket forecasts. Because this information continues to be available to the public, we believe we have supplied the public with sufficient information concerning the development of the market basket forecasts, including specific data sources for interested parties. As pointed out previously, because of the limited interest that these data would have for the majority of readers, it is not our policy to publish the voluminous amount of data associated with the various factors developed for the prospective payment system. However, we note that this does not imply that the information is unavailable to the public upon request.

e. *Composite Policy Target Adjustment Factor—(1) General considerations.* In analyzing the prospective payment system [1] we considered the effects of the rates we set on outcomes such as quality of health care, access to care, and the financial viability of the hospital industry. The annual prospective payment percentage increase factor should be set so that it provides incentives for desired outcomes under the prospective payment system. To achieve incentives for the desired outcome targets, we must ensure that the annual prospective payment update factor takes proper account of variables affecting the cost, efficiency, effectiveness and quality of production of hospital inpatient care. Our objective is to translate the intent of the statutory requirements for updating the prospective payment rates into a methodology for making adjustments to the current update factor that would enable us to express our consideration of these variables as policy targets.

To this end, we have identified three factors that correspond to matters that must be considered under sections 1886(e)(2) and (e)(4) of the Act. For FY 1986, we are incorporating into the prospective payment update factor a composite "policy target adjustment factor" that takes account of productivity (efficiency), cost-effective technologies, and cost-ineffective practice patterns. Although, for the purposes of analysis and discussion, we have developed separate values for each of these three factors, we are combining them into a composite policy target adjustment factor, which we used in determining the FY 1986 prospective payment update factor.

Comment: Several commenters suggested there was lack of data or data known only to us that were used in the development of the policy target adjustment factors. In particular, one commenter asserted an inability to comment on the productivity adjustment because the BLS productivity indexes were not adequately identified.

Response: HCFA and ProPAC were fully aware that there were not as many data available on the update factors as would be preferred. On the other hand, both HCFA and ProPAC also agreed that sufficient data were available on the public domain to make estimates to carry out the congressional intent to consider and account for the effects of productivity, new technologies, and other factors. These data sources and related studies are specifically cited in Appendix B of the June 10, 1985 proposed rule (50 FR 24440) or in the Technical Appendix of the ProPAC Report to the Secretary. The BLS indexes used to develop the productivity adjustment were those cited in the "Current Labor Statistics" section of the *Monthly Labor Review* of the U.S. Department of Labor, BLS. These are readily available to the public and were not cited specificially in Appendix B of the NPRM because of our assumption that the availabitiy of government data was generally known. Currently there is no specific productivity measure for hospitals; however, BLS is in the process of developing such a measure. In developing the productivity adjustment, we benefited from discussion with BLS staff on productivity measures.

Our add-on for cost-effective new technologies of 1.5 percent takes into account the congressional intent for continued growth in intensity of services associated with new technologies and scientific advances. It is important to note that capital-related costs for new technologies continue to be paid for on a retrospective cost basis. The new technologies factor is for operating expenses only. HCFA's 1.5 percent add-on for new technologies is within the range recommended by ProPAC for its factor "Scientific and Technological Advances."

[1] In determining how to implement the requirements of sections 1886(e)(2) and (e)(4) of the Act, we have adopted an analytic framework developed by the Division of National Cost Estimates of HCFA's Office of the Actuary. A technical explanation of this framework was issued as Appendix B of the proposed rule (50 FR 24440). A revised version of Appendix B will be appearing in the Fall 1985 *Health Care Financing Review* in the Legislative Update section.

ProPAC recommended two offset factors: Hospital Productivity (−1.5 to −2.0 percent) and Changes in Hospital Product (−1.0 percent). Combined, these two offset factors equal −2.5 to −3.0 percent. ProPAC's "Changes in Hospital Product" factor is included within HCFA's "Ineffective Practice Pattern Offset" factor. Using essentially the same publicly available data sources, ProPAC and HCFA derived similar estimates for the combined offsets. Our combined offset was ×3.0 percent; whereas, ProPAC's was −2.5 to −3.0 percent. The analytical framework that we incorporated contributed to a different interpretation and split between the two ProPAC offset factors, with HCFA allocating relatively more emphasis to the changes in the hospital product factor and less to the hospital productivity factor.

Both HCFA and ProPAC concur that as more data become available, we can incorporate it to improve the update adjustment factors. Likewise, in order to meet congressional intent, both HCFA and ProPAC also agree that more clear-cut methodologies must be developed. The interactions among the factors and the difficulty of disentangling these factors from other factors contributing to cost increases require that judgment will be necessary.

Comment: Some commenters suggested that because we did not use terminology identical to ProPAC, we did not adequately consider ProPAC's analyses and recommendations.

Response: HCFA began its study of the prospective payment rate increase factor by carefully examining section 1886(e)(4) of the Act, which we quoted in the proposed rule (50 FR 24392). Section 1886(e)(4) of the Act reads as follows:

> (4) Taking into consideration the recommendations of the Commission [that is, ProPAC] the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for the purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

Further, as prescribed by section 1886(e)(2) of the Act, the Commission, in making its recommendations to the Secretary,

> . . . shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

We believe that our framework more accurately captures the congressional intent of the statute than does ProPAC's formulation. For example, section 1886(e)(4) of the Act specifically states that the effectiveness dimension of health care delivery be considered and accounted for in the percent increase factor. Further, we believe that our framework has a substantially stronger analytical basis than the ProPAC formulation. Our framework incorporates ProPAC's factors where they are specifically included in the statute. We believe that ProPAC made important conceptual and quantitative contributions to our understanding of the percent increase factor. However, we used different terminology, such as policy target adjustment factor rather than the discretionary adjustment factor, for two reasons:

- To more accurately characterize our framework and the decision-making process, and
- To reduce confusion between our framework and ProPAC's approach, since they differ, as mentioned above.

Some commenters made recommendations for changing some of the terminology used in describing the policy adjustment target factors. We are now considering certain changes in terminology as a result of these comments. Some examples are changing "productivity offsets" to "productivity improvements," and changing "cost-effective practice patterns" to "clinical practice pattern improvements."

Comment: Some commenters suggested that to measure cost-effectiveness of care, we needed to measure total systems cost for the entire episode of illness, including costs before and after the hospital stay.

Response: Our policy target adjustment factor, like ProPAC's discretionary adjustment factor, focuses on the percent increase for hospital *inpatient* services only. This focus is appropriate because hospital prospective payments are for inpatient hospital services only. However, we are very concerned about the effect of the prospective payment system on total system costs.

Comment: Several commenters suggested that there potentially can be double-counting between our offsets for productivity and ineffectiveness.

Response: We were fully aware that significant interactions exist among the components of the policy target adjustment factor (see the June 10, 1985 proposed rule (50 FR 24396)), and took this into account when using the analytical framework to assure no duplicative counting. For inpatient stays, ineffective practice patterns include certain services that are more appropriately provided in lower cost settings (for example, preadmission testing in outpatient facilities, skilled nursing care, and home health agency services), or services that do not give value for money expended. Those persons whose care is shifted totally to a noninpatient setting are not included in this analysis. HCFA used the observed reductions in length of stay during FY 1984 as an indicator of reductions in inpatient hospital ineffective practice patterns. Physicians reduced outputs and we assume that this reduction in outputs, associated with the decline in length of stay, is because they concluded that such outputs did not give value for money expended or could be provided more effectively in a lower cost setting. Under the retrospective cost-based reimbursement system in effect prior to prospective payment system, there was a financial incentive that encouraged longer lengths of stay. The offset factor will not take effect until FY 1986, even though the costs associated with the observed reductions in length of stay occurred in FY 1984. There is no duplication caused by offsets for both productivity and ineffective practice patterns, because the latter are for observed changes in FY 1984 and the productivity offset is for prospective improvements during FYs 1985 and 1986. The policy target adjustment factor for productivity takes into account that productivity increases may occur with a lag after reductions in ineffective pattern outputs associated with the reduction in length of stay in FY 1984. It should be noted that reductions in length of stay do not necessarily translate into increases in productivity when using conventional definitions of productivity (real output per unit of input). Measures of both outputs and inputs are necessary to quantify productivity.

ProPAC agreed with us that the minus one percent allowance for productivity change in the proposed rule represents a reasonable target for FY 1986—even excluding reductions of length of stay observed in FY 1984.

Comment: Several commenters raised questions on the most appropriate assumptions for the marginal cost of a day in a hospital relative to average cost. This ratio is needed to make an estimate of the likely cost savings

associated with observed reductions in length of stay.

Response: For purposes of determining additional payments for day outlier cases, NCFA currently assumes that the marginal cost of an additional day of stay is equal to 60 percent of the average per diem payment for the applicable DRG, excluding payment for pass-through costs that are not included in the prospective payment rate. (See the January 3, 1984 final rule (49 FR 266) for the discussion of marginal cost assumptions.) The 11 percent reduction in length of stay results in a 6.6 percent reduction in cost per case using this assumption. Our offset factor for the observed length of stay reduction is 2 percent. This allows for the majority of FY 1984 estimated savings to accrue to the hospital industry, and does not take any additional amounts for potential gains in FYs 1985 and 1986. We are not applying an offset of 2 percent until FY 1986, even though the observed reduction in length of stay occurred in FY 1984.

ProPAC points out that studies indicate the marginal cost associated with a patient day ranges from 20 percent to 80 percent, depending on the timeframe. Given this variation in empirical studies, we chose the marginal cost percentage (60 percent) already in place under the prospective payment system. It must also be noted that all overhead associated with capital-related costs and other pass-through items have been eliminated.

As an alternative, we also estimated a 4.4 percent cost savings that would be associated with a 40 percent marginal cost assumption. However, we believe it would be inconsistent to use a higher estimate of marginal cost for outliers and a lower one for the cost effects of reductions in length of stay. We believe the two percent offset used is reasonable and conservative.

(2) *Productivity.* Productivity measures output per unit of input and answers the question as to whether the same output can be accomplished with fewer resources or with a different, less costly, mix of resources. Hospitals often hire industrial engineers and management experts to increase productivity (efficiency) in hospital operations. Productivity improvements result in increases in output prices that are less than the increase in the price of inputs (holding profit margin and the nature of the outputs constant). In competitive industries, consumers benefit from the increases in productivity by paying lower prices. Likewise, under the prospective payment system, increases in productivity should be reflected by lower prices (that is, prospective payment rates) than would otherwise be the case.

Although studies of hospital productivity have been done, and some measures of productivity have been devised for specific applications. Valid productivity indexes comparable to those for other industries are not currently available for the entire hospital industry. Various economy-wide productivity indexes developed by BLS indicate national productivity increases of approximately three percent annually for the last two years (1983 and 1984). However, long-term avarage rates of increase show substantial variation depending upon the time period covered, the industries included, and the productivity measure used (multi-factor productivity or labor productivity).

Given the years of retrospective, cost-based reimbursement, with attendant perverse incentives for productivity, we believe hospitals have the potential for substantial improvements in productivity. We expect that a two percent or more annual increase in productivity would not be unreasonable. Therefore, we are incorporating a 1.0 percent productivity offset (reduction) in the FY 1986 policy target adjustment factor. We believe this is a conservative offset that will allow hospitals to retain more than half of potential productivity gains. We believe sharing the benefits of the prospective payment system in this way provides desirable incentives.

(3) *Cost-effective technologies.* Certain technological changes, especially those related to the adoption of new products (with accompanying labor and nonlabor inputs), increase the operating cost of treating illness but also improve health status commensurately. We believe that the prospective payment rates should recognize new science and technology factors, which are cost-increasing, but also enhance health status. This should provide positive incentives for continued technological and scientific excellence.

The effects of new technologies and scientific advances on operating cost and health status are very complex and are difficult to isolate. Typically, a specific new technology increases cost in some uses and decreases costs in other uses. Concurrently, in some situations, health status is improved while in other situations, it may be unaffected or even worsened using the same technology. Separating out the relative importance of each of these effects for individual technologies and new technologies that are cost-increasing has proven to be elusive from a statistical point of view. Yet, it is important to allow for new technologies and scientific advances. Therefore, we are incorporating a 1.5 percent add-on in the FY 1986 policy target adjustment factor. We expect this add-on to promote, within bounds, the development and use of cost-effective new technologies. The 1.5 percent add-on allows significant growth over time in cost-increasing, health-enhancing new technologies and scientific advances, especially when one considers that all capital costs are currently paid on a cost basis and that this affords an additional allowance for accompanying labor and nonlabor inputs.

(4) *Elimination of ineffective practice patterns.* Just as cost-effective new technologies and scientific advances are expected to increase a hospital's production of cost-effective outputs, and must be encouraged, existing practice patterns that are ineffective in the production of outputs should be discouraged. We believe the implementation of the prospective payment system has substantially increased the incentive for such changes of behavior, by affording hospitals a clear benefit from pursuing them, rather than the disincentive of potential decreases in cost reimbursement. As a prudent buyer, we want to get value for our money. We desire the Medicare Trust Funds and its contributors to share in the benefits accruing from more effective and economical provision of care. Thus, one of our policy targets in setting the level of the Federal rates is to ensure that those rates afford an opportunity for both buyer and provider of services to share the benefits resulting from the elimination of ineffective practice patterns.

Effectiveness compares the objective of improving health status with alternative uses of resources for achieving that objective to determine whether the right, or best available, care is being provided. A hospital can improve the effectiveness with which it delivers health care by—

- Eliminating practices that do not need to be done at all; and
- Ensuring that the only procedures and services furnished in the hospital are those that require a hospital level of care.

We believe that the data on per case costs on which the FY 1984 and FY 1985 standardized amounts were based included a component of unnecessarily high costs reflecting ineffective practice patterns. We believe that hospitals deserve to accrue benefits from these changes, but, nonetheless, we believe it

is reasonable for us to share in them also. Therefore, for these reasons and for the reasons we stated in the addendum to the NPRM (50 FR 24396), we are incorporating a 2.0 percent offset (reduction) in the policy target adjustment factor for FY 1986.

(5) *Composite Policy Target Adjustment.* For FY 1986 and thereafter, we are adjusting the average standardized amounts by a percentage composite policy target adjustment factor, as authorized under section 1886(e)(4) of the Act. For FY 1986, this composite policy target adjustment factor is a composite of the offsets and add-ons for productivity, cost-effective technologies, and cost-ineffective practice patterns, as follows:

	Percent
Productivity	−1.0
Cost-effective technologies	+1.5
Cost-ineffective practice patterns	−2.0
Composite policy target adjustment factor	−1.5

f. *Summary.* The combined effect of the forecasted increase in the hospital market basket, the adjustments for Part B costs and FICA taxes, the composite correction factor, and the composite policy target adjustment factor would be a negative FY 1986 prospective payment update factor, as follows:

	Percent
Forecasted market basket increase	+4.27
Part B costs and FICA taxes	+.31
Composite correction factor	−7.5
Composite policy target adjustment factor	−1.5
	−4.42

Such a negative update factor would result in a significant decrease in the standardized amounts for FY 1986, compared to those for FY 1985, and a corresponding reduction of anticipated revenue for hospitals subject to the prospective payment system. However, although we have substantial technical and legal justification for issuing FY 1986 standardized amounts that would be lower, on the average, than FY 1985 standardized amounts, we are not establishing lower amounts. In addition, because we believe it is important to protect the prospectivity of this payment system, we are not recouping any excessive payments resulting from the overstated FY 1985 standardized amounts.

The prospective payment system was intended, from its inception, to produce significant changes in the hospital industry. However, if these changes take place too rapidly, disruptions and unintended consequences may result that would adversely affect the industry and Medicare beneficiaries. Neither do we want to encourage changes that would compromise the access to quality inpatient hospital care historically enjoyed by Medicare beneficiaries. Our objective is to set the FY 1986 update factor at a percentage level that takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, in accordance with section 1886(e)(4) of the Act, and we believe that the payment rates should be set no lower than we have proposed in order to assure that this statutory standard is met.

Thus, we are establishing FY 1986 standardized amounts that are set at the same level as those for FY 1985. Because we restandardized the base year costs to reflect the proposed new survey-based wage index, and because the standardized amounts are adjusted to reflect EOMB's revised MSA designations, the amounts set forth in Table 1, in section IV, below, are not identical to those of last year. For the reasons given above, we believe that the resulting payments take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

4. *Other Adjustments to the 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 under which Medicare's payment to the hospital discharges the beneficiary's liability to pay for the services furnished. In order to adjust urban and rural regional and national standardized amounts per discharge so that they represent costs previously billed under Part B, we increased the amounts by a 0.13 percentage increase (as described in the September 1, 1983 interim final rule (48 FR 39766) and the August 31, 1984 final rule (49 FR 34768)) in both FY 1984 and FY 1985.

We refer the reader to the comment and response discussed in the following section on FICA taxes.

b. *FICA Taxes.* Section 1886(b)(6) of the Act requires that adjustments be made in the base period costs in recognition that certain hospitals were required to enter the Social Security system and begin paying FICA taxes as of January 1, 1984. In FY 1984 and FY 1985, we increased the urban and rural regional and national standardized amounts by 0.18 percent to account for additional costs of payroll taxes for hospitals entering the Social Security system.

Comment: One commenter stated that the budget neutrality adjustment in FY 1985 effectively eliminated the adjustments for Part B costs and FICA taxes (estimated at about .31 percent). Therefore, because budget neutrality no longer applies in FY 1986, these adjustments should be restored.

Response: We agree with the commenter that although specific add-on adjustments were made to the average standardized amounts for Part B costs and FICA taxes, these adjustments were nullified through the budget neutrality adjustment. In compliance with sections 1862(a)(14) and 1886(b)(6) of the Act, which require that these costs be reflected in the standardized amounts, we are making an upward adjustment for Part B costs and FICA taxes. However, because we decided against reducing the prospective payment rates for FY 1986, these upward adjustments are offset against the amount by which the rates should have decreased. Since the percent magnitude of these adjustments is small, there still is a justified decrease in the rates. Hence, the zero percent increase of the prospective payment rates more than compensates for these adjustments.

c. *Nonphysician anesthetist costs.* In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.

We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts. (See 49 FR 34794; August 31, 1984). Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

d. *Outliers.* Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made

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

In the September 1, 1983 interim final rule (48 FR 39767), we estimated that outlier payments for FY 1984 would be 6.0 percent of total payments (including both standard prospective payment system payments and outlier payments). We made the maximum estimate permitted under the law in order to ensure that we would provide an adequate margin for outlier payments.

In the final rule published August 31, 1984 (49 FR 34728), we reduced 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 for FY 1985, while providing proportionately greater payment for typical cases and avoiding any great risk of general disadvantage to hospitals. We believe that it was in the greater interest of hospitals and the program to eliminate some of the reserve for outliers and correspondingly increase the amount of the standardization rates, thereby providing hospitals with somewhat larger Federal rates for typical cases. We note that this has had the effect of increasing the predictability of total payments for hospitals in that less of the total is attributable to those cases that meet particular qualifications. Therefore, we are continuing to set the size of the outlier reserve at apporoximately the five percent level for FY 1986. As indicated in the previous rules on prospective payments, we will pay for any outlier that meets the criteria in § 412.80, even if aggregate outlier payments result in more than five percent of total payments.

The FY 1985 standardized amounts were reduced by means of the budget neutrality methodology to the level necessary to take into account outlier payments of five percent of total payments based on the Federal rates. (See the August 31, 1984 final rule (49 FR 34795).) We are not making further adjustments to the standardized amounts for FY 1986 or future years, unless we later propose to increase the size of the outlier reserve.

We are revising the day outlier and cost outlier thresholds, using the most recent length of stay and charge data available, to ensure that total estimated outlier payments for FY 1986 are 5.0 percent of total payments. A discharge in FY 1986 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 17 days or 1.94 standard deviations. (For FY 1985, we set the day outlier threshold at the lesser of 22 days or 1.94 standard deviations.) We refer the reader to Table 5 in this addendum for the DRG day outlier thresholds. For FY 1986, 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 $13,500. (For FY 1985, we set the cost outlier thresholds at the greater of 2.0 times the Federal rate for the DRG, or $13,000.)

Comment: Several commenters suggested that the cost outlier thresholds should remain at the greater of 2.0 times the Federal rate for the DRG or $13,000, or be indexed in proportion to the increase in the prospective payment rates. Because we are not increasing the prospective payment rates in FY 1986, the commenters recommended that the cost outlier threshold criterion should not increase from $13,000 to $13,500.

Response: The thresholds for both cost and day outliers are set so as to achieve estimated outlier payments of five percent. 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.

In order that the outlier thresholds reflect as closely as possible changing conditions in the hospital industry, we reduced the length-of-stay threshold for day outliers to 17 days in recognition of the continuing decline in hospital lengths of stay. Similarly, as discussed in the NPRM (50 FR 24398), we raised the cost outlier threshold criterion to $13,500 based on the most recent data available (that is, 1984 PATBILL data) that reflect current experience under the prospective payment system.

The cost of discharges is determined by multiplying the billed charges for covered services by .72. This figure represents a national ratio of Medicare inpatient charges and was derived from an analysis of cost and billing data used to establish the DRG relative weights. The .72 figure has remained constant, so that an increase in the charges would lead to increases in costs used to determine cost outlier payments. Therefore, if we did not increase the charge threshold, we would be paying, in the aggregate, too much for cost outliers.

We reiterate that the thresholds are set in order to yield an estimated dollar volume of outlier payments. If we were to retain the cost outlier criterion at $13,000, we would have to change other thresholds in order to achieve the same estimated dollar volume.

Comment: Commenters suggested that we are not following the requirements of section 1886(d)(5)(A)(iv) of the Act concerning outlier payments for hospitals. This section provides that payments for outliers 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 for a given year. Another commenter requested that we publish data to show that outlier payments are in fact between five and six percent of total payments.

Response: We believe that these comments may reflect a misunderstanding of the way in which outlier payments are made. In response to the comments received on the September 1, 1983 interim final rule, in the January 3, 1984 final rule we restricted the reduction for outlier payments to the Federal share of the prospective payment rates based on a literal interpretation of sections 1886(d)(2)(E), 1886(d)(3)(B), and 1886(d)(5)(A) of the Act (49 FR 261). Accordingly, we have limited the reduction for outlier payments to the Federal rates, and apply the outlier reduction factor only to the standardized amounts used to compute the Federal portion of the rates. The hospital-specific portion of the prospective payment rate is not reduced for outlier payments.

Because the hospital-specific portion included the cost of outlier cases in each provider's base period, (and in the January 3, 1984 final rule we had determined that the hospital-specific portion was no longer reduced to take account of outliers (49 FR 264)), outlier payment amounts to individual hospitals were reduced in FY 1984 to 25 percent of the otherwise applicable outlier amount. Similarly, in the second year of the transition period (FY 1985), outlier payment amounts were 50 percent of the otherwise applicable outer amount. In the third year of the transition period (FY 1986), outlier payment amounts are 75 percent, and in the fourth year (FY 1987), outlier payment amounts to individual hosptials will be 100 percent of the outlier amount that is computed. Once outlier payments to individual hospitals are based on 100 percent of the computed outlier amount, total system-wide outlier payments will be estimated

to equal five percent of total prospective payments.

As a result of this change in policy, that is, the hospital-specific portion was no longer reduced for outlier payments, which was made in response to comments from the hospital industry, a further calculation is made in determining the appropriate level of outlier payments. Assuming that the threshold level is set at five percent, outlier payments must be multiplied by the appropriate Federal blend percentage for the year involved. For example, during the second year of the transition period (FY 1985), outlier payments should approximate 2.5 percent (5 percent times 50 percent) of total DRG payments.

It is also important to note that, given the data available, forecasts of probable future outlier payments are inexact. Yet, it is these same data that must be used in setting the outlier thresholds. When more recent data become available, they are used in determining whether the outlier thresholds should be revised in order to achieve the percentage of outlier payments within the corridor specified in the law. As with all other aspects of the prospective payment system, we use the most recent data availabe to set the outlier criteria. To the extent that average hospital length of stay remains the same in the future as it is reflected in the most recent data, then we would be paying for outliers at the proper level. If average length of stay continues to decline, we will reflect that in subsequent years' outlier thresholds. It should be noted that, if average length of stay goes up, we will, in effect, overpay the outliers. However, we would not correct this retroactively. Data on actual outlier payments are incomplete at this time and therefore not available.

Comment: One commenter suggested that outlier payments are insufficient and should be increased.

Response: We refer the reader to the previous comment and response regarding our literal interpretation of the law on the level of outlier payment. In addition, the imprecision of data, also discussed in the previous comment and response, is relevant in this regard. The changes in the outlier thresholds that were set in the August 31, 1984 final rule (49 FR 34768) should also be noted. In that document, we stated that hospitals appeared to be encountering fewer outlier cases than originally anticipated. Therefore, we believe that it was justifiable to increase the outlier thresholds. This had the effect of reducing the offset of the standardized amounts for outlier payments required under section 1886(d)(2)(E) of the Act, and, in effect, increasing the payments (standardized amounts) to all hospitals for typical cases rather than outlier (atypical) cases. We believe that these adjustments are fully within our authority under the law (that is, outlier payments must be within five to six percent of total payments projected to be made under the prospective payment system), and benefitted the large majority of hospitals.

Comment: One commenter suggested that HCFA should increase the FY 1986 rates because outlier payments in FY 1985 were lower than expected.

Response: Sections 1886(d)(3)(B) and 1886(d)(5)(A)(iv) of the Act require that the standardized amounts be reduced by an amount sufficient to create a fund for outlier payments equal to five to six percent of the total payments estimated to be made during the following year. The outlier payments are then made based on criteria ("trimpoints") established under sections 1886(d)(5)(A)(i) and (ii). Although we properly reduced the standardized amounts in FY 1984 and FY 1985 to create an outlier fund equal to six percent and five percent of total estimated payments respectively, not all of the fund has been disbursed in outlier payments. This low level of payments resulted from the unexpectedly small number of cases that met the criteria established for such payments. Although we believe that the criteria were reasonable at the time they were determined, the subsequent substantial reduction in average hospital length of stay significantly reduced the number of cases qualifying for outlier payments.

We have considered whether this underpayment should be included in the composite correction factor used to establish the rates for FY 1986, but we have concluded that this would not be appropriate. The purpose of the composite correction factor is not to recover overpayments or reimburse for underpayments but to assure that the appropriate percentage change in the rates is applied to the correct base amount. Although fewer outlier payments were made than anticipated, this did not result in lower standardized amounts than would have been the case if outlier payments had been made as predicted. Standardized amounts could not have been increased because of the statutory requirement that they be so reduced as to create at least a five percent outlier fund. Hence, the underpayment does not affect the correctness of the current base and no correction factor would be appropriate.

