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- Schwartz, F.J., R. Rubelmann, and J. Allison. 1983. Ecological population expansion of the introduced crayfish, *Orconectes virilis*. *Ohio Journal of Science*. 63:266-273.

Author

The primary author of this rule is Dr. Jeurel Singleton, Sacramento Endangered Species Office, U.S. Fish and Wildlife Service, 2800 Cottage Way, Room E-1823, Sacramento, California (916/978-4866 or FTS 460-4866).

List of Subjects in 50 CFR Part 17

Endangered and threatened wildlife, Fish, Marine mammals, Plants (agriculture).

Regulation Promulgation**PART 17—[AMENDED]**

Accordingly, Part 17, Subchapter B of Chapter I, Title 50 of the Code of Federal Regulations, is amended as set forth below:

1. The authority citation for Part 17 continues to read as follows:

Authority: Pub. L. 93-205, 87 Stat. 884; Pub. L. 94-359, 90 Stat. 911; Pub. L. 95-632, 92 Stat. 3751; Pub. L. 96-159, 93 Stat. 1225; Pub. L. 97-304, 96 Stat. 1411 (16 U.S.C. 1531 *et seq.*); Pub. L. 99-625, 100 Stat. 3500 (1986), unless otherwise noted.

2. Amend § 17.11(h) by adding the following, in alphabetical order under "CRUSTACEANS", to the List of Endangered and Threatened Wildlife:

§ 17.11 Endangered and threatened wildlife.

* * * * *

(h) * * *

Species		Historic range	Vertebrate population where endangered or threatened	Status	When listed	Critical habitat	Special rules
Common name	Scientific name						
CRUSTACEANS							
Crayfish, Shasta (=placid)	<i>Pacifastacus fortis</i>	U.S.A. (CA)	NA	E	337	NA	NA

Dated: September 22, 1988.

Susan Recce,

Acting Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 88-22399 Filed 9-29-88; 8:45 am]

BILLING CODE 4310-53-M

50 CFR Part 17**Endangered and Threatened Wildlife and Plants; Determination of Endangered Status for the Stephens' Kangaroo Rat**

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: The Fish and Wildlife Service (Service) determines the Stephens' kangaroo rat (*Dipodomys stephensi*), a small mammal found in southern California, to be an endangered species. The species has suffered widespread habitat loss and degradation, resulting in small isolated populations. This rule implements the protection provided by the Endangered Species Act of 1973, as amended (Act), for the Stephens' kangaroo rat.

DATE: The effective date of this rule is October 31, 1988.

ADDRESS: The complete file for this rule is available for inspection, by appointment, during normal business hours at U.S. Fish and Wildlife Service, 24000 Avila Road, Laguna Niguel, California 92656.

FOR FURTHER INFORMATION CONTACT: Ms. Nancy M. Kaufman, field supervisor,

at the above address (714/643-4270 or FTS 796-4270).

SUPPLEMENTARY INFORMATION:**Background**

The Stephens' kangaroo rat (*Dipodomys stephensi*) is a small mammal of the rodent family Heteromyidae. Like other kangaroo rats, it has a large head, external cheek pouches, elongated rear legs used for jumping, and relatively small front legs. The front feet are frequently used to hold seeds that the animal eats. There are five toes on the hind foot and the tail is 1.45 times the length of the head and body. The Stephens' kangaroo rat is distinguished from the sympatric agile kangaroo rat (*Dipodomys agilis*) by a lateral white tail band that is one half or less (rather than one half or more) times the width of the dorsal tail stripe, dusky (rather than dark) soles on the hind feet, a more grizzled appearance to the dorsal tail stripe due to many white hairs, a darker tail tuft due to fewer white hairs, a smaller ear (averaging 0.5 inch [15 millimeters] in length), and a relatively broad head. The average adult Stephens' kangaroo rat is 11 to 12 inches (277 to 300 millimeters) in length and weighs 2.3 ounces (67 grams) (Bleich 1977).

The Stephens' kangaroo rat was first described by Merriam (1907) as *Perodipus stephensi*. The type locality is the San Jacinto Valley, a little west of the town of Winchester, Riverside County. Grinnell (1921) placed the species in the genus *Dipodomys*. Huey (1962) described a kangaroo rat from the

San Luis Rey River valley as *Dipodomys cascus*. However, Lackey later (1967a) determined *D. cascus* to be a synonym of *D. stephensi*.

The Stephens' kangaroo rat is endemic to the Perris and San Jacinto Valleys in western Riverside County and the San Luis Rey and Temecula Valleys in northern San Diego County (Grinnell 1922, Lackey 1967a, O'Farrell and Uptain 1986, Thomas 1973). Occupied habitats are usually described as sparse, slightly disturbed coastal sage scrub or annual grassland. The actual distribution of suitable habitat is normally mixed with other habitat types in a natural mosaic. The populations with the highest densities have been found in areas where the herbaceous layer still contains California native annuals, and where perennial cover is less than 30 percent (Hogan 1981). The Stephens' kangaroo rat is most commonly associated with *Artemisia californica* and *Eriogonum fasciculatum* because these shrubs are often the most obvious elements of the habitat. The animal is actually using the herbaceous layer which is often dominated by filaree (*Erodium cicutarium*). Many areas supporting the species are shrubless (O'Farrell, 1988 pers. comm.). The Stephens' kangaroo rat occurs on level or low rolling terrain; it is not found on extremely hard or sandy soils (Lackey 1967a). Bleich (1977) noted that gravel is a common component of soils where the animal is found.

All of the occupied sites found by Thomas (1973) had been previously disturbed, usually by plowing. Remnant

populations that survived at the natural edges had reinvaded after the fields had been left fallow. At that time most populations were considered isolated from one another and were found predominantly in the western portions of the range. Rapid urbanization has reinforced this pattern.

Like all kangaroo rats, *D. stephensi* is nocturnal, spending the day in underground burrows and foraging on the surface at night. Pregnant and lactating females have been caught in the spring and summer months (Lackey 1967b). To date, few population density studies have been completed and none have covered an entire year. Relatively high densities (over 20 per acre or 50 per hectare) have been found during the summer months when the young are out of the nest (Thomas 1975). Hogan (1981) reported fall-winter densities of about 2.5 to 6 per acre (6 to 15 per hectare). According to Dr. Michael J. O'Farrell (private consultant, Santa Ynez, California), high density areas contain over 4 animals per acre (10 per hectare), moderate density areas support about 2 to 4 animals per acre (5 to 10 per hectare), and low density areas contain less than 2 per acre (5 per hectare). Most of the occupied range probably has low to moderate density populations.

Most remaining habitat for the Stephens' kangaroo rat is in private ownership. Federal agencies or installations with land holdings supporting this species include March Air Force Base, Fallbrook Naval Weapons Annex, Camp Pendleton Marine Corps Base, and the Bureau of Land Management. The Vista Irrigation District, Metropolitan Water District, and State of California also own comparatively large blocks of suitable habitat.

In its original Review of Vertebrate Wildlife, published in the *Federal Register* of December 30, 1982 (47 FR 58454-58460), the Service included *D. stephensi* in category 2, meaning that information then available indicated that a proposal to determine endangered or threatened status was possibly appropriate, but was not yet sufficiently substantial to support such a proposal. Subsequently, many new data on the species became available, and in its revised Vertebrate Review of September 18, 1985 (50 FR 37958-37967), the Service included *D. stephensi* in category 1, meaning that substantial information was on hand to support the biological appropriateness of proposing to list as endangered or threatened. The Service published the proposed rule for this species on November 19, 1987 (53 FR 44453-44456).

Summary of Comments and Recommendations

In the November 19, 1987, proposed rule (52 FR 44453-44456) and associated notifications, all interested parties were requested to submit factual reports or information that might contribute to the development of a final rule. The public comment period was extended twice, until April 19, 1988, to accommodate a requested public hearing held on March 11, 1988 (53 FR 5022), and again until June 20, 1988, to allow for the receipt of additional comments (53 FR 17964). Hence, the total comment period was 7 months. A newspaper notice was published in the *Los Angeles Times* on December 5, 1987, the *Riverside Press Enterprise* on December 17, 1987, and the *San Diego Union* on December 15, 1987, announcing the proposed rule and requesting comments. Announcements for the public hearing were published in the above newspapers on March 9, 1988. A total of 11 individuals and organizations submitted written comments. Two people provided oral testimony at the public hearing.

The only opposing statement was received from the U.S. Air Force, which was the only Federal agency to submit comments. The California Department of Fish and Game submitted supporting comments, and provided a copy of a recent status update. The cities of Moreno Valley and Riverside provided neutral comments and submitted information on the status of the species within their boundaries. One utility company and a water district also submitted neutral comments. One conservation organization, and two researchers also submitted supporting comments. Twelve individuals submitted signed photocopies of the same supporting letter, which were treated as one comment. Of the 11 comments received, 7 supported listing, 1 opposed, and 3 were neutral. The written and oral comments received are grouped under issues and discussed below:

Issue 1: The Stephens' kangaroo rat should not be listed as endangered until its range is more accurately delineated. The species may be more widespread than previously thought.

Service Response: The total range of the Stephens' kangaroo rat has been well documented (Bleich 1977, Lackey 1967a, Price and Endo 1988, Thomas 1973, Thomas 1975, O'Farrell and Uptain 1986). It is unlikely that this small mammal occurs outside of this range. The presence or absence of the Stephens' kangaroo rat at specific locations within this range is sometimes uncertain. Furthermore, the population

densities of this species fluctuate greatly from one year to the next (Price and Endo 1988), hence, suitable habitat may not always be occupied. The discussions under Factor A regarding habitat loss and Factor E regarding habitat fragmentation indicate that the threats facing the kangaroo rat are occurring range-wide. To wait until the species' occurrence is more precisely known would allow the present rate of habitat loss to continue unabated, making extinction of the species more likely.

Issue 2: Once the kangaroo rat is listed, the Federal and other public lands containing the species will become defacto reserves for this species. The Service may have "written-off" privately owned parcels for purposes of establishing Stephens' kangaroo rat reserves. All land owners should share in the burden of Stephens' kangaroo rat protection.

Service Response: The lands now held in public ownership are not sufficient to ensure the maintenance of the species in perpetuity. Consequently, the preservation of many presently privately owned parcels likely will be necessary. The Canyon Lake Property Owners Association has expressed interest in actions intended to preserve Stephens' kangaroo rat habitat. The County of Riverside has formed a committee to begin the development of a Habitat Conservation Plan for the kangaroo rat. A key feature of this program is to identify the best Stephens' kangaroo rat habitat in Riverside County for the establishment of viable reserves and develop the means to provide permanent protection and management for these sites. Many of the public parcels contain the species because the major public purpose of the land is at least partially compatible with preservation of the Stephens' kangaroo rat.

Issue 3: Many land uses appear to be compatible with the preservation of Stephens' kangaroo rats. For example, the species occurs along power line corridors, in grazed areas, at a solar facility, near napalm storage crates on military lands, and in areas where off-road vehicle travel has occurred.

Service Response: The habitat requirements of the Stephens' kangaroo rat are not well defined. The species does appear to need some bare ground, and the habitat is usually described as being open or sparsely vegetated. Consequently, land uses that cause artificial disturbance and perpetuate the sparse nature of the habitat may be compatible with the preservation of the species. However, further study is needed to determine which kinds of

disturbances under what circumstances truly are compatible. During a recent 1-year study (O'Farrell 1988, pers. comm.) noted a population increase of Stephens' kangaroo rats following development of a solar facility. The population change was attributed to increased protection from predators and increased herbaceous growth. Given that populations of this species fluctuate greatly from year to year (Price and Endo 1988), conclusions based on this short time period should be drawn conservatively. Thus, further careful study is needed to confidently assess the long-term impacts of various land uses on this species. Nevertheless, despite the fact that some land uses may be compatible, the primary threat to this species is permanent loss and fragmentation of habitat resulting from urbanization and other land uses.

Issue 4: In the proposed rule, it was suggested that some small land areas lacked viable populations; however, apparently this is not the case.

Service Response: The areas referred to were fairly small, approximately 40 acres (100 hectares) in size. As discussed below under Factor E, such small areas would support the species indefinitely. Although the population size that would be needed for viability is not known, it may contain 500 or more individuals. Additionally, on most lands supporting the species, not all habitat is suitable or occupied by Stephens' kangaroo rats; consequently, a viable population would more likely require several square miles. However, further study is needed to determine how many animals are needed for a viable population, and how much land they require.

In summary, no information was received indicating that the species is more widespread or under a lesser degree of threat than was originally thought.

Summary of Factors Affecting the Species

After a thorough review and consideration of all information available, the Service has determined that the Stephens' kangaroo rat should be classified as an endangered species. Procedures found at section 4(a)(1) of the Endangered Species Act (16 U.S.C. 1531 *et seq.*) and regulations (50 CFR Part 424) promulgated to implement the listing provisions of the Act were followed. A species may be determined to be an endangered or threatened species due to one or more of the five factors described in Section 4(a)(1). These factors and their application to the Stephens' kangaroo rat (*Dipodomys stephensi*) are as follows:

A. The present or threatened destruction, modification, or curtailment of its habitat or range. The habitat and range of the Stephens' kangaroo rat have been greatly reduced. The species probably once occurred through annual grassland or sparse coastal sage scrub communities of the Perris and San Jacinto Valleys and up adjoining washes in southern California. As the flatter plains were developed by people, however, the kangaroo rat became confined to isolated bases of low rolling hills and level ridge tops.