We have also considered whether the policy target adjustment factor should be increased to account for the lower-than-expected outlier payments in previous years, but we do not believe that such an increase would be appropriate. The policy target adjustment factor is intended to adjust rates for the upcoming year to a level appropriate for the future. It is not appropriately used as a device to collect overpayments or reimburse for underpayments in past years, since such a use would be contrary to the prospective nature of the prospective payment system.

As discussed above, we have made, however, revised the outlier criteria for FY 1986 on the basis of the latest data available. This should reuslt in payment of the full outlier fund in the future.

Comment: Many commenters questioned why we pay hospitals only for the number of days indicated by the geometric mean length of stay assigned to each DRG listed in Table 5.

Response: There are no requirements under the prospective payment system that Medicare patients, who are classified within a given DRG, be discharged after a specific number of days as indicated by the geometric mean length of stay for that DRG, nor will hospitals be paid for only a certain number of days of care for each discharge within a given DRG. The prospective payment system is not predicated on the belief that all patients should receive the mean or average unit of services or length of stay.

Subject to Medicare eligibility and coverage requirements, payment under the prospective payment system is on a discharge basis without regard to the actual number of days of care furnished to a patient.

The geometric mean length-of-stay figures published in Table 5 of this addendum are geometric means, not the arithmetic means that an individual would usually consider in calculating the average of a distribution. The geometric mean is used as the appropriate statistical measure of central tendency for the purpose of determining day outlier (atypically long length of stay) cases. The geometric mean length-of-stay values, which are usually less than the arithmetic mean values, were used in calculating day outliers because of the particular skewness that is typical of the length-of-stay distribution for each DRG. Because the geometric mean length of stay is typically lower than the arithmetic mean, the day outlier thresholds were lower and less affected by atypically long stays in the data base used to establish outlier thresholds. Those values should not be considered

treatment norms or thresholds for requiring a patient's discharge.

With respect to both geometric and arithmetic mean length-of-stay values, it is important to note that, by virtue of being averages, each measure contains cases on both the high side and the low side. Therefore, it is to be expected that hospitals will encounter cases in which the lengths of stay are longer than the geometric or arithmetic means. Theoretically, it is possible that no case within a particular DRG will fall at exactly the mean length of stay value.

To assist the reader in understanding the difference between arithmetic and geometric mean lengths-of-stay, Table 5 now includes the arithmetic as well as the geometric mean length of stay for each DRG. Note that the addition of the arithmetic mean length-of-stay values is for illustrative and comparative purposes only. The arithmetic values, like the geometric values, do *not* represent limits on the number of hospital days that are paid for under Medicare. The geometric mean lengths of stay will continue to be used in the determination of day outlier cases.

Comment: One commenter believes that we should change our outlier policy for hospitals serving as regional referral centers for burn treatment patients. The commenter suggested that these hospitals receive 100 percent of reasonable costs for the outlier portions of patient stays. For the non-outlier portions of stays, the hospital would receive no more than the full DRG payment.

Response: The prospective payment system is not designed to recognize all the costs of furnishing services to each Medicare beneficiary. Instead, a predetermined payment amount per discharge is established to provide incentives for hospitals to manage their operations more efficiently. A hospital's payment may be more than its costs for some DRGs, and less than its costs for other DRGs. We believe that aggregate Medicare outlays for inpatient hospital services will equal or exceed the aggregate costs of treating Medicare beneficiaries in efficiently run hospitals.

Section 1886(d)(5)(A) of the Act requires the Secretary to provide an additional payment (day outlier payment) to hospitals for a DRG discharge that exceeds the geometric mean length of stay for discharges within that DRG by the lesser of a fixed number of days or a fixed number of standard deviations. For discharges that do not qualify as day outliers, or for discharges occurring in transferring hospitals, we provide cost outlier payments if the cost of covered services exceeds specified levels.

Under section 1886(d)(5)(A) of the Act, payment for outliers must approximate the marginal cost of care beyond the established cutoff criteria. Consistent with the basic nature of the prospective payment system, we believe that the amount of the additional payments for day outlier cases should be determined in advance, rather than be on a cost-reimbursement basis, as suggested by the commenter. According to health and hospital literature, marginal cost estimates range from 20 to 60 percent of average cost. For purposes of making outlier payments, we are using a 60 percent marginal cost estimate which is at the high end of this range. This 60 percent marginal cost factor is applied to all outlier cases under all DRGs. We do not, however, have sufficient data to estimate marginal costs on a DRG-specific basis or by type of provider.

We recognize that we have general authority under section 1886(d)(5)(C)(iii) of the Act to grant exceptions and adjustments, as we deem appropriate, to the prospective payment amounts. However, we believe that it is generally the better course of action to handle problems that occur under the prospective payments system in a manner that preserves the basis of the system in a fundamentally prospective formula for setting payment for individual DRGs. Establishing individual exceptions and adjustments, to the extent the changes are based on actual costs incurred, tends to undermine the prospective and predictable nature of the system.

We do realize that there may be instances in which the DRG payment may not be reflective of the resources used in treating a patient. We are currently in the process of determining the feasibility as well as the necessity of a severity of illness index. The development of such an index, however, is in the preliminary stage. Still to be determined is whether this index is actually needed, and, if so, what type of index would be most equitable, and at the same time, administratively simple to implement.

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

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 D. below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Table 1, as we revised it in this addendum, contains the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates.

1. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amount by the appropriate wage index for the area in which the hospital is located. In section III of the preamble to this final rule, we discuss a new wage index based on our own wage survey data. This index is set forth in Tables 4a and 4b of section IV of this addendum.

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 1986, the adjustment necessary for nonlabor-related costs for hosptials in Alaska and Hawaii will be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Table—Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

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

(The above factors are based on data obtained from the U.S. Office of Personnel Management, published in their FPM-581 letter series.)

C. DRG Weighting Factors

As discussed in section II of the preamble to this final rule, we have developed a classification system for all hospital discharges, sorting them into DRGs and have developed weighting factors for each DRG that are intended to reflect the relative resource consumption associated with each DRG.

Table 5 of section IV of this addendum contains the weighting factors that we use for discharges occurring in FY 1986. These factors have been recalibrated as explained in section II of the preamble, and reflect

the changes in the GROUPER program summarized in Table 6.

To indentify certain DRGs more clearly, the titles of the following DRGs are revised as indicated below. These changes are in addition to those discussed in section II.B. of the preamble.

DRG	Current title	Revised title
15	Transient Ischemic Attack.	Transient Ischemic Attack and Precerebral Occlusions.
39	Lens Procedures	Lens Procedures with or W/O Vitrectomy.
61	Myringotomy Age >17.	Myringotomy with Tube Insertion Age >17.
62	Myringotomy Age 0–17.	Myringotomy with Tube Insertion Age 0–17.
76	O.R. Proc on the Resp System Except Major Chest With C.C.	Other Respiratory System O.R. Procedures with C.C.
77	O.R. Proc on the Resp System Except Major Chest W/O C.C.	Other Respiratory System O.R. Procedures W/O C.C.
101	Other Respiratory Diagnoses Age >69 and/or C.C.	Other Respiratory System Diagnoses Age >69 and/or C.C.
102	Other Respiratory Diagnoses Age <70 W/O C.C.	Other Respiratory System Diagnoses Age <70 W/O C.C.
108	Cardiothor Proc, Except Valve and Coronary Bypass, With Pump.	Other Cardiovascular or Thoracis Proc With Pump.
110	Major Reconstructive Vascular Procedures Age >69 and/or C.C.	Major Reconstructive Vascular Proc W/O Pump Age >69 and/or C.C.
111	Major Reconstructive Vascular Procedures Age <70 W/O C.C.	Major Reconstructive Vascular Proc W/O Pump Age <70 W/O C.C.
112	Vascular Procedures Except Major Reconstruction.	Vascular Procedures Except Major Reconstruction W/O Pump.
115	Permanent Cardiac Pacemaker Implant with AMI or CHF.	Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock.
116	Permanent Cardiac Pacemaker Implant W/O AMI or CHF.	Permanent Cardiac Pacemaker Implant W/O AMI, Heart Failure or Shock.
120	Other O.R. Procedures on the Circulatory System.	Other Circulatory System O.R. Procedures.
144	Other Circulatory Diagnoses with C.C.	Other Circulatory System Diagnoses with C.C.
145	Other Circulatory Diagnoses W/O C.C.	Other Circulatory System Diagnoses W/O C.C.
157	Anal Procedures Age >69 and/or C.C.	Anal and Stomal Procedures Age >69 and/or C.C.
158	Anal Procedures Age <70 W/O C.C.	Anal and Stomal Procedures Age <70 W/O C.C.
168	Procedures on the Mouth Age >69 and/or C.C.	Mouth Procedures Age >69 and/or C.C.
169	Procedures on the Mouth Age <70 W/O C.C.	Mouth Procedures Age <70 W/O C.C.
170	Other Digestive System Procedures Age >69 and/or C.C.	Other Digestive System O.R. Procedures Age >69 and/or C.C.
171	Other Digestive System Procedures Age <70 W/O C.C.	Other Digestive System O.R. Procedures Age <70 W/O C.C.
209	Major Joint Procedures.	Major Joint and Limb Reattachment Procedures.
244	Bone Diseases and Septic Arthropathy Age >69 and/or C.C.	Bone Diseases and Specific Arthropathies Age >69 and/or C.C.
245	Bone Diseases and Septic Arthropathy Age <70 W/O C.C.	Bone Diseases and Specific Arthropathies Age <70 W/O C.C.
260	Subtotal Mastectomy for Malignancy Age <70.	Subtotal Mastectomy for Malignancy Age <70 W/O C.C.
263	Skin Grafts for Skin Ulcer or Cellulitis Age >69 W/O C.C.	Skin Grafts and/or Debridement for Skin Ulcer or Cellulitis Age >69 W/O C.C.
264	Skin Grafts for Skin Ulcer or Cellulitis Age <70 W/O C.C.	Skin Grafts and/or Debridement for Skin Ulcer or Cellulitis Age <70 W/O C.C.
265	Skin Grafts Except for Skin Ulcer or Cellulitis with C.C.	Skin Grafts and/or Debridement Except for Skin Ulcer or Cellulitis with C.C.
266	Skin Grafts Except for Skin Ulcer or Cellulitis W/O C.C.	Skin Grafts and/or Debridement Except for Skin Ulcer or Cellulitis W/O C.C
285	Amputations for Endocrine, Nutritional + Metabolic Disorders.	Amputations of Lower Limb for Endocrine, Nutritional + Metabolic Disorders.
304	Kidney, Ureter and Major Bladder Proc For Non-Malignancy Age >69 and/or C.C.	Kidney, Ureter and Major Bladder Proc For Non-Neopl Age >69 and/or C.C.
305	Kidney, Ureter and Mayor Bladder Proc For Non-Malignancy Age <70 W/O C.C.	Kidney, Ureter, and Major Bladder Proc For Non-Neopl Age <70 W/O C.C
359	Tubal Interruption for Non-malignancy.	Incisional Tubal Interruption for Non-malignancy.
376	Postpartum Diagnoses W/O O.R. Procedure.	Postpartum and Postabortion Diagnoses W/O O.R. Procedure
377	Postpartum Diagnoses with O.R. Procedure..	Postpartum and Postabortion Diagnoses with O.R. Procedure
381	Abortion with D+C.	Abortion with D+C, Aspiration Curettage or Hysterotomy.
386	Extreme Immaturity, Neonate.	Extreme Immaturity or Respiratory Distress Syndrome, Neonate.
401	Lymphoma or Leukemia with minor O.R. Proc Age >69 and/or C.C.	Lymphoma or Leukemia with other O.R. Proc Age >69 and/or C.C.
402	Lymphoma or Leukemia with Minor O.R. Procedure Age <70 W/O C.C.	Lymphoma or Leukemia with Other O.R. Procedure Age <70 W/O C.C
408	Myeloprolif Disord or Poorly Diff Neopl with Minor O.R. Proc.	Myeloprolif Disord or Poorly Diff Neopl with Other O.R. Proc.
449	Toxic Effects of Drugs Age >69 and/or C.C.	Poisoning and Toxic Effects of Drugs Age >69 and/or C.C.

DRG	Current title	Revised title
450 ..	Toxic Effects of Drugs Age 18 to 69 W/O C.C.	Poisoning and Toxic Effects of Drugs Age 18 to 69 W/O C.C.
451 ..	Toxic Effects of Drugs Age 0–17.	Poisoning and Toxic Effects of Drugs Age 0 to 17.

D. Calculation of Prospective Payment Rates for FY 1986

FY 1986 represents the third 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, 1985 and Before October 1, 1986

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. For the first cost reporting period under prospective payment, a hospital-specific rate was calculated for each hospital, derived generally from the following formula:

$$\frac{\text{(Base year costs per discharge)}}{\text{(1981 case-mix index)}} \times \text{Updating factor} = \text{Hospital specific rate}$$

For the first prospective payment cost reporting period, the hospital-specific portion equaled 75 percent of the hospital-specific rate. For each subsequent transition period cost reporting period, the hospital-specific portion is derived as follows:

Previous Period's Hospital-Specific Rate × Updating Factor × Blending Percentage × DRG Weight

The blending percentage for cost reporting periods beginning in FY 1986 is 25 percent. For a more detailed discussion of the hospital-specific portion, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772).

a. *Updating the Hospital-Specific Rates for FY 1986 Cost Reporting Periods.* We are carrying forward the hospital-specific rates for FY 1985 cost reporting periods without increasing them for FY 1986. For reasons discussed below, the FY 1985 hospital-specific rates were set too high, just as the FY 1985 Federal rates were. If we were to correct the rates prospectively for the full amount of the overstatement, it would result in a reduction of the hospital-specific rates. For the same reasons that we have decided not to reduce the FY 1986 Federal rates, we have decided that it is preferable to carry the rates forward unchanged for the last year of the transition period.

For cost reporting periods beginning in FY 1985, we determined each hospital's hospital-specific rate (before applying the 50 percent blending percentage for the second year of the prospective payment transition period) by applying the applicable compounded target rate percentage, as adjusted for budget neutrality, to the hospital's previous year's hospital-specific rate. The target rate percentages we used incorporated the same overstated market basket percentages as were used in determining the FY 1985 standardized amounts (Federal rates). In addition, each hospital's base-year costs were adjusted to remove the effect of the hospital's 1981 case-mix index, so that the hospital-specific portion, as well as the Federal portion, could be adjusted by a DRG weight in determining payment. As a result, the unanticipated rate of increase in case mix since the implementation of the prospective payment system, discussed above, has also resulted in overstated hospital-specific rates. Note that these are the same factors for which corrections are being applied in determining the revised Federal rates, as discussed in section II.A.3., above.

The requirement of budget neutrality (section 1886(e)(1) of the Act), which is discussed in relation to the Federal rates in section II.A.3 . . above, also governed the level of the target rate percentage increase for hospital-specific rates for cost reporting periods beginning in FY 1985. As we discussed above in regard to the Federal rates, the intent of Congress was that the hospital-specific rates for FY 1986 be updated from *budget neutral* rates for the previous period. However, the target rate percentages for cost reporting periods beginning in FY 1985 were too high to achieve actual budget neutrality. Therefore, we believe that we are required to adjust those hospital-specific rates downward before updating them for cost reporting periods beginning in FY 1986. Similarly, for the same reasons discussed above in relation to the Federal rates, we also believe that the proper exercise of our responsibility under the law would require us to make these adjustments even in the absence of a requirement that the FY 1985 rates be budget neutral.

The reductions to the hospital-specific rates that would be necessary to correct the FY 1985 overstatement fully are as follows:

	Percent
Case-mix	6.3
Market basket	1.2
Combined	7.5

b. *Calculation of Hospital-Specific Portion.* For hospital cost reporting periods beginning in FY 1986, the hospital-specific portion of a hospital's payment for a given discharge is calculated by:

Step 1—Multiplying the previous cost reporting period's hospital-specific rate by 25 percent, and

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

The result is the hospital-specific portion of the FY 1986 prospective payment for a given discharge.

c. *New Providers.* Hospitals that had not completed a 12-month cost reporting period under Medicare (either under current or previous ownership) prior to September 30, 1983, or hospitals that meet the criteria in § 412.74(a)(2), are considered new providers for purposes of the prospective payment system. Their prospective payment rates are computed solely on the Federal rates. Thus, new providers are paid a blend of 50 percent of the appropriate Federal regional rate and 50 percent of the Federal national rate for discharges occurring on or after October 1, 1985 and before October 1, 1986.

2. Federal Portion

For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the Federal portion of the hospital's total prospective payment will be 75 percent of the hospital's Federal rate. Beginning with discharges occurring on or after October 1, 1985, the Federal rate is comprised of a blend of the appropriate Federal regional rate (50 percent) and the Federal national rate (50 percent).

Comment: Various commenters suggested that, if there is a zero percent increase in the prospective payment rate, the blend of the payment rate should remain at the same levels as in FY 1985; that is, 50 percent of the Federal portion (standardized amounts) and 50 percent of the hospital-specific portion. However, other commenters

recommended that the transition to national prospective payment rates should continue as scheduled.

Response: We agree with the latter commenters' recommendation that we should proceed with the transition period as scheduled. The blend of the Federal portion and the hospital-specific portion of the prospective payment rates is mandated by section 1886(d)(1) of the Act. That section provides for a three-year transition period during which a declining portion of the 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 of the transition period. Section 1886(d)(1) of the Act provides that for discharges occurring on or after October 1, 1983 and before October 1, 1984, the blend was 75 percent hospital-specific portion and 25 percent of the Federal portion; for discharges occurring on or after October 1, 1984 and before October 1, 1985, the blend is 50 percent of the hospital-specific portion and 50 percent of the Federal portion; and for discharges occurring on or after October 1, 1985 and before October 1, 1986, the blend will be 25 percent hospital-specific portion and 75 percent Federal portion. Because the law states exactly what the blend is to be, we must proceed with the third year of the transition period using a blend of 25 percent hospital-specific portion and 75 percent Federal portion. Any change in the blend would require congressional action.

We also point out that hospitals have known since the passage of Pub. L. 98–21 early in 1983 that there would be a transition to national prospective payment rates, and what the transition schedule would be. In our view, hospitals have had sufficient time to accomodate themselves to the transition and to anticipate the implementation of national rates in FY 1987. To delay the transition period at this point would, we believe, have the effect of penalizing efficient hospitals who have taken those steps necessary in anticipation of implementing the national rates in FY 1987.

III. Revised Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Background

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established by section 1886(b) of the Act and implemented in § 405.463 of the regulations. Under these limits, an annual target amount (stated as inpatient operating cost per discharge) is set for each hospital, based on the hospital's own cost experience. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

A hospital that has inpatient operating costs per discharge in excess of its target amount would be paid no more than that target amount. However, a hospital that has inpatient operating costs less than its target amount would be paid its costs plus the lower of (1) 50 percent of the difference between the inpatient operating cost per discharge and the target amount, or (2) five percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period, prorated based on calendar year target rate percentages. For cost reporting periods beginning in FY 1983 and FY 1984, the applicable target rate percentage was the estimated hospital market basket increase factor plus one percentage point. For cost reporting periods beginning in FY 1985, the applicable target rate percentage is the estimated hospital market basket increase factor plus one-quarter of one percentage point, as prescribed by section 1886(b)(3)(B) of the Act. For cost reporting periods beginning in FY 1986 and thereafter (that is, on or after October 1, 1985), the target rate percentage will be adjusted by an update factor determined by the Secretary under section 1886(e)(4) of the Act, considering the recommendations of ProPAC under section 1886(e)(2) of the Act.

B. Revised Target Amounts for Cost Reporting Periods Beginning in FY 1986

For cost reporting periods beginning in FY 1986, we are carrying forward each hospital's previous year's target amount without increase. This is consistent with the update we are establishing for both Federal rates and hospital-specific rates under the prospective payment system and would comply with the provisions of sections 1886(b)(3)(B) and 1886(e)(4) of the Act, which contemplate a single "percentage change" for all hospitals. In discussing the percentage change, these sections of the Act do not distinguish between hospitals subject to or excluded from the prospective payment system. Thus, we are required to apply the same update factor to both groups of hospitals and to units excluded from the prospective payment system. Given the fact that the target rate is a limit rather than a payment rate, and only affects those hospitals whose costs exceed the limit, it was reasonable for Congress to specify use of the same update factor rather than requiring independent development of different factors for each type of hospital.

In addition, even if we were not required by law to apply the same update factor to hospitals both included in and excluded from prospective payment, we believe it is appropriate to do so. Although certain of the adjustments and factors considered in determining the appropriate update under prospective payment may not apply to excluded hospitals and units, there are other considerations that we believe justify a zero percent increase for FY 1986.

Comment: Some commenters stated that it was inappropriate to apply the same prospective payment system update factor to excluded hospitals and units. These commenters disagreed with our determination that the statute requires us to apply the same update factor to both prospective payment hospitals and excluded hospitals and units. One commenter stated that the composite adjustment factor represents a correction of the standardized amounts and is not part of the update factor; therefore, it should not be applied to excluded hospitals and units.

Response: Since the rate-of-increase limits were established by Pub. L. 97–248, we have used the same market basket forecast for setting and updating hospitals' target amounts and, effective with the implementation of the prospective payment system, Federal regional and national standardized payment amounts. Moreover, as noted in the June 10, 1985 NPRM (50 FR 24401), in reviewing ProPAC's recommendation that separate market basket weights be used for hospitals and units excluded from the prospective payment system but subject to the rate-of-increase limits, studies to date indicate little difference in market baskets. Therefore, because we have used the same market basket forecasts in the past, and since little evidence supports the hypothesis that the market basket input weights would differ for excluded hospitals, we believe that it is appropriate to use the same market basket forecast of 4.27 percent in updating the target amounts in lieu of developing a separate update factor. Use of the same market basket forecast in the past means that the current target amounts are overstated relative to the most recent market basket forecasts. For this reason, we believe that it is appropriate to apply the same correction

factor of −1.2 percent for market basket forecast error.

While excluded hospitals and units have not had the opportunity to increase their reimbursement through coding changes that increase their case-mix index, it is important to note that an excluded hospital may qualify for an exception to the rate-of-increase limit based on a change in case mix as a result of an addition or discontinuance of services that results in a distortion in the rate of cost increase. (See § 405.463(g).) As to the appropriateness of the policy target adjustment factor, it might at first appear that the incentives to increase productivity and cost-effectiveness are not as strong for hospitals and units still reimbursed on a reasonable cost basis. The determinative factor, however, is that the excluded hospitals have the same opportunities for cost reduction that the prospective payment system hospitals have already exploited and thereby shown to be feasible. Moreover, we believe that the limit on the rate-of-increase in such hospitals' target amounts does, in fact, create the same incentives. This is especially true in view of the fact that a hospital, whose costs are below its target amount, is paid its costs plus the lower of—

- Fifty percent of the difference between its inpatient operating cost per discharge and the target amount; or
- Five percent of the target amount.

For these reasons, we believe it is appropriate to apply the composite policy target adjustment factor of −1.5 percent to the target amounts of hospitals and units subject to the rate-of-increase limits.

We believe that applying the same update factor to *all* hospitals and units is particularly important in view of our goal (and, we believe, Congressional intent) of bringing excluded hospitals and units under the prospective payment system as soon as possible. It is, therefore, appropriate at this time to begin providing excluded hospitals and units with incentives comparable to those experienced by hospitals under the prospective payment system. We expect many excluded hospitals and units will be able to achieve greater efficiency and effectiveness in the delivery of needed services as a response to these limits.

Since the rate-of-increase ceiling is a limit and not a payment rate, excluded hospitals and units that operate efficiently and maintain per case costs below their target amounts would continue to have a margin for increasing costs. In addition, under the provisions of section 1886(b)(4)(A) of the Act and § 405.463(g), a hospital or unit subject to the rate of increase limit may qualify for exceptions to that limit if it demonstrates that a portion of its costs above the limit is attributable to extraordinary circumstances or abrupt changes in patient mix. The availability of such exceptions affords protection for those hospitals that may exceed their target amount ceiling for reasons other than inefficiency.

Beginning with FY 1986, section 1886(e)(3)(A) of the Act instructs the Secretary to "adjust" the standardized amounts in accordance with her final determination under section 1886(e)(4) of the Act, which describes the update factor as the "percentage change". This would include any and all adjustments made to the standardized amounts. The "percentage change" under section 1886(e)(4) replaces the "percentage increase" under section 1886(b)(3)(B) of the Act, which applies to both prospective payment system hospitals and excluded hospitals and units. The law refers to the "percentage change" as a single factor and does not contemplate the application of separate factors for prospective payment system hospitals and excluded hospitals and units. Therefore, we are required to apply the same "percentage change" to both the prospective payment standardized amounts and the target rate of increase limit for excluded hospitals and units.

IV. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For Tables 2, 3a, and 3b, refer to the September 1, 1983 interim final rule (48 FR 39845).

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)	2361.23	668.56	2132.35	507.22
2. Middle Atlantic (PA, NJ, NY)	2217.30	660.71	2166.25	514.40
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2354.76	612.14	1987.52	427.03
4. East North Central (IL, IN, MI, OH, WI)	2435.73	712.68	1971.73	478.79
5. East South Central (AL, KY, MS, TN)	2235.04	544.16	1977.12	399.85
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2260.57	633.09	1836.34	410.83
7. West South Central (AR, LA, OK, TX)	2307.62	599.67	1853.44	398.47
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2203.70	634.49	1819.46	445.73
9. Pacific (AK, CA, HI, OR, WA)	2208.57	745.34	1828.74	521.49
10. National	2308.29	664.16	1920.46	437.97

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
Abilene TX	.8937
Taylor, TX	
Akron, OH	1.1000
Portage, OH	
Summit, OH	
Albany, GA	.8124
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	.9278
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Albuquerque, NM	1.0998
Bernalillo, NM	
Alexandria, LA	.9102
Rapides, LA	
Allentown-Bethlehem, PA-NJ	1.0379
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Altoona, PA	.9950
Blair, PA	
Amarillo, TX	.9526
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2528
Orange, CA	
Anchorage, AK	1.5735

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Anchorage, AK	
Anderson, IN	.9185
Madison, IN	
Anderson, SC	.8309
Anderson, SC	
Ann Arbor, MI	1.2515
Washtenaw, MI	
Anniston, AL	.8457
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	1.0671
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Asheville, NC	.8780
Buncombe, NC	
Athens, GA	.8120
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	.9594
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	
Atlantic City, NJ	1.0489
Atlantic, NJ	
Cape May, NJ	
Augusta, GA–SC	.9533
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	1.0936
Kane, IL	
Kendall, IL	
Austin, TX	1.1096
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.1972
Kern, CA	
Baltimore, MD	1.1069
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	.9135
Penobscot, ME	
Baton Rouge, LA	.9754
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	1.0228
Calhoun, MI	
Beaumont-Port Arthur, TX	1.0009
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0840
Beaver, PA	
Bellingham, WA	1.1388
Whatcom, WA	
Benton Harbor, MI	.8847
Berrien, MI	
Bergen-Passaic, NJ	1.0670
Bergen, NJ	
Passaic, NJ	
Billings, MT	1.0152
Yellowstone, MT	
Biloxi-Gulfport, MS	.8428
Hancock, MS	
Harrison, MS	
Binghamton, NY	.9489
Broome, NY	
Tioga, NY	
Birmingham, AL	.9594
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	.9871
Burleigh, ND	
Morton, ND	
Bloomington, IN	.9828
Monroe, IN	
Bloomington-Normal, IL	.9773
McLean, IL	
Boise City, ID	1.0508
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1485
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	1.1244
Boulder, CO	
Bradenton, FL	.9129
Manatee, FL	
Brazoria, TX	.8679
Brazoria, TX	
Bremerton, WA	.9742
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1760
Fairfield, CT	
Brownsville-Harlingen, TX	.8912
Cameron,TX	
Bryan-College Station, TX	.9500
Brazos, TX	
Buffalo, NY	1.0474
Erie, NY	
Burlington, NC	.7868
Alamance, NC	
Burlington, VT	1.0058
Chittenden, VT	
Grand Isle, VT	
Canton, OH	1.0007
Carroll, OH	
Stark, OH	
Casper, WY	1.0984
Natrona, WY	
Cedar Rapids, IA	1.0101
Linn, IA	
Champaign-Urbana-Rantoul, IL	.9893
Champaign, IL	
Charleston, SC	.8847
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	1.0406
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	.8926
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	.9278
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	.9968
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	.9631
Laramie, WY	
Chicago, IL	1.2299
Cook, IL	
Du Page, IL	
McHenry, IL	
Chico, CA	1.2373
Butte, CA	
Cincinnati, OH-KY-IN	1.0970
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	.8124
Christian, KY	
Montgomery, TN	
Cleveland, OH	1.1481
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.0363
El Paso, CO	
Columbia, MO	1.0942
Boone, MO	
Columbia, SC	.9102
Lexington, SC	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Richland, SC	
Columbus, GA-AL	.7872
Russell, AL	
Chattanoochee, GA	
Muscogee, GA	
Columbus, OH	.9614
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	.9827
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	.8931
Allegeny, MD	
Mineral, WV	
Dallas, TX	1.0656
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	.8028
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	1.0583
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.0860
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	.9073
Volusia, FL	
Decatur, IL	.9523
Macon, IL	
Denver, CO	1.2772
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	1.0480
Dallas, IA	
Polk, IA	
Warren, IA	
Detroit, MI	1.1640
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	.8396
Dale, AL	
Houston, AL	
Dubuque, IA	1.0514
Dubuque, IA	
Duluth, MN-WI	.9858
St. Louis, MN	
Douglas, WI	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Eau Claire, WI	.9429
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	.9369
El Paso, TX	
Elkhart-Goshen, IN	.9581
Elkhart, IN	
Elmira, NY	.9670
Chemung, NY	
Enid, OK	.9557
Garfield, OK	
Erie, PA	.9919
Erie, PA	
Eugene-Springfield, OR	1.1082
Lane, OR	
Evansville, IN-KY	1.0143
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0567
Clay, MN	
Cass, ND	
Fayetteville, NC	.8270
Cumberland, NC	
Fayetteville-Springdale, AR	.8020
Washington, AR	
FLint, MI	1.2016
Genesee, MI	
Florence, AL	.7832
Colbert, AL	
Lauderdale, AL	
FLorence, SC	.7631
FLorence, SC	
Fort Collins-Loveland, CO	1.0768
Larimor, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.1168
Broward, FL	
Fort Myers-Cape Coral, FL	.9464
Lee, FL	
Fort Pierce, FL	1.0141
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	.9176
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	.8688
Okaloosa, FL	
Fort Wayne, IN	.9499
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	.9926
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.1407
Fresno, CA	
Gadsden, AL	.8713
Etowah, AL	
Gainesville, FL	.9572
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.1329
Galveston, TX	
Gary-Hammond, IN	1.0899

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Lake, IN	
Porter, IN	
Glens Falls, NY	.9538
Warren, NY	
Washington, NY	
Grand Forks, ND	.9800
Grand Forks, ND	
Grand Rapids, MI	1.0586
Kent, MI	
Ottawa, MI	
Great Falls, MT	1.0644
Cascade, MT	
Greeley, CO	1.0685
Weld, CO	
Green Bay, WI	1.0252
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	.9320
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	.9064
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	.9516
Washington, MD	
Hamilton-Middletown, OH	1.0140
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	.9796
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
Hartford-New Middletown-Britain-Bristol, CT	1.1379
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	.8917
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1935
Honolulu, HI	
Houma-Thibodaux, LA	.9162
Lafourche, LA	
Terrebonne, LA	
Houston, TX	1.0591
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	.9441
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	.8599
Madison, AL	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Indianapolis, IN	1.0517
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.2990
Johnson, IA	
Jackson, MI	1.0132
Jackson, MI	
Jackson, MS	.9279
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	.7859
Madison, TN	
Jacksonville, FL	.9412
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	.7908
Onslow, NC	
Janesville-Beloit, WI	.9353
Rock, WI	
Jersey City, NJ	1.0529
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN-VA	.8555
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	.9457
Cambria, PA	
Somerset, PA	
Joliet, IL	1.1172
Grundy, IL	
Will, IL	
Joplin, MO	.9136
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.2252
Kalamazoo, MI	
Kankakee, IL	.9441
Kankakee, IL	
Kansas City, KS-MO	1.0583
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	1.0796
Kenosha, WI	
Killeen-Temple, TX	.8785
Bell, TX	
Coryell, TX	
Knoxville, TN	.8931
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	.9799
Howard, IN	
Tipton, IN	
LaCrosse, WI	1.0093
LaCrosse, WI	
Lafayette, LA	1.0041
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	.9097
Tippecanoe, IN	
Laake Charles, LA	.9964
Calcasieu, LA	
Lake County, IL	1.1552
Lake, IL	
Lakeland-Winter Haven, FL	.8787
Polk, FL	
Lancaster, PA	1.0320
Lancaster, PA	
Lansing-East Lansing, MI	1.0692
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	.8104
Webb, TX	
Las Cruces, NM	.8703
Dona Ana, NM	
Las Vegas, NV	1.1173
Clark, NV	
Lawrence, KS	1.0106
Douglas, KS	
Lawton, OK	.9400
Comanche, OK	
Lewiston-Auburn, ME	.9357
Androscoggin, ME	
Lexington-Fayette, KY	.9802
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	.9795
Allen, OH	
Auglaize, OH	
Lincoln, NE	.9640
Lancaster, NE	
Little Rock-North Little Rock, AR	1.1055
Faulker, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	.8349
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	1.0205
Lorain, OH	
Los Angeles-Long Beach, CA	1.3193
Los Angeles, CA	
Louisville, KY-IN	1.0009
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock,TX	1.0055
Lubbock, TX	
Lynchburg, VA	.8198
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	.9257
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0823
Dane, WI	
Manchester-Nashua, NH	.9508
Hillsboro, NH	
Merrimack, NH	
Mansfield, OH	.9847
Richland, OH	
McAllen-Edinburg-Mission, TX	.8046
Hidalgo, TX	
Medford, OR	1.0281
Jackson, OR	
Melbourne-Titusville, FL	.9310
Brevard, FL	
Memphis, TN-AR-MS	1.0418
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Miami-Hialeah, FL	1.0625
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	1.0274
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.1223
Midland, TX	
Milwaukee, WI	1.1329
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis-St. Paul, MN-WI	1.1687
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	.8863
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.2015
Stanislaus, CA	
Monmouth-Ocean, NJ	.9853

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	.9275
Ouachita, LA	
Montgomery, AL	.8812
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	.9993
Delaware, IN	
Muskegon, MI	.9640
Muskegon, MI	
Naples, FL	1.0373
Collier, FL	
Nashville, TN	.9846
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Ruthford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
Nassau-Suffolk, NY	1.3278
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	.9725
Bristol, MA	
New Haven-West Haven-Waterbury-Meriden, CT	1.1194
New Haven, CT	
New London-Norwich, CT	1.1023
New London, CT	
New Orleans, LA	.9277
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
New York, NY	1.3710
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.1321
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	.8894
Niagara, NY	
Norfolk-Virginia Beach-Newport News, VA	.9622
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	
Oakland, CA	1.4793
Alameda, CA	
Contra Costa, CA	
Ocala, FL	.8672
Marion, FL	
Odessa, TX	.9550
Ector, TX	
Oklahoma City, OK	1.0851
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	1.0709
Thurston, WA	
Omaha, NE-IA	1.0433
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	.9232
Orange, NY	
Orlando, FL	1.0115
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	.8184
Daviess, KY	
Oxnard-Ventura, CA	1.2807
Ventura, CA	
Panama City, FL	.8293
Bay, FL	
Parkersburg-Marietta, WV-OH	.9055
Washington, OH	
Wood, WV	
Pascagoula, MS	.9608
Jackson, MS	
Pensacola, FL	.8679
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	1.0508
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA-NJ	1.1789
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.0723
Maricopa, AZ	
Pine Bluff, AR	.7952
Jefferson, AR	
Pittsburgh, PA	1.0932
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	1.0172
Berkshire, MA	
Portland, ME	.9808
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.1987
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	.9305
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	1.0174
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	1.0426
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Statewide, RI	
Washington, RI	
Provo-Orem, UT	.9786
Utah, UT	
Pueblo, CO	1.1129
Pueblo, CO	
Racine, WI	.9930
Racine, WI	
Raleigh-Durham, NC	.9650
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	.9554
Pennington, SD	
Reading, PA	1.0174
Berks, PA	
Redding, CA	1.2306
Shasta, CA	
Reno, NV	1.1753
Washoe, NV	
Richland-Kennewick, WA	1.0182
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	.9529
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	
Riverside-San Bernardino, CA	1.2426
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	.8932
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0210
Olmsted, MN	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Rochester, NY	1.0152
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.1272
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.2875
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.0990
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	.9945
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	.9418
Buchanan, MO	
St. Louis, MO-IL	1.0748
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0892
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2480
Monterey, CA	
Salt Lake City-Ogden, UT	1.0279
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	.8656
Tom Green, TX	
San Antonio, TX	.8878
Bexar, TX	
Comal, TX	
Guadalupe, TX	
San Diego, CA	1.3009
San Diego, CA	
San Francisco, CA	1.6380
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.4698
Santa Clara, CA	
Santa Barbara-Santa Maria-Lompoc, CA	1.1749
Santa Barbara, CA	
Santa Cruz, CA	1.2343
Santa Cruz, CA	
Santa Fe, NM	.9738
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.3017
Sonoma, CA	
Sarasota, FL	.9569
Sarasota, FL	
Savannah, GA	.8853
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	.9910
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.1495
King, WA	
Snohomish, WA	
Sharon, PA	.9687
Mercer, PA	
Sheboygan, WI	.9813
Sheboygan, WI	
Sherman-Denison, TX	.8557
Grayson, TX	
Shreveport, LA	.9543
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	.9989
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	1.0137
Minnehaha, SD	
South Bend-Mishawaka, IN	1.0014
St. Joseph, IN	
Spokane, WA	1.1475
Spokane, WA	
Springfield, IL	1.0587
Menard, IL	
Sangamon, IL	
Springfield, MO	.9792
Christian, MO	
Greene, MO	
Springfield, MA	.9988
Hampden, MA	
Hampshire, MA	
State College, PA	1.0694
Centre, PA	
Steubenville-Wairton, OH-WV	.9585
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.2778
San Joaquin, CA	
Syracuse, NY	1.0389
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0972
Pierce, WA	
Tallahassee, FL	.9441
Gadsden, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	.9759
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	.8395
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	.8588
Miller, AR	
Bowie, TX	
Toledo, OH	1.2178
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	1.0555
Shawnee, KS	
Trenton, NJ	1.0242
Mercer, NJ	
Tucson, AZ	1.0017
Pima, AZ	
Tulsa, OK	1.0058
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	1.0099
Tuscaloosa, AL	
Tyler, TX	.9963
Smith, TX	
Utica-Rome, NY	.8667
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.3300
Napa, CA	
Solano, CA	
Vancouver, WA	1.1574
Clark, WA	
Victoria, TX	.8145
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	.9858
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.0566
Tulare, CA	
Waco, TX	.9051
McLennan, TX	
Washington, D.C.-MD-VA	1.1878
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	
Waterloo-Cedar Falls, IA	.9920
Black Hawk, IA	
Bremer, IA	
Wausau, WI	.9800
Marathon, WI	
West Palm Beach-Boca Raton-Delary Beach, FL	.9900
Palm Beach, FL	
Wheeling, WV-OH	.9700
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.1506

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Butler, KS	
Sedgwick, KS	
Wichita Falls, TX	.8712
Wichita, TX	
Williamsport, PA	.8983
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0511
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	.9522
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	.9961
Worcester, MA	
Yakima, WA	1.0314
Yakima, WA	
York, PA	.9782
Adams, PA	
York, PA	
Youngstown-Warren, OH	1.0404
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	1.0385
Sutter, CA	
Yuba, CA	

TABLE 4B.—WAGE INDEX FOR RURAL AREAS

Non-urban area	Wage index
Alabama	.7412
Alaska	1.4880
Arizona	.9255
Arkansas	.7647
California	1.1374
Colorado	.9258
Connecticut	1.0384
Delaware	.8582
Florida	.8751
Georgia	.7723
Hawaii	1.0084
Idaho	.9064
Illinois	.9726
Indiana	.8622
Iowa	.8656
Kansas	.8419
Kentucky	.7978
Louisiana	.8543
Maine	.8585
Maryland	.8710
Massachusetts	1.0516
Michigan	.9520
Minnesota	.8725
Mississippi	.7650
Missouri	.8265
Montana	.9087
Nebraska	.8250

TABLE 4B.—WAGE INDEX FOR RURAL AREAS—Continued

Non-urban area	Wage index
Nevada	1.0721
New Hampshire	.9185
New Jersey [1]	
New Mexico	.9146
New York	.8766
North Carolina	.8071
North Dakota	.8995
Ohio	.9034
Oklahoma	.8401
Oregon	1.0704
Pennsylvania	.9359
Rhode Island [1]	
South Carolina	.7770
South Dakota	.8203
Tennessee	.7677
Texas	.8121
Utah	.9436
Vermont	.8824
Virginia	.8167
Washington	1.0199
West Virginia	.8752
Wisconsin	.8929
Wyoming	.9674

[1] All counties within the State are classified urban.

BILLING CODE 4120-01-M

TABLE 5

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

DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.5632	21.4	16.2	33
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.8117	19.7	13.4	30
3	1	SURG *	CRANIOTOMY AGE <18	2.9183		12.7	30
4	1	SURG	SPINAL PROCEDURES	2.7300	20.2	15.0	32
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6510	9.7	8.0	25
6	1	SURG	CARPAL TUNNEL RELEASE	.4072	2.8	2.3	7
7	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE >69 +/OR C.C.	1.3867	11.5	6.1	23
8	1	SURG	PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE <70 W/O C.C.	.7466	5.6	3.7	19
9	1	MED	SPINAL DISORDERS + INJURIES	1.4237	14.4	8.4	25
10	1	MED	NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR C.C.	1.1324	11.6	7.8	25
11	1	MED	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	.9338	10.2	6.1	23
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.0016	11.4	7.8	25
13	1	MED	MULTIPLE SCLEROSIS + CEREBELLAR ATAXIA	.9789	10.9	7.7	25
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3144	12.6	8.5	26
15	1	MED	TRANSIENT ISCHEMIC ATTACK AND PRECEREBRAL OCCLUSIONS	.6241	6.1	4.7	19
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	.9044	8.9	6.8	24
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	.6803	7.8	5.6	23
18	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE >69 AND/OR C.C.	.7567	8.2	6.1	23
19	1	MED	CRANIAL + PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	.6548	7.2	5.3	22
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.4090	11.5	7.8	25
21	1	MED	VIRAL MENINGITIS	1.3144	10.6	7.9	25
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	.7087	6.5	5.0	20
23	1	MED	NONTRAUMATIC STUPOR + COMA	1.1242	8.5	5.2	22
24	1	MED	SEIZURE + HEADACHE AGE >69 AND/OR C.C.	.7644	6.8	5.0	22
25	1	MED	SEIZURE + HEADACHE AGE 18-69 W/O C.C.	.5522	5.5	4.0	18
26	1	MED	SEIZURE + HEADACHE AGE 0-17	.6255	3.9	2.7	14
27	1	MED	TRAUMATIC STUPOR + COMA, COMA >1 HR	1.5648	9.8	4.7	22
28	1	MED	TRAUMATIC STUPOR + COMA, COMA <1 HR AGE >69 AND/OR C.C.	.9422	8.5	5.0	22
29	1	MED	TRAUMATIC STUPOR + COMA <1 HR AGE 18-69 W/O C.C.	.6462	6.0	3.6	21
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.	.5383	5.7	3.9	20
32	1	MED	CONCUSSION AGE 18-69 W/O C.C.	.4064	4.1	2.9	14
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.	.9777	8.9	6.1	23
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	.7384	7.6	4.9	22

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	2 SURG		RETINAL PROCEDURES	.7103	4.7	4.1	12
37	2 SURG		ORBITAL PROCEDURES	.6688	4.2	3.2	12
38	2 SURG		PRIMARY IRIS PROCEDURES	.3990	3.1	2.4	8
39	2 SURG		LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5721	2.3	2.1	4
40	2 SURG		EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.4129	2.5	2.1	6
41	2 SURG	*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3657		1.6	4
42	2 SURG		INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS + LENS	.6543	3.7	3.0	10
43	2 MED		HYPHEMA	.3462	4.6	3.7	15
44	2 MED		ACUTE MAJOR EYE INFECTIONS	.6397	7.3	5.9	21
45	2 MED		NEUROLOGICAL EYE DISORDERS	.5409	4.7	3.6	14
46	2 MED		OTHER DISORDERS OF THE EYE AGE >17 WITH C.C.	.6010	5.6	3.7	21
47	2 MED		OTHER DISORDERS OF THE EYE AGE >17 W/O C.C.	.4192	3.6	2.5	11
48	2 MED	*	OTHER DISORDERS OF THE EYE AGE 0-17	.4018		2.9	13
49	3 SURG		MAJOR HEAD + NECK PROCEDURES	2.8745	17.1	13.1	30
50	3 SURG		SIALOADENECTOMY	.7034	4.4	3.7	11
51	3 SURG		SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.5887	4.0	3.3	10
52	3 SURG		CLEFT LIP + PALATE REPAIR	.6956	4.4	3.5	13
53	3 SURG		SINUS + MASTOID PROCEDURES AGE >17	.6176	3.8	3.0	10
54	3 SURG	*	SINUS + MASTOID PROCEDURES AGE 0-17	.6889		3.2	11
55	3 SURG		MISCELLANEOUS EAR, NOSE + THROAT PROCEDURES	.4342	2.6	2.1	6
56	3 SURG		RHINOPLASTY	.4358	2.8	2.3	7
57	3 SURG		T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE >17	.7718	5.7	3.7	20
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	.4132	2.9	2.3	7
60	3 SURG	*	TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	.2616		1.5	3
61	3 SURG		MYRINGOTOMY WITH TUBE INSERTION AGE >17	.4274	2.9	2.0	8
62	3 SURG	*	MYRINGOTOMY WITH TUBE INSERTION AGE 0-17	.3089		1.3	3
63	3 SURG		OTHER EAR, NOSE + THROAT O.R. PROCEDURES	1.1619	8.1	5.1	22
64	3 MED		EAR, NOSE + THROAT MALIGNANCY	.9769	8.5	4.8	22
65	3 MED		DYSEQUILIBRIUM	.4499	4.8	3.8	14
66	3 MED		EPISTAXIS	.4146	4.3	3.3	13
67	3 MED		EPIGLOTTITIS	.9364	6.5	4.8	21
68	3 MED		OTITIS MEDIA + URI AGE >69 AND/OR C.C.	.6092	6.3	5.1	17
69	3 MED		OTITIS MEDIA + URI AGE 18-69 W/O C.C.	.5040	5.1	4.1	14
70	3 MED		OTITIS MEDIA + URI AGE 0-17	.5251	4.2	3.3	12

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	3 MED		LARYNGOTRACHEITIS	.6594	5.8	4.6	18
72	3 MED		NASAL TRAUMA + DEFORMITY	.5217	5.2	3.5	19
73	3 MED		OTHER EAR, NOSE + THROAT DIAGNOSES AGE >17	.6049	5.1	3.4	18
74	3 MED	*	OTHER EAR, NOSE + THROAT DIAGNOSES AGE 0-17	.3427		2.1	9
75	4 SURG		MAJOR CHEST PROCEDURES	2.9780	16.2	13.4	30
76	4 SURG		OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH C.C.	2.5667	14.9	10.3	27
77	4 SURG		OTHER RESPIRATORY SYSTEM O.R. PROCEDURES W/O C.C.	1.6735	11.5	7.0	24
78	4 MED		PULMONARY EMBOLISM	1.4802	11.7	9.5	27
79	4 MED		RESPIRATORY INFECTIONS + INFLAMMATIONS AGE >69 AND/OR C.C.	1.9546	13.0	9.6	27
80	4 MED		RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 18-69 W/O C.C.	1.4403	12.2	8.5	26
81	4 MED	*	RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 0-17	.8652		6.1	23
82	4 MED		RESPIRATORY NEOPLASMS	1.1259	9.9	6.6	24
83	4 MED		MAJOR CHEST TRAUMA AGE >69 AND/OR C.C.	.8398	8.6	6.6	24
84	4 MED		MAJOR CHEST TRAUMA AGE <70 W/O C.C.	.5921	6.0	4.6	19
85	4 MED		PLEURAL EFFUSION AGE >69 AND/OR C.C.	1.1198	9.9	7.2	24
86	4 MED		PLEURAL EFFUSION AGE <70 W/O C.C.	.9761	8.8	5.9	23
87	4 MED		PULMONARY EDEMA + RESPIRATORY FAILURE	1.8078	10.2	7.0	24
88	4 MED		CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0769	8.5	6.6	24
89	4 MED		SIMPLE PNEUMONIA + PLEURISY AGE >69 AND/OR C.C.	1.1768	9.6	7.5	25
90	4 MED		SIMPLE PNEUMONIA + PLEURISY AGE 18-69 W/O C.C.	.8900	7.7	6.2	22
91	4 MED		SIMPLE PNEUMONIA + PLEURISY AGE 0-17	.8216	5.7	4.4	19
92	4 MED		INTERSTITIAL LUNG DISEASE AGE >69 AND/OR C.C.	1.1117	9.0	6.8	24
93	4 MED		INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	.8642	7.5	5.4	22
94	4 MED		PNEUMOTHORAX AGE >69 AND/OR C.C.	1.3044	10.1	7.6	25
95	4 MED		PNEUMOTHORAX AGE <70 W/O C.C.	.8797	7.8	5.9	23
96	4 MED		BRONCHITIS + ASTHMA AGE >69 AND/OR C.C.	.8448	7.3	6.0	20
97	4 MED		BRONCHITIS + ASTHMA AGE 18-69 W/O C.C.	.7092	6.2	5.1	17
98	4 MED		BRONCHITIS + ASTHMA AGE 0-17	.7202	4.5	3.8	12
99	4 MED		RESPIRATORY SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.8078	6.4	4.6	22
100	4 MED		RESPIRATORY SIGNS + SYMPTOMS AGE <70 W/O C.C.	.6255	5.0	3.6	16
101	4 MED		OTHER RESPIRATORY SYSTEM DIAGNOSES AGE >69 AND/OR C.C.	.8461	7.5	5.5	23
102	4 MED		OTHER RESPIRATORY SYSTEM DIAGNOSES AGE <70 WITHOUT C.C.	.6843	6.1	4.3	21
103	5 SURG		HEART TRANSPLANT	.0000			
104	5 SURG		CARDIAC VALVE PROCEDURE WITH PUMP + WITH CARDIAC CATH	7.3161	21.0	18.0	35
105	5 SURG		CARDIAC VALVE PROCEDURE WITH PUMP + W/O CARDIAC CATH	6.3400	18.2	15.0	32

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	5 SURG		CORONARY BYPASS WITH CARDIAC CATH	5.3332	16.3	14.7	32
107	5 SURG		CORONARY BYPASS W/O CARDIAC CATH	4.6614	14.5	12.7	30
108	5 SURG		OTHER CARDIOVASCULAR OR THORACIC PROC, WITH PUMP	4.7810	14.7	10.6	28
109	5 SURG		CARDIOTHORACIC PROCEDURES W/O PUMP	4.3597	14.7	9.0	26
110	5 SURG		MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP AGE >69 AND/OR C.C.	3.3215	16.4	13.1	30
111	5 SURG		MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP AGE <70 W/O C.C.	2.4581	13.1	11.2	28
112	5 SURG		VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	2.2239	11.8	8.1	25
113	5 SURG		AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB + TOE	2.5406	21.8	17.2	34
114	5 SURG		UPPER LIMB + TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.8946	17.2	12.4	29
115	5 SURG		PERM CARDIAC PACEMAKER IMPLANT WITH AMI, HEART FAILURE OR SHOCK	4.1634	16.6	13.9	31
116	5 SURG		PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	2.9709	9.6	7.8	25
117	5 SURG		CARDIAC PACEMAKER REPLACE + REVIS EXC PULSE GEN REPL ONLY	1.4684	6.5	4.8	20
118	5 SURG		CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	1.8784	4.7	3.4	14
119	5 SURG		VEIN LIGATION + STRIPPING	.9165	7.7	5.6	23
120	5 SURG		OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.2580	17.0	11.4	28
121	5 MED		CIRCULATORY DISORDERS WITH AMI + C.V. COMP. DISCH. ALIVE	1.7694	12.4	10.3	27
122	5 MED		CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.3270	10.6	8.8	26
123	5 MED		CIRCULATORY DISORDERS WITH AMI, EXPIRED	1.3525	5.6	3.0	20
124	5 MED		CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH + COMPLEX DIAG	1.2553	7.1	5.0	22
125	5 MED		CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG	.7266	3.8	2.8	11
126	5 MED		ACUTE + SUBACUTE ENDOCARDITIS	2.9840	23.8	18.1	35
127	5 MED		HEART FAILURE + SHOCK	1.0100	8.9	6.8	24
128	5 MED		DEEP VEIN THROMBOPHLEBITIS	.8456	9.9	8.6	24
129	5 MED		CARDIAC ARREST, UNEXPLAINED	1.7200	7.9	3.8	21
130	5 MED		PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR C.C.	.8254	8.3	5.7	23
131	5 MED		PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	.6712	6.7	4.5	22
132	5 MED		ATHEROSCLEROSIS AGE >69 AND/OR C.C.	.8040	7.0	5.3	22
133	5 MED		ATHEROSCLEROSIS AGE <70 W/O C.C.	.7050	5.2	3.8	16
134	5 MED		HYPERTENSION	.6365	6.6	5.1	20
135	5 MED		CARDIAC CONGENITAL + VALVULAR DISORDERS AGE >69 AND/OR C.C.	.8936	7.3	5.3	22
136	5 MED		CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 18-69 W/O C.C.	.7526	5.6	3.8	18
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.	.8138	6.5	4.9	21
139	5 MED		CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE <70 W/O C.C.	.6517	5.1	3.9	16
140	5 MED		ANGINA PECTORIS	.6895	5.7	4.6	16