Price and Endo (1988) have completed a mapping effort focusing on suitable soil types and relatively flat topography to compare the amount of estimated habitat available to the Stephens' kangaroo rat prior to Twentieth-century agriculture and again in 1984 in Riverside County. Price and Endo (1988) estimated that approximately 308,195 acres (124,775 hectares) of potential habitat originally existed for this species. In 1984, 124,779 acres (50,518 hectares) remained. Habitat had been lost due to urban and agricultural developments. Moreover, of the remaining habitat patches, 84 percent were less than 1 square kilometer (384 acres) in size. Only 21,212 acres (8,588 hectares) remained in patches larger than one square kilometer (Price and Endo 1988). cursory observations indicate that since 1984, the situation has worsened. Most recent habitat loss is the result of urban development and is permanent; losses from agricultural development are less severe because Stephens' kangaroo rats can reinvade plowed fields following abandonment (Thomas 1973, 1975).

Some areas in public ownership contain substantial habitat for *D. stephensi*. O'Farrell and Uptain (1986) indicated that approximately 12,600 acres (5,100 hectares) of suitable habitat remain at Lake Henshaw and that another 4,940 acres (2,000 hectares) appear suitable on the Fallbrook Naval Weapons Annex. The species, however, probably has been extirpated between the latter facility and the San Luis Rey River. The Metropolitan Water District owns some habitat surrounding Lake Mathews where, including contiguous private parcels, an area of about 17,000 acres (6,800 hectares) remains, although not all of this habitat is suitable. Many proposed projects, however, threaten the land surrounding Lake Mathews.

No attempt to trap the species has been made at Lake Perris since 1973. On the east side of the San Jacinto Valley, it is now restricted mainly to insular patches at the edges of plowed fields. It is similarly restricted in the Lakeview Mountains, where only a few thousand

non-contiguous acres are now thought to contain adequate habitat. The species has been reported on the Beaumont-Banning Plain; however, this area is also undergoing rapid urbanization. The U.S. Bureau of Land Management (Bureau) owns some parcels near Lake Elsinore, but survival of the kangaroo rat there is tenuous because of rapid urbanization and an expected increase in casual human use (off-road vehicles already have been noted). Land exchanges are being pursued to consolidate these Bureau parcels to provide a viable preserve for the Stephens' kangaroo rat.

Further compounding the fragmented nature of the current distribution is the fact that the Stephens' kangaroo rat does not occupy all apparently suitable habitat (Friesen 1985a). Relatively large areas may include only a small percentage of occupied habitat. Grazing, off-road vehicle activity (common in southern California), and rodent control programs all potentially reduce habitat suitability.

These habitat losses are likely to continue. An examination of Riverside County's General Plan guidelines revealed that 78 percent of the sites where the kangaroo rat has been trapped are zoned for use incompatible with preservation of the species. Only 3 percent of the sites were zoned for vegetation or wildlife protection, and much of this land is not suitable for the kangaroo rat. Within the overall range of the Stephens' kangaroo rat, only 6 percent of the land is zoned for uses compatible with the preservation of the species. Because not all of the habitat in this 6 percent is suitable, much less is available for the kangaroo rat. Although biological consultants have sometimes located the species and informed appropriate land owners or project proponents, some of the sites, nonetheless, have been disked or plowed.

B. Overutilization for commercial, recreational, scientific, or educational purposes. Not now known to be applicable.

C. Disease or Predation. Not now known to be applicable. However, many areas of occurrence are adjacent to urban neighborhoods and increased predation from domestic and feral cats can be expected (Friesen 1985b).

D. The inadequacy of existing regulatory mechanisms. The California State Fish and Game Commission has listed the Stephens' kangaroo rat as threatened. Recently, the Department of Fish and Game recommended that the kangaroo rat's status be upgraded to endangered. The California Endangered Species Act (State Act) of 1985 provides

protection from take, and contains provisions that call for a consultation process, similar to Section 7 of the Federal Act, when a State lead agency's project may affect a State-listed species. The regulations implementing the consultation process under the State Act were not completed until June of 1986, and it is still unclear how effective the State Act will be. Few State agencies are expected to propose State projects as defined under the State Act. Under the California Environmental Quality Act, an attempt is made to "mitigate" for losses of occupied Stephens' kangaroo rat habitat. This procedure has been inadequate because the usual suggested "mitigation" measures presented in most proposed projects consist of preserving habitat in another location. There is thus a constant, ongoing habitat loss. Additionally, because the species does not occupy all suitable habitat, losses of unoccupied habitat remain uncompensated.

County zoning restrictions do not now provide adequate protection for the kangaroo rat and its habitat. Although "open space" designations are sometimes made, these can be altered to allow subdivision and development. Only a small fraction of the involved land is currently zoned for uses compatible with the preservation of the kangaroo rat (see "Factor A" above).

Federal lands form only a small part (approximately 15 percent) of the range of the species. Although a significant population of *D. stephensi* may occur on the Fallbrook Naval Weapons Annex, the Navy has no established policy regarding the protection of sensitive species. The involved Bureau of Land Management-administered lands are small and also lack specific protective policies, however, the Bureau does intend to consolidate some of its holdings through land exchanges and provide a reserve for the Stephens' kangaroo rat.

E. Other natural or manmade factors affecting its continued existence. Coastal sage scrub plant communities may become less sparse through time. As plant density and ground cover increase, patches of habitat would become unsuitable for Stephens' kangaroo rat.

The State recreation areas have rodent control programs that probably adversely affect the Stephens' kangaroo rat populations. Consultants also have noted the disappearance of kangaroo rat sign due to unknown causes. A hypothesis concerning such unexplained disappearances is that rodenticides have been used.

Further compounding the habitat loss and degradation referred to under

Factor A is the fragmented nature of the remaining habitat. Price and Endo (1988) have provided an estimate of original habitat and that available in 1984 based upon mapping of soil types. This effort has revealed approximately 84 percent of the remaining habitat patches are less than 1 square kilometer in extent. The size of a reserve that would be needed to support the Stephens' kangaroo rat in perpetuity is currently unknown; however, preliminary estimates indicate that it may be close to 6 square miles (1,536 hectares). Thus, most remaining habitat patches cannot be expected to support the species indefinitely.

Populations occupying fragments can be more easily extirpated from unpredictable natural catastrophes such as floods, fires, or disease outbreaks. Many of the habitat patches supporting the species are less than 10 acres (4 hectares) in size. Areas this small support such low numbers of Stephens' kangaroo rats that fluctuations in birth and death rates, unequal sex ratios, and loss of genetic diversity can be expected to adversely affect the survival of these populations.

The Service has carefully assessed the best scientific and commercial information available regarding the past, present, and future threats faced by this species in determining to make this rule final. Based upon this evaluation, the preferred action is to list the Stephens' kangaroo rat as endangered. Threatened status would not adequately reflect the drastic habitat decline that already has occurred and the continued rapid habitat loss that is likely to occur in association with human activity. Although certain sites supporting the species receive some protection, these areas have management problems that could adversely affect the kangaroo rat. For the reasons given below, a critical habitat designation is not included in this rule.

Critical Habitat

Section 4(a) of the Endangered Species Act, as amended, requires that "critical habitat" be designated "to the maximum extent prudent and determinable," at the time a species is determined to be endangered or threatened. The Service finds that designation of critical habitat is not prudent or determinable for *D. stephensi* at this time. For example, as discussed after factor "A" in the "Summary of Factors Affecting the Species," some landowners or project developers have disked or plowed their lands upon the discovery of this species. Populations in other areas have mysteriously disappeared following discovery, possibly from rodenticide use.

Prevention of take, as described in Section 9 of the Act, would be difficult to enforce under these circumstances. Publication of critical habitat descriptions and maps would likely make the species more vulnerable and increase enforcement problems. Affected parties and landowners will be notified of the location and importance of protecting this species' habitat. Protection of the species' habitat will be addressed through the recovery process and through the Section 7 jeopardy clause as described below.

Available Conservation Measures

Conservation measures provided to species listed as endangered or threatened under the Endangered Species Act include recognition, recovery actions, requirements for Federal protection, and prohibitions against certain practices. Recognition through listing encourages and results in conservation actions by Federal, State, County, and private agencies, groups, and individuals. The Endangered Species Act provides for possible land acquisition and cooperation with the States and requires that recovery actions be carried out for all listed species. Such actions are initiated following listing. The protection required of Federal agencies and the prohibitions against taking and harm are discussed, in part, below.

Section 7(a) of the Act, as amended, requires Federal agencies to evaluate their actions with respect to any species that is proposed or listed as endangered or threatened and with respect to its critical habitat, if any is being designated. Regulations implementing this interagency cooperation provision of the Act are codified at 50 CFR Part 402. Section 7(a)(2) requires Federal agencies to ensure that activities they authorize, fund, or carry out are not likely to jeopardize the continued existence of listed species or to destroy or adversely modify its critical habitat. If a proposed Federal action may affect a listed species, the responsible Federal agency must enter into formal consultation with the Service.

Several Federal actions may involve *D. stephensi*. The Bureau of Land Management owns several isolated parcels supporting the species (Hicks and Cooperrider 1975). The Bureau is interested in consolidating its land holdings within this area and has proposed that this effort could result in the formation of all or part of a reserve for this species. The Veterans Administration or Federal Housing Administration may finance housing loans in areas where the species now

occurs. The U.S. Army Corps of Engineers may permit or carry out flood control projects in sandy washes where the species has been found. The U.S. Air Force has proposed activities such as a housing development project on March Air Force Base which may involve the Stephens' kangaroo rat. The U.S. Marine Corps and U.S. Navy also own land that supports this species. To facilitate survival of the kangaroo rat on public lands, it would be necessary to carry out conducive management activities, such as preserving natural habitat where it now exists, conducting controlled burns to keep vegetation at the low densities favored by the species, and other activities.

The Act and implementing regulations found at 50 CFR 17.21, set forth a series of general prohibitions and exceptions that apply to all endangered wildlife. These prohibitions, in part, make it illegal for any person subject to the jurisdiction of the United States to take, import, or export, ship in interstate or foreign commerce in the course of a commercial activity, or sell or offer for sale in interstate or foreign commerce any listed species. It is also illegal to possess, sell, deliver, carry, transport, or ship any such wildlife that has been taken illegally. Certain exceptions apply to agents of the Service and State conservation agencies.

Permits may be issued to carry out otherwise prohibited activities involving endangered wildlife species under certain circumstances. Regulations governing permits are at 50 CFR 17.22 and 17.23. Such permits are available for scientific purposes, to enhance the propagation or survival of the species, and/or for incidental take in connection with otherwise lawful activities.

National Environmental Policy Act

The Fish and Wildlife Service has determined that an Environmental Assessment, as defined under the authority of the National Environmental Policy Act of 1969, need not be prepared

in connection with regulations adopted pursuant to section 4(a) of the Endangered Species Act of 1973, as amended. A notice outlining the Service's reasons for this determination was published in the Federal Register on October 25, 1983 (48 FR 49244).

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Author

The primary author of this rule is Karla Kramer, U.S. Fish and Wildlife Service, 24000 Avila Road, Laguna Niguel, CA 92656 (714) 643-4270 or FTS 796-4270.

List of Subjects in 50 CFR Part 17

Endangered and threatened wildlife, Fish, Marine mammals, Plants (agriculture).

Regulation Promulgation

Part 17—[AMENDED]

Accordingly, Part 17, Subchapter B of Chapter I, Title 50 of the Code of Federal Regulations, is amended as set forth below:

1. The authority citation for Part 17 continues to read as follows:

Authority: Pub. L. 93-205, 87 Stat. 884; Pub. L. 94-359, 90 Stat. 911; Pub. L. 95-632, 92 Stat. 3751; Pub. L. 96-159, 93 Stat. 1225; Pub. L. 97-304, 96 Stat. 1411 (16 U.S.C. 1531 et seq.); Pub. L. 99-625, 100 Stat. 3500 (1986), unless otherwise noted.

2. Amend § 17.11(h) by adding the following, in alphabetical order under "Mammals," to the List of Endangered and Threatened Wildlife:

§ 17.11 Endangered and threatened wildlife.

(h) * * *

Species		Historic range	Vertebrate population where endangered or threatened	Status	When listed	Critical habitat	Special rules
Common name	Scientific name						
MAMMALS							
Rat, Stephens' Kangaroo.....	<i>Dipodomys stephensi</i>	U.S.A. (CA).....	Entire.....	E	338	NA	NA

Dated: September 22, 1988.

Susan Recce,

Acting Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 88-22400 Filed 9-29-88; 8:45 am]

BILLING CODE 4310-55-M

50 CFR Part 17

Endangered and Threatened Wildlife and Plants; Determination of Endangered Status for *Sarracenia rubra* ssp. *jonesii* (Mountain Sweet Pitcher Plant)

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: The Service determines *Sarracenia rubra* ssp. *jonesii* (mountain sweet pitcher plant), a perennial insectivorous herb limited to 10 populations in North and South Carolina, to be an endangered species under authority of the Endangered Species Act of 1973, as amended (Act). *Sarracenia rubra* ssp. *jonesii* is endangered by drainage and other forms of habitat destruction and by collecting. This action will implement Federal protection provided by the Act for *Sarracenia rubra* ssp. *jonesii*.