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	5	MED	SYNCOPE + COLLAPSE AGE >69 AND/OR C.C.	.6188	5.7	4.4	18
142	5	MED	SYNCOPE + COLLAPSE AGE <70 W/O C.C.	.5335	4.7	3.6	14
143	5	MED	CHEST PAIN	.5895	4.5	3.5	13
144	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH C.C.	1.1158	8.4	6.2	23
145	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O C.C.	.8477	7.1	5.0	22
146	6	SURG	RECTAL RESECTION AGE >69 AND/OR C.C.	3.0755	18.9	16.6	34
147	6	SURG	RECTAL RESECTION AGE <70 W/O C.C.	2.2737	15.4	14.0	31
148	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	2.9407	17.8	15.3	32
149	6	SURG	MAJOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	2.1072	14.3	12.6	30
150	6	SURG	PERITONEAL ADHESIOLYSIS AGE >69 AND/OR C.C.	2.3428	14.9	12.8	30
151	6	SURG	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	1.5902	11.5	10.1	27
152	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C.	1.4069	10.8	8.6	26
153	6	SURG	MINOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	1.0993	9.1	7.3	24
154	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE >69 AND/OR C.C.	2.6880	15.1	11.5	29
155	6	SURG	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 18-69 W/O C.C.	1.7906	11.7	8.9	26
156	6	SURG *	STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 0-17	.8382		6.0	20
157	6	SURG	ANAL AND STOMAL PROCEDURES AGE >69 AND/OR C.C.	.7302	6.4	4.8	21
158	6	SURG	ANAL AND STOMAL PROCEDURES AGE <70 W/O C.C.	.5513	4.9	3.9	14
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE >69 AND/OR C.C.	1.0000	7.8	6.3	22
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE 18-69 W/O C.C.	.7457	5.9	5.0	16
161	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE >69 AND/OR C.C.	.6538	5.3	4.4	14
162	6	SURG	INGUINAL + FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C.	.5264	4.1	3.6	10
163	6	SURG	HERNIA PROCEDURES AGE 0-17	.9648	5.6	4.2	18
164	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR C.C.	2.0649	12.2	10.7	28
165	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	1.4379	9.2	8.4	19
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR C.C.	1.3606	9.0	7.5	23
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C.	.8855	6.0	5.3	13
168	6	SURG	MOUTH PROCEDURES AGE >69 AND/OR C.C.	.9188	6.2	4.8	21
169	6	SURG	MOUTH PROCEDURES AGE <70 W/O C.C.	.6585	4.0	3.0	12
170	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE >69 AND/OR C.C.	2.7615	17.6	12.3	29
171	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE <70 W/O C.C.	2.3305	15.4	9.8	27
172	6	MED	DIGESTIVE MALIGNANCY AGE >69 AND/OR C.C.	1.0749	10.4	6.7	24
173	6	MED	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	.9604	9.3	5.4	22
174	6	MED	G.I. HEMORRHAGE AGE >69 AND/OR C.C.	.9075	7.5	5.8	23
175	6	MED	G.I. HEMORRHAGE AGE <70 W/O C.C.	.7069	6.0	4.7	18

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

DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
176	6 MED		COMPLICATED PEPTIC ULCER	.9318	8.3	6.3	23
177	6 MED		UNCOMPLICATED PEPTIC ULCER >69 AND/OR C.C.	.6617	6.6	5.4	18
178	6 MED		UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	.5556	5.5	4.6	15
179	6 MED		INFLAMMATORY BOWEL DISEASE	.9877	9.6	7.1	24
180	6 MED		G.I. OBSTRUCTION AGE >69 AND/OR C.C.	.7584	7.4	5.4	22
181	6 MED		G.I. OBSTRUCTION AGE <70 W/O C.C.	.5828	5.8	4.5	18
182	6 MED		ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE >69 +/OR C.C.	.6034	6.1	4.8	18
183	6 MED		ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE 18-69 W/O C.C.	.5107	5.0	4.0	15
184	6 MED		ESOPHAGITIS, GASTROENTERITIS + MISC. DIGEST. DISORDERS AGE 0-17	.4828	3.7	2.6	12
185	6 MED		DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE >17	.7147	6.6	4.3	21
186	6 MED	*	DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE 0-17	.4112		2.9	11
187	6 MED		DENTAL EXTRACTIONS + RESTORATIONS	.4211	2.9	2.3	7
188	6 MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR C.C.	.7173	6.4	4.3	21
189	6 MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	.5272	4.8	3.3	17
190	6 MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.9178	6.1	4.3	21
191	7 SURG		MAJOR PANCREAS, LIVER + SHUNT PROCEDURES	4.4608	22.0	18.1	35
192	7 SURG		MINOR PANCREAS, LIVER + SHUNT PROCEDURES	4.0442	21.7	16.7	34
193	7 SURG		BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 +/OR C.C.	2.8120	18.4	15.7	33
194	7 SURG		BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C.	2.1206	15.0	12.3	29
195	7 SURG		TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR C.C.	2.2727	14.6	13.1	30
196	7 SURG		TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C.	1.5976	11.2	10.3	22
197	7 SURG		TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR C.C.	1.7058	11.9	10.5	27
198	7 SURG		TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C.	1.1400	8.7	8.0	17
199	7 SURG		HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3378	17.4	14.2	31
200	7 SURG		HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.6286	15.8	10.9	28
201	7 SURG		OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7130	16.1	10.4	27
202	7 MED		CIRRHOSIS + ALCOHOLIC HEPATITIS	1.1665	10.8	7.8	25
203	7 MED		MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0339	10.1	6.9	24
204	7 MED		DISORDERS OF PANCREAS EXCEPT MALIGNANCY	.9703	8.2	6.5	24
205	7 MED		DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR C.C.	1.0720	9.5	6.7	24
206	7 MED		DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C.	.7735	7.5	5.0	22
207	7 MED		DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR C.C.	.7775	7.0	5.4	22
208	7 MED		DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	.5794	5.2	4.0	16
209	8 SURG		MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES	2.3930	15.8	14.4	31
210	8 SURG		HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR C.C.	2.0320	16.9	14.6	32

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
211	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C.	1.7867	15.0	12.7	30
212	8	SURG	HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.6609	9.7	8.3	23
213	8	SURG	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM + CONN. TISSUE DISORDERS	1.9753	17.1	12.1	29
214	8	SURG	BACK + NECK PROCEDURES AGE >69 AND/OR C.C.	1.8776	15.6	13.1	30
215	8	SURG	BACK + NECK PROCEDURES AGE <70 W/O C.C.	1.4281	12.0	10.2	27
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	1.5566	13.7	8.9	26
217	8	SURG	WND DEBRID + SKN GRFT EXC HAND,FOR MUSCSKELETAL + CONN.TISS.DIS	2.3100	18.8	11.2	28
218	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 +/OR C.C.	1.3798	11.2	8.9	26
219	8	SURG	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C.	1.0437	8.1	6.7	22
220	8	SURG *	LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	.9242		5.3	22
221	8	SURG	KNEE PROCEDURES AGE >69 AND/OR C.C.	.9758	7.0	4.7	22
222	8	SURG	KNEE PROCEDURES AGE <70 W/O C.C.	.7113	4.7	3.4	15
223	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE >69 AND/OR C.C.	.9853	7.1	5.3	22
224	8	SURG	UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE <70 W/O C.C.	.7891	5.2	4.1	15
225	8	SURG	FOOT PROCEDURES	.6520	4.8	3.9	13
226	8	SURG	SOFT TISSUE PROCEDURES AGE >69 AND/OR C.C.	.9811	8.1	5.4	22
227	8	SURG	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	.6872	5.2	3.8	17
228	8	SURG	GANGLION (HAND) PROCEDURES	.3661	2.3	1.9	5
229	8	SURG	HAND PROCEDURES EXCEPT GANGLION	.6212	4.0	2.9	12
230	8	SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES OF HIP + FEMUR	1.0555	9.2	6.1	23
231	8	SURG	LOCAL EXCISION + REMOVAL OF INT FIX DEVICES EXCEPT HIP + FEMUR	.7516	5.6	3.8	19
232	8	SURG	ARTHROSCOPY	.6706	4.6	3.2	14
233	8	SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE >69 +/OR C.C.	1.3723	11.5	8.1	25
234	8	SURG	OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE <70 W/O C.C.	.9457	7.5	5.3	22
235	8	MED	FRACTURES OF FEMUR	1.4137	17.9	10.1	27
236	8	MED	FRACTURES OF HIP + PELVIS	1.0714	13.1	8.8	26
237	8	MED	SPRAINS, STRAINS, + DISLOCATIONS OF HIP, PELVIS + THIGH	.6049	7.4	5.4	22
238	8	MED	OSTEOMYELITIS	1.6470	15.8	11.1	28
239	8	MED	PATHOLOGICAL FRACTURES + MUSCULOSKELETAL + CONN.TISS.MALIGNANCY	.9272	10.6	8.0	25
240	8	MED	CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR C.C.	.9049	9.5	7.3	24
241	8	MED	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	.7492	8.2	6.2	23
242	8	MED	SEPTIC ARTHRITIS	1.4562	13.5	9.7	27
243	8	MED	MEDICAL BACK PROBLEMS	.6843	8.0	6.2	23
244	8	MED	BONE DISEASES + SPECIFIC ARTHROPATHIES AGE >69 AND/OR C.C.	.6748	7.9	6.1	23
245	8	MED	BONE DISEASES + SPECIFIC ARTHROPATHIES AGE <70 W/O C.C.	.6407	6.7	5.1	22

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
246	8 MED		NON-SPECIFIC ARTHROPATHIES	.5936	6.9	5.4	21
247	8 MED		SIGNS + SYMPTOMS OF MUSCULOSKELETAL SYSTEM + CONN TISSUE	.5797	6.4	4.7	21
248	8 MED		TENDONITIS, MYOSITIS + BURSITIS	.5892	6.3	4.8	20
249	8 MED		AFTERCARE, MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE	.7899	8.8	5.6	23
250	8 MED		FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE >69 +/OR C.C.	.5162	5.6	3.8	20
251	8 MED		FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C.	.4004	3.5	2.5	11
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.	.6323	7.8	5.4	22
254	8 MED		FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C.	.4931	5.8	4.0	20
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	.6993	7.2	4.9	22
257	9 SURG		TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	1.0634	8.7	7.8	19
258	9 SURG		TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	.9698	7.6	6.9	16
259	9 SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C.	.8605	7.0	4.9	22
260	9 SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	.6661	4.8	3.5	15
261	9 SURG		BREAST PROC FOR NON-MALIG EXCEPT BIOPSY + LOC EXC	.6104	4.1	3.3	11
262	9 SURG		BREAST BIOPSY + LOCAL EXCISION FOR NON-MALIGNANCY	.4252	2.8	2.3	6
263	9 SURG		SKIN-GRAFTS AND/OR DEBRID ULCER OR CELLULITIS AGE >69 AND/OR C.C.	2.4177	22.1	16.1	33
264	9 SURG		SKIN-GRAFTS AND/OR DEBRID ULCER OR CELLULITIS AGE <70 W/O C.C.	2.1802	21.7	14.9	32
265	9 SURG		SKIN-GRAFT AND/OR DEBRID EXC SKIN ULCER OR CELLULITIS WITH C.C.	1.3993	11.6	7.6	25
266	9 SURG		SKIN-GRAFT AND/OR DEBRID EXC SKIN ULCER OR CELLULITIS W/O C.C.	.7313	6.1	4.0	21
267	9 SURG		PERIANAL + PILONIDAL PROCEDURES	.6362	5.4	4.0	17
268	9 SURG		SKIN,SUBCUTANEOUS TISSUE + BREAST PLASTIC PROCEDURES	.5690	3.9	2.8	12
269	9 SURG		OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE >69 +/OR C.C.	1.1338	9.6	5.5	23
270	9 SURG		OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE <70 W/O C.C.	.7625	6.3	3.8	21
271	9 MED		SKIN ULCERS	1.2609	14.1	10.1	27
272	9 MED		MAJOR SKIN DISORDERS AGE >69 AND/OR C.C.	.8523	9.5	7.2	24
273	9 MED		MAJOR SKIN DISORDERS AGE <70 W/O C.C.	.7972	9.4	6.5	24
274	9 MED		MALIGNANT BREAST DISORDERS AGE >69 AND/OR C.C.	1.0368	10.9	7.0	24
275	9 MED		MALIGNANT BREAST DISORDERS AGE <70 W/O C.C.	.9882	10.4	5.8	23
276	9 MED		NON-MALIGANT BREAST DISORDERS	.5676	5.4	3.4	19
277	9 MED		CELLULITIS AGE >69 AND/OR C.C.	.8866	9.2	7.3	24
278	9 MED		CELLULITIS AGE 18-69 W/O C.C.	.7594	7.9	6.2	23
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.	.5417	6.4	4.6	22

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 18-69 W/O C.C.	.4468	4.8	3.4	16
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.	.6368	7.0	5.0	22
284	9	MED	MINOR SKIN DISORDERS AGE <70 W/O C.C.	.5172	5.3	3.7	18
285	10	SURG	AMPUTATION OF LOWER LIMB FOR ENDOCRINE,NUTRITIONAL&METABOLIC DIS.	3.2724	28.0	21.5	39
286	10	SURG	ADRENAL + PITUITARY PROCEDURES	2.6731	15.8	13.3	30
287	10	SURG	SKIN GRAFTS + WOUND DEBRIDE FOR ENDOC,NUTRIT + METAB DISORDERS	2.3781	21.5	15.7	33
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1130	12.4	9.7	27
289	10	SURG	PARATHYROID PROCEDURES	1.3308	8.8	6.9	24
290	10	SURG	THYROID PROCEDURES	.8563	5.9	5.0	14
291	10	SURG	THYROGLOSSAL PROCEDURES	.6073	4.2	3.4	11
292	10	SURG	OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE > 69 +/OR C.C.	2.3131	16.7	11.3	28
293	10	SURG	OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE <70 W/O C.C.	1.7962	14.0	8.2	25
294	10	MED	DIABETES AGE =>36	.7454	8.3	6.7	24
295	10	MED	DIABETES AGE 0-35	.7886	6.7	5.0	22
296	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE >69 AND/OR C.C.	.8271	8.3	6.1	23
297	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C.	.6998	7.0	4.9	22
298	10	MED	NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 0-17	.7202	5.3	3.3	18
299	10	MED	INBORN ERRORS OF METABOLISM	.8080	7.7	5.3	22
300	10	MED	ENDOCRINE DISORDERS AGE >69 AND/OR C.C.	.9349	9.2	6.9	24
301	10	MED	ENDOCRINE DISORDERS AGE <70 W/O C.C.	.6882	6.9	5.1	22
302	11	SURG	KIDNEY TRANSPLANT	4.6273	24.6	21.3	38
303	11	SURG	KIDNEY,URETER + MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.7610	16.6	14.2	31
304	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-NEOPL AGE >69 +/OR C.C.	2.0323	13.5	10.8	28
305	11	SURG	KIDNEY,URETER + MAJ BLDR PROC FOR NON-NEOPL AGE <70 W/O C.C.	1.4894	10.4	8.4	25
306	11	SURG	PROSTATECTOMY AGE >69 AND/OR C.C.	1.2595	9.8	8.1	25
307	11	SURG	PROSTATECTOMY AGE <70 W/O C.C.	.9587	7.7	6.5	19
308	11	SURG	MINOR BLADDER PROCEDURES AGE >69 AND/OR C.C.	1.1490	8.8	6.1	23
309	11	SURG	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	.8665	6.7	4.7	22
310	11	SURG	TRANSURETHRAL PROCEDURES AGE >69 AND/OR C.C.	.7266	5.6	4.3	17
311	11	SURG	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	.5563	4.1	3.3	11
312	11	SURG	URETHRAL PROCEDURES, AGE >69 AND/OR C.C.	.7308	5.8	4.4	18
313	11	SURG	URETHRAL PROCEDURES, AGE 18-69 W/O C.C.	.5936	4.7	3.5	14
314	11	SURG *	URETHRAL PROCEDURES, AGE 0-17	.4323		2.3	11
315	11	SURG	OTHER KIDNEY + URINARY TRACT O.R. PROCEDURES	2.7760	15.4	9.8	27

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11 MED		RENAL FAILURE	1.3212	10.0	6.4	23
317	11 MED		ADMIT FOR RENAL DIALYSIS	.4907	3.4	2.3	10
318	11 MED		KIDNEY + URINARY TRACT NEOPLASMS AGE >69 AND/OR C.C.	.9231	8.8	5.5	23
319	11 MED		KIDNEY + URINARY TRACT NEOPLASMS AGE <70 W/O C.C.	.7418	6.6	3.8	21
320	11 MED		KIDNEY + URINARY TRACT INFECTIONS AGE >69 AND/OR C.C.	.8629	8.2	6.5	24
321	11 MED		KIDNEY + URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	.6753	6.4	5.1	19
322	11 MED		KIDNEY + URINARY TRACT INFECTIONS AGE 0-17	.6998	6.4	5.2	19
323	11 MED		URINARY STONES AGE >69 AND/OR C.C.	.5863	5.1	3.7	17
324	11 MED		URINARY STONES AGE <70 W/O C.C.	.4098	3.6	2.8	11
325	11 MED		KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE >69 AND/OR C.C.	.6504	6.5	4.6	22
326	11 MED		KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 18-69 W/O C.C.	.5159	4.9	3.5	16
327	11 MED		KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 0-17	.5511	28.6	3.3	20
328	11 MED		URETHRAL STRICTURE AGE >69 AND/OR C.C.	.5939	5.4	4.0	18
329	11 MED		URETHRAL STRICTURE AGE 18-69 W/O C.C.	.4870	4.1	3.0	12
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.	.8333	7.6	5.4	22
332	11 MED		OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C.	.6740	6.0	4.1	21
333	11 MED		OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 0-17	.7915	5.9	3.7	21
334	12 SURG		MAJOR MALE PELVIC PROCEDURES WITH C.C.	1.8038	13.5	12.3	28
335	12 SURG		MAJOR MALE PELVIC PROCEDURES W/O C.C.	1.4644	11.9	11.0	23
336	12 SURG		TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR C.C.	.9871	7.9	7.0	18
337	12 SURG		TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	.7788	6.3	5.8	12
338	12 SURG		TESTES PROCEDURES, FOR MALIGNANCY	.8907	7.3	4.9	22
339	12 SURG		TESTES PROCEDURES, NON-MALIGNANT AGE >17	.5766	4.4	3.4	12
340	12 SURG	*	TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	.4335		2.4	7
341	12 SURG		PENIS PROCEDURES	.9974	6.4	5.3	16
342	12 SURG		CIRCUMCISION AGE >17	.4266	3.0	2.4	8
343	12 SURG	*	CIRCUMCISION AGE 0-17	.3788		1.7	4
344	12 SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1216	8.3	6.3	23
345	12 SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	.8196	6.5	4.8	22
346	12 MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR C.C.	.8569	8.5	5.6	23
347	12 MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O C.C.	.6441	5.9	3.7	21
348	12 MED		BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR C.C.	.6260	5.6	3.9	19
349	12 MED		BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	.4854	3.9	2.9	12
350	12 MED		INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6270	5.9	4.8	17

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
351	12 MED		STERILIZATION, MALE	.3334	1.9	1.6	5
352	12 MED		OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5388	4.8	3.3	16
353	13 SURG		PELVIC EVISCERATION, RADICAL HYSTERECTOMY + VULVECTOMY	1.8818	14.0	10.8	28
354	13 SURG		NON-RADICAL HYSTERECTOMY AGE >69 AND/OR C.C.	1.2335	9.7	8.8	19
355	13 SURG		NON-RADICAL HYSTERECTOMY AGE <70 W/O C.C.	.9767	7.8	7.4	13
356	13 SURG		FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.8511	7.7	7.0	15
357	13 SURG		UTERUS + ADENEXA PROCEDURES, FOR MALIGNANCY	2.1101	14.9	12.3	29
358	13 SURG		UTERUS + ADENEXA PROC FOR NON-MALIGNANCY EXCEPT TUBAL INTERRUPT	1.1185	8.6	6.9	24
359	13 SURG		INCISIONAL TUBAL INTERRUPTION FOR NON-MALIGNANCY	.5044	3.3	2.7	9
360	13 SURG		VAGINA, CERVIX + VULVA PROCEDURES	.6055	4.8	3.4	16
361	13 SURG		LAPAROSCOPY + ENDOSCOPY (FEMALE) EXCEPT TUBAL INTERRUPTION	.7063	4.8	3.2	17
362	13 SURG		LAPAROSCOPIC TUBAL INTERRUPTION	.3596	2.0	1.8	4
363	13 SURG		D+C,CONIZATION + RADIO-IMPLANT, FOR MALIGNANCY	.6176	4.9	3.6	15
364	13 SURG		D+C,CONIZATION EXCEPT FOR MALIGNANCY	.3922	2.8	2.3	7
365	13 SURG		OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9086	14.0	10.9	28
366	13 MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR C.C.	.8626	8.4	4.9	22
367	13 MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C.	.5354	4.7	2.8	16
368	13 MED		INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.7610	7.8	5.9	23
369	13 MED		MENSTRUAL + OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5498	5.6	3.9	20
370	14 SURG		CESAREAN SECTION WITH C.C.	1.0856	7.9	7.1	16
371	14 SURG		CESAREAN SECTION W/O C.C.	.7670	6.2	5.6	12
372	14 MED		VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	.5945	5.2	4.0	14
373	14 MED		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3538	3.1	2.8	7
374	14 SURG		VAGINAL DELIVERY WITH STERILIZATION AND/OR D+C	.5755	3.7	3.3	8
375	14 SURG	*	VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D+C	.6817		4.4	15
376	14 MED		POSTPARTUM AND POSTABORTION DIAGNOSES W/O O.R. PROCEDURE	.4523	4.9	3.3	16
377	14 SURG		POSTPARTUM AND POSTABORTION DIAGNOSES WITH O.R. PROCEDURE	.7886	4.3	3.3	15
378	14 MED		ECTOPIC PREGNANCY	.7358	5.2	4.3	14
379	14 MED		THREATENED ABORTION	.2409	2.6	1.9	8
380	14 MED		ABORTION W/O D+C	.3609	2.8	1.9	9
381	14 MED		ABORTION WITH D+C, ASPIRATION CURETTAGE, OR HYSTEROTOMY	.3783	2.1	1.7	5
382	14 MED		FALSE LABOR	.1137	1.5	1.2	3
383	14 MED		OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	.4453	4.8	3.4	16
384	14 MED		OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.4586	4.4	2.6	16
385	15	*	NEONATES, DIED OR TRANSFERRED	.6811		1.8	14

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
386	15	*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.6480		17.9	35
387	15	*	PREMATURITY WITH MAJOR PROBLEMS	1.8267		13.3	30
388	15	*	PREMATURITY W/O MAJOR PROBLEMS	1.1571		8.6	26
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	3.2494	17.3	13.7	31
393	16	SURG *	SPLENECTOMY AGE 0-17	1.5206		9.1	26
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS	1.0891	8.0	5.0	22
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7153	6.7	4.7	22
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	.2952	1.7	1.3	4
397	16	MED	COAGULATION DISORDERS	.9971	8.4	5.9	23
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >69 AND/OR C.C.	.9753	8.1	5.5	23
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O C.C.	.7247	6.4	4.2	21
400	17	SURG	LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE	2.6646	16.7	12.8	30
401	17	SURG	LYMPHOMA OR LEUKEMIA WITH OTHER O.R. PROC AGE >69 AND/OR C.C.	1.5902	12.3	8.2	25
402	17	SURG	LYMPHOMA OR LEUKEMIA WITH OTHER O.R. PROCEDURE AGE <70 W/O C.C.	1.0555	8.2	5.6	23
403	17	MED	LYMPHOMA OR LEUKEMIA AGE >69 AND/OR C.C.	1.3279	10.7	6.7	24
404	17	MED	LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C.	1.0449	8.4	5.0	22
405	17	MED *	LYMPHOMA OR LEUKEMIA AGE 0-17	1.0407		4.9	22
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC & C.C.	2.5307	16.8	12.9	30
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C.	1.7127	13.0	9.6	26
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH OTHER O.R.PROC	1.0502	8.3	5.3	22
409	17	MED	RADIOTHERAPY	.9856	10.9	7.0	24
410	17	MED	CHEMOTHERAPY	.4285	3.1	2.4	9
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.5907	5.9	3.8	21
412	17	MED	HISTORY OF MALIGNANCY WITH ENDOSCOPY	.3389	2.4	1.9	6
413	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL Dx AGE>69 +/OR C.C	1.0457	10.7	6.9	24
414	17	MED	OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL Dx AGE<70 W/O C.C.	.8984	9.2	5.4	22
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.3292	20.5	14.7	32
416	18	MED	SEPTICEMIA AGE >17	1.6183	11.7	8.3	25
417	18	MED	SEPTICEMIA AGE 0-17	1.1532	7.6	5.4	22
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0026	9.8	7.5	25
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR C.C.	.9306	8.4	6.1	23
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	.8319	7.5	5.5	23

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED	VIRAL ILLNESS AGE >17	.5674	5.8	4.6	16
422	18	MED	VIRAL ILLNESS + FEVER OF UNKNOWN ORIGIN AGE 0-17	.6582	5.2	3.6	18
423	18	MED	OTHER INFECTIOUS + PARASITIC DISEASES DIAGNOSES	1.3207	11.0	8.0	25
424	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	2.2112	22.1	15.0	32
425	19	MED	ACUTE ADJUST REACT + DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6097	7.6	4.8	22
426	19	MED	DEPRESSIVE NEUROSES	.8330	11.8	7.8	25
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.7019	9.8	6.4	23
428	19	MED	DISORDERS OF PERSONALITY + IMPULSE CONTROL	.8513	11.9	7.4	24
429	19	MED	ORGANIC DISTURBANCES + MENTAL RETARDATION	.8424	11.0	7.6	25
430	19	MED	PSYCHOSES	1.0762	15.5	10.5	28
431	19	MED	CHILDHOOD MENTAL DISORDERS	.8495	10.4	6.6	24
432	19	MED	OTHER DIAGNOSES OF MENTAL DISORDERS	.6969	8.1	4.9	22
433	20		SUBSTANCE USE AND INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	.3906	4.4	2.9	16
434	20		SUBST ABUSE,INTOX INDUCE MNTL SYN EXC DEPEND & OR OTH SYMPT TRT	.7098	8.2	5.4	22
435	20		SUBSTANCE DEPENDENCE, DETOX AND/OR OTHER SYMPTOMATIC TREATMENT	.7980	10.2	6.7	24
436	20		SUBSTANCE DEPENDENCE WITH REHABILITATION THERAPY	1.0166	14.2	9.8	27
437	20		SUBSTANCE DEPENDENCE, COMBINED REHABILITATION AND DETOX THERAPY	1.3276	19.0	14.6	32
438			NO LONGER VALID	.0000			
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7930	15.4	9.0	26
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.0315	15.8	9.3	26
441	21	SURG	HAND PROCEDURES FOR INJURIES	.7305	4.6	2.7	16
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR C.C.	1.8156	10.5	6.1	23
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C.	1.4872	9.4	5.6	23
444	21	MED	MULTIPLE TRAUMA AGE >69 AND/OR C.C.	.7074	7.7	5.4	22
445	21	MED	MULTIPLE TRAUMA AGE 18-69 W/O C.C.	.6015	6.2	4.1	21
446	21	MED	* MULTIPLE TRAUMA AGE 0-17	.4796		2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4471	4.1	2.9	14
448	21	MED	* ALLERGIC REACTIONS AGE 0-17	.3470		2.9	9
449	21	MED	POISONING AND TOXIC EFFECTS OF DRUGS AGE >69 AND/OR C.C.	.6954	6.5	4.7	22
450	21	MED	POISONING AND TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C.	.5422	5.1	3.3	18
451	21	MED	POISONING AND TOXIC EFFECTS OF DRUGS AGE 0-17	.5498	5.0	3.4	20
452	21	MED	COMPLICATIONS OF TREATMENT AGE >69 AND/OR C.C.	.8080	7.0	4.7	22
453	21	MED	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	.7505	6.5	4.3	21
454	21	MED	OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE >69 AND/OR C.C.	.8098	7.5	4.6	22
455	21	MED	OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE <70 W/O C.C.	.6003	6.0	3.5	21

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.8156	11.9	5.5	23
457	22		EXTENSIVE BURNS	7.5688	22.0	8.8	26
458	22	SURG	NON-EXTENSIVE BURNS WITH SKIN GRAFTS	3.9455	26.0	18.9	36
459	22	SURG	NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT + OTHER O.R. PROC	3.2662	20.8	13.5	31
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.1595	11.2	7.5	25
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.3572	10.2	5.3	22
462	23	MED	REHABILITATION	2.1408	24.2	18.0	35
463	23	MED	SIGNS + SYMPTOMS WITH C.C.	.7951	8.0	5.9	23
464	23	MED	SIGNS + SYMPTOMS W/O C.C.	.6948	7.8	5.0	22
465	23	MED	AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	.2882	2.1	1.7	5
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	.4153	4.5	2.7	16
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.7223	7.9	3.9	21
468			UNRELATED OR PROCEDURE	2.4542	17.1	11.7	29
469		**	PDX INVALID AS DISCHARGE DIAGNOSIS	.0000		.0	0
470		**	UNGROUPABLE	.0000		.0	0
471	8	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF THE LOWER EXTREMI	3.8994	23.5	20.9	36

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TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
A. DRG LOGIC ISSUES	
1. In MDC 5 (Diseases and Disorders of the Circulatory System), GROUPER assigns a patient who has had a toe or upper limb amputation to DRG 114 (Upper Limb and Toe Amputation for Circ. Sys. Disorders). If this same patient also has a leg amputated during the same hospital episode, the patient is still assigned to DRG 114, rather than to DRG 113(Amputations for Circ. Sys. Disorders Except Upper Limb and Toe).	Assign a patient to DRG 114 if only a toe or upper limb has been amputated. If the patient also had a leg amputation or any amputation of the lower extremity for circulatory disorders other than a toe, the assignment is DRG 113.
2. In MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), GROUPER assigns a patient who does not have a principal diagnosis of malignancy and who has had an open breast biopsy to DRG 262 (Breast Biopsy and Local Excision for Non-malignancy). If the patient also has, for example, a unilateral simple mastectomy during the same hospital episode, the patient is still assigned to DRG 262 rather than DRG 261 (Breast Proc. for Non-malignancy Except Biopsy and Loc. Excision).	Change the initial search from "Principal Diagnosis of Malignancy" to "Any Diagnosis of Malignancy" and assign those patients who do not have any diagnosis of a breast malignancy and who have a biopsy and local excision only to DRG 262. If the patient also has a breast procedure for nonmalignancy other than a biopsy or local excision, the assignment is DRG 261.
3. Most of the congenital anomaly diagnosis codes are included in the MDC associated with the organ system affected. There are, however, four congenital anomaly codes in MDC 15 (Newborns and Neonates with Conditions Originating in the Perinatal Period) that would be more appropriately included in another MDC as they are not solely used as newborn or neonate diagnoses.	Move diagnosis code 7583 (Autosmal Deletion Snyd.) to MDC 19 (Mental Diseases and Disorders); DRG 429 (Organic Disturbances and Mental Retardation). Move diagnosis code 7584 (Balance Autosom. Transloc.) and diagnosis code 7585 (Autosomal Anomolies NEC) to MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services); DRG 467 (Other Factors Influencing Health Status). Move diagnosis code 7586 (Gonadal Dsygenesis) to MDC 12 (Diseases and Disorders of the Male Reproductive System); DRG 352 (Other Male Reproductive System Diagnoses); and MDC 13 (Diseases and Disorders of the Female Reproduction System); DRG 369 (Menstrual and Other Female Reproductive System Disorders). The MDC assignment is dependent on the sex of the patient.
4. MDC 17 (Myeloproliferative Diseases and Disorders, Poorly Differentiated Neoplasms) differs from all other MDCs with a surgical hierarchy because patients with O.R. procedures are, in some cases, assigned to medical DRGs. That is, patients who had selected O.R. procedures are assigned to certain DRGs and patients who had an O.R. procedure not in the selected list are assigned to the medical DRGs (403-405, 409-414).	Assign patients who have any surgical procedure, other than those listed as major procedures (DRGs 400, 406, and 407), in MDC 17 to DRGs 401, 402, and 408, rather than to the medical DRGs. Consequently, the titles of DRGs 401, 402, and 408 are revised by changing the phrase "Minor O.R. Procedures" to "Other O.R. Procedures."

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
5. DRG 243 (Medical Back Problems) includes diagnosis codes for all type of back pain except code 7241 (Pain in Thoracic Spine), which is assigned to DRG 247 (Signs and Symptoms of Musculoskeletal System and Connective Tissues).	Add diagnosis code 7241 to DRG 243 and remove it from DRG 247.
6. DRG 108 and DRG 109 include cardiothoracic procedures. The distinction is that procedures in DRG 108 (Cardiothoracic Proc., Except Valve and Coronary Bypass, with Pump) are performed with a heart pump and procedures in DRG 109 (Cardiothoracic Procedures Without Pump) are performed without a heart pump. Currently, however, not all procedures in DRG 108 always require the use of a heart pump and procedures in DRG 109 are not always performed without a heart pump.	Combine the O.R. procedures in DRG 108 and DRG 109. The presence of procedure code 3961 (Extracoporeal Circulation) determines whether or not a heart pump was used. If code 3961 is present on the record, assign the patient to DRG 108; if code 3961 is not present, assign to DRG 109.
*7a. Procedure code 36.0 (Remove Coronary Artery Obstruction) is now used almost exclusively to code percutaneous transluminal coronary angioplasty. Code 36.0 is currently assigned to DRG 108 (Cardiothoracic Proc., Except Valve and Coronary Bypass, With Pump), which is considered to be major cardiac surgery with heart pump. Percutaneous transluminal coronary angioplasty is not done with heart pump. However, the open procedure on the coronary artery requiring the use of a heart-lung machine should remain in DRG 108 using the identifying codes combination of 36.0 plus 39.61 (Extracorporal Circulation). The use of resources for these patients is similar to the other patients classified in DRG 108.	a. Move procedure code 36.0 to DRG 112 (Vascular Procedures Except Major Reconstruction). However,if procedure code 36.0 is used in combination with 3961, it is still assigned to DRG 108.
b. Some procedures in DRGs 110 and 111 (Major Reconstructive Vascular Procedures) and DRG 112 (Vascular Procedures Except Major Reconstruction) are performed with a heart pump.	b. If patients currently assigned to DRGs 110, 111 and 112 have procedure code 39.61 present, assign them to DRG 108.
*8a. Presently, diagnosis code 7746 (Fetal/Neonatal Jaundice, NOS) is on the list of complications and comorbidities (CC). It is also listed in MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period); DRG 391 (Normal Newborns) as an incidental problem.	Remove code 7746 from the list of CCs and continue to treat it as an incidental problem for DRG 391.
b. In the past, there have been problems with the assignment of patients to DRG 391 (Normal Newborns) in MDC 15.	A patient is assigned to DRG 391 if the principal diagnosis is from the following list:

V300 Single liveborn-in hosp	V360 Multiple nb/sb-in hosp
V301 Singl livebrn-before adm	V361 Mult nb/sb-before adm
V310 Twin, mate lb-in hosp	V370 Mult birth NOS-in hosp
V311 Twin, mate lb-before adm	V371 Mult brth NOS-before adm
V320 Twin, mate sb-in hosp	V390 Liveborn NOS-in hosp
V321 Twin, mate sb-before adm	V391 Liveborn NOS-before adm
V330 Twin NOS-in hospital	7624 Prolapsed cord aff nb
V331 Twin NOS-before admissn	7625 Oth umbil cord compress
V340 Oth multiple nb-in hosp	7626 Umbil cord NEC aff nb
V341 Oth mult nb-before adm	7630 Breech del/extrac aff nb
V350 Oth multiple sb-in hosp	7631 Malpos/dispro NEC aff nb
V351 Oth mult sb-before adm	7632 Forceps delivery aff nb

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
	7633 Vacuum extrac del aff nb 7636 Precipitate del aff nb 7639 Compl deliv NOS aff nb 7660 Exceptionally large baby 7661 Heavy-for-date infan NEC 7662 Post-term infant NOS 7671 Scalp injury at birth 7686 Mild/mod birth asphyxia 7746 Fetal/neonatal jaund NOS 7788 Nb integument cond NEC A patient is assigned to DRG 391, if there is a principal diagnosis from the list above and there is no secondary diagnosis or all secondary diagnoses are from the following: V300 Single liveborn-in hosp V301 Singl livebrn-before adm V310 Twin, mate lb-in hosp V311 Twin, mate lb-before adm V320 Twin, mate sb-in hosp V321 Twin, mate sb-before adm V330 Twin NOS-in hosp V331 Twin NOS-before admissn V340 Oth multiple nb-in hosp V341 Oth mult nb-before adm V350 Oth multiple sb-in hosp V351 Oth mult sb-before adm V360 Multiple nb/sb-in hosp V361 Mult nb/sb-before adm V370 Mult birth NOS-in hosp V371 Mult brth NOS-before adm V390 Liveborn NOS-in hosp V391 Liveborn NOS-before adm V502 Routine circumcision V703 Med exam NEC-admin purposes V773 Screen-phenylketonuria 605 Redun prepuce phimosis 6869 Local skin infection NOS 6910 Diaper or napkin rash 7624 Prolapsed cord aff nb 7625 Oth umbil cord compress 7626 Umbil cord NEC aff nb 7630 Breach del/extrac aff nb 7631 Malpos/dispro NEC aff nb 7632 Forceps delivery aff nb 7633 Vacuum extrac del aff nb 7636 Precipitate del aff nb 7639 Compl deliv NOS aff nb 7660 Exceptionally large baby 7661 Heavy-for-date infan NEC 7662 Post-term infant NOS 7671 Scalp injury at birth 7686 Mild/mod birth asphyxia 7746 Fetal/neonatal jaund NOS 7788 Nb integument cond NEC Therefore, the branching criteria on the tree diagram in MDC 15 changes from "Normal Newborns Without Significant Secondary Diagnosis" to "Normal Newborns Without Any Significant Complicating Diagnosis."
9. Diagnosis codes 1946 (Malig. Neopl. Paraganglia NEC), 2276 (Benign neopl. paraganglia), and 2373 (Unc. Behav. Neo. Paragang.) are in MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) while other related diagnoses are in MDC 1 (Diseases and Disorders of the Nervous System).	Add diagnosis codes 1946, 2276, and 2373 to MDC 1 (DRGs 10 and 11) and remove from MDC 10.
10. Diagnosis code 9968 (Complication Transplanted Organ) is assigned to MDC 21 (Injury, Poisoning and Toxic Effects of Drugs). Since this code relates to any transplanted organ, it cannot be assigned to an organ specific MDC. Currently, codes 5051 (Ancillary Liver Transplant) and 5059 (Liver Transplant) are allowed with MDC 21 and assigned to DRG 442 and DRG 443 (Other O.R. Procedures for Injuries). Payment for these DRGs is inadequate for the procedure. All other transplant procedures associated with rejected organs are grouped to DRG 468.	Remove procedure codes 5051 and 5059 from MDC 21 (DRG 442 and DRG 443) and allow assignment to DRG 468.

TABLE 6 – CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
11. Procedure code 5494 (Create Peritoneal Vascular Shunt) is a major shunt procedure, yet it is DRG 201 (Other Hepatobiliary or Pancreas O.R. Procedures) and not in DRG 191 (Major Pancreas, Liver and Shunt Procedures).	Add procedure code 5494 to DRG 191 and remove it from DRG 201.
12. Diagnosis code 4565 (Pelvic Varices) is assigned only to MDC 13 (Diseases and Disorders of the Female Reproductive System. This diagnosis code is also applicable to MDC 12 (Diseases and Disorders of the Male Reproductive System).	Add diagnosis code 4565 (Pelvic Varices) to MDC 12, DRG 352 (Other Male Reproductive System Diagnoses).
13. Procedure code 031 (Division Intraspinal Nerve Root) is applicable to neck and back procedures and therefore should also be assigned to MDC 8 (Disease and Disorder of the Musculosketetal Sep. and Connective Ties.)	Add procedure code 031 (Division Intraspinal Nerve Root) to MDC 8, DRGS 214 and 215 (Back and Neck Procedures).
14. DRG 209 (Major Joint Procedures) does not adequately distinguish multiple joint procedures from single joint procedures.	Create DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) to include any combination of two or more of the following procedure codes: 8141, 8148, 8151, 8159, 8161, 8162, 8163, and 8164.
15. DRGs 434 through 438 do not adequately reflect substance dependence detoxification and rehabilitation treatment.	Revise DRGs 434 through 438 as follows: Move all diagnosis codes in DRGs 435, 437, and 438 (except diagnosis codes 2910, 2913, 2918, 2919, 2920, 30300, 30301, 30302, 30303, and 30390) to DRG 434 (Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence). Move all diagnosis codes in DRGs 434 and 436 and diagnosis codes 2910, 2920, 30300, 30301, 30302, 30303, and 30390 to DRGs 435, 436, and 437. Move diagnosis codes 2913, 2918, and 2919 to DRG 435. Diagnosis procedure code V57.89 must be present for a case to be assigned to DRG 436. Diagnosis procedure codes V57.89 and 94.25 must be present for a case to be assigned to DRG 437. Delete DRG 438.
*16. Patients with a principal diagnosis of diabetes mellitus with manifestations in an organ system other than the endocrine system (that is, renal circulatory, or neurologic) currently group to DRG 468 (Unrelated O.R. Procedure) when they undergo a procedure that is properly assigned to the MDC of the organ system that is affected.	Move "diabetes with manifestation of ..." codes to the MDC for the manifestation as follows: a. Move diabetes with renal manifestations (250.40 and 250.41) from DRGs 294 and 295 in MDC 10 to DRGs 331, 332, and 333 in MDC 11. For example, if the diagnosis of 250.40 or 250.41 and procedure 55.69 (Kidney Transplant), the case will group to DRG 302. b. Move diabetes with neurological manifestations (250.60 and 250.61) from DRGs 294 and 295 in MDC 10 to DRGs 18 and 19 in MDC 1. Move diabetes with circulatory manifestations (250.70 and 250.71) from DRGs 294 and 295 in MDC 10 to DRGs 130 and 131 in MDC 5. c. Diabetes with ophthalmic manifestations (250.50 and 250.51) is already in MDC 2.

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
**17. Procedure Code 57.33 (Transurethral biopsy of bladder) should be added as a valid code for MDC 12- Diseases and Disorders of the Male Reproductive System and MDC-13 Diseases and Disorders of the Female Reproductive System.	Add procedure code 57.33 to MDC 12, DRGs 344 and 345 (Other Male Reproductive System O.R. Procedures) and also to MDC 13-Diseases and Disorders of the Female Reproductive System, DRG 365 (Other Female Reproductive System O.R. Procedures). Procedure code 57.33 remains in its current assignment, DRGs 310 and 311 (Transurethral Procedures), as well.
**18. Since code 724.1 (Pain in Thoracic Spine) will be transferred from DRG 247 to DRG 243, in order to consistently classify all back symptoms to the same DRG, it is recommended that code 724.8 (Other unspecified back disorders) also be transferred from DRG 247 to DRG 243.	Add diagnosis code 724.8 to DRG 243 (Medical Back Problems) and remove from DRG 247 (Signs and Symptoms of Musc Sys. and Conn. Tissue.)
**19. Procedure 77.28 (wedge osteotomy of tarsals and metatarsals) done for Keratoderma plantaris improperly codes to DRG 468. This procedure appears in DRG 225 (Foot Procedures) but it should also be listed in DRGs 269 and 270 (Other Skin Subcutaneous Tissue and Breast O.R. Procedures).	Add procedure code 77.28 to MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), DRGs 269 and 270.
**20. Procedure codes 6952 (Aspiration curettage following delivery or abortion) and 7491 (Hysterotomy to terminate pregnancy) are not delivery codes. Therefore, they should not be in DRG 375 (Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C). These codes should be added to DRG 381 (Abortion with D&C). Correspondingly, aspiration curettage is considered to be a procedure generally performed in the operating room.	Add procedure codes 6952 and 7491 to DRG 381 (Abortion with D&C) and remove procedure code 7491 from DRG 375. Also add 6952 to the list of O.R. Procedures.
**21. If performed, an appendectomy procedure is an incidental procedure for DRG 365 (Other Female Reproductive Sys O.R. Procedures).	Remove procedure code 470 (Appendectomy) from DRG 365 and replace it with procedure code 471 (Incidental Appendectomy).
**22. The diagnosis code 228.1 (Lymphangiona, any site) should be classified in MDC 16 (Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders) and not in its current MDC 5 (Circulatory System) assignment. This was an inadvertent misclassification made during the original DRG classification process.	Move diagnosis code 228.1 to DRGs 398 and 399 (Reticuloendothelial and Immunity Disorders) and remove it from MDC 5.

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
B. OPERATING ROOM vs NON-OPERATING ROOM ASSIGNMENT	
1. Procedure code 3786 (Remove Cardiac Pacemaker) is used for the removal of both a temporary pacemaker and a permanent pacemaker. Presently, this code appears on the list of operating room procedures and, when coded, results in assignment to one of the operative pacemaker DRGs. In general, the removal of a temporary pacemaker is not performed in the operating room. If a permanent pacemaker is removed, then usually a replacement pacemaker is inserted. In that case, the reinsertion is coded and the patient is assigned to the appropriate DRG. The current operating room procedures, listed below, are also considered to be procedures not generally performed in the operating room. 8623 (Removal of nail) 5499 (Abdomen region operation, NEC) 3996 (Total body perfusion) 5196 Percutaneous Extraction of common duct stones)	Remove codes 3786, 8623, 5499, 3996, and 5196 from the list of operating room procedures and from the DRGs to which they are currently assigned.
2. Procedure codes 6813 (Uterine Biopsy) and 7076 (Hymenorrhaphy) are generally performed in an operating room and therefore should be assigned to the list of O.R. procedures.	Add procedure codes 6813 (Uterine biopsy) and 7076 (Hymenorrhaphy) to the list of O.R. procedures and to MDC 13, DRG 360 (Vagina, cervix and vulva procedures).
**3. Procedure code 3961 (Extracorporeal circulation) is performed in conjunction with another operating procedure, and is not generally considered the only procedure performed.	Remove procedure code 3961 from the list of O.R. procedures.
C. COMPLICATION AND COMORBIDITY MEMBERSHIP	
*1. A number of diagnostic codes should be added to the list of complications and comorbidities.	Add the following diagnosis codes to the list of complications and comorbidities: 25090 Diab w compl NOS adult 25091 Diab w compl NOS juven 64820 Anemia compl preg 64821 Anemia - delivered 64822 Anemia - delivered w P/P 64823 Anemia - antepartum 64824 Anemia - postpartum 87272 Open wnd ossicles-comp 87273 Open wnd eustach tb-comp 87274 Open wound cochlea-comp 87333 Open wnd nas sinus-compl 8743 Open wound thyroid-compl 8745 Open wound pharynx-compl 8870 Amput below elb, unilat 8871 Amp below elb, unil-comp 8872 Amput abv elbow, unilat 8873 Amput abv elb, unil-comp 8874 Amputat arm, unilat NOS 8875 Amputat arm, unil NOS-comp 8876 Amputation arm, bilat 8877 Amputat arm, bilat-compl 8960 Amputation foot, unilat 8961 Amput foot, unilat-compl 8962 Amput foot, bilat 8963 Amputat foot, bilat-comp 8970 Amput below knee, unilat 8971 Amputat bk, unilat-compl 8972 Amput above knee, unilat 8973 Amput abv kn, unil-compl 8974 Amputat leg, unilat NOS 8975 Amput leg, unil NOS-comp 8976 Amputation leg, bilat 8977 Amputat leg, bilat-compl
**2. Diagnosis transient hypertension of pregnancy-unspecified (code 64230) and transient hypertension of pregnancy - antepartum (code 64233) are not significant antepartum complications.	Remove diagnosis codes 64230 and 64233 from the list of medical complications for DRG 383 (Other Antepartum Diag with Medical Complications).

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
D. SURGICAL HIERARCHY AND WEIGHT ISSUES 1. When a cataract operation is performed, the patient is assigned to DRG 39 (Lens Procedure). If a vitrectomy or anterior chamber injection or evacuation is performed during the cataract operation, and coded accordingly, the patient is assigned to DRG 42 (Intraocular Procedures Except Retina, Iris and Lens). This is because vitrectomies and anterior chamber procedures are higher than lens procedures in the surgical hierarchy. However, the process of removing a small amount of vitreous or an injection or evacuation from the anterior chamber during a cataract operation is incidental to the lens extraction and the DRG assignment, therefore, should be for the lens extraction, not for the higher weighted vitrectomy or anterior chamber.	If a lens procedure only or a lens procedure and one of the following procedures is performed, assign to DRG 39. 1291 Therapeut Evac Ant Chamber) 1292 Anterior Chamber Inject. 1471 Anterior Removal Vitreous 1472 Vitreous Removal NEC 1473 Anterior Mechan Vitrect. 1474 Mechan Vitrectomy 1475 Vitreous Substitut Inject. 1479 Vitreous Operation NEC If any of the procedures listed above are performed without a lens procedure, assign to DRG 42.
2. There has been concern regarding the DRG surgical hierarchy in MDC 6 (Diseases and Disorders of the Digestive System). The position of Peritoneal Adhesiolysis, DRG 150-151, in relation to Minor Small and Large Bowel Procedures, DRG 152-153, and Hernia Procedures, DRG 159-163 is of particular concern. Analysis of HCFA average LOS and average charge data for the surgical DRGs in MDC 6 supports modification of the surgical hierarchy for MDC 6.	Change MDC 6 surgical hierarchy as follows: MDC 6-Diseases and Disorders of the Digestive System DRG 146-147 Rectal Resection DRG 148-149 Major Small and Large Bowel Procedures DRG 154-156 Stomach, Esophageal and Duodenal Procedures DRG 150-151 Peritoneal Adhesiolysis DRG 152-153 Minor Small and Large Bowel Procedures DRG 164-167 Appendectomy DRG 159-163 Hernia Procedures DRG 157-158 Anal Procedures DRG 168-169 Procedures in the Mouth DRG 170-171 Other Digestive System O.R. Procedures
**3. Analysis of HCFA average LOS and average charge data supports modification of the following MDCs:	
MDC 8 (Diseases and Disorders of the Musculoskeletal and Connective Tissues) wound debridement should be placed above amputations.	a. Place wound debridement above amputation in the surgical hierarchy for MDC 8.
MDC 9 (Diseases and Disorders of the Skin and Subcutaneous Systems) skin grafts should be placed above breast procedures.	b. Place skin grafts above breast procedures in the surgical hierarchy for MDC 9.
MDC 12 (Diseases and Disorders of the Male Reproductive System) penis procedures should be placed above transurethral resections.	c. Place penis procedures above transurethral prostatectomy in the surgical hierarchy for MDC 12.
**4. New DRG 471 (Bilateral or Multiple Joint Procedures of the Lower Extremity) should be included only in MDC 8 - Diseases and Disorders of the Musculoskeletal System, and should acquire the first position in the surgical hierarchy for MDC 8, before Major Joint and Limb Reattachment Procedures.	DRG 471 is to be included in MDC 8 only and acquires the first position in the surgical hierarchy for the MDC.