EFFECTIVE DATE: October 31, 1988.

ADDRESSES: The complete file for this rule is available for inspection, by appointment, during normal business hours at the U.S. Fish and Wildlife Service, 100 Otis Street, Room 224, Asheville, North Carolina 28801.

FOR FURTHER INFORMATION CONTACT: Ms. Nora Murdock at the above address (704/259-0321 or FTS 672-0321).

SUPPLEMENTARY INFORMATION:

Background

Sarracenia rubra ssp. *jonesii* was first described by E.T. Wherry (1929) from material collected in North Carolina in 1920. The taxonomy of this genus is extremely complex, with extensive natural hybridization documented (Bell 1949, 1952). There has been substantial disagreement about the taxonomic classification of *Sarracenia rubra* ssp. *jonesii*, with different authors having treated it as a regional variant

(McDaniel 1971), a form (Bell 1949), a subspecies (Wherry 1972, Schnell 1977, 1978), and as a distinct species (Wherry 1929, Case and Case 1976, McDaniel 1986). If *Sarracenia rubra* ssp. *jonesii* is formally redescribed as a full species (as recommended in McDaniel's 1986 report) after it is added to the List of Endangered and Threatened Plants, an editorial change to the list will be made to reflect this nomenclatural change.

Sarracenia rubra ssp. *jonesii* is an insectivorous, rhizomatous, perennial herb, which grows from 21 to 73 centimeters tall. The numerous erect leaves grow in clusters and are hollow and trumpet-shaped, forming slender, almost tubular pitchers (inspiration for the most frequently used common name) covered by a cordate hood. The pitchers are a waxy dull green, usually reticulate-veined with maroon-purple. The tube of the pitchers is retrorsely hairy within and often partially filled with liquid and decayed insect parts. The uniquely showy and fragrant flowers have recurving sepals, are borne singly on erect scapes, and are usually maroon in color. The species blooms from April to June, with fruits developing in August (Massey *et al.* 1983, Wood 1960). Reproduction is by seeds or by fragmentation of rhizomes. *Sarracenia rubra* ssp. *jonesii* can be distinguished from other subspecies of *Sarracenia rubra* by its greater pitcher height, scape length equal to pitcher height, long petiole, abruptly expanded pitcher orifice, cordate and slightly reflexed hood, and petals and capsules, which are twice as large as those of other *Sarracenia rubra* (Massey *et al.* 1983, Sutter 1987, Wherry 1929).

Other common names of pitcher plants include trumpets, bugle-grass, bod-bugles, dumb-watches, watches, buttercups, Eve's cups, biscuit flowers, frog bonnets, fly bugles, and huntsman's cups (Wood 1960, Radford *et al.* 1964). The many common names are illustrative of the fascination generated by these unique organisms. The evolutionary role of carnivory in such plants as *Sarracenia rubra* ssp. *jonesii* is not fully understood, but some evidence indicates that absorption of minerals from insect prey may allow carnivorous species to compete in nutrient-poor

habitats (Folkerts 1977). Insects are attracted by nectar secreted from glands near the pitcher orifice, or by the plant's coloration, and fall or crawl into the pitchers. Just inside the mouth of the pitcher tube is a very smooth surface, offering no foothold to most insects; below this the pitcher is lined with stiff downward-pointing hairs which assist descent and virtually prevent ascent. Those insects which cannot escape are eventually digested by enzymes in the fluid secreted inside the pitchers.

Sarracenia rubra ssp. *jonesii* is a plant endemic to a few mountain bogs and streams in southwestern North Carolina and northwestern South Carolina along the Blue Ridge Divide. Twenty-six populations of *Sarracenia rubra* ssp. *jonesii* have been reported historically; 10 remain in existence. Four of these populations are in Henderson and Transylvania Counties, North Carolina, and six are in Greenville County, South Carolina. Eight of the remaining populations are located on privately owned lands, and two populations are located on public lands administered by the South Carolina Wildlife and Marine Resources Department and the South Carolina Department of Parks, Recreation, and Tourism. The continued existence of this species is threatened by drainage, impoundment, grazing and cultivation, natural succession, commercial and scientific collection, and development for recreational, residential, and industrial facilities.

Most of the remaining populations are extremely small, with some covering an area of less than 50 square feet. Any significant alteration of the hydrology of these sensitive sites could further jeopardize the species. The site owned by the South Carolina Wildlife and Marine Resources Department is protected. However, the other publicly owned site is part of the State parks system in South Carolina and is vulnerable to any significant increase in intensity of recreational use. The remaining eight sites in private ownership are vulnerable to destruction by habitat alteration or by taking of plants by amateur and professional collectors.

Federal government actions on this species began with Section 12 of the Endangered Species Act of 1973, which directed the Secretary of the Smithsonian Institution to prepare a report on those plants considered to be endangered, threatened, or extinct. This report, designated as House Document No. 94-51, was presented to Congress on January 9, 1975. The Service published a notice in the July 1, 1975, *Federal Register* (40 FR 27832) of its acceptance of the report of the Smithsonian Institution as a petition within the context of Section 4(c)(2) [now Section 4(b)(3)] of the Act and of its intention thereby to review the status of the plant taxa named within. *Sarracenia rubra* ssp. *jonesii* was included in the Smithsonian report and in the July 1, 1975, Notice of Review. On December 15, 1980, the Service published a revised Notice of Review for Native Plants in the *Federal Register* (45 FR 82480). *Sarracenia rubra* ssp. *jonesii* was included in that notice as a category-1 species. Category-1 species are those species for which the Service currently has on file substantial information on biological vulnerability and threats to support proposing to list them as endangered or threatened species. A revision of the 1980 notice that maintained *Sarracenia rubra* ssp. *jonesii* in category-1 was published on September 27, 1985 (50 FR 39526).

Section 4(b)(3)(B) of the Endangered Species Act, as amended in 1982, requires the Secretary to make certain findings on pending petitions within 12 months of their receipt. Section 2(b)(1) of the 1982 amendments further requires that all petitions pending on October 13, 1982, be treated as having been newly submitted on that date. This was the case for *Sarracenia rubra* ssp. *jonesii* because of the acceptance of the 1975 Smithsonian report as a petition. In October of 1983, 1984, 1985, 1986, and 1987, the Service found that the petitioned listing of *Sarracenia rubra* ssp. *jonesii* was warranted but precluded by other listing actions of a higher priority and that additional data on vulnerability and threats were still being gathered.

On February 10, 1988, the Service published, in the *Federal Register* (53 FR 3901), a proposal to list *Sarracenia rubra* ssp. *jonesii* as an endangered species. That proposal constituted the final finding as required by the 1982 amendments to the Endangered Species Act.

Summary of Comments and Recommendations

In the February 10, 1988, proposed rule and associated notifications, all

interested parties were requested to submit factual reports or information that might contribute to the development of a final rule. Appropriate State agencies, county governments, Federal agencies, scientific organizations, and other interested parties were contacted and requested to comment. Newspaper notices inviting public comment were published in *The Times-News* (Hendersonville, North Carolina) and the *Greenville News* (Greenville, South Carolina) on February 20, 1988, and February 21, 1988, respectively.

Eight comments were received. Of these, six respondents expressed support for the proposal, including the Natural Heritage Program of the North Carolina Department of Natural Resources and Community Development; the Plant Conservation Program of the North Carolina Department of Agriculture; the South Carolina Nature Conservancy; a South Carolina chapter of the Sierra Club; and the U.S. Army Corps of Engineers, Wilmington District (Corps). Two comments were received which offered no new information and did not state a position on the proposal. The Corps indicated their intent to assert regulatory jurisdiction over the species' habitats, which would normally be covered under Nationwide Permit No. 26 (33 CFR 330.5(a)(26)). The Corps' response further stated that the listing of this species as endangered was not expected to significantly affect their regulatory activities in the area and stated the belief that, "... its listing will be an important step toward assuring its survival."

Summary of Factors Affecting the Species

After a thorough review and consideration of all information available, the Service has determined that *Sarracenia rubra* ssp. *jonesii* should be classified as an endangered species. Procedures found at Section 4(a)(1) of the Endangered Species Act (16 U.S.C. 1531 et seq.) and regulations (50 CFR Part 424) promulgated to implement the listing provisions of the Act were followed. A species may be determined to be an endangered or threatened due to one or more of the five factors described in Section 4(a)(1). These factors and their application to *Sarracenia rubra* ssp. *jonesii* Wherry (mountain sweet pitcher plant) are as follows:

A. The present or threatened destruction, modification, or curtailment of its habitat or range

Ten populations of *Sarracenia rubra* ssp. *jonesii* are known to exist in

Henderson and Transylvania Counties, North Carolina, and Greenville County, South Carolina. Sixteen other historically known populations have been extirpated due to drainage, impoundment, grazing and cultivation, collection, and development for recreational, residential, and industrial purposes. At least 2 of the remaining 10 populations have also been damaged to some extent by these activities. Only two of the extant populations are afforded some protection from human-induced habitat alterations; neither of these is protected from commercial or private collectors. Of the 16 populations that have been extirpated, at least 6 were eliminated by drainage of their habitat, 4 were flooded by impoundments, 3 were destroyed by construction of golf courses, 2 were eliminated by industrial development, and 1 was destroyed when its habitat was converted to agricultural use (Charles Moore, Brevard, North Carolina, personal communication, 1987; R. Sutter, North Carolina Plant Conservation Program, personal communication, 1987). Eight of the remaining 10 populations are currently threatened by habitat alteration. In some cases this takes the form of natural succession, with woody species encroaching onto the site, resulting in a drier, shadier habitat which is unsuitable for *Sarracenia rubra* ssp. *jonesii*. The area occupied by the species is rapidly developing as a center of tourism and, as such, is extremely vulnerable to continued and accelerated habitat destruction. Alteration of drainage patterns, unrestricted grazing of livestock, or development for residential/recreational or industrial purposes could further threaten the species if proper planning is not implemented.

B. Overutilization for commercial, recreational, scientific, or educational purposes

Sarracenia rubra ssp. *jonesii*, because of its rarity, is not currently a significant component of the commercial trade in native plants; however, pitcher plants in general are very attractive to the horticultural trade, and many species have been collected for sale and export for well over a century (Harper 1918). According to landowners and others (Craig Moretz, North Carolina State University, personal communication, 1987), collectors have removed plants as well as the entire seed crop from some populations in recent years, in spite of State legislation which makes this practice illegal. Publicity could generate an increased demand, which could

easily result in complete extirpation of some of the tiny remaining populations.

C. Disease or predation

Not applicable to this species at this time.

D. The inadequacy of existing regulatory mechanisms

Sarracenia rubra ssp. *jonesii* is afforded legal protection in North Carolina by North Carolina General Statutes, § 106-202.12 to 106-202.19 (Cum. Supp. 1985), which provides for protection from intrastate trade (without a permit), for monitoring and management of State-listed species, and prohibits taking of plants without written permission of landowners. *Sarracenia rubra* ssp. *jonesii* is listed in North Carolina as endangered-special concern—a category which allows for controlled sale of propagated plants. State prohibitions against taking are difficult to enforce and do not cover adverse alterations of habitat such as disruption of drainage patterns and water tables or conversion to agriculture or development. The species is recognized in South Carolina as endangered and of national concern by the South Carolina Advisory Committee on Rare, Threatened, and Endangered Plants in South Carolina; however, this State offers no statutory protection. Section 404 of the Federal Water Pollution Control Act could provide some protection for the habitat of *Sarracenia rubra* ssp. *jonesii*, particularly since the Corps has stated their intent to assert regulatory jurisdiction over sites occupied by the species (see "Summary of Comments and Recommendations" section); however, these sites will not be protected from habitat disturbance which does not involve the placement of fill on the site. The Endangered Species Act would provide additional protection and encouragement of active management where necessary for *Sarracenia rubra* ssp. *jonesii*.

E. Other natural or manmade factors affecting its continued existence

As mentioned in the "Background" section of this proposed rule, many of the remaining populations are small in numbers of individual stems and in terms of area covered by the plants. This, in addition to the rhizomatous nature of the species, indicates that little genetic variability exists in this species, making it more important to maintain as much habitat and as many of the remaining populations as possible. In some cases shrubs and trees threaten to invade this species' habitat, which could result in the elimination of *Sarracenia*

rubra ssp. *jonesii* by shading and desiccation. Since this type of succession is a relatively slow process, it is not considered an immediate threat to survival of the species at most sites. However, research and proper management planning for *Sarracenia rubra* ssp. *jonesii* is needed to address this aspect of the species' biology.

The Service has carefully assessed the best scientific and commercial information available regarding the past, present, and future threats faced by this species in determining to propose this rule. Based on this evaluation, the preferred action is to list *Sarracenia rubra* ssp. *jonesii* as endangered. With more than 60 percent of the species' populations having already been eliminated, and only 10 remaining in existence, it definitely warrants protection under the Act. Endangered status seems appropriate because of the imminent serious threats facing most populations. As stated by Folkerts (1977), "More than any other member of the genus, its future seems bleak and it needs immediate attention." Critical habitat is not being designated for the reasons discussed below.

Critical Habitat

Section 4(a)(3) of the Act, as amended, requires that, to the maximum extent prudent and determinable, the Secretary designate any habitat of a species which is considered to be critical habitat at the time the species is determined to be endangered or threatened. The Service finds that designation of critical habitat is not prudent for *Sarracenia rubra* ssp. *jonesii* at this time. With its history of illegal collection and the ongoing horticultural trade in pitcher plants, any increased publicity or provision of specific location information associated with critical habitat designation could result in increases of collecting pressures on the species. Many of the remaining populations, being extremely small, could be extirpated as a result. None of the remaining populations occur on lands under Federal jurisdiction; therefore, the Act's prohibition against removal and reduction to possession of endangered plants from such lands would not apply, and these populations would be completely vulnerable to collectors. Even without plant collection, increased visits to population locations stimulated by critical habitat designation could adversely affect the species through trampling of the plants and their sensitive habitat. The State agencies and private landowners involved in managing the habitat of this species have been informed of the plant's locations and of the importance of protection. Protection of the species'

habitat will be addressed through the recovery process and through the Section 7 jeopardy standard. Therefore, it would not be prudent to determine critical habitat for *Sarracenia rubra* ssp. *jonesii* at this time.

Available Conservation Measures

Conservation measures provided to species listed as endangered or threatened under the Endangered Species Act include recognition, recovery actions, requirements for Federal protection, and prohibitions against certain practices. Recognition through listing encourages and results in conservation actions by Federal, State, and private agencies, groups, and individuals. The Endangered Species Act provides for possible land acquisition and cooperation with the States and requires that recovery actions be carried out for all listed species. Such actions are initiated by the Service following listing. The protection required of Federal agencies and the prohibitions against taking are discussed, in part, below.

Section 7(a) of the Act, as amended, requires Federal agencies to evaluate their actions with respect to any species that is proposed or listed as endangered or threatened and with respect to its critical habitat, if any is designated. Regulations implementing this interagency cooperation provision of the Act are codified at 50 CFR Part 402. Section 7(a)(2) requires Federal agencies to ensure that activities they authorize, fund, or carry out are not likely to jeopardize the continued existence of a listed species or to destroy or adversely modify its critical habitat. If a Federal action may adversely affect a listed species or its critical habitat, the responsible Federal agency must enter into formal consultation with the Service.

Federal activities that could impact *Sarracenia rubra* ssp. *jonesii* in the future include, but are not limited to, the following: road construction, permits for mineral exploration, permits for placing fill in wetlands, and any other activities that do not include planning for this species' continued existence. The Service will work with the involved agencies to secure protection and proper management of *Sarracenia rubra* ssp. *jonesii* while accommodating agency activities to the extent possible.

The Act and its implementing regulations found at 50 CFR 17.61, 17.62, and 17.63 set forth a series of general trade prohibitions and exceptions that apply to all endangered plants. All trade prohibitions of Section 9(a)(2) of the Act, implemented by 50 CFR 17.61, would

apply. These prohibitions, in part, make it illegal for any person subject to the jurisdiction of the United States to import or export any endangered plant, transport it in interstate or foreign commerce in the course of commercial activity, sell or offer it for sale in interstate or foreign commerce, or remove it from areas under Federal jurisdiction and reduce it to possession. Certain exceptions can apply to agents of the Service and State conservation agencies. The Act and 50 CFR 17.62 and 17.63 also provide for the issuance of permits to carry out otherwise prohibited activities involving endangered species under certain circumstances. It is anticipated that some trade permits will be sought and issued, since this species is, to some extent, already a part of the commercial trade. Requests for copies of the regulations on plants and inquiries regarding them may be addressed to the Office of Management Authority, U.S. Fish and Wildlife Service, P.O. Box 27329, Washington, D.C. 20038-7329 (202/343-4955).

On June 6, 1981, *Sarracenia rubra* sp. *jonesii* was included (as *S. jonesii*) in Appendix I of the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES). The effect of this listing is that both export and import permits are required before international shipment may occur. Such shipment is strictly regulated by CITES member nations to prevent it from being detrimental to the survival of the species and cannot be allowed if it is for primarily commercial purposes. If plants are certified as artificially propagated, however, international shipment requires only export documents under CITES, and commercial shipments may be allowed.

National Environmental Policy Act

The Fish and Wildlife Service has determined that an Environmental Assessment, as defined under the

authority of the National Environmental Policy Act of 1969, need not be prepared in connection with regulations adopted pursuant to Section 4(a) of the Endangered Species Act of 1973, as amended. A notice outlining the Service's reasons for this determination was published in the Federal Register on October 25, 1983 (48 FR 49244).

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Author

The primary author of this proposed rule is Ms. Nora Murdock, Asheville Field Office, U.S. Fish and Wildlife Service, 100 Otis Street, Room 224, Asheville, North Carolina 28801 (704/259-0321 or FTS 672-0321).

List of Subjects in 50 CFR Part 17

Endangered and threatened wildlife, Fish, Marine mammals, Plants (agriculture).

Regulation Promulgation

Accordingly, Part 17, Subchapter B of Chapter I, Title 50 of the Code of Federal Regulations, is amended as set forth below:

PART 17—[AMENDED]

1. The authority citation for Part 17 continues to read as follows:

Authority: Pub. L. 93-205, 87 Stat. 884; Pub. L. 94-359, 90 Stat. 911; Pub. L. 95-632, 92 Stat. 3751; Pub. L. 96-159, 93 Stat. 1225; Pub. L. 97-304, 96 Stat. 1411 (16 U.S.C. 1531 *et seq.*); Pub. L. 99-625, 100 Stat. 3500 (1986), unless otherwise noted.

2. Amend § 17.12(h) by adding the following, in alphabetical order under the family Sarraceniaceae, to the List of Endangered and Threatened Plants:

§ 17.12 Endangered and threatened plants.

* * * * *

(h) * * *

Species		Historic range	Status	When listed	Critical habitat	Special rules
Scientific name	Common name					
SARRACENIACEAE—Pitcher plant family:						
<i>Sarracenia rubra</i> ssp. <i>Jonesii</i> (= <i>Sarracenia jonesii</i>).	Mountain sweet pitcher plant	U.S.A. (NC, SC)	E	339	NA	NA

Dated: September 22, 1988.
 Susan Recce,
 Assistant Secretary for Fish and Wildlife and
 Parks.
 [FR Doc. 88-22401 Filed 9-29-88; 8:45 am]
 BILLING CODE 4310-55-M

Estimote

Friday
September 30, 1988

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405, 412, 413, and 489
Medicare Program; Changes to the
Inpatient Hospital Prospective Payment
System and Fiscal Year 1989 Rates; Final
Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, 413, and 489

[BERC-465-FC]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates

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

ACTION: Final rule with comment period.

SUMMARY: We are revising the Medicare inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system. In addition, in the addendum to this rule, we describe changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. In general, these changes are applicable to discharges occurring on or after October 1, 1988. We also set forth rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system.

DATES:

Effective Date: This final rule is effective on October 1, 1988. We refer the reader to section VII.A. of this preamble for a discussion of specific provisions that apply to specific periods.

Comment Date: The Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) made certain changes concerning hospitals located in certain rural counties adjacent to urban areas, and concerning adjusting the rates, weights, and outlier thresholds applicable to prospective payment hospitals and target amounts applicable to hospitals and units excluded from the prospective payment system to take into account payment reductions due to the expansion of inpatient hospital benefits. Comments about these changes, which are located at sections V.C.2. and V.M. of the preamble, § 412.63(b), and § 413.40(i), will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on November 29, 1988.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-465-FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC,

or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code BERC-465-FC. Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

For Individual Copies of This Final Rule, Contact: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, (202) 783-3238.

The charge for individual copies is \$1.50 for each issue or for each group of pages as actually bound, payable by check or money order to the Superintendent of Documents.

FOR FURTHER INFORMATION CONTACT:

Thomas Hoyer—Physician Attestation, (301) 966-4607.

Gwen Shipe—DRG Classification Changes, Ed Rees—Rate-of-Increase Limits, Lana Price—All Other Issues, (301) 966-4529.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), a system for payment of inpatient hospital services under Medicare Part A (Hospital Insurance) based on prospectively-set rates was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the inpatient hospital prospective payment system are located in 42 CFR Part 412.

Sections 1886(d)(1) (A), (C), and (D) of the Act provide for the implementation of the prospective payment system over a four-year transition period. During the transition period, payment to hospitals was based on a combination of the Federal prospective payment rates and hospital-specific rates, the proportions of which changed with the hospital's cost reporting period. In addition, during that period, the Federal rate was a combination of regional and national

rates, the proportions of which changed with the Federal fiscal year.

On September 1, 1987, we published a final rule to update the prospective payment rates for Federal fiscal year (FY) 1988. On September 29, 1987, the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (Pub. L. 100-119) was enacted. Section 107(a)(1) of Pub. L. 100-119 made several changes to payment for inpatient hospital services under the prospective payment system in FY 1988. We published a notice on October 23, 1987 (52 FR 39647) to announce those changes. In general, the prospective payment rates effective in FY 1987 and the prospective payment transition period were extended for the first 51 days of FY 1988 or for the first 51 days of a hospital's cost reporting period beginning in FY 1988, as appropriate.

B. Summary of April 5, 1988 Notice

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) was enacted. Portions of sections 4002, 4005, 4008, and 4009 of Pub. L. 100-203 affected FY 1988 payments to prospective payment hospitals and hospitals excluded from the prospective payment system. On April 5, 1988, we published a notice with comment period (53 FR 11134) to describe these statutory changes as follows:

- For discharges in FY 1988 occurring on or after April 1, 1988, the applicable percentage increase used to update the standardized amounts for prospective payment system hospitals is—
—3.0 percent for hospitals located in rural areas;
—1.5 percent for hospitals located in large urban areas; and
—1.0 percent for hospitals located in other urban areas.

• A "large urban area" is defined as an urban area that the Secretary determines has a population of more than 1,000,000 based on the most recent available population data published by the Bureau of the Census. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

• For discharges occurring in a fiscal year beginning on or after October 1, 1987, the Secretary computes average standardized amounts separately for hospitals located in rural, large urban, and other urban areas, respectively. For FY 1988 discharges occurring on or after April 1, 1988, the average standardized amounts for large urban and other urban areas are computed by applying the applicable update factor to the urban average standardized amount that was

in effect for the 51-day period beginning October 1, 1987.

- For discharges occurring on or after April 1, 1988 and before October 1, 1990, "regional floors" for the standardized amounts are established. The regional floor for a region is the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region.

- Hospitals and hospital units excluded from the prospective payment system receive a 2.7 percent increase for cost reporting periods beginning in FY 1988, excluding the first 51 days of these cost reporting periods for which the increase is zero percent.

- For cost reporting periods beginning on or after October 1, 1987, a sole community hospital's hospital-specific portion is increased by zero percent for the first 51 days of the cost reporting period, 2.7 percent for the next 132 days, and for the remainder of the cost reporting period by the same percentage increase as is used in updating the applicable Federal rate (that is, 3.0 percent for hospitals located in rural areas, 1.5 percent for hospitals located in large urban areas, and 1.0 percent for hospitals located in other urban areas).

- Effective with discharges on or after April 1, 1988, rural hospitals may qualify as rural referral centers if they have 275 or more beds.

- For discharges occurring on or after April 1, 1988 and before October 1, 1989 that are classified in DRGs relating to burn cases, the marginal cost factor to be used in computing payments for outliers is 90 percent.

The comment period for the April 5, 1988 notice ended on June 6, 1988. We are responding to the comments received on that notice as a part of this final rule, as discussed below in section I.D. of this preamble.

G. Summary of the Provisions of the May 27, 1988 Proposed Rule

On May 27, 1988, we published a proposed rule in the *Federal Register* (53 FR 19498) (and a correction notice on July 21, 1988 (53 FR 27535)) to further amend the prospective payment system as follows:

- We proposed to adjust the DRG classifications and weighting factors for FY 1989 as required by section 1886(d)(4)(C) of the Act.

- We proposed to update the wage index by basing it entirely on 1984 wage data. In addition, to reflect the provisions of sections 4004(b) and 4005(a) of Pub. L. 100-203, we proposed certain adjustments to the wage data.

- We discussed several current provisions of the regulations in 42 CFR Parts 412 and 413 and set forth certain proposed changes concerning—
 - Physician attestation;
 - Updating the prospective payment rates and rate-of-increase limits;
 - Changes in geographic classifications;
 - Creation of a regional floor for standardized amounts;
 - Payment for outlier cases;
 - Payments to sole community hospitals;
 - Referral center criteria;
 - Payment for disproportionate share hospitals;
 - Classification of capital-related costs and direct medical education costs;
 - Elimination of interim payments for the indirect costs of medical education;
 - Payment for the indirect costs of medical education; and
 - Ceiling on the rate of hospital cost increases.

- In the addendum to this proposed rule, we set forth proposed changes to the methods, amounts, and factors for determining the FY 1989 prospective payment rates. We also proposed new target rate percentages for determining the rate-of-increase limits for FY 1989 for hospitals and hospital units excluded from the prospective payment system.

In addition, the proposed rule discussed in detail the April 1, 1988 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 classifications 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 sections 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 and thereafter. We printed ProPAC's report, which includes its recommendations, as Appendix C to the proposed rule (53 FR 19630).

D. Number and Types of Public Comments

Five letters containing comments on the April 5, 1988 notice were received timely. Two hundred and fourteen letters containing comments on the May 27, 1988 proposed regulations were received timely.