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
*E. DRG 468 Patients are assigned to DRG 468 (Unrelated O.R. Procedure) when all the operating room procedures are unrelated to the MDC of the patients' principal diagnosis. There appears to be a need to update certain DRGs by including O.R. procedures that could possibly be performed for diagnoses within the MDC, so patients would no longer be assigned to DRG 468.	Add the following list of O.R. procedures, listed by MDC, to the DRG specified: MDC 01 - Diseases and Disorders of the Nervous System DRG 4 (Spinal procedures) 7781 Oth chest cage ostectomy 7791 Tot chest cage ostectomy DRG 5 (Extracranial vascular procedures) 3832 Head/neck ves resec-anas 3929 Vasc shunt and bypass NEC 3930 Suture of vessel NOS 3931 Suture of artery 3932 Suture of vein 3956 Repair vess w tis patch 3957 Rep vess w synth patch 3958 Repair vess w patch NOS 3959 Repair of vessel NEC 398 Vascular body operations 3992 Vein inject-scleros agnt DRGs 7 and 8 (Peripheral and cranial nerve and other nervous sys. procs.) 0719 Endocrine dx proc NEC 0780 Thymectomy NOS 0781 Part excision of thymus 0782 Total excision of thymus 0851 Canthotomy 0852 Blepharorrhaphy 0859 Adjust lid position NEC 8131 Foot arthroplas w prosth 8139 Foot/toe arthroplast NEC 8171 Hand arthroplas w prosth 8179 Hand arthroplasty NEC 8186 Carpal arthropl-syn pros 8187 Wrist arthroplasty NEC 8313 Other tenotomy 8314 Fasciotomy 8319 Soft tissue division NEC 8321 Soft tissue biopsy 8341 Tendon excision for grft 8343 Musc/fasc excis for grft 8345 Other myectomy 8349 Other soft tissue excis 8681 Repair facial weakness MDC 02 - Diseases and Disorders of the Eye DRG 37 (Orbital procedures) 7679 Open reduct face fx NEC 7691 Bone graft to face bone 7692 Syn implant to face bone 7646 Facial bone reconstr NEC DRG 38 (Primary iris procedures) 1273 Cyclophotocoagulation DRG 39 (Lens Procedures) 1301 Removal of foreign body from lens with magnet

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
	DRGs 40 and DRG 41 (Extraocular procedures except orbit)
	864 Radical excis skin les
	MDC 03 - Diseases and Disorders of the Ear, Nose and Throat
	DRG 55 (Miscellaneous ear, nose and throat procs.)
	0609 Incis thyroid field NEC
	0912 Lacrimal sac biopsy
	0919 Lacrimal sys dx proc NEC
	0981 Dacryocystorhinostomy
	0999 Lacrimal system op NEC
	DRG 63 (Other ear, nose and throat O.R. procs.)
	0474 Periph nerv anastom NEC
	0475 Postop revis per nerv op
	0476 Late repair per nerve inj
	1652 Orbit exent w bone remov
	1665 2ndry exent cavity graft
	1666 Revis exenter cavity NEC
	1698 Operation on orbit NEC
	7779 Excise bone for gft NEC
	MDC 04 - Diseases and Disorders of the Respiratory System
	DRGs 76 and 77 (O.R. proc. on the resp. sys. except major chest with O.R.)
	5012 Liver biopsy NEC
	8321 Soft tissue biopsy
	MDC 05 - Diseases and Disorders of the Circulatory System
	DRG 120 (Other O.R. procedures)
	251 Destruction tongue les
	863 Other local destruc skin
	5591 Renal decapsulation
	MDC 06 - Diseases and Disorders of the Digestive System
	DRGs 146 and 147 (Rectal resection)
	688 Pelvic evisceration
	DRGs 152 and 153 (Minor small and large bowel procs.)
	5684 Close ureter fistula NEC
	5783 Repair rectovesical fistula
	6942 Closure uterine fistula
	7075 Repair vag fistula NEC
	7172 Repair vulvar fistula
	DRGs 154, 155, and 156 (Stomach, esophageal and duodenal procs.)
	293 Ex. or destr. of lesion or tissue of pharynx
	3173 Trachea fistula clos NEC
	3805 Thoracic vessel resect/anast
	3835 Thor vessel resec/anast
	3845 Thor ves resect w replac
	3865 Thoracic vessel excision
	3885 Occlude thoracic ves NEC
	5183 Pancreat sphincteroplas
	527 Rad pancreaticoduodenect
	DRGs 170 and 171 (Other digestive procedures)
	3804 Incision of aorta
	3949 Vasc. proc revision NEC
	3991 Freeing of vessel
	5103 Cholescystostomy NEC
	MDC 07 - Diseases and Disorders of the Hepatobiliary System and Pancreas
	DRG 201 (Other Hepatobiliary or Pancreas O.R. Procedure)
	4439 Gastroenterostomy

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
	MDC 08 - Diseases and Disorders of the Musculoskeletal Sys. and Connective Tiss.
	DRG 217 (Wound debridement and skin graft exc. hand)
	8665 Heterograft to skin
	8666 Homograft to skin
	8671 Cut. prep. ped graft
	8672 Pedicle graft advancement
	DRGs 233 and 234 (Other musculoskel. sys. and connect. tiss. O.R. procs.)
	1651 Radical orbitomaxillect
	1659 Orbital exenteration NEC
	2172 Open reduction nasal fx
	2262 Exc max sinus lesion NEC
	3327 Other lung biopsy
	3481 Excise diaphragm lesion
	4051 Rad dissec axillary node
	4052 Rad dissec periaort node
	4053 Rad dissect illac nodes
	4054 Radical groin dissection
	4059 Rad node dissection NEC
	5900 Retroperit dissect NOS
	6241 Remove both testes
	DRGs 226 and 227 (Soft tissue procedures)
	543 Destruc abdom wall les
	864 Radical excis skin les
	8681 Repair facial weakness
	MDC 09 - Diseases and Disorders of the Skin, Subcutaneous Tissue & Breast
	DRG 268 (Skin, subcutaneous tissue and breast plastic procs.)
	0838 Correct lid retraction
	2755 Full-thick grft to mouth
	2756 Skin graft to mouth NEC
	2769 Oth plastic repair palat
	8289 Hand plastic op NEC
	DRGs 269 and 270 (Other skin, subcutaneous tissue and breast O.R. procs.)
	0609 Incis thyroid field NEC
	0722 Unitateral adrenalectomy
	073 Bilateral adrenalectomy
	0763 Part excis pituitary NOS
	0764 Tot exc pituit-transfron
	0765 Tot exc pituit-transsphen
	0768 Total exc pituitary NEC
	0769 Total exc pituitary NOS
	0772 Pituitary gland incision
	0779 Pituitary operation NEC
	0823 Exc major les lid, part-thick
	6561 Remove both tubes and ovar
	6711 Endocervical biopsy
	6712 Cervical biopsy NEC
	6719 Cervical dx procedur NEC
	6739 Cervical les destruc NEC
	7024 Vaginal biopsy
	7111 Vulvar biopsy
	7119 Vulvar diagnos proc NEC
	MDC 10 - Endocrine, Nutritional and Metabolic Diseases and Disorders
	DRGs 292 and 293 (Other endocrine, nutritional and metabolic O.R. procs.)
	3426 Other mediastinal biopsy

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
	3802 Head/neck ves incis NEC
	3829 Blood vessel dx proc NEC
	3830 Vessel resect/anest NOS
	3833 Arm vessel resect/anast
	3838 Leg artery resect/anast
	3843 Arm ves resect w replace
	3848 Leg artery resec w repla
	3855 Thorac var v lig-strip
	3863 Arm vessel excision
	3868 Leg artery excision
	3883 Occlude arm vessel NEC
	3888 Occlude arm vessel NEC
	3925 Aorta-iliac-femor bypass
	3931 Suture of artery
	3941 Postop vasc op hem contr
	3949 Vasc proc revision NEC
	3956 Repair vess w tis patch
	3957 Rep vess w snyth patch
	3958 Repair vess w patch NOS
	3959 Repair of vessel NEC
	3991 Freeing of vessel
	544 Destruct peritoneal tiss
	MDC 11 - Diseases and Disorders of the Kidney and Urinary Tract
	DRGs 310 and 311 (Transurethral Procedures)
	6012 Other biopsy of prostate
	DRG 315 (Other kidney and urinary tract O.R. procs.)
	0681 Total Parathyroidectomy
	0689 Other parathyroidectomy
	3806 Abdomen artery incision
	3807 Abdominal vein incision
	3816 Abdominal endarterectmy
	3836 Abd vessel resect/anast
	3837 Abd vein resect and anast
	3846 Abd artery resc w repla
	3847 Abd vein resect w replac
	3866 Abdominal artery excis
	3867 Abdominal vein excision
	3886 Occlude abd artery NEC
	3887 Occlude abd vein NEC
	3952 Aneurysm repair NEC
	3956 Repair vess w tis patch
	3957 Repair vess w synth patch
	3958 Repair vess w patch NOS
	3959 Repair of vessel NEC
	5493 Create cutaneoperiton fist
	8622 Wound debridement
	MDC 12 - Diseases and Disorders of the Male Reproductive System
	DRGs 334 and 335 (Major male pelvic procs.)
	4869 Rectal resection NEC
	5411 Exploratory laparotomy
	DRGs 344 and 345 (Other male reproductive Sys. O.R. procs.)
	5641 Partial ureterectomy
	5751 Excision of urachus

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
	MDC 13 - Diseases and Disorders of the Female Reproductive System
	DRG 360 (Vagina, cervix and vulva-procedures)
	4873 Closure of other rect fistula
	7023 Cul-de-sac biopsy
	7029 Vagin/cul-de-sac dx NEC
	7119 Vulvar diagnos proc NEC
	DRG 365 (Other female reproductive system O.R. procs.)
	5641 Partial ureterectomy
	5734 Bladder biopsy NEC
	5751 Excision of urachus
	5759 Open Ex or dest oth les ortis of blad
	576 Partial cystectomy
	5771 Radical cystectomy
	5779 Total cystectomy
	5902 Oth lys of periter adhes
	5909 Perirenal/ureterexc NEC
	5919 Oth incis of perives tiss
	7012 Culdotomy
	MDC 14 - Pregnancy, Childbirth and the Puerperium
	DRG 374 (Vaginal delivery with sterilization and/or O.C.)
	6697 Bury fimbriae in uterus
	DRG 375 (Vaginal delivery with O.R. proc. except steril. and/or D.C.)
	387 Plication of vena cava
	4024 Excise inguinal node
	403 Regional lymph node exc
	5411 Exploratory laparotomy
	5421 Laparoscopy
	680 Hysterotomy
	MDC 16 - Blood, Blood Forming Organs and Immunological Diseases and Disorders
	DRG 394 (Other O.R. procs. of the blood and blood forming organs)
	400 Incis lymphatic structur
	MDC 17 - Myeloproliferative Diseases and Poorly Differentiated Neoplasms
	DRG 400 (Lymphoma or leukemia with major O.R. proc.) and
	DRGs 406 and 407 (Myeloprolif, disord. or poorly diff. neopl. with maj. O.R. With C.C.)
	3229 Destroy loc lung les NEC
	343 Destruct mediastin les
	0371 Spin subarach-peritoneal shunt
	0372 Spin subarach-ureteral shunt
	0379 Other shunt spinal theca
	410 Bone marrow transplant

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
MDC 21 - Injury, Poisoning and Toxic Effects of Drugs	
DRGs 442 and 443 (Other O.R. procedures for injuries)	
0141	Thalamus operations
0201	Linear craniectomy
0444	Tarsal tunnel release
0780	Thymectomy NOS
0781	Part excision of thymus
0782	Total excision of thymus
0791	Thymus field exploration
0792	Incision of thymus
0793	Repair of thymus
100	Remov embed FB conjunct w incis
110	Magnet remov embed FB cornea
111	Corneal incision
1372	Secondary insert lens
138	Implanted lens removal
139	Other operations on lens
1839	Excis external ear NEC
214	Resection of nose
2169	Turbinectomy NEC
245	Alveoloplasty
2792	Mouth incision NOS
2799	Oral cavity ops NEC
287	Hemorr contri post T and A
2891	Incis to remov tonsil FB
290	Pharyngotomy
294	Plastic op on pharynx
2953	Closure pharynx fistula NEC
2959	Pharyngeal repair NEC
2999	Pharyngeal operation NEC
301	Hemilaryngectomy
3021	Epiglottidectomy
3022	Vocal cordectomy
3029	Other part laryngectomy
303	Complete laryngectomy
3173	Trachea fistula clos NEC
3199	Other tracheal operation
321	Other bronchial excision
330	Incision of bronchus
331	Incision of lung
3392	Bronchial ligation
3398	Bronchial operation NEC
3399	Lung operation NEC
341	Incision of mediastinum
3421	Transpleura thoracoscopy
3489	Diaphragm operation NEC

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION	
	3499	Thoracic operation NEC
	3711	Cardiotomy
	537	Abd repair-diaphr hernia
	5380	Thor rep-diaph hern NOS
	5381	Diaphragmatic plication
	5382	Parastern hernia repair
	5553	Rejected kidney nephrect
	5554	Bilateral nephrectomy
	576	Partial cystectomy
	5779	Total cystectomy NEC
F. DOCUMENTATION ISSUES		
1. Some of the language in the DRG documentation is not completely descriptive of the classification of cases.	Make the following changes to the DRG documentation:	

- Update MDC tree diagrams to reflect the surgical hierarchy of each MDC. The tree diagrams have each surgical group ordered from top to bottom in hierarchical order. Since DRG numbers are not changed, the trees no longer increase in numerical order from left to right.
- In the medical partitioning section of MDC 5 (Diseases and Disorders of the Circulatory System), change the labels to better define the list of "Cardiovascular Complications" and "Complex Cardiovascular Diagnoses."
- Remove procedure codes 431 (Temporary Gastrostomy) and 7022 (Culdoscopy) from the list of operating room procedures in MDC 3 and MDC 14, respectively. These codes do not appear in the list of operating room procedures and are not considered by GROUPER to be operating procedures.
- The title of the branching criteria in the tree diagram for DRG 115 (Permanent Cardiac Pacemaker Inplant with AMI or CHF) is changed from "Principal Diagnoses of AMI or CHF" to "Principal Diagnoses of AMI, Heart Failure or Shock."
- The title of the branching criteria in the tree diagram for DRGs 164 and 165 (Appendectomy With a Complicated Principal Diagnoses) is changed from "Complicated Diagnosis" to "Complicated Principal Diagnosis."
- The title of the branching criteria in the tree diagram for DRG 303 (Kidney, Ureter and Major Bladder Proc. for Neoplasm) is changed from "Principal Diagnosis of Malignancy" to "Principal Diagnois of Neoplasm.

These changes are editorial in nature and do not affect in any way the classification of cases.

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
**2. Some of the operating room and nonoperating room codes are erroneously listed.	Make the following changes: * Remove operating room procedures 3421, 3422, and 5421 from the nonoperating room procedure listing for DRG 412 (History of Malignancy With Endoscopy) * Remove nonoperating room code 431 from the list of operating room procedures for DRG 63 (Other Ear, Nose and Throat O.R. Procedures). * Remove nonoperating room code 7022 from the list of operating room procedures for DRG 375 (Vaginal Delivery With O.R. Procedure Except Sterilization and/or D and C).

* These items have been revised based on public comments.
** These items have been added to the table based on public comments.

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Appendix—Regulatory Impact Analysis

A. Introduction

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any major rule. A major rule is defined as any regulation that is likely to result in: (1) An annual effect on the economy of $100 million or more, (2) a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions, or (3) 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. Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we also prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations would not have a significant economic impact on a substantial number of small entities.

Several provisions of this final rule will exceed the $100 million threshold under E.O. 12291. Therefore, we are including an impact analysis that contains a discussion of each significant change. In our summary, we discuss the expected net effects resulting from these changes.

Under the RFA, we treat all hospitals as small entities. It is clear that the changes contained in this final rule will affect all hospitals, and the effects on some may be significant. Therefore, we are providing a regulatory flexibility analysis.

The discussion below, in combination with the preamble of this final regulation, constitutes a combined regulatory impact analysis and regulatory flexibility analysis meeting the requirements of E.O. 12291 and the RFA.

B. Objectives

We expect the changes contained in this rule to further our original objectives in implementing the prospective payment system, which include:

- Creating incentives for efficiency, which translates into lower rates of increase in hospitals' costs and reduction of expenditures from the Medicare trust fund;
- Basing payment on a system that identifies the product being purchased more accurately than cost reimbursement; and
- Reinforcing the role of the Federal Government as a prudent buyer of services.

We believe these regulations will further our goals while maintaining the financial viability of the hospital industry and assuring access to high quality care for beneficiaries.

We expect these changes to further our objectives while avoiding or minimizing unintended adverse consequences and ensuring that outcomes of this payment system, in general, are reasonable and equitable. Thus, the intent is to refine further the prospective payment system without undercutting our objectives.

C. Problems of Impact Quantification and Attributing Causality

In previously published interim and final rules, we discussed the objectives and impacts of the rules largely in general conceptual terms. We did not always have adequate data, analytic resources, or time to perform a detailed quantitative impact analysis of particular provisions for publication with these previous rules. However, we did solicit comments and information that would enable us to describe and quantify better the anticipated effects of the Medicare prospective payment system.

As noted in the NPRM, we still have no adequate way to model potential behavioral changes on the part of hospitals, hospital managers and employees, physicians, suppliers, or beneficiaries. Much of the available Medicare program data reflect only patterns and trends of utilization and payment. Also, much of our data still reflects hospital behavior under cost reimbursement. Where it is feasible and appropriate, we have used these data to model and analyze the effects of particular proposals. Nonetheless, any of the quantitative estimates given below should be viewed with a qualified recognition of the limitations of the data on which they are based.

A second problem that limits our ability to quantify the effects of this rule is attributing the causation of particular changes in the hospital industry directly to specific statutory or regulatory provisions. This is made especially difficult by the changing nature of the health care sector. The prospective payment system is but one of numerous efforts aimed at controlling rapidly rising health care costs. In many cases, then, it may be difficult to determine the extent that the prospective payment system, or some other initiative, caused the result, or whether two (or more) initiatives caused the result interactively.

Apart from the more easily identifiable initiatives that are affecting the health care market, especially on the demand side, changes also have been occurring on the supply side. Most notable of the latter, is the increase in the supply of physicians, which enhances the competition for patients among providers. There has also been a significant growth of facilities furnishing out-of-hospital treatment. For example, since 1973, 2,000 ambulatory care clinics have opened. There are currently about 300 ambulatory surgical centers participating in Medicare, with another 100 awaiting approval. In addition, home health services are the fastest growing component of the Medicare program.

The multiple changes in the health care system require the use of caution in attributing positive or adverse effects to one or another initiative or policy change. However, the incentives provided by prospective payment are identifiable, and the system has been implemented and is revised on a regular schedule. Therefore, it is possible to attribute some of the effects resulting from this payment system to the system itself and to changes to its structure.

Comment: Several commenters expressed dissatisfaction with the degree and extent of analysis published in the NPRM. For example, one commenter felt that the summary table showing relative (percent) impacts (50 FR 24438) was not specific enough; the commenter believes that we should have examined and presented the impact of recalibration on specific hospitals. Several commenters argued that the effects of reclassifying DRGs should have been separately identified and presented.

Response: We disagree with commenters who claim that we should publish an analysis of the impact of recalibration or any other changes on specific hospitals. E.O. 12291 and the RFA require us to identify affected entities in general. An analysis of potential effects on specific entities would go substantially beyond those requirements. Further, we believe that the lower the level of aggregation of the data available to us, and the more specific the focus of analysis of that data, the less reliable are the results.

We have tried to present an analysis of impacts that would be consistent with the national scope of the program. We recognize that payment amounts hinge on urban/rural status and census division, and that impacts vary significantly by hospital size. We have, therefore, prepared a simple and understandable summary table of the relative impacts for hospitals using those identifying criteria. We believe that this meets both the letter and the intent of the requirements of E.O. 12291 and the RFA.

More importantly, we are aware of the limitations of our data. Seeking to use it to assess impacts on very small groups or individual hospitals would be misleading and methodologically unjustifiable. As the level of data aggregation is lowered, the magnitude of distortions caused by anomalies and undetected errors in the data base increase. Hospital-specific analyses would have a very high risk of encouraging misleading or inaccurate conclusions, and providing such analyses would be irresponsible. Moreover, hospital-specific analyses necessarily rely on historical cost data, and since we do not yet have complete hospital cost data under prospective payment, we cannot quantify the effects of changes in hospital behavior on costs. Consequently, affected hospitals are in a better position than we are to estimate the probable impact of the changes on their specific operations.

We agree that we are obligated to analyze the impact of changes to the prospective payment system to the extent that time, resources, and the availability, accuracy, and completeness of data permit. In fact, the very table that elicited these comments was the product of our efforts to provide more such analysis than we had been able to provide during the first two years of the prospective payment system. We believe it afforded hospitals a reasonable framework for grouping the probable effects of the proposals. Nevertheless, we agree with some commenters that there are some aggregate analyses that we could have provided that would have been helpful to them. Therefore, we are providing further analysis and expanded tables below.

In view of the problems we have experienced in quantifying impacts and attributing causality, we believe that the approach we are taking in the specific impact discussions below is the best feasible. In some cases we have included quantitative estimates of program savings. However, since it is not possible to develop a reliable quantitative analysis and comparison of the costs and benefits of all the provisions to the various affected parties, we have primarily focused on explaining the kinds of interactions, and the decisions, which those parties will have to consider.

D. Hospitals Included in and Excluded From the Prospective Payment System

Since October 1983, hospitals operating under prospective payment have been phasing-in to the system according to their own accounting year starting dates. As of September 1984, 5,405 hospitals (81 percent of all hospitals) were operating under the prospective payment system. This represents virtually 100 percent of all hospitals currently subject to the new payment system. As of May 1985, 1,249 Medicare-participating hospitals were excluded from the prospective payment system and continue to be paid either on the basis of reasonable cost reimbursement (for example, psychiatric, long-term care, and children's hospitals) or on the basis of special reimbursement methodologies in waiver States. Another 1,489 psychiatric, rehabilitation, and alcohol/drug units of hospitals were excluded from prospective payment as of the same date.

Additionally, as of May 1985, 454 hospitals were being paid on a special basis under the prospective payment system. They included hospitals accorded special treatment under our regulations at 42 CFR Part 412, Subpart G, such as sole community hospitals and cancer treatment and research hospitals. Also included in this group receiving payment on a special basis are referral centers and hospitals that previously allowed extensive direct billing under Part B.

Comment: We received a significant number of comments requesting that we extend the exclusion from prospective payment by one year for alcohol and drug treatment centers and units.

Response: As of June 4, 1985, 23 hospitals and 317 units that furnish alcohol and drug treatment services have been excluded from the prospective payment system under §§ 412.23 and 412.32 of our regulations. Exclusion was afforded these hospitals and units on a temporary basis because of difficulties associated with implementation of DRGs for the related services. As discussed in the preamble of this final rule, we have decided to extend the exclusion for one additional year to those hospitals and units that were excluded from the system for their cost reporting periods beginning during Federal FY 1985.

Because the exclusion is mandatory for hospitals and units that meet the requirements in § 412.23 or § 412.32, we do not believe that our decision to extend it for a year will cause a significant change in the number of excluded units. There is a possibility that a few institutions or units would be adversely affected if required to join the prospective payment system at present and we are concerned that beneficiaries' treatment not be adversely affected.

E. DRG Classification and Weights

1. Recalibration

We are making certain changes in the DRG classification system and recalibrating the DRG weights based on 1984 PATBILL charge data. The changes we are making are discussed in detail in section II of the preamble.

The advantages of using newer and more complete data from the PATBILL file outweigh both the potential disadvantages of using charges, and the advantages of using currently available cost report data. Charges appear to be a valid measure of relative resource use, at least on the basis of historical data, the existing DRG classifications, and the current methodology for deriving DRG weights. Use of 1984 charge information would also explicitly incorporate the effects of changes in hospital behavior, whereas the 1981 cost data would not.

Since its implementation in October 1983, the prospective payment system has used DRG relative weights calculated by a complex methodology using data from the 1981 MEDPAR file, a 1981 Medicare Cost Report abstract file, and a 1981 hospital wage index based on hospital wage information collected by BLS. These cost-based relative weights were used in the Medicare prospective payment system on the assumption that they would better reflect differences in true resource costs among DRGs than would relative weights derived from charges. However, as discussed in section II of the preamble, charge data have some potential advantages compared to operating cost data. Weights based on charges could be constructed without cost report data, which is typically two to three years old before it becomes available for analysis. Charge-based relative weights are also simpler to compute, since complex adjustments are not required to convert charges to costs and to remove capital and medical education costs. Because of these potential advantages of charge-based weights, we initiated a study to determine whether it would be feasible to recalibrate the DRG relative weights on the basis of charges rather than costs.[1]

Using the 1981 data upon which the prospective payment system was based, this study investigated the extent to which relative weights based on costs differ from relative weights derived

[1] Philip Cotterill, Joel Bobula, and Rose Connerton, "A Comparison of Alternative DRG Relative Weights for the Medicare Prospective Payment System." HCFA Internal Working Paper, February 1985.

exclusively from charge data. The study also assessed the validity of a case-mix index developed from charge-based relative weights as a measure of the relative costliness of a hospital's Medicare cases. The main findings of the analysis indicate that charge-based and operating cost relative weights, based on 1981 MEDPAR data, are very similar, as follows:

- The difference between relative weights based on operating costs and relative weights based on total charges is less than five percent for most of the DRGs.
- The structure of the relative weights across DRGs for each method are also very similar. The Spearman and Pearson correlation coefficients are greater than .99.
- The relative dispersion of costs or charges within a DRG are also very similar, although for most DRGs the coefficients of variation are slightly higher using charge data than the coefficients of variation using cost data.
- The dispersion of average costs or charges across DRGs are also very similar. However, DRGs with high (low) relative weights tend to have slightly higher (lower) relative weights if computed using charge data rather than cost data.
- Large, urban hospitals and teaching hospitals tend to have slightly higher case-mix index values using charge-based weights rather than cost-based weights, whereas small, rural hospitals and nonteaching hospitals tend to have slightly lower case-mix index values using charge-based weights.

The results of the analysis support the use of charge data in constructing DRG relative weights. We believe that differences among hospitals in cost-to-charge ratios do not result in large, arbitrary differences between charge-based and operating cost weights.

Whether the data are standardized for differences in capital and medical education costs also appears to make little difference. These inter-hospital differences would only affect the DRG relative weights if there were a high degree of specialization among hospitals in different groups of DRGs they treat. Our results indicate that, in 1981, hospitals' case mixes were similar enough that most inter-hospital effects disappear when the data are partitioned by DRG.