The contents of the April 5, 1988 notice, the May 27, 1988 proposed rule,

the public comments received concerning both documents, and our responses to the comments are discussed throughout this document in the appropriate sections. In addition, on March 22, 1988, we published a proposed rule entitled *Miscellaneous Changes Affecting Payment for Inpatient Hospital Services* (53 FR 9337). The contents of that proposal are discussed in section II of this preamble, below, along with the public comments received concerning that proposal and our responses.

In addition, we note that in this document we are not responding to comments that raised issues not specific to the proposals we made. These issues include the general prospective payment methodology (which is, for the most part, set by law) and provisions addressed in previous prospective payment notices, such as the basis for revising the DRGs for treatment of alcohol and drug hospitals and units.

There are six general comments that we are responding to here rather than in the more issue-specific areas below.

Comment: Some commenters expressed concern that data used to establish new DRGs, to modify surgical hierarchies, and to develop a new wage index were not provided to the public.

Response: In order to be as fully responsive as possible, we described in detail in the May 27, 1988 proposed rule (53 FR 19526) the process we had implemented under which commenters could gain access to raw data on an expedited basis. Unfortunately, due to a typographical error, the reader was referred to section IV.B., instead of section VI.B., which contained the information about access to data.

In addition to making raw data available and furnishing sufficient detail in the proposed rule to permit interested parties to replicate analysis, other data are made available upon request but on the whole, we received relatively few requests for these data. We did receive a few requests for clarification of the DRG classification changes. Most of these requests were made by firms programming their own Grouper software. The limited interest in additional detail on DRG changes has convinced us that a narrative summary of the analysis and findings, such as that furnished in the proposed rule, is sufficient for the vast majority of our readers. Those who wish more detail should contact us directly, as provided for in section VI.B. of the preamble of the proposed rule.

As to the surgical hierarchy changes, the methodology we use was described in the proposed rule at 53 FR 19502, the

DRG weighting factors were provided in Table 5, and the frequency of cases in each DRG (necessary for analyzing appropriate placement of DRG pairs) were provided in Table 7b. We believe it to be totally unnecessary to publish each of the mathematical calculations used to arrive at our proposed hierarchy changes. Should an interested party fail to understand what we did or perform similar analysis but arrive at different conclusions, the contact person or persons whose telephone numbers are published at the beginning of each proposed rule are available to respond to inquiries.

Comment: One commenter indicated that data used in publishing the May 27, 1988 proposed rule was not readily available.

Response: To accommodate organizations and individuals who wished to obtain the data used in the proposed rule, we published an extensive list of files, tapes and data available upon request. We also indicated that interested parties could contact specific individuals to request these data, or other data that were not specifically mentioned. (See 53 FR 19526-19527.) During the comment period, all requests for data were given priority status and expedited immediately. It was not necessary for interested parties to make their requests under the Freedom of Information Act provisions. To further accommodate these requests, we also indicated that the data could be examined at HCFA's central office in Baltimore, Maryland. We intend to continue this practice of expediting availability of data in future proposed rules.

Comment: One commenter argued that the discharge-weighted national average standardized amount applicable to prospective payment hospitals in Puerto Rico and the Puerto Rico standardized amounts should reflect a lower labor-related portion than is used for the national and regional standardized amounts applicable to all other hospitals. The commenter argues that hospitals in Puerto Rico pay lower wages and face higher costs for nonlabor inputs than do hospitals outside Puerto Rico. In support of his position, the commenter submitted the results of a survey of hospital costs in Puerto Rico in 1986. Since the wage index is quite low in Puerto Rico, it is to the advantage of hospitals there to have a lower labor-related portion, since this would result in a smaller amount being adjusted (multiplied) by a wage index value lower than 1.0. At the same time, the nonlabor-related portion of the standardized amount, which is not

adjusted by the low wage index, would be correspondingly higher.

Response: The determination of the labor-related portion of the standardized amounts is based on the relative importance weights of labor-related and nonlabor-related items and services that comprise the hospital market basket, as rebased in 1982 based on data from the American Hospital Association (AHA) panel survey. Accordingly, we computed the labor related portion of hospital costs based solely on Puerto Rico hospitals represented in the AHA database. These data reveal a difference of fewer than three percentage points in the labor related share of Puerto Rico hospitals compared to the national labor-related share used to compute the prospective payment rates of all hospitals. This difference is much smaller than that claimed by the commenter based on the survey performed. We believe such differences may be attributable to the different time periods used (1982 for the hospital market basket versus 1986 for the Puerto Rico survey), as well as to the hospitals represented in the survey compared to those represented in the AHA database.

Moreover, as the commenter's own study indicates, "Total payments to Puerto Rican hospitals would not be greatly affected by a change in the Puerto Rican regional amounts alone. However, since 25 percent of the payment amount * * * is based upon a national average amount, a change in the methods used to calculate the national standardized amounts for Puerto Rico could result in a change in payments. Increases or decreases in total payments to Puerto Rican hospitals are a result only of the influence of the national portion on the Puerto Rican hospital payment."

The national portion of the rate paid to hospitals in Puerto Rico, as specified in section 1886(d)(9)(A)(ii) of the Act, is: "25 percent of the discharge-weighted average of—(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area, and (II) such rate for hospitals located in other urban areas, and (III) such rate for hospitals located in a rural area." As the amounts determined under section 1886(d)(3)(D) of the Act are identical to the rates published in Table 1a and used as the basis for the Puerto Rico national standardized amounts published in Table 1c of the Addendum to this final rule. We note that there is no provision for computing the national rates one way for purposes of paying virtually all prospective payment hospitals and another way for purposes of establishing

the weighted average of which the Puerto Rico national rate is comprised.

Finally, the use of a different labor-related portion for purposes of establishing the rates for hospitals in Puerto Rico raises a number of issues regarding the appropriateness of making corresponding changes elsewhere in the payment system. For example, if in a particular fiscal year, the price proxies for the labor-related component of the market basket were projected to rise more rapidly than those for nonlabor-related components, then the forecasted market basket increase would be overstated for hospitals in Puerto Rico because their rates were based on a lower labor-related share. For all of the above reasons, we have not accepted this comment, but we will further investigate the issue, and we encourage the commenter to provide us with any additional information that is available.

Comment: We received two comments opposing all changes to the prospective payment system that allow special treatment for certain areas of the country such as the regional floor provision, and the provision to allow hospitals in certain rural counties to be paid as if located in an urban county, and the establishment of higher payment rates for large urban areas.

Response: We do not generally support changes to the prospective payment system that are designed to benefit certain groups of hospitals unless there is significant evidence that these changes are warranted. However, we are required by law to implement the regional floor, the payment of the urban rates to hospitals located in certain rural counties, and the large urban provisions established under sections 1886(d)(1)(A)(iii), (d)(9), and (d)(3)(ii) of the Act, respectively, as enacted by sections 4002(d), 4005(a), and 4002(c)(1) of Pub. L. 100-203, respectively.

Comment: An association representing nonproprietary hospitals stated that anecdotal evidence confirms that average length of stay data continue to be misused. For example, patients are erroneously advised that they must be discharged upon reaching the mean length of stay because Medicare does not pay for their care beyond this point. The commenter urged that we reevaluate the usefulness of publishing the arithmetic and geometric mean length of stay information for each DRG.

Response: It is necessary to publish the geometric mean lengths of stay in the table of DRG relative weights (Table 5 of the addendum to this final rule) since they are needed in order to compute the per diem payment rate for

transfer cases. In addition, geometric mean lengths of stay are used in the computation of day outlier thresholds. In the proposed rule, we also published the arithmetic mean lengths of stay to assist the reader in understanding the difference between the geometric and arithmetic mean lengths of stay. This difference was explained in detail in the September 3, 1985 final rule at 50 FR 35710.

The arithmetic mean lengths of stay also appear in Tables 7a and 7b of the addendum to this final rule; these tables contain information on the distribution of Medicare lengths of stay by DRG. Therefore, we have deleted the arithmetic mean length-of-stay figures from the table of DRG relative weights (Table 5).

Tables 7a and 7b display the lengths of stay by DRG for cases at the 10th, 25th, 50th, 75th, and 90th percentiles of the distribution of all cases within that DRG. Table 7a shows the distribution of cases classified in accordance with the current DRG definitions while table 7b shows the distribution of cases regrouped in accordance with the DRG classifications that will be in effect for FY 1989. Both tables are based on the MEDPAR file of FY 1987 Medicare discharges from hospitals subject to the prospective payment system received in HCFA central office through June 1988.

We reiterate that the length of stay figures published in the aforementioned tables are illustrative only and reflect historical lengths of stay for Medicare beneficiaries classified within each DRG. They represent neither treatment norms nor limitations on Medicare coverage or benefits. In addition, they do not represent expectations regarding future lengths of stay. In short, the lengths of stay are published for information purposes only and, except for the use of the geometric mean length of stay in calculating day outlier and transfer payments, have no bearing whatsoever on Medicare payment for inpatient hospital services.

In addition, as provided for under section 1886(a)(1)(M) of the Act as added by section 9305(b) of Pub. L. 99-509, upon hospital admission, all Medicare beneficiaries are given a written "Message from Medicare" that explains their rights as Medicare patients. This information includes the statement in bold type that "Your discharge date must be determined solely by your medical needs, not by 'DRGs' or Medicare payments." This message stresses the importance of making all decisions about the patient's need for continued care based on the patient's health condition according to both the patient and physician.

Information concerning hospitals that discharge patients prematurely should be reported to HCFA or the Department's Office of the Inspector General.

Comment: One commenter, representing hospitals with high Medicare utilization, requested that the Secretary provide a special adjustment for hospitals that have a disproportionately large percentage of Medicare patients. As support for this position, the commenter quotes section 1886(d)(5)(C) of the Act which, in part, provides that "The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs * * * of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of this title."

Response: We believe that the special adjustment called for by the commenter is not called for by current law. Specifically, section 9105(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) added section 1886(d)(5)(F) to the Act which established an adjustment, effective May 1, 1986, for hospitals that serve a disproportionate share of Medicaid patients or patients who are entitled to both Medicare Part A and Supplemental Security Income (SSI). Congress simultaneously enacted a conforming amendment in section 9105(c) of Pub. L. 99-272 striking that part of section 1886(d)(5)(C) of the Act that referred to possible exceptions or adjustments for hospitals with high Medicare utilization. It appears that Congress intended the disproportionate share provision enacted by section 9105(a) of Pub. L. 99-272 to substitute for the discretionary authority of the Secretary previously contained in section 1886(d)(5)(C) of the Act regarding adjustments for hospitals with disproportionately high Medicare utilization.

HCFA's research has consistently failed to identify a positive relationship between Medicare utilization and adjusted Medicare inpatient operating costs per case. Such a relationship needs to be established before the type of adjustment sought by the commenter could be entertained. Therefore, we encourage the commenter to research this issue further and present detailed findings on the relationship between Medicare utilization and inpatient operating cost per case.

E. New Legislation

After publication of the May 27, 1988 proposed rule, on July 1, 1988, the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) was enacted. Section 411(b) of Pub. L. 100-360 made several technical corrections to the amendments to Title XVIII of the Act that were enacted by sections 4002 through 4009 of Pub. L. 100-203, some of which affect the provisions we are implementing through this final rule. Any technical changes relevant to the provisions we are implementing are discussed in the appropriate sections of this document.

In addition to the technical corrections, section 104(c)(1) of Pub. L. 100-360 directs the Secretary in adjusting the prospective payment rates, outlier thresholds, and DRG weighting factors for discharges occurring on or after October 1, 1988, to take into consideration, to the extent appropriate, the reductions in payments to hospitals by Medicare beneficiaries resulting from the elimination of a day limitation on Medicare inpatient hospital services (section 101 of Pub. L. 100-360). Section 104(c)(2) of Pub. L. 100-360 directs the Secretary to take the same reductions in payments into account, on a hospital-specific basis, in adjusting the target amounts for cost reporting periods beginning on or after October 1, 1988 for hospitals excluded from the prospective payment system.

The adjustments we are making for prospective payment hospitals and hospitals excluded from the prospective payment system are discussed in detail in section V.M. of this preamble.

II. Comments and Responses to the March 22, 1988 Proposed Rule

A. Summary of Proposed Rule

On March 22, 1988, we published a proposed rule in the *Federal Register* (53 FR 9337) to make several revisions to the regulations governing payments for inpatient hospital services. The provisions of that proposed rule, which, in general, are necessary to conform the regulations to current policy, are as follows:

- For purposes of paying hospitals under the prospective payment system, we proposed that changes in Metropolitan Statistical Area (MSA) and New England County Metropolitan Area (NECMA) designations would be recognized only at the beginning of a Federal fiscal year under §§ 412.63(b) and 412.210(b). Depending on the changes, a county may be reclassified as urban and thus hospitals located in the county would receive a higher urban

rate, or a county may lose its urban area status, and thus hospitals located in the county would receive the lower, rural payment rate.

- Under § 412.92(b), we proposed that a hospital classified as a sole community hospital (SCH) would receive a revised payment rate effective with discharges occurring on or after 30 days after the date of HCFA approval of the classification.

- For purposes of determining a hospital's qualification for payment as a disproportionate share hospital under § 412.106(a)(1), we proposed that the Supplemental Security Income (SSI)/Medicare percentage would be based on Medicare patient days associated with discharges occurring during the Federal fiscal year. In addition, we proposed to add to the regulations a definition of patient days.

- We proposed to revise §§ 413.30(c) and 413.40(e), which govern hospital requests regarding applicability of the rate-of-increase ceiling, to make it clear that they apply to a hospital's request for an adjustment to the rate-of-increase ceiling as well as to the currently included requests for an exemption or exception. We also proposed to revise § 413.40 (g) and (h) to clarify that a request for an exemption or adjustment is granted only in those cases in which the hospital's costs exceed its rate of increase ceiling.

- We proposed to make two technical, conforming changes to the regulations as follows:

- We would add payment adjustments for hospitals that serve a disproportionate share of low-income patients to the list of additional payments to hospitals set forth at § 412.2(e).

- We would delete § 489.23, the special provision for hospitals that provides for waiver of requirements concerning Part A billing, and cross-references to that deleted section, since the authority to provide such waivers expired with cost reporting periods beginning on or after October 1, 1986.

We received six items of correspondence concerning the provisions of the March 22, 1988 proposed rule. The comments and our responses are discussed below.

B. Comments and Responses

1. Recognition of Changes in Urban/Rural Designations

Comment: One commenter suggested that we should provide that hospitals affected by modifications to the MSA designations be given at least 30 days notice before modifications are recognized for Medicare purposes. This

would ensure that hospitals would have adequate notification if any changes were announced fewer than 30 days prior to the beginning of the Federal fiscal year.

Response: Given the fact that changes to the MSA designations are generally announced by EOMB in June of each year, we do not anticipate that an additional notice period would be necessary. The only situation in which EOMB might announce MSA changes at other times during the year is for changes that were Congressionally mandated. In the event that such a change is announced after our final prospective payment notice has gone to the printer and before October 1, the change would be effective with discharges occurring on or after October 1 and affected hospitals would be notified by the HCFA regional office or their own fiscal intermediary.

2. Hospitals that Serve a Disproportionate Share of Low-Income Patients

Comment: One commenter stated that since the regulations did not previously define inpatient days to be used in the disproportionate patient percentage calculation, the proposed definition of inpatient days in § 412.106(a)(5) should be applied prospectively only. Specifically, the commenter stated that patient days in excluded units should also be counted in the formula in section 1886(d)(5)(F)(vi) of the Act, not just patient days subject to the prospective payment system. The commenter stated that retroactive application of the definition is not appropriate since Congress did not specify in the law that patient days in excluded units of the hospital should not be counted.

Response: The definition of inpatient days we are adding to § 412.106(a) does not represent new policy but is the same definition that we have used to calculate the disproportionate patient percentage since the adjustment was implemented on May 1, 1986. Therefore, this does not represent retroactive application of a new policy but is a restatement of an existing policy.

Although previously the Medicare regulations did not specifically define the inpatient days for use in the computation of a hospital's disproportionate share patient percentage, we believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a

disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of a subsection (d) hospital, which is the only type of hospital subject to the prospective payment system.

Section 1886(d)(1)(B) of the Act defines a subsection (d) hospital as "a hospital located in one of the fifty States or the District of Columbia * * * and does not include a psychiatric or rehabilitation unit of a hospital which is a distinct part of the hospital." In providing for the disproportionate share adjustment, section 1886(d)(5)(F) of the Act specifically refers to a subsection (d) hospital. Thus, section 1886(d)(5)(F)(i) of the Act refers only to "an additional payment amount for each subsection (d) hospital * * *." Other references in section 1886(d)(5)(F) of the Act are to "hospital" and "such hospital." However, since 1886(d)(5)(F) of the Act incorporates the definition of "hospital" by reference to "subsection (d)", all further references in that subparagraph, unless stated otherwise, are taken to mean a subsection (d) hospital. As such, the fact that the prior proposed and final rules that implement the disproportionate share adjustment did not specifically distinguish between prospective payment hospitals and units excluded from the prospective payment system for the purpose of counting inpatient days does not support the conclusion that we must count inpatient days in hospital units that are excluded from the prospective payment system for the periods prior to this change in the regulations.

Moreover, this reading of section 1886(d)(5)(F) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals or from hospital units subject to the prospective payment system are used in determining both the qualification for and the amount of additional payments to hospitals that are eligible for a disproportionate share adjustment.

Comment: One commenter recommended that we clarify the regulation change that specifies that, in computing a hospital's SSI/Medicare percentage, the total number of patient days associated with a particular hospital stay is counted in the Federal fiscal year in which the patient is discharged. This proposed change does not address how patient days are counted for a hospital that chooses to use its own cost reporting period to compute the SSI/Medicare percentage, as permitted for under § 412.106(a)(2).

Therefore, the commenter suggests that we also revise this section to specify how patient days would be counted in this situation.

Response: We agree with this comment and are therefore revising § 412.106(a)(2) to be consistent with § 412.106(a)(1). That is, in computing a hospital's SSI/Medicare percentage, the total number of patient days associated with a particular hospital stay is counted in the hospital's cost reporting period in which the patient is discharged.

3. Adjustments to the Rate-of-Increase Ceiling and Hospital Cost Limits

Comment: One comment was received from a law firm protesting the clarification that a hospital cannot receive an adjustment to its rate-of-increase ceiling if the hospital's costs do not exceed its target amount. The commenter asserted that the effect of the proposed rule would be to directly contravene Congressional intent that hospitals receiving incentive payments be permitted to receive exceptions or adjustments solely for the purpose of increasing these incentive payments rather than to recover cost disallowances.

Response: We disagree with the assertion that there was any Congressional intent to award hospitals additional incentive payments under the exemption, exception, or adjustment authority in section 1886(b)(4) of the Act. The rate-of-increase provisions are an extension of the cost containment provisions in section 1886(a)(1)(A)(i) of the Act (limits on inpatient operating costs). The relationship between the two separate cost containment measures can be seen in the parallel language used under both provisions with respect to providing an exemption from, or an exception and adjustment to, the methods of payment. Also, in addressing the incentive payment and excess cost disallowance, section 1886(b)(1) of the Act states " * * * except that in no case may the amount payable under this title * * * with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a)." The interrelationship of the two limitation methodologies enforces the intent of the Act to promote cost containment.

As stated in the proposed rule, the Senate provision regarding the adjustment process was adopted by the Conference Committee (H.R. Rep. No. 760, 97th Cong., 2nd Sess. 419-421 (1982)). Since the Senate amendments did not contain an incentive payment provision, it could not be construed that the

exemption, exception, and adjustment process was contemplated without the knowledge or consideration of an incentive program. Also, it seems that the Senate was concerned about hospitals reducing costs through elimination of patient services. This concern can be seen in the discretionary authority given to the Secretary for providing other exemptions from, and exceptions and adjustments to, the limit methodology. Section 1886(b)(4) of the Act states "the Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which result in a significant distortion in the operating costs of inpatient hospital services."

It was recognized that hospitals, through this cost containment effort, would have to cut costs but not to the detriment of services being furnished to beneficiaries. The area of patient care was the only area of reductions to be evaluated under these provisions. Therefore, since the reductions employed by a hospital to create incentive payments, other than those decreasing inpatient services, are not adjusted upward in determining an incentive payment, the increases should not be adjusted downward to provide for additional incentive payments. We still believe that the main concern in the exemption, exception, and adjustment provisions was to protect hospitals from being harmed by the rate-of-increase provisions for reasons outside the control of hospital management.

C. Conclusion

We are revising § 412.106(a)(2) to be consistent with § 412.106(a)(1) to indicate that in computing a hospital's SSI/Medicare percentage, the total number of patient days associated with a particular hospital stay is counted in the hospital's cost reporting period in which the patient is discharged. We are correcting the cross reference to § 413.55(b) in § 412.2 (c)(1) and (c)(3). The correct cross reference is to § 413.53(b). As discussed above, based on our consideration of the comments we received, otherwise we are not making any other changes to the provisions of the proposed rule and are adopting those provisions as final in this document.

However, based on inquiries we have received, we wish to further clarify the effective dates for several situations in which a hospital gains or gives up SCH

status. First, SCH status and the associated payment adjustment is effective 30 days after HCFA's written notification to the SCH. Thus, 30 days after the issuance of HCFA's notice of approval, the hospital is considered to be an SCH and the payment adjustment is applied to discharges occurring on or after that date.

Second, we also wish to clarify the effective date when a hospital chooses to give up its SCH status. Our policy has always been that an SCH can elect to give up its SCH status at any time by submitting a written request to the appropriate HCFA regional office. The change to fully national rates becomes effective no later than 30 days after the hospital submits its request. We believe that "no later than 30 days" policy in the effective date for cancelling SCH status is in keeping with the prospective nature of the prospective payment system. In addition, the 30-day time frame to give up SCH status provides the intermediaries with enough time to alter their automated payment systems prospectively, thus avoiding expensive and time consuming reprocessing of claims. The variable time frame of "no later than 30 days from the date of the hospital's request" also permits the regional office, the intermediary, and the hospital to select a mutually agreeable date, for example, at the end of a month, to facilitate the change in SCH status. We expect that hospitals will anticipate when they wish to give up SCH status and to submit their requests in sufficient time to permit the 30-day period for making the change.

Finally, we wish to clarify the effective date when a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses HCFA's denial of SCH status to a hospital and there is no further appeal made. In this situation, if the hospital's application was submitted prior to October 1, 1983, its status as an SCH will be effective at the start of the cost reporting period for which it sought exemption from the cost limits. If the hospital's application for SCH status was filed on or after October 1, 1983, the effective date will be 30 days after the date of HCFA's original written notification of denial.

If a hospital is granted retroactive approval of SCH status by a court order or a PRRB decision and it wishes its SCH status terminated prior to the current date (that it wishes to be paid as an SCH for a time-limited period, all of it in the past), it must submit written notice to the regional office within 90 days of the court order or PRRB decision. This written notice must

clearly state that although SCH status was granted retroactively by the court or the PRRB, the hospital wants this status terminated as of a specific date. If written notice is not received within 90 days of the court order or PRRB decision, SCH status will continue. Written requests to terminate SCH status that are received subsequent to the 90-day period will be effective no later than 30 days after the request is submitted, as discussed above.

III. Changes to DRG Classifications and Weighting Factors

A. Background

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the national average of resources used to treat all Medicare cases. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average Medicare case.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors annually beginning with discharges occurring in FY 1988. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 1988 are discussed below.

B. Reclassification of DRGs

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to four additional diagnoses, and certain procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnoses and procedures are expressed by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). The intermediary enters the information into its claims system

and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the MCE and any further development of the claims, cases are classified by the Grouper software program into the appropriate DRG. The Grouper program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights and to classify current cases for purposes of determining payment.

The list of DRGs is organized into 23 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

Principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual surgical procedures or groups of surgical procedures by resource intensity) and medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis only. Some categories of both medical and surgical cases are further disaggregated on the basis of patient age or the presence or absence of complications or comorbidities (hereafter CC) only. Generally, Grouper does not consider nonsurgical procedures or minor surgical procedures that usually do not require an operating room (OR). However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

In the proposed rule published on May 27, 1988, we proposed to make some changes to the DRG classification system on the basis of problems identified over the past year. These proposed changes and the comments we received concerning them as well as our responses are set forth below. In addition to comments related to each of the specific proposed DRG classification changes, we received some general comments, as follows:

Comment: Several commenters expressed concern that HCFA does not

provide details on the analyses that led to proposed DRG changes. In addition, the commenters stated that the criteria we used should be explicit and provide for public review and comment.

Response: Providing a detailed description of the analytic bases for our proposed changes is a reasonable alternative and is consistent with the level of detail most readers desire. For those individuals wishing more information, a contact person's name and telephone number are published in each proposed and final rule or notice.

With regard to the comments recommending that detailed criteria for classification be developed and published for comment, we do not believe such steps are necessary. The DRGs, as originally developed, were intended to represent groups of hospital patients who were clinically similar to one another and were relatively homogeneous with respect to resource use as measured by length of stay. The algorithm used to define the DRGs was designed to establish partitions that would both reduce the variance with respect to length of stay within groups and maximize the differences between groups. It was originally thought that in order to be manageable, the DRGs should number something less than 500.

In our efforts to refine the DRG classifications and respond to changing medical practice, we have attempted to adhere to those principles. Since we have based DRG weighting factors on total charges (standardized to account for variations among hospitals in area wages, teaching intensity, and the proportion of low income patients), we have used standardized charges rather than the length of stay as our primary measure of relative resource use when examining the extent to which a proposed classification change makes the DRGs more or less homogeneous. In addition, with respect to new technologies, we prefer adding cases involving new technologies to an existing DRG, clinical heterogeneity notwithstanding, until there is relatively compelling evidence (based on Medicare patient experience) that a separate DRG would improve both the clinical coherence and the homogeneity with respect to resource use for the new DRG. Moreover, we described the bases on which we proposed DRG classification changes in our proposed rule. In general, the changes we have proposed are ones that either reduced within DRG variance among patients in resource use (as measured by standardized charges); incorporated new ICD-9-CM codes into the DRGs; incorporated new technologies into the

DRGs; or represented housekeeping changes, such as consistency or other logic checks.

Generalizing beyond these goals to overriding criteria could be counterproductive in that the criteria thus adopted may be too narrow to permit adoption of a reasonable DRG classification change or too broad to forestall consideration of reassignment of each and every ICD-9-CM code from the DRG(s) to which it is presently assigned to all other possible DRGs. We believe it is better to continue to evaluate each DRG classification issue independently and that it is sufficient to describe the analytic basis upon which we propose each of the individual DRG classification changes.