In addition, we analyzed the relationship between hospitals' 1981 Medicare cost per case and their case-mix index values constructed from the charge-based relative weights. Using multiple regression analysis, the charge-based case-mix index was found to be approximately proportional to the expected costliness of an individual hospital's Medicare patient mix. This result further supports the study's major finding that there do not appear to be large differences between charge-based and cost-based weights, or between case-mix indexes constructed from charge-based or cost-based weights.

2. Proposed New Weight Values

Table 5 in section IV of the Addendum to this rule sets forth the recalibrated DRG weights. This table reflects all the reclassifications and GROUPER changes discussed in section II of the preamble. The revised DRG weights are highly correlated with the published FY 1985 DRG weights. The Pearson correlation coefficient for the two sets of relative weights is .95.

The changes in values for particular DRGs are affected by a number of factors other than the use of charge data. In fact, we believe that the use of charge data accounts for a smaller proportion of the change in weights than some of the other factors. The changes are accounted for largely by GROUPER changes and behavioral changes that are reflected in the more recent data base.

Approximately 83 percent of FY 1984 discharges fell into DRGs for which the revised weights will differ from the FY 1985 weights by less than 15 percent. Nonetheless, 125 DRGs have weights that will differ from their previous weights by 15 percent or more. Of these, 60 will increase and 65 decrease. Only about 6 percent of all FY 1984 discharges occurred in DRGs with weights that will decrease more than 15 percent, whereas about 11 percent occurred in DRGs with more than a 15 percent increase.

Many of the DRGs that show weight changes of more than 15 percent have relatively low Medicare case frequencies. Thirty-five of the DRGs that will go up more than 15 percent are DRGs for which non-Medicare data was used to calculate their previous weights. These 35 DRGs account for only about 2.3 percent of the cases that fall into the 60 DRGs that will increase by more than 15 percent. More than half of the cases in the 60 high-increase DRGs are in only 3 DRGs: DRG 39 (lens procedures) will increase 15.4 percent, DRG 148 (major bowel procedures) will increase 16.6 percent, and DRG 468 (unrelated OR procedure) will increase 17.9 percent. Further, among the 25 most common DRGs, only DRGs 39, 148, and 468 will increase by 10 percent or more.

Each hospital will have to assess the effect of the revised DRG weights for itself. As noted elsewher, the general tendency of the recalibration is to decompress both charge weights and case-mix index values, so that the higher weights and index values are, on average, a little higher, and the lower ones are, on average, a little lower. However, the degree to which this occurs will vary from hospital to hospital. Further, changes in the DRG weights will interact with changes in Federal rates, wage indexes, and the blending of Federal and hospital-specific portions. (See additional discussion in section J below.)

3. Alcohol and Drug-Related DRG Reclassification

As previously discussed, we have decided to allow an extension of one year, of limited application, to the time-limited exclusion from prospective payment for alcohol and drug treatment centers and units. We have, however, reclassified the alcohol and drug-related DRGs to better reflect the patterns of practice in alcohol and drug detoxification and rehabilitation services. Thus, for cost reporting periods beginning in FY 1986, the revised weights will be applied to alcohol and drug-related services furnished by hospitals under the prospective payment system.

We are replacing the six DRGs in the previous classification for this MDC with five DRGs. The revised weights for DRGs 436 and 437 (rehabilitation therapy and combined detoxification and rehabilitation treatment) are higher than the weights for treatment without rehabilitation. However, there are many more cases in the DRGs for treatment without rehabilitation (DRGs 433 to 435). As a result, the average weight for the cases in the alcohol and drug-related MDC, taken as a whole, will decline about 5 percent.

F. Wage Index

1. Background

As discussed in section III of the preamble, this final rule incorporates a new wage index based on our own survey data rather than on the hospital wage and employment data obtained from the ES 202 reporting system of BLS. The new survey-based wage index will be applied in two ways:

- Prospectively, to restandardize hospitals' operating costs per case to remove the effects of wage differences (as measured by the HCFA gross wage index) in computing the Federal rates; and
- Retroactively, to determine overpayments and underpayments resulting from the use of a wage index based on BLS data since the implementation of the prospective

payment system for cost reporting periods beginning on or after October 1, 1983.

The revised wage index is discussed in detail in the *Report on Hospital Wage Index Required by Section 2316(a) of Public Law 98–369*, submitted to Congress by the Department on March 29, 1985. That report includes detailed estimates of the effects of implementing the proposed index and an alternative wage index that we considered using, based on certain adjustments to the survey data to exclude wages and salaries for certain classes of hospital employees.

2. Prospective Impact of the New Index

Implementation of the survey-based gross wage index prospectively for cost reporting periods beginning on or after October 1, 1985 will have several effects. Of course, each hospital will be relatively advantaged or disadvantaged according to whether the wage-adjusted Federal rates for its geographic area increased or decreased. (Note, however, that a number of other factors will affect whether a hospital's actual total prospective payment revenue increased or decreased.) In addition, the new index will be used to restandardize the standardized amounts on which the Federal national and regional rates are based. This should have a negligible effect on the national urban and rural rates, but will affect the relative level of regional rates significantly.

Since FY 1986 is the last year during which regional rates will be included in the blended Federal rates, this secondary impact of the new index will be time-limited. Nonetheless, for FY 1986, some regional rates will go up and others will go down, with concomitant advantages and disadvantages for affected hospitals.

All hospitals under the prospective payment system will be affected, although some only slightly. For FY 1986, affected hospitals will fall into four groups, as follows:

- Those doubly advantaged by increases to both their wage index values and their regional rates;
- Those doubly disadvantaged by decreases to both their wage index values and their regional rates;
- Those advantaged by an increased wage index value and relatively disadvantaged by a revised regional rate; and
- Those disadvantaged by a decreased wage index value and relatively advantaged by a revised regional rate.

In addition, the changes to the wage index will interact with changes to the DRG weights, the effects of the increased proportion of the national rate in the Federal rate, and the change in blending proportions between Federal and hospital-specific portions. (For further discussion, see section J. below, especially the table summarizing the anticipated percent payment changes for FY 1986.)

4. Retroactive Impact of the New Index

Under section 2316(b) of Pub. L. 98–369, any new wage index that is adopted as a result of the study conducted in accordance with section 2316(a) must be implemented retroactively for hospital cost reporting periods beginning on or after October 1, 1983.

As explained previously, we will begin making refunds to underpaid hospitals and collecting from overpaid hospitals after April 1, 1986, absent any Congressional action on this issue. Because the revised wage index is implemented effective October 1, 1985, some hospitals (that is, those whose reporting periods began October 1, 1983) will have been paid using the BLS index for two full years. If a hospital's payments based on a revised wage index are higher than its payments using the previous index, the Medicare program will have to compensate the hospital for the underpayments. Conversely, where a hospital has been overpaid using the previous index compared to what it will be paid using the revised index, the program will have to recoup the overpayments that have been made.

G. Excluded Hospitals

As discussed in section III. of the Addendum, for cost reporting periods beginning in FY 1986, each hospital or unit subject to the rate-of-increase limits (§ 405.463) will have a target amount equal to the target amount for its previous cost reporting period. We estimate that this will result in $20 million in savings for FY 1986 Medicare Part A expenditures, compared to the maximum level of expenditures allowable under law.

The effect this will have on affected hospitals and units will vary depending on each one's existing relationship of costs per discharge to its target amount for FY 1985, any increase in inpatient costs from FY 1985 to FY 1986, and the relative gains in productivity (efficiency) the hospital or unit is able to achieve. For hospitals and units that continue to achieve per discharge costs lower than their target amounts, the primary impact will be a reduction of the level of additional payments made under § 405.463(d)(2) proportional to the increases in per-discharge costs.

For hospitals and units whose costs are currently in excess of their target amounts, we would expect FY 1986 excess costs to increase, unless the hospitals are able to achieve significant productivity improvements.

In general, we expect the continued ceiling on payments to increase existing incentives for economy and efficiency experienced by excluded hospitals and units. We do not believe that even these limits would achieve incentives comparable to those produced by the prospective payment system. Therefore, we will, as required under the law, continue to study means for establishing an appropriate prospective payment methodology for those hospitals and units that are currently excluded from the prospective payment system. Nonetheless, we believe this decision will ensure that services furnished to beneficiaries by affected hospitals and units will, for the most part, be paid for at a level no higher than necessary for the efficient delivery of needed health services.

H. Indirect Medical Education Costs

As noted in the NPRM, we are changing the way interns and residents are counted for purposes of making payment for the indirect costs of medical education. The indirect medical education payment would be computed based on the ratio of interns and residents to beds, including only those interns and residents furnishing services paid for under the prospective payment system. We are also changing the requirements for counting interns and residents from using actual hours worked at the hospital and reported quarterly, to a one-time count on September 1 of each year or, should September 1 fall on a weekend or holiday, the first workday thereafter.

We anticipate that the change in our counting of interns and residents will result in levels of payment that are reflective of the actual intensity of teaching activity during the cost reporting period. In addition, we estimate budget savings to result from eliminating duplicate payments for the indirect costs of intern and resident time spent furnishing services to hospital outpatients.

We estimate payments of $1.510 billion in FY 1986 and $2.294 billion in FY 1987 to about 975 participating hospitals for their related indirect medical education expenses. As discussed below, we anticipate reductions in payments to most of these hospitals due to implementation of the provisions of this final rule dealing with the method of counting interns and

residents. However, we cannot quantify these reductions in payment because of the absence of adequate data regarding interns' and residents' time spent furnishing services to outpatients. Several commenters submitted their own data concerning residents' time furnishing services to outpatients. The comments suggest that residents' time spent treating outpatients varies widely among programs and depends on the residents' specialties.

However, the estimates submitted by different comments are neither comparable, nor sufficient, to form the basis of a reliable budget estimate. Therefore, although we cannot estimate potential savings, based on what information is available, we have some indication that savings will be far greater than we stated in the NPRM's analysis.

The primary effect on those hospitals whose intern and resident programs include time spent furnishing services to outpatients will be a reduction in indirect medical education payments. The actual impact on a particular hospital would be related to the volume of services its interns and residents furnish to outpatients for which additional indirect medical education payments will not longer be made. The distribution of the impact will vary according to characteristics of hospitals, including: regional and urban/rural settings; bed size; the amount of reimbursement that is related to time spent furnishing services to outpatients and actions hospitals are taking to control the operating costs associated with their training programs. Limiting our payment to affected hospitals may lead to changes in the distribution of residents' time. However, we are unable to predict what specific actions these hospitals will take in response to this change in our payment policy.

In addition to the impact of this particular regulation, some hospitals and their medical education programs have been affected by the limits on payments for direct medical education costs published on July 5, 1985 (50 FR 27722). On page 27730 of that final rule, we discussed the anticipated impact of that limitation on certain hospitals incurring direct medical expenses. For those hospitals that are affected by both the direct medical education limitation and the provision of this final rule affecting indirect medical education payments, the impact of these provisions could well be additive and intermingle with the effects of the direct medical education regulation. However, we cannot determine the exact impact, either in the aggregate or on a particular hospital, due to the variation in hospital characteristics as discussed above and because of the absence of data regarding intern and resident treatment of outpatients.

I. Referral Centers

As discussed in section IV. E. of the preamble to this rule, we are updating the case-mix criteria for hospitals to qualify as referral centers under our regulations at § 412.96(c). Currently, there are about 150 referral centers, all but one of them rural hospitals, that are paid under the prospective payment system, on the basis of urban standardized amounts as a result of their referral center status.

More than 95 percent of the referral centers are eligible for higher payment because they meet the criteria of § 412.96(c) rather than those of § 412.96(b). These criteria refer to case-mix index, number of discharges, medical staff, source of inpatients, and volume of referrals. Each new qualifying hospital and those wishing to retain their referral center status must meet both the case-mix and discharge criteria, and at least one of the other criteria. Thus, the level at which the case-mix and discharge criteria are set determines whether a specific hospital meets the criteria.

We expect that a substantial number of the current referral centers will not meet the case-mix criterion that applies to cost reporting periods beginning in FY 1985. However, this will not result in their being terminated as referral centers, since once qualified, referral center status continues for three years. For the triennial review, they need meet the criteria only two out of three years. At this time, we are unable to determine how many hospitals may gain referral center status under the revised FY 1986 criteria. However, we believe the new criteria will afford us a reasonable measure of the degree to which hospitals seeking special treatment under this provision differ from the average rural hospital and resemble typical urban hospitals, nationally or in their region.

J. Updated Payment Rates and Resulting FY 1986 Payment Amounts

One of the primary functions of this final rule is to publish updated prospective payment rates in accordance with requirements in the law and regulations (section 1886(d) of the Act and § 412.8 of the regulations). Accordingly, the addendum to this document, which is printed after the text of the changes in 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 1986 will be a blend set at 50 percent of the Federal regional rate plus 50 percent of the Federal national rate. This blend will take effect for all Federal rates for all discharges occurring on or after October 1, 1985. Further, as each hospital begins its third year under prospective payment, with its cost reporting period beginning on or after October 1, 1985, the relative proportions of hospital-specific and Federal portions will change from 50 percent and 50 percent, respectively, to 25 percent hospital-specific and 75 percent Federal.

In FY 1986, for the first time, the updated Federal rates (that is, the adjusted average standardized amounts) will not be adjusted to achieve "budget neutrality". Under section 1886(e)(1) of the Act, for FYs 1984 and 1985, the rates were adjusted so that estimated aggregate payments for inpatient hospital services would be the same as they would have been had the Medicare payment system in effect at the time of the prospective payment legislation continued in effect. This requirement for budget neutrality does not apply to rates for FY 1986 and thereafter.

In determining the level of the payments and the adjustment factors to be applied to them, such as DRG weights and wage index values, two issues of impact are paramount: the size of the prospective payment pie, which may be expressed in terms of either the average payment per case or the estimated total expenditures, and how that pie will be divided, that is, how payments will be distributed among DRGs or hospitals. Under budget neutrality, the size of the pie, expressed as average payment per case, was, to the extent it could be predicted and controlled, prescribed by law. As a result, in assessing the impacts of the revised rates, adjustments, and special treatment provisions of previous proposed rules, we focused primarily on the distributive effects of our proposals. This year, however, our primary concern is the proper level of payments, and the major alternatives we considered in setting the payment rates were assessed in light of this concern.

By the end of 1984, we realized that, despite our best efforts to achieve budget neutrality, the FY 1985 prospective payment rates were too high. As a result, in preparing the President's budget, we assumed that the FY 1986 payment rates would be

maintained at the FY 1985 level.[3] At that time, we did not realize that later data and experience would show that we would have substantial legal and technical justification to actually reduce the rates.

In the end, we had to choose among a fairly wide range of potential percentage changes. The hypothetical upper end was constrained by the legal requirement, under section 1886(b)(3)(B) of the Act, that rates for FY 1986 be increased by no more than the forecasted market basket increase plus one-quarter of one percentage point. Thus, the highest conceivable increase for the FY 1986 prospective payment rates was +4.52 percent.

On the other hand, as explained in section II.A.3. of the addendum of this rule, we had a number of reasons for finding the FY 1985 prospective payment rates too high. Considering the combined effect of case-mix increases, market basket forecasting error, inaccurate cost per case assumptions, and the consequences of using unaudited cost data as a basis for rate-setting, the FY 1985 rates are probably overstated by at least 9.8 percent.

ProPAC's first recommendation was a major alternative that had to be considered. It recommended increasing the FY 1985 rates by the forecasted market basket increase, minus one percentage point, plus an allowance for the estimated increase in real case-mix complexity during FY 1985. It described the negative one percentage point, or "discretionary adjustment factor," as a combined adjustment of a positive allowance for scientific and technological advancement and a negative allowance for productivity improvement and hospital product change. It also recommended that we made corrections for market basket forecasting error. In essence, by identifying a number of factors to be considered in determining an update percentage, including both negative and positive values, ProPAC performed an analysis very similar to ours.

In considering the same kinds of things as ProPAC did in developing its proposed discretionary adjustment factor, we developed categories and allowances with some analytic differences, but nonetheless arrived at a policy target adjustment factor of −1.5 percentage points, in lieu of their −1.0 percentage point factor.

In theory, it would be possible to choose to combine the various corrections, adjustments, and inflation factors in a variety of combinations, yielding nearly any percentage change between +4.52 percent and −9.8 percent. However, we believe the preponderance of the evidence, including recent industry reports on hospital profitability margins, shows that current payments are already set at levels that are at least adequate. Accordingly, in section II.A.3. of the addendum, we set forth the factors we believe are best, and show that these factors, in combination, would result in a −4.02 percent reduction of the FY 1986 prospective payment rates. For the reasons given in the Addendum, we are maintaining FY 1986 Federal rates at the same level as FY 1985.

The Federal rates change only as a result of restandardization of the base data to reflect the survey-based gross wage index. Further, as explained in section II. D. of the addendum, we are not increasing the hospital-specific rates for cost reporting periods beginning in FY 1986. As a result, the amounts a hospital may expect to receive from prospective payments for FY 1986 discharges will change as a result of the effects of the new wage index, the new DRG classifications and weights, and the statutorily required changes in blending of Federal and hospital-specific portions.

We have projected the separate and combined expected effects of changes to the DRG weights and wage index on payments to hospitals grouped by census regions, urban/rural status, bed-size, teaching status, and type of control (ownership). This estimate of payment changes is based on 5302 hospitals with Medicare discharges in the PATBILL file and for which hospital-specific information (hospital-specific rates, resident/bed ratios, rural referral center status, and so forth) was provided by the fiscal intermediaries. We did not include any hospitals from waiver States (Maryland, Massachusetts, New Jersey, New York) or hospitals excluded from the prospective payment system. This projection also reflects the impact of the statutorily required retroactive application of the survey-based wage index. The following table summarizes our findings.

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[3] *U.S. Budget in Brief, Fiscal Year 1986.* Executive Office of the President, Office of Management and Budget, Washington, D.C. February 4, 1985. Page 46.

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TABLE-ESTIMATED IMPACT OF CHARGE-BASED DRG WEIGHTS AND THE SURVEY-BASED WAGE INDEX ON FY 1986 OPERATING PAYMENTS

Percent Change in Total Payments for FY 1986 Due to:

	DRG Recalibration[1]	Revised Wage Index [2]	Combined Prospective Effects[3]	Retroactive Wage Index Application	Total Combined Effects
All Hospitals	-0.01	-0.08	-0.09	-0.11	-0.20
By Census Regions					
New England	0.49	0.40	0.89	0.51	1.40
Mid Atlantic	0.47	-0.51	-0.04	-0.59	-0.62
South Atlantic	-0.13	-0.55	-0.69	-0.66	-1.35
East North Central	-0.13	-0.11	-0.24	-0.17	-0.41
East South Central	-0.41	-0.31	-0.72	-0.19	-0.91
West North Central	0.03	0.19	0.22	0.14	0.37
West South Central	-0.32	-0.26	-0.58	-0.26	-0.84
Mountain	-0.13	-0.06	-0.19	-0.10	-0.28
Pacific	0.35	0.61	0.96	0.68	1.64
Urban Hospitals	0.13	-0.07	0.06	-0.10	-0.04
0-99 Beds	-0.19	0.19	-0.00	0.25	0.25
100-404 Beds	0.06	0.04	0.10	0.04	0.14
405-684 Beds	0.15	-0.19	-0.03	-0.24	-0.27
685 + Beds	0.46	-0.35	0.10	-0.46	-0.36
Rural Hospitals	-0.65	-0.13	-0.78	-0.15	-0.93
0-99 Beds	-1.16	-0.00	-1.16	-0.00	-1.17
100-169 Beds	-0.43	-0.05	-0.48	-0.05	-0.53
170 + Beds	-0.12	-0.38	-0.50	-0.44	-0.94
By Teaching Status[4]					
Non-teaching	-0.23	-0.12	-0.35	-0.15	-0.51
Light-teaching	0.06	-0.04	0.02	-0.04	-0.01
Heavy-teaching	1.04	-0.05	1.00	-0.08	0.92
By Type of Control					
Voluntary	0.08	-0.02	0.06	-0.04	0.02
Proprietary	-0.24	-0.24	-0.48	-0.29	-0.77
Government	-0.29	-0.25	-0.53	-0.31	-0.84

1/ This is the combined effect of using charge weights and a revised GROUPER program.

2/ Prospective application only. This comparison reflects the difference we expect from using the HCFA gross index in FY 1986 as compared to estimated FY 1986 payments using the BLS index. It does not include MSA redesignations or other changes that would have occurred in any event.

3/ This is the combined effect of DRG recalibration and the revised wage index.

4/ Non-teaching hospitals are defined as those with 0 residents. Light-teaching hospitals are those with a ratio of residents-to-beds less than 0.25. Heavy-teaching hospitals are those with a ratio of residents-to-beds greater than 0.25.

Note that the magnitude of the changes is generally small and that changes to DRG weights and wage index values will often offset each other. Nevertheless, it is clear that some groups will be advantaged and others disadvantaged. Generally, large urban hospitals in New England or on the Pacific coast will be benefited most by these changes. Small rural hospitals, especially those in the South, will be disadvantaged most.

The change in blending gives more effect to the Federal national rates and less to hospital-specific rates. Thus, a hospital's payments will be affected by the relation between its Federal national rate and its hospital-specific rate. If the applicable Federal rate is higher, a hospital will benefit; if lower, it will be disadvantaged. Even though the payment rates are maintained at the same level for FY 1986, we expect the average payment per case to increase by about 2 percent, because many FY 1985 discharges occurred during hospitals' cost reporting periods beginning in FY 1984, and thus were paid for using a lower hospital-specific rate.

K. Conforming and Minor Proposed Regulation Changes

We are making several other regulation changes that will have relatively minor impacts.

- The revisions to the medical review regulations to conform to the recently published PRO regulations will not have a significant effect on provider revenues.
- The elimination of the prepayment review requirement for all cost outlier payment claims will be administratively simpler for us and for the hospitals, and will give the hospitals quicker payment, but will not affect aggregate revenues significantly.
- The clarification of when hospitals may send denial notices to beneficiaries does not represent a change of policy. It may benefit beneficiaries who might otherwise be sent an inappropriate notice, or hospitals who may not have sent an appropriate notice.

L. Quality of and Access to Care

As we have stated on other occasions, the prospective payment system endeavors to change hospital behavior through financial incentives. We are acutely aware of the possibility that for some hospitals, economic incentives might, in some cases, overshadow concerns for the quality of care delivered and access to appropriate services and levels of services.

There are a number of public and private programs involved in evaluating the quality of hospital care. Utilization and Quality Control Peer Review Organizations (PROs) have, under contract with HCFA, responsibility for evaluating whether the quality of services meets professionally recognized standards of health care and may intervene to correct various patient care problems. Sanctions may be applied to hospitals where standards are not met or notices to beneficiaries are improperly utilized. In addition, we survey hospitals for compliance with the health and safety requirements of the conditions of participation for hospitals participating in the Medicare program (42 CFR Part 405 Subpart J). (Hospitals accredited either by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet these requirements.) Under each of the above programs, we investigate any allegations of poor care. There are additional Federal programs involved in review of specific areas such as radiation safety and infectious diseases. In addition, voluntary second-opinion programs and the efforts of PROs appear to have contributed to a decline in unnecessary surgery.

On the State level, health departments enforce a variety of facility and professional licensure requirements aimed at reducing health care risks and ensuring that only appropriately trained personnel provide services.

Numerous private programs are involved in quality issues. The Joint Commission on Accreditation of Hospitals and the American Osteopathic Association accredit facilities meeting their high standards of care. Almost all of the health professions themselves have and review professional standards of practice. Finally, health care literature suggests that a large number of special research projects are underway, publicly and privately financed, and aimed at measuring various aspects of the quality of hospital care.

The hospital delivery system seems to be adjusting to prospective payment generally as we anticipated, at least as measured by utilization and consumption of resources. We have noted a significant decrease in average length-of-stay and an increase in reported average case mix. To date, there is no systematic evidence linking the behavioral changes that have taken place to any of the potential problems in quality that some expected to result from the changed incentives (for example, shift of acutely ill patients to lower-level providers unable to furnish necessary care, or inappropriate reductions of diagnostic testing or support services). Moderate shifting of patients to less expensive settings has occurred, but the extent of such shifting is not yet known. However, we have seen no data showing an increased number of deaths or complications as a result. Simply stated, a shorter stay in the hospital has not been equated with lower quality care. There may be reason to believe that, in many instances, shorter stays expose patients to fewer risks.

We received a number of comments on the effects of various requirements in this rule on the overall quality of care. These comments generally can be categorized as follows:

- Restraints on payment rates may/will result in a reduction of quality;
- Economic incentives created by prospective payment may/will result in hospital closings or reduction of services provided, thus restricting access;
- Inadequate DRG weighting factors in specific MDCs (for example, in alcohol and drug abuse treatment) may/well result in inadequate treatment; and
- Various technologies (for example, shock wave lithotripsy) may/will be discontinued.

Although none of the comments received on these issues included objective data in support of the assertions, we accept the basic premise that there is an indirect relationship between payment levels and quality of and access to care. We, however, reject the notion that more money equals better care and less money, therefore, must result in poorer care. This argument presented by some commenters ignores the many non-economic variables involved in patient treatment decision-making. We believe that hospital administrators, practicing physicians, and all health care providers are first and foremost guided by the desire to provide the best care possible.

Because payment levels can indirectly affect quality of care, we have been and will continue to be cautious in setting rates and providing for special circumstances. We have evaluated the comments received to date and have made revisions where appropriate. We expect to make many adjustments and policy-revisions in the future, further refining the program as we gain more experience. We encourage those commenters concerned about quality to continue providing us with feedback on the effects of the prospective payment system on patient care.

Ensuring proper access to care is of great concern to us. It is possible that the prospective payment system may in time create incentives for hospitals to establish more outreach programs, expand outpatient services, and form delivery systems to reach populations

that were once ignored. To some extent, this seems to be occurring. The hospital industry's literature encourages hospitals to develop outreach programs and frequently suggests that these will strengthen a hospital's financial picture.

The issues of quality and access are particularly important to certain subgroups of enrollees. Disabled enrollees (especially aged disabled), end-stage renal disease (ESRD) enrollees, and those dually entitled to Medicare and Medicaid coverage ("crossovers") have certain health and socio-economic characteristics that make them particularly vulnerable to changes in health care programs. For example, ESRD enrollees are hospitalized at a rate three times as often as other enrollees. Also, we know that the dually eligible are characterized by higher hospital utilization and costs relative to other aged enrollees. This group represented 2.6 million beneficiaries, or about nine percent of an estimated 28 million aged persons (as of July 1, 1984 according to the U.S. Census Bureau). Thus, a significant portion of the Medicare beneficiary population is particularly sensitive to changes in health care programs and we must ensure that their health care needs are met.