We will continue to base our decisions on clinical grounds, comparability of the average charge for one type of case to the mean for the DRG in which it is classified and the DRG to which its movement is proposed, frequency of the procedure or diagnosis at issue, variation in a particular DRG relative to DRGs in general, and other issues pertinent to the type of case being considered for reclassification. We believe such individual consideration is superior to the development of criteria that could potentially prevent movement of cases in instances where reclassification is appropriate.

We recognize the need to make available the data upon which our decisions were reached. Therefore, in the proposed rule, we listed the types of information that could be obtained on an expedited basis (53 FR 19526). If the data that were needed were not listed, any concerned commenter could call for the necessary information. We also provided for inspection of the data onsite at the HCFA central office. We believe that we have demonstrated our commitment to provide the public with the necessary information to submit informed comments.

Comment: A few commenters wrote concerning the classification of thoracoabdominal aortic aneurysm repair (TAAA). In the September 1, 1987 final notice concerning changes to the DRG classification system (52 FR 33148), we indicated that we would continue to review the classification of this repair. The commenters noted that we had not addressed the issue in the May 27, 1988 proposed rule. The commenters suggested that the current classification of TAAA does not recognize the resources involved in this procedure.

Response: We agree with the commenters that we need to continue to review the classification of TAAA as well as other procedures in the analysis of DRGs. Currently, TAAA repairs are

classified in DRG 108 (Other Cardiothoracic or Vascular Procedures with Pump) and DRG 109 (Other Cardiothoracic Procedures without Pump). We reviewed the current data available to note the exact number of procedures performed. In FY 1987, there were 1,647 discharges in DRG 108; 69 involved TAAA repairs. Of the 9,386 total discharges in DRG 109, 270 discharges involved TAAA repairs. We are not generally persuaded that such small numbers of cases warrant special treatment in the context of a system built on averages. However, because other problems have been brought to our attention regarding the classification of certain major cardiovascular procedures, we plan to conduct a broader analysis during the coming year to identify potential restructuring of DRGs 108 through 112, which would necessarily involve review of the placement of TAAA repair. Because of the extensiveness of this review, we invite interested parties to submit specific concerns or alternative configurations of these DRGs to us in writing at: HCFA Grouper Changes, P.O. Box 26681, Baltimore, Maryland 21207.

2. MDC 3: Diseases and Disorders of the Ear, Nose and Throat

Based on our analysis of cases brought to our attention and the overall logic of the DRG classification system, we proposed to restructure MDC 3 (Diagnoses of Disorders of the Ear, Nose and Throat) and MDC 6 (Diagnoses and Disorders of the Digestive System) by removing mouth-related diagnoses and procedures from MDC 6 and adding them to MDC 3, to be retitled "Diseases and Disorders of the Ear, Nose, Mouth and Throat." We proposed to move DRGs 168 and 169 (Mouth Procedures)¹ and DRGs 185 and 186 (Dental and Oral Disease Except Extractions and Restorations) and 187 (Dental Extractions and Restorations) from MDC 6 to MDC 3. We proposed to delete the diagnosis and procedure codes in these three DRGs from MDC 6.

Because the mouth malignancy diagnosis codes (140.0-145.9) in DRGs 185, 186, and 187 fit more appropriately with other MDC 3 malignancy codes in DRG 64 (Ear, Nose and Throat Malignancy), we proposed to delete codes 140.0-145.9 from DRGs 185, 186, and 187 and add them to DRG 64, which

¹ Unless otherwise noted, a single title combined with two DRG numbers is used to signify pairs, the first DRG of which is cases with CC and the second of which is cases without CC. If a third number is included, it represents cases of patients who are age 0-17, and the first two DRGs are limited to patients age greater than 17, with CC and without CC, respectively.

would be retitled Ear, Nose, Mouth and Throat Malignancy. In addition, we found that several mouth-related diagnosis codes that were in DRGs 73 and 74 (Other Ear, Nose and Throat Diagnoses) would fit more appropriately into DRGs 185, 186, and 187. Therefore, we proposed to delete the diagnosis codes listed below from DRGs 73 and 74 and add them to DRGs 185, 186, and 187.

Diagnosis code	Description
210.1.....	Benign neoplasm tongue.
744.81-744.84.....	Other specified anomalies of the face and neck.
749.00-749.04.....	Cleft palate.
749.10-749.14.....	Cleft lip.
749.20-749.25.....	Cleft palate with cleft lip.

We proposed to retitle DRGs 73 and 74 as "Other Ear, Nose, Mouth and Throat Diagnoses" to conform with the rest of the restructured MDC 3.

Finally, we determined that four neoplasm codes included in DRGs 188, 189, and 190 (Other Digestive System Diagnoses) would be better classified in the revised DRGs 185, 186, and 187 in MDC 3. We proposed to delete diagnosis codes 210.0, 210.3, 210.4, and 213.1, benign neoplasms of the lip, mouth floor, mouth, and lower jawbone, respectively, from MDC 6 and add them to DRGs 185, 186, and 187 now in MDC 3.

As noted in the proposed rule (53 FR 19500), all of the procedure codes in the surgical DRGs 168 and 169 were already also assigned to clinically coherent DRGs in MDC 3. Thus, merely moving DRGs 168 and 169 into MDC 3 would produce a situation in which a case involving one of the mouth procedures could be assigned to multiple DRGs or, alternatively, a situation in which DRGs 168 and 169 would be empty. In order to prevent such an outcome, we proposed deleting from DRGs 168 and 169 all procedures except the following, which are very specific to the mouth:

Procedure code	Description
24.2.....	Gingivoplasty.
24.4.....	Excision of dental lesion of jaw.
24.5.....	Alveoloplasty.
25.1.....	Excision or destruction of lesion or tissue of tongue.
25.59.....	Other repair and plastic operations on tongue.
25.94.....	Other glossectomy.
25.99.....	Other operations on tongue.
27.0.....	Drainage of face and floor of mouth.
27.1.....	Incision of palate.
27.21.....	Biopsy of bony palate.
27.22.....	Biopsy of uvula and soft palate.
27.31.....	Local excision or destruction of lesion or tissue of bony palate.
27.42.....	Wide excision of lesion of lip.
27.43.....	Other excision of lesion or tissue of lip.

Procedure code	Description
27.49.....	Other excision of mouth.
27.53.....	Closure of fistula of mouth.
27.55.....	Full-thickness skin graft to lip and mouth.
27.56.....	Other skin graft to lip and mouth.
27.57.....	Attachment of pedicle or flap graft to lip and mouth.
27.59.....	Other plastic repair of mouth.
27.61.....	Suture of laceration of palate.
27.71.....	Incision of uvula.
27.72.....	Excision of uvula.
27.73.....	Repair of uvula.
27.79.....	Other operations on uvula.
27.92.....	Incision of mouth, unspecified structure.
27.99.....	Other operations on oral cavity.

Since these procedures were also assigned to DRG 63 (Other Ear, Nose and Throat Procedures), we proposed to remove them from DRG 63. By removing these procedures from DRG 63 and including them in the restructured DRGs 168 and 169 in MDC 3, we proposed to create a specific DRG pair for mouth-related procedures in MDC 3. We proposed to assign cases involving all other procedures in DRGs 168 and 169 to DRGs 49 through 62. We proposed to add DRGs 168 and 169 to the revised surgical hierarchy for MDC 3 described below in section III.B.4.a. of this preamble. To conform with the restructured MDC, we proposed that DRG 63 be retitled as Other Ear, Nose, Mouth and Throat Procedures and that DRG 55 be retitled as Miscellaneous Ear, Nose, Mouth and Throat Procedures. We received two comments on this proposal, both of which expressed approval and support. Therefore, we are adopting our proposed reconfiguration unchanged.

3. Reclassification of MDC 7

Recently, a problem with the DRG assignment of certain cases involving multiple biliary tract procedures in MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas) was brought to our attention. Based on our review, we proposed that, for operating room procedures done on the biliary tract, procedures first be differentiated on the basis of whether a total cholecystectomy, with or without common bile duct exploration, had been the only procedure performed, or whether some other biliary tract procedure had also been performed. If, in addition to cholecystectomy with or without common bile duct exploration, another biliary tract procedure had been performed, we proposed that the case group to DRG 193 or 194 (Biliary Tract Procedures Except Total Cholecystectomy). If a cholecystectomy and common bile duct exploration had

been the only procedures performed, we proposed that the case be assigned to DRG 195 or 196 (Total Cholecystectomy with Common Duct Exploration). Finally, we proposed that DRGs 197 and 198 (Total Cholecystectomy without Common Duct Exploration) be reserved for those cases in which the only biliary tract procedure performed is a cholecystectomy.

In MDC 7, another problem in the surgical hierarchy was found in DRG 191 (Major Pancreas, Liver and Shunt Procedures) and DRG 192 (Minor Pancreas, Liver and Shunt Procedures). The relative weights suggested that DRG 192 was more resource intensive than DRG 191 and, therefore, should be ordered above it in the surgical hierarchy. Logically, however, minor procedures should not be ordered above major procedures. Consequently, this occurrence suggested that something was amiss in our delineation of major and minor procedures. To solve this problem, we proposed to combine all the procedures in DRGs 191 and 192 and group discharges having these procedures based on the presence or absence of a CC and to entitle DRG 191 "Pancreas, Liver and Shunt Procedures with CC," and DRG 192 "Pancreas, Liver and Shunt Procedures without CC."

We indicated that as part of our ongoing review, we would also examine the data to determine if procedures involving the pancreas should be separated from the other procedures in DRGs 191 and 192. Having completed this examination of data, we found little difference in the standardized charges for pancreatic procedures compared to other procedures in these DRGs. However, the minimal difference in the standardized charges does not explain the discrepancy we had originally found when reviewing the weights for the major and minor procedures. Based on our review, we believe differentiation between DRGs 191 and 192 based on the presence or absence of a CC is the most logically coherent approach.

Comment: One commenter wrote concerning the methodology under which discharges currently group to DRGs in MDC 7 when a cholecystectomy is performed. The commenter noted that the presence or absence of a cholecystectomy procedure, regardless of which other biliary tract procedures have been performed, determines which DRG is assigned to the discharge. This happens even when the other procedures are more resource intensive.

Response: This is the type of problem we addressed in the proposed rule at 53 FR 19501. For operating room procedures

performed on the biliary tract, the discharge will first be differentiated on the basis of whether a total cholecystectomy with or without common bile duct exploration was the only procedure performed or whether some other biliary tract procedure was also performed. The discharge would be assigned to DRG 193 or 194 if, in addition the cholecystectomy with or without common bile duct exploration, another biliary tract procedure was performed. The discharge will be assigned to DRG 195 or 196 if a cholecystectomy and common bile duct exploration are the only procedures performed. DRG 197 or 198 will be assigned to discharges in which the only biliary tract procedure performed was a cholecystectomy.

Comment: One commenter, in discussing the changes in MDC 7, stated that we did not identify to which DRG a discharge would be assigned when only a biliary tract procedure except total cholecystectomy was performed.

Response: In the proposed rule, we only discussed the changes we were making to correct the problem of DRG assignment of cases involving multiple biliary tract procedures, one of which is a total cholecystectomy. We did not propose to change the methodology under which discharges involving only biliary tract procedures other than total cholecystectomy group. These discharges will continue to group one of DRGs 193 and 194, which we have retitled "Biliary Tract Procedure with CC, Except Only Total Cholecystectomy with or without Common Bile Duct Exploration" and "Biliary Tract Procedure without CC, Except Only Total Cholecystectomy with or without Common Bile Duct Exploration", respectively.

4. Surgical Hierarchies

Because the relative resource intensity of procedure groups can shift as a function of DRG reclassification and recalibration, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications, to determine if the ordering of procedures coincided with the intensity of resource utilization, as measured by the same billing data used to compute the DRG relative weights.

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy as set forth below. As discussed below in section III.C. of this preamble, the final recalibrated weights are somewhat different from those proposed since they are based on more complete data. Consequently, we have

further revised the hierarchy in this final rule as described below.

We proposed to revise the surgical hierarchy for MDCs 3, 5, 6, and 8 as follows:

a. As discussed above in section III.B.2. of this preamble, we proposed to move all mouth diagnoses and procedures into MDC 3 to create one MDC for the Ear, Nose, Mouth and Throat. Accordingly, DRGs 168 and 169 would move from MDC 6 into MDC 3 and must be placed into the surgical hierarchy for MDC 3. Based on this change and the resulting relative weights, we proposed to reorder the procedure groups in MDC 3 as follows:

Major Head and Neck Procedures (DRG 49)
Tonsillectomy and Adenoidectomy
Procedure Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58)

Mouth Procedures (DRGs 168 and 169)
Cleft Lip and Palate Repair (DRG 52)
Myringotomy with Tube Insertion (DRGs 61 and 62)
Sialoadenectomy (DRG 50)
Sinus and Mastoid (DRGs 53 and 54)
Salivary Gland Except Sialoadenectomy (DRG 51)

Miscellaneous Ear, Nose, Mouth and Throat (DRG 55)
Rhinoplasty (DRG 56)
Tonsillectomy and/or Adenoidectomy Only (DRGs 59 and 60)
Other Ear, Nose, Mouth, and Throat OR Procedures (DRG 63)

b. In MDC 5 (Diseases and Disorders of the Circulatory System), we proposed to reorder Other Cardiothoracic or Vascular Procedures with Pump (DRG 108) above Coronary Bypass (DRGs 106 and 107).

c. In MDC 6, we proposed to remove Mouth Procedures (DRGs 168 and 169) from the hierarchy and place them into MDC 3.

d. In MDC 8 (Disease and Disorders of the Musculoskeletal System and Connective Tissue), we proposed to reorder Soft Tissue (DRGs 226 and 227) above Local Excision and Removal of Internal Fixation Devices of Hip and Femur (DRG 230).

e. We proposed to differentiate the DRG pair for pancreas, liver, and shunt procedures based on the presence or absence of a CC. However, the surgical hierarchy would not change. Pancreas, Liver and Shunt Procedures will continue to precede Biliary Tract Procedures in the hierarchy for MDC 7.

We received three comments concerning the proposed reordering within the surgical hierarchies. The comments were all favorable and supported the proposed changes. We are

finalizing these proposed changes except as provided below.

Although moving mouth procedures into MDC 3 is an improvement to the surgical hierarchies, further analysis has indicated an error in the proposed ordering of the surgical hierarchy in MDC 3. When we propose changes to the surgical hierarchy, we are not always able to test the effects of the revisions due to the unavailability of revised Grouper software at the time of publication. Rather, in performing analysis of the surgical hierarchies, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then recalculate the DRG weights. The weighting factor for each procedure group then serves as our best estimate of relative resource use for that procedure group.

Since we published the proposed rule, we have received a revised Grouper program and a more complete 1987 MEDPAR file, and we were able to test the proposed surgical hierarchy changes. Test results indicated that two changes are necessary. First, the weighted average of the relative weights for Mouth Procedures (DRGs 168 and 169) was less than the weight for Cleft Lip and Palate Repair (DRG 52) and also less than the weighted average of relative weights for Myringotomy with Tube Insertion, Age >17 and Age <17, respectively (DRGs 61 and 62), both of which we had proposed to place lower than Mouth Procedures (DRGs 168 and 169). Consequently, we are revising the proposed ordering of the surgical hierarchy in MDC 3 to provide that Mouth Procedures (DRGs 168 and 169) has now been moved to below Myringotomy with Tube Insertion (DRGs 61 and 62). The complete surgical hierarchy for MDC 3 is as follows:

Major Head and Neck Procedures (DRG 49)
Tonsil and Adenoid Procedures Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58)
Cleft Lip and Palate Repair (DRG 52)
Myringotomy with Tube Insertion (DRGs 61 and 62)
Mouth Procedures (DRGs 168 and 169)
Sialoadenectomy (DRG 50)
Sinus and Mastoid (DRGs 53 and 54)
Salivary Gland Except Sialoadenectomy (DRG 51)
Miscellaneous Ear, Nose, Mouth and Throat (DRG 55)
Rhinoplasty (DRG 56)
Tonsillectomy and/or Adenoidectomy Only (DRGs 59 and 60)
Other Ear, Nose, Mouth and Throat OR Procedures (DRG 63)

In addition, we have found from analysis with the revised Grouper

program that reordering of the MDC 6 surgical hierarchy is necessary since Rectal Resection (DRGs 146 and 147) was ordered above Major Small and Large Bowel Procedures (DRGs 148 and 149) but is of a lower-weighted average relative weight. This occurs largely as a result of the reclassification of Hartmann resections, owing to the elimination of procedure code 48.66 and the future use of procedure code 45.75 (Left hemicolectomy) to identify that procedure. Consequently, we are revising the hierarchy in MDC 6 to provide that Major Small and Large Bowel Procedures (DRGs 148 and 149) are ordered above Rectal Resection (DRGs 146 and 147).

5. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications and comorbidities (CCs). This list was developed by physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial CC, in turn, is defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase of at least one day in length of stay for at least 75 percent of the patients.

We proposed a limited revision of the CC Exclusion Lists, which included corrections of errors in the existing list, addition of a number of excluded CCs, and the deletion of a number of excluded CCs.

Tables 6d and 6e in section IV of the addendum to the proposed rule contained the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1988. Although 67 principal diagnoses have both deletions from and additions to the diagnoses that are excluded as CCs, for clarity we showed the additions and deletions to the CC Exclusions List in separate tables. The tables show the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses was shown with an asterisk and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis. We received no negative comments on these revisions. Therefore, in the final rule, we have updated these tables as proposed except to make conforming changes to reflect the treatment as CCs of certain of the new neonate diagnosis codes that will become effective October 1, 1988.

CCs that are added to the list are in Table 6d—Additions to the CC Exclusions List. (The indented diagnoses were previously recognized by the Grouper as valid CCs for the asterisked principal diagnosis but will be excluded from the CC list for that principal diagnosis and thus ignored by the Grouper beginning with discharges on or after October 1, 1988.)

CCs that are deleted from the list are in Table 6e—Deletions from the CC Exclusions List. (The indented diagnoses were previously excluded and were not recognized by the Grouper as valid CCs for the asterisked principal diagnosis but will be recognized as valid CCs beginning with discharges on or after October 1, 1988.)

Copies of the entire original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for \$59.95 and on microfiche for \$17.50. A request for the FY 1988 CC Exclusions List (which should include the identification accession number, ((PB) 88-133970)) should be made to the following address: National Technical Information Service, United States Department of Commerce, Springfield, Virginia 22161, or by calling (703) 487-4650.

Users should be aware of the fact that the revisions in Tables 6d and 6e must be incorporated into the original FY 1988 list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1988. (We do not currently intend to update the listing available from NTIS to take into account future revisions.)

Alternatively, the complete documentation of the Grouper logic, including the current CC Exclusions List, is available from Health Systems International (HSI). HSI, under contract with HCFA, is responsible for updating and maintaining the Grouper program. The DRG Definitions Manual, Fifth Revision, which is effective for discharges on or after October 1, 1988 will be available soon after October 1, 1988, for \$165.00, which includes \$15.00 for shipping and handling. The fifth revision of this manual includes the changes in this document. This manual may be obtained by writing HSI at: 100 Broadway, New Haven, Connecticut 06511, or by calling (203) 562-2101.

Please specify the revisions requested.

6. Additional Procedure Code Changes in DRG 468

Each year, we review cases assigned to DRG 468 (Unrelated Operating Room Procedures) in order to determine

whether, in conjunction with certain principal diagnoses, there are certain procedures performed that are not currently included in the surgical hierarchy for the MDC in which the diagnosis falls. Since DRG 468 is reserved for those cases in which none of the operating room (OR) procedures shown on the bill is related to the principal diagnosis, it is intended to capture atypical medical cases, that is, those not occurring with sufficient frequency to represent a distinct recognizable clinical group. On the basis of this review, we proposed several DRG classification changes in order to reduce unnecessary assignment of cases to DRG 468.

In MDC 5 (Diseases and Disorders of the Circulatory System), when procedure code 54.93 (Creation of cutaneous peritoneal fistula) is performed with a principal diagnosis such as mechanical complication of other vascular device, implant and graft (diagnosis code 996.1), the discharge is assigned to DRG 468. We proposed to add procedure code 54.93 to the list of operating room procedures in DRG 120 (Other Circulatory System OR Procedures). We also proposed in DRG 120 to include procedure code 54.95 (Incision of peritoneum), which previously, if paired with a principal diagnosis in MDC 5 such as mechanical complication of other vascular device, implant and graft (diagnosis code 996.1), grouped to DRG 468.

In DRGs 170 and 171 (Other Digestive System OR Procedures), we proposed to add procedure code 39.27 (Arteriovenostomy for renal dialysis) as one of the operating room procedures. This would preclude assignment of a discharge to DRG 468 if this procedure is performed with a principal diagnosis such as diagnosis code 567.2 (Other Suppurative peritonitis).

Previously, procedure code 39.25 (Aorta-iliac-femoral bypass), when combined with a diagnosis code such as 707.1 (Ulcer of lower limbs, except decubitus) in MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), resulted in assignment to DRG 468 (Unrelated OR Procedures). We proposed to include procedure code 39.25 as an operating room procedure in DRGs 269 and 270 (Other Skin, Subcutaneous Tissue and Breast Procedures). We also proposed to add procedure code 39.29 (Other (peripheral) vascular shunt or bypass) to the operating room procedures included in DRGs 269 and 270.

Previously, procedure code 54.95 (Incision of peritoneum) if performed with a principal diagnosis in MDC 11 (Diseases and Disorders of the Kidney

and Urinary Tract) such as 585 (Chronic renal failure) grouped to DRG 468. We proposed to add this procedure code to the list of operating room procedures in DRG 315 (Other Kidney and Urinary Tract OR Procedures).

Diagnosis code 617.5 (Endometriosis of intestine) had been previously classified in MDC 13 (Diseases and disorders of the female reproductive system), while surgical procedures on the intestine had been in MDC 6. Hence, if this condition had been treated surgically, the discharge was assigned to DRG 468. We proposed to remove diagnosis code 617.5 from MDC 13 and place it into MDC 6. We proposed to assign medical cases to DRGs 182, 183, and 184 (Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders).

Similarly, diagnosis code 617.6 (Endometriosis in scar of skin) had been classified in MDC 13 while the surgical procedures performed for this diagnosis had been in MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast). We proposed to remove diagnosis code 617.6 from MDC 13 and add it to MDC 9, in DRGs 283 and 284 (Minor Skin Disorders).

In MDC 14 (Pregnancy, Childbirth and Puerperium), we proposed to add three procedure codes to the operating room procedures in DRG 374 (Vaginal Delivery With Sterilization and/or D&C). Previously, these procedures, when combined with a principal diagnosis in MDC 14 such as 605.41 (High vaginal laceration), had grouped to DRG 468. The three procedure codes proposed to be added to DRG 374 are procedure codes 66.4 (Total unilateral salpingectomy), code 66.69 (Other partial salpingectomy), and 66.92 (Unilateral destruction or occlusion of fallopian tube).

Previously, if procedure code 54.93 (Creation of cutaneous peritoneal fistula) had been performed as part of treating a principal diagnosis in MDC 21 (Injury, Poisoning and Toxic Effects of Drugs) such as diagnosis code 996.6 (Infection or inflammation of a device or graft), the discharge grouped to DRG 468. We proposed to add procedure code 54.93 as part of the operating procedures in DRGs 442 and 443 (Other OR Procedures for Injuries). In addition, we also proposed to add procedure code 54.95 (Incision of peritoneum) to the list of the operating room procedures in DRGs 442 and 443.

Patients hospitalized for a long period of time run the risk of developing decubitus ulcers for which wound debridement may be the appropriate treatment. Previously, procedure code 86.22 (Wound debridement) with a

principal diagnosis in MDC 2 (Diseases and Disorders of the Eye), MDC 4 (Diseases and Disorders of the Respiratory System), MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas), MDC 13 (Diseases and Disorders of the Female Reproductive System), and MDC 16 (Diseases and Disorders of the Blood and Blood-Forming Organs and Immunological Disorders) grouped to DRG 468. We proposed to add procedure code 86.22 to the list of operating room procedures in DRGs 40 and 41 (Extraocular Procedures Except Orbit), DRGs 76 and 77 (Other Respiratory System OR Procedures), DRG 201 (Other Hepatobiliary or Pancreas OR Procedures), DRG 365 (Other Female Reproductive System OR Procedures), and DRG 394 (Other OR Procedures of Blood and Blood Forming Organs).

We received no comments on these revisions and are therefore adopting them as proposed.

7. Refinement of DRG 468

ProPAC, as stated in its Recommendation No. 16, believes that refinements to DRG 468 are needed to improve the accuracy of patient classification. ProPAC recommended that all cases currently assigned to DRG 468 should be reassigned to existing surgical DRGs, using secondary, rather than principal, diagnoses. Based on ProPAC's recommendation, cases that could be reassigned to more than one DRG should be assigned to the DRG with the highest relative weight.

DRG 468 is reserved specifically for those cases in which none of the surgical procedures furnished to a patient is related to the patient's principal diagnosis. It was established as a means of identifying those cases that do not readily lend themselves to classifications within groups of clinically similar patients because the cases themselves do not reflect typical treatment patterns. For example, cases in which the patient develops pressing medical-surgical needs related to a secondary diagnosis or complication are assigned to DRG 468.

Adoption of ProPAC's recommendation would result in cases that are currently assigned to DRG 468 being moved to one of the existing surgical DRGs. We believe that this would not produce improved DRG definitions because the net effect of the redistribution of DRG 468 cases would make the current DRGs less homogeneous from both a clinical and statistical perspective.

A second difficulty with the redistribution of DRG 468 cases is the recommendation that the relative

weights be used to select the precise DRG to which a case would be reassigned. Across MDCs, the weights of many DRGs are similar. Each year, the recalibration of the relative weights results in minor changes in the individual DRG weights even when there are no clinical logic changes for a particular DRG. Therefore, if the ProPAC recommendation were adopted, over the years, patients with identical clinical characteristics could be assigned to different DRGs solely as a result of small fluctuations in the relative weights.

Further, some Blue Cross plans, Medicaid agencies, and State commissions are using DRGs for payment purposes. In general, these payors use the Medicare DRG definitions with their own relative weights. Thus, if we were to adopt ProPAC's recommendation, a hospital would obtain a different DRG assignment for a patient based on which payor's weights are being used. This would be very confusing to hospitals and would appear illogical to physicians