We emphasize our commitment to carefully review the quality of care provided and to investigate any allegations of poor care. We believe that growth in health care expenditures can be restrained without harming patients. In the short-term, we have proper safeguards in place to protect patients. On a long-term basis, there are mechanisms (both public and private) that will enable us to recognize potential problem areas and respond through appropriate changes in policy. The changes contained in this document essentially represent further refinement of the basic prospective payment system. We do not believe any of these changes will create new problems in quality or alter the incentives that might add risks to patient care.

M. Alternatives Considered

Throughout the discussions in the preamble and this analysis, we have explained why we are doing one thing rather than another. As noted in section I.B. of the preamble, as part of our analysis we have been considering various approaches to updating DRG weights and wage indexes while trying to minimize fluctuations of payments. Many interrelated decisions are involved in this process, and the number of possible combinations of different wage indexes, different DRG weights, and different update factors is large. Further, there are additional alternatives that had to be considered within each of the key technical methodologies for deriving the proposed wage index, DRG weights, and Federal rates. Altogether, there is a potentially enormous number of permutations.

Nonetheless, we have been particularly concerned with the impact of certain main options, and we have reviewed them in the light of how they would interact with each other. These include, for example, using unstandardized DRG weights, rather than weights standardized for geographic wage differences and indirect medical education. This would have had the effect of "decompressing" average case mix relative to standardized weights and would have disadvantaged rural hospitals. We also considered all the ProPAC recommendations. Each of the factors taken into consideration in the development of the FY 1986 standardized amounts was challenged and debated both individually and in combination with other factors.

N. Summary and Conclusions

E.O. 12291 requires us to assess the benefits, costs, and net benefits of all rules, major or otherwise. For major rules, we must discuss those costs and benefits in impact analyses, and show that the potential benefits outweigh the potential cost to society. In addition, we must discuss alternative methods of achieving the objectives we propose in our regulations. Throughout the preamble, addendum, and other sections of this impact analysis, such alternatives are discussed. In this summary, we assess the overall costs of the changes we are making, the overall benefits, and the resulting net benefits.

For the most part, the costs and disadvantages that may result from these changes will take the form of reductions in anticipated revenue to affected hospitals. Most of the changes will have their major effect through their influence on the level of FY 1986 prospective payments. The only significant exception will be the retroactive application of the revised wage index.

As we have said before, the primary benefit expected to result from this rule is the maintenance and effective management of the prospective payment system itself. The incentives of this system are expected to produce substantial benefits in the form of economical and efficient operation of participating hospitals, and as improvements in trends of the health care marketplace as a whole. As noted earlier, the objective of these changes is to refine the prospective payment system. Whereas the system as a whole has had a large and dramatic impact, the refinements are of a marginal nature, rather than large-scale adjustments.

We believe that, from this perspective, the overall benefits to society more than offset any resulting liabilities. For the above reasons, we believe that this analysis meets the objectives of E.O. 12291 and the RFA as noted in the Introduction to the Regulatory Impact Analysis.

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federal register

Tuesday
September 3, 1985

Part IV

Department of the Interior

Fish and Wildlife Service

50 CFR Part 20

Final Migratory Bird Hunting Regulations on Certain Federal Indian Reservations, Indian Territory, and Ceded Lands; Final Rule

DEPARTMENT OF THE INTERIOR

50 CFR Part 20

Final Migratory Bird Hunting Regulations on Certain Federal Indian Reservations, Indian Territory, and Ceded Lands

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: This rule prescribes final hunting regulations to be established for certain tribes on Federal Indian reservations, Indian Territory, and ceded lands in the 1985–86 hunting season. The rule also implements revised guidelines for establishing migratory bird hunting regulations on Federal Indian reservations, Indian Territory, and ceded lands. However, because of the complex nature of the subject, and the need for ample time for comment, the comment period on the guidelines will remain open indefinitely. These final regulations contain no information collections subject to Office of Management and Budget review under the Paperwork Reduction Act of 1980.

EFFECTIVE DATE: This rule takes effect on September 1, 1985.

ADDRESSES: Comments received on the proposed regulations for certain tribes, the proposed guidelines for establishing regulations, and the environmental assessment are available for public inspection during normal business hours in room 536, Matomic Building, 1717 H Street, NW., Washington, D.C. Communications regarding the documents should be directed to Director (FWS/MBMO), Room 536, Matomic Building, U.S. Fish and Wildlife Service, Washington, D.C. 20240.

FOR FURTHER INFORMATION CONTACT: Rollin D. Sparrowe, U.S. Fish and Wildlife Service, Department of Interior, Washington, D.C. 20240 (202) 254–3207.

SUPPLEMENTARY INFORMATION: The Migratory Bird Treaty Act of July 3, 1918 (40 Stat. 755; 16 U.S.C. 703 et seq.), authorizes and directs the Secretary of the Interior, having due regard for the zones of temperature and for the distribution, abundance, economic value, breeding habits, and times and lines of flight of migratory game birds, to determine when, to what extent, and by what means such birds or any part, nest or egg thereof may be taken, hunted, captured, killed, possessed, sold, purchased, shipped, carried, exported or transported.

In the June 4, 1985, **Federal Register** (50 FR 23459–23470 and particularly 23467–23468), the U.S. Fish and Wildlife Service (hereinafter the Service) proposed revised guidelines for migratory bird hunting regulations on Federal Indian reservations, Indian Terrority, and ceded lands. The guidelines would replace proposed criteria published in the March 23, 1984, **Federal Register** (49 FR 11125–11126). The revised guidelines were prepared in response to tribal assertion of reserved hunting rights, and tribal interest in exercising these rights. The guidelines include possibilities for: (1) On-reservation hunting (including Indian Terrority), by both tribal and non-tribal members, with hunting by non-tribal members on some reservations to take place within Federal frameworks but on dates different from those selected by surrounding State(s); (2) on-reservation hunting (including Indian Territory) by tribal members only, outside of usual Federal frameworks; and (3) off-reservation hunting by tribal members on ceded lands, outside of usual framework dates and season length, with some added flexibility in daily bag and possession limits. In all cases, the regulations established under the proposed guidelines would have to be consistent with the closed season requirement mandated by the 1916 Migratory Bird Treaty with Canada.

The Service requested comments on the proposed guidelines and on a draft environmental assessment that evaluates their likely impacts. The Service also indicated the intention to establish special regulations for some tribes in the 1985–86 hunting season. Tribes that desired special seasons were asked to submit a proposal that included details on anticipated harvest, methods that would be used to monitor harvest, steps that would be taken to limit harvest where it could be shown that failure to do so would impact seriously on the resource, and tribal capabilities to establish and enforce migratory bird hunting regulations.

Four State conservation agencies wrote the Service in regard to the proposed guidelines, and their comments are discussed in the August 6, 1985, **Federal Register** (50 FR 31828). The States generally recognize the special status of reserved hunting rights of Indian tribes and the need to provide flexibility in this area. However, the comments reflected concern regarding the potential adverse effects that the ad hoc exercise of these hunting rights and management authority could have on the waterfowl resource and on State waterfowl management programs. In a July 30, 1985, letter that was received too late for inclusion in the August 6, 1985, **Federal Register**, Mr. James H. Glass, President, The Wildlife Legislative Fund of America, stated his concern that the guidelines offer the possibility for longer hunting seasons and higher bag limits for Indians than non-Indians, even in cases where both will be hunting on the same public lands. In his letter, Mr. Glass recognized that the treaty hunting rights of Indians cannot be ignored. However, he urged the Service to stand for regulations that are designed to protect and improve the resource for all people, whether Indian or non-Indian.

The Service recognizes that the guidelines may provide greater hunting opportunities in some instances for Indians than for non-Indians, and that this will be viewed as discriminatory by some non-Indians. Nevertheless, the Service believes that it is appropriate to recognize the unique nature of the reserved hunting rights of Indian tribes and, to the extent possible and commensurate with the conservation of the resource, to provide them reasonable flexibility in hunting regulations. As discussed in the June 4, 1985, **Federal Register**, the Service believes that hunting by tribal members is unlikely to cause a substantial increase in migratory bird harvest. However, hunting seasons on ceded lands and hunting seasons for non-tribal members on Federal Indian reservations where tribes have full wildlife management authority could result in increased harvest. The Service will scrutinize proposals for such seasons carefully to ensure that they do not have serious impacts on the migratory bird resource, and most seasons will be experimental.

Five Indian tribes, bands, and Indian organizations also commented on the June 7, 1985, proposed guidelines. Their comments and the Service responses are summarized in the August 6, 1985, **Federal Register** (50 FR 31829–31833), in which the Service announced proposed regulations in the 1985–86 hunting season for certain Indian tribes.

On August 14, 1985, Mr. Allen R. McKay, Director of the Game and Fish Division, Three Affiliated Tribes, Fort Berthold Reservation, New Town, North Dakota, commented on the proposed guidelines and the draft environmental assessment. Mr. McKay stressed that the Three Affiliated Tribes (Mandan, Hidatsa, and Arikara) assert jurisdiction over hunting by tribal and non-tribal members on the reservation. He stated that the tribes support the guildeline that would permit establishment of seasons for non-tribal members that might differ from the State regulations, but the tribes do not request action at this time. Mr. McKay indicated that the tribes have the capability to establish and enforce

migratory bird hunting regulations, and that they would like to be included in meetings or correspondence regarding establishment of waterfowl hunting regulations that affect the Three Affiliated Tribes.

In earlier **Federal Registers** the Service has stated that Indian tribes that wish to do so should have the opportunity to participate in technical meetings on migratory bird matters. The Service intends to investigate ways in which this can be accomplished.

While there were some questions and concerns raised by Indian tribes and organizations, their comments generally were supportive of the revised guidelines and of the Service's attempts to develop reasonably uniform standards dealing with reserved hunting rights of Indian tribes. The Shoshone-Bannock Tribes on the Fort Hall Reservaton in Idaho are an exception. In letters dated June 27, 1985, and August 16, 1985, the tribes raised a number of objections to the guidelines. Among other things, Mr. John D. Ross III, Tribal Attorney, pointed out that a number of tribes were not aware of the proposed guidelines published in the June 4, 1985, **Federal Register** and thus did not have an opportunity to comment on them. The Service believes that tribes on all Federal Indian reservations should have this opportunity and, therefore, the Service intends to keep the comment period on the guidelines open indefinitely, and to ensure that all tribes receive them for review. The Service has acknowledged that the revised guidelines might not cover all situations. For this reason, some changes may be required, and they should not be viewed as inflexible. However, the Service believes they are reasonable and necessary interim standards to employ in establishing migratory bird hunting regulations for Indian tribes, and they will be used for his purpose for the affected tribes in the 1985–86 hunting season.

Nontoxic Shot Regulations

In the February 12, 1985, **Federal Register** (50 FR 5759–5764) and more recently in the May 7, 1985, **Federal Register** (50 FR 19178–19182), the Service published a list of zones and areas where nontoxic shot will be required for waterfowl hunting in the 1985–86 hunting season.

More recently, on June 14, 1985, the National Wildlife Federation sued the Department of the Interior to block use of lead shotgun ammunition for waterfowl hunting in parts of 22 counties in California, Illinois, Missouri, Oklahoma, and Oregon. The issues in the case involve the protection of the endangered bald eagle from lead poisoning. The outcome of this lawsuit could have a bearing on future nontoxic shot regulations on Federal Indian reservations and ceded lands where waterfowl are hunted by tribal and non-tribal members.

NEPA Consideration

The "Final Environmental Statement for the Issuance of Annual Regulations Permitting the Sport Hunting of Migratory Birds (FES 75–54)" was filed with the Council of Environmental Quality on June 6, 1975, and notice of availability was published in the **Federal Register** on June 13, 1975 (40 FR 25242). In addition, several environmental assessments have been prepared on specific matters that serve to supplement the material in the Final Environmental Statement. Of particular importance is the environmental assessment, "Guidelines for Migratory Bird Hunting Regulations on Federal Indian Reservations and Ceded Lands" that was distributed for review and public comment on June 4, 1985. The Service has concluded that the action proposed in the assessment is not a major Federal Action that would significantly affect the quality of the human environment within the meaning of Section 102(2)(c) of the National Environmental Policy Act of 1969. Accordingly, the preparation of an environmental impact statement on the proposed action is not required. Copies of the assessment are available from the Office of Migratory Bird Management, U.S. Fish and Wildlife Service, Room 536, Matomic Building, Washington, D.C. 20240.

Endangered Species Act Consideration

Section 7 of the Endangered Species Act provides that, "The Secretary shall review other programs administered by him and utilize such programs in furtherance of the purposes of this Act" [and] "by taking such action necessary to insure that any action authorized, funded or carried out . . . is not likely to jeopardize the continued existence of such endangered or threatened species or result in the destruction or modification of habitat of such species . . . which is determined to be critical." Consequently, the Service initiated Section 7 consultation under the Endangered Species Act for the proposed hunting seasons on Federal Indian Reservations, Indian Territory, and ceded lands. On June 18, 1985, the Acting Chief, Office of Endangered Species, gave a biological opinion that the proposed action is not likely to jeopardize the continued existence of listed species or result in the destruction of adverse modification of their critical habitats.

Regulations Promulgation

The rulemaking process for migratory bird hunting must, by its nature, operate under severe time constraints. However, the Service is of the view that every attempt should be made to give the public the greatest possible opportunity to comment on the regulations. Thus, when the proposed guidelines were published on June 4, 1985, and when the proposed hunting regulations for certain tribes were published on August 6, 1985, the Service established the longest period possible for public comment. In doing this the Service recognized that time would be of the essence. The comment periods provided the maximum amount of time possible while ensuring that a final rule was published before the beginning of the hunting season on September 1, 1985. The Navajo Nation's regulatory proposal has been adopted in this final rule, even though it was not described in the proposed rule of August 6, 1985. The Service finds that, because its guidelines on Native American hunting on Indian reservations have been the subject of repeated public comment and review, and because the Navajo's proposal falls within prescribed Federal frameworks, good cause exists for adopting the Navajo regulations in this final rule. To require a new public comment period at this stage of the rulemaking process for migratory game hunting would be impracticable, unnecessary, and contrary to the public interest.

Therefore, under authority of the Migratory Bird Treaty Act of July 3, 1918, as amended (40 Stat. 755; 16 U.S.C. 703 et seq.), the Service prescribes the final hunting regulations for certain tribes on Federal Indian reservations, Indian Territory, and ceded lands. The regulations specify the species to be hunted and establish season dates, bag and possession limits, season length, and shooting hours for migratory game birds other than waterfowl. However, final Federal frameworks for waterfowl hunting seasons (opening and closing framework dates, daily bag and possession limits, etc.) are planned for publication on September 2, 1985. Because it was necessary to publishing this document by September 1, 1985, most waterfowl regulations for the tribes listed here are shown as within final frameworks to be established.

The Service finds that "good cause" exists, within the terms of 5 U.S.C. 553(d)(3) of the Administrative Procedure Act, and this final rule will,

therefore, take effect on September 1, 1985.

Regulatory Flexibility Act and Executive Order 12291

In the **Federal Register** dated March 14, 1985 (at 50 FR 10282), the Service reported measures it had undertaken to comply with requirements of the Regulatory Flexibility Act and the Executive Order. These included preparing a Determination of Effects and an updated Final Regulatory Impact Analysis, and publication of a summary of the latter. These regulations have been determined to be major under Executive Order 12291 and they have a significant economic impact on substantial numbers of small entities under the Regulatory Flexibility Act. This determination is detailed in the aforementioned documents which are available upon request from the Office of Migratory Bird Management, U.S. Fish and Wildlife Service, Department of the Interior, Washington, D.C. 20240.

Memorandum of Law

The Service published its Memorandum of Law, required by Section 4 of Executive Order 12291, in the **Federal Register** dated July 26, 1985 (at 50 FR 30424).

Authorship

The primary author of this proposed rulemaking is Fant W. Martin, Office of Migratory Bird Management, working under the direction of Rollin D. Sparrowe, Chief.

List of Subjects in 50 CFR Part 20

Hunting, Wildlife, Exports, Imports, Transportation.

Accordingly, 50 CFR Part 20 is amended as follows:

PART 20—[AMENDED]

1. The authority citation for Part 20 continues to read as follows:

Authority: Migratory Bird Treaty Act, sec. 3, Pub. L. 65–186, 40 Stat. 755 (16 U.S.C. 704); sec 3(h), Pub. L. 95–616, 92 Stat. 3112 (16 U.S.C. 712), unless otherwise noted.

2. Section 20.110 is added to read as follows:

§ 20.110 Seasons, limits, and other regulations for certain Federal Indian reservations, Indian Territory, and ceded lands.

This section provides for establishing annual migratory bird hunting regulations for certain tribes on Federal Indian reservations, Indian Territory, and ceded lands.

(Editorial Note.—The following annual hunting regulations will not appear in the Code of Federal Regulations because of their seasonal nature)

§ 20.110 Seasons, limits, and other regulations for certain Federal Indian reservations, Indian Territory, and ceded lands.

(a) *Great Lakes Indian Fish and Wildlife Commission.* In letters dated August 15, 1985, and August 19, 1985, the Commission and the Wisconsin Department of Natural Resources, respectively, accepted the following experimental hunting regulations proposed by the Service for Chippewa tribal members hunting on ceded lands in public ownership in Wisconsin, which are hereby adopted in this final rule for the 1985–86 season:

(1) *Ducks*[1]

Season Dates: Begin 15 days prior to opening of regular Wisconsin duck season. End with closure of State hunting season.

Daily Bag and Possession Limits: Same as permitted under Federal frameworks.

Special Scaup-only Season: Same dates, season length, and daily bag and possession limits permitted Wisconsin under Federal frameworks.

Rest Period: A 5-day non-hunting period beginning 5 days before the regular State duck hunting season.

(2) *Geese*[1]

(i) *Canada Geese*

Season Dates: Same as permitted under Federal frameworks.

Bag and Possession Limits: Daily bag limit 3. Possession limit.

6. No season limit.

(ii) *Other Geese* (Snow Geese, Blue Geese, White-fronted Geese): Same dates, season length, and daily bag and possession limits permitted Wisconsin under Federal frameworks.

(3) *Other migratory birds.*

(i) *Coots, Common Moorhens, and Purple Gallinules (Gallinules)*

Season Dates: Same as for ducks.

Bag limit: 15 daily, singly or in aggregate. Possession limit 30.

(ii) *Sora and Virginia Rails*

Season Dates: September 15 through November 19.

Bag Limit: 25 daily, singly or in aggregate. Possession limit 30.

(iii) *Common Snipe*

Season Dates: September 15 through November 19.

Bag Limit: 8 daily. Possession limit 16.

(iiii) *Woodcock*

Season Dates: September 15 through November 18.

Bag Limit: 5 daily. Possession limit 10.

[1] Final frameworks for waterfowl to be established.

(4) *General conditions.* Tribal members will comply with all basic Federal migratory bird hunting regulations, 50 CFR Part 20, shooting hour regulations, 50 CFR Part 20, Subpart K, and nontoxic shot zone regulations, 50 CFR 20.108. For purposes of enforcing bag and possession limits, all waterfowl or other migratory birds in the possession or custody of tribal hunters on ceded lands will be considered to have been taken on these lands.

(b) *Colorado River Indian Reservation.* The following regulations will apply to both tribal and non-tribal members while hunting on the reservation during in 1985–86 hunting season:

(1) *Ducks*[1]

Season Dates: Same as Arizona and Colorado River Zone in California.

Daily Bag and Possession Limits: Same as permitted under Federal frameworks for Arizona and Colorado River Zone in California.

(2) *Geese*[1]

Season Dates: Same as Arizona and Colorado River Zone in California.

Daily Bag and Possession Limits: Same as permitted under Federal frameworks for Arizona and Colorado River Zone in California.

(3) *Other migratory birds*

(i) *Coots and Common Moorhens (Gallinule)*

Season Dates: Same as for ducks in Arizona and Colorado River Zone in California.

Daily Bag and Possession Limits: 25 singly or in aggregate.

(ii) *Common Snipe*

Season Dates: Same as for ducks in Arizona and Colorado River Zone in California.

Daily Bag and Possession Limits: 8 daily. Possession limit 16.

(iii) *Mourning Doves and White-winged Doves*

Season Dates: September 1–October 15; November 16–November 30.

Daily Bag and Possession Limits: Daily bag limit is 15 and possession limit is 30 mourning and white-winged doves, singly or in the aggregate of these species; however, the bag and possession limits of white-winged doves may not exceed 10 and 20, respectively.

(4) *General conditions.* Tribal and non-tribal hunters will comply with all basic Federal migratory bird hunting regulations in 50 CFR Part 20 regarding shooting hours and manner of taking. In addition, each waterfowl hunter 16 years of age or over must carry on his person a valid Migratory Bird Hunting and Conservation Stamp, or duck stamp, signed in ink across the face. Hunters

under 16 may voluntarily purchase a duck stamp and help preserve wetlands for waterfowl. Special regulations established by the Colorado River Indian Tribes also may apply on the reservation.

(c) *Penobscot Indian Nation.* (1) In a June 25, 1985, letter, the tribe proposed to adopt 2 separate migratory bird seasons: a general season for both tribal and non-tribal members, and a sustenance season for tribal members only. The general season would be the same as selected by the State of Maine, as has been the case in the past. The proposed sustenance season would include only ducks and would begin on September 21 and end on November 30, and it would permit Sunday hunting (not permitted under State regulations). The daily bag limit under sustenance hunting regulations would be 4 ducks, with no more than 2 wood ducks or 2 black ducks. Where sustenance and general seasons coincide, the daily bag limit for any species or in total would be the greater of the 2 possible limits. All usual Federal basic regulations would apply.

(2) In a letter to the Service dated July 19, 1985, Mr. Norman Trask, Maine Department of Inland Fish and Wildlife, expressed concern regarding the proposed black duck regulations. Mr. Trask pointed out that the more liberal tribal regulations might erode continued support by non-Indians for the restrictive regulations that have been set in the State during the past 3 years to reduce black duck harvest.

(3) The Service did not object to the tribe adopting different hunting regulations for tribal and non-tribal members. The guidelines provide for this possibility. However, in the August 6, 1985, **Federal Register**, the Service proposed that the tribe limit subsistence harvest to species that are more abundant than the black duck. In an August 15, 1985, response, Mr. Tim Lukas, Wildlife Biologist for the tribe indicated that the Service proposal was not feasible for several reasons and asked that the Service approve the tribal proposal. Mr. Lukas requested consultation with the Service and State if there were continuing concerns regarding the tribal proposal. The Service met with tribal and State officials on August 21, 1985. At the meeting, tribal officials assured the Service that the subsistence harvest would be too small to impact adversely on local populations and that the tribe would carefully monitor the harvest to ensure that this is the case. The Service has approved the 1985 sustenance hunting regulations on an experimental basis, pending an evaluation.

(d) *White Earth and Other Minnesota Chippewa Indians.* In a June 27, 1985, letter, Mr. Dwight Wilcox, White Earth Reservation Biologist, submitted proposed 1985 migratory bird hunting regulations for on-reservation hunting by tribal members. Mr. Wilcox suggested that a memorandum of agreement between the White Earth Tribal Council and the Service may be appropriate. The Service concurred with this suggestion in the August 6, 1985, **Federal Register** and has subsequently arranged a meeting for this purpose with Tribal Council officials. The Service also intends to consult with officials of other Chippewa Indian reservations in Minnesota, with the aim of reaching agreement on 1985 hunting regulations.

(e) *The Navajo Nation.* (1) In a June 29, 1984, letter, Mr. John E. Antonio, Director, Navajo Game and Fish Program, stated that the Navajo Nation has full wildlife management authority, and he submitted a proposal for uniform migratory bird hunting regulations throughout the reservation (in parts of Arizona, New Mexico, and Utah). The proposed regulations would apply to both tribal and non-tribal hunters. The Service had not developed the revised guidelines at that time and the proposal could not be approved. However, in the June 4, 1985, **Federal Register**, the Service announced the intention to establish uniform regulations on the reservation in the 1985–86 hunting season.

(2) In an August 20, 1985, telephone conversation, Mr. Antonio requested that the Service approve regulations for the 1985–86 hunting season. Mr. Antonio indicated that it had not been possible to make a request earlier, and that the tribe would meet all law enforcement and other criteria for special seasons that were described in the June 4, 1985, **Federal Register**. The 1985–86 hunting regulations proposed by the tribe are more restrictive than Federal frameworks permit, and the Service approves the following regulations for both tribal and non-tribal members in the 1985–86 hunting season, on an experimental basis, pending an evaluation of hunting activity and harvest:

(i) *Ducks* [1]

Season Dates: October 12, 1985–December 1, 1985.

Daily Bag and Possession Limits: Same as permitted Pacific Flyway States under Federal frameworks.

(ii) *Geese*

Canada Geese (season closed on other geese):

Season Dates: December 28, 1985–January 5, 1986.

Daily Bag and Possession Limits: 2 per season.

(iii) *Other migratory birds*

(A) *Coots and Common Moorhens (Gallinule)*

Season Dates: October 12, 1985–December 1, 1985.

Daily Bag and Possession Limits: 25 singly or in aggregate.

(B) *Mourning Doves*

Season Dates: September 7, 1985–September 29, 1985.

Daily Bag and Possession Limits: 12 daily. Possession limit 24.

(C) *Band-tailed Pigeons*

Season Dates: September 7, 1985–September 29, 1985.

Daily Bag and Possession Limits: 5 daily. Possession limit 10.

(iv) *General conditions.* Tribal and non-tribal hunters will comply with all basic Federal migratory bird hunting regulations in 50 CFR Part 20 regarding shooting hours and manner of taking. In addition, each waterfowl hunter 16 years of age or over must carry on his person a valid Migratory Bird Hunting and Conservation Stamp, or duck stamp, signed in ink across the face. Hunters under 16 may voluntarily purchase a duck stamp and help preserve wetlands for waterfowl. Special regulations established by the Navajo Nation also may apply on the reservation.

The final rule promulgated here that implements interim guidelines for migratory bird hunting regulations on Federal Indian reservations, Indian Territory, and ceded lands, and that also establishes final hunting regulations for certain tribes for the 1985–86 hunting season is authorized under the Migratory Bird Treaty Act of July 3, 1918 (40 Stat. 755; 16 U.S.C. 703 et seq.), as amended.

Dated: August 23, 1985.

P. Daniel Smith,

Acting Deputy Assistant Secretary for Fish and Wildlife and Parks.

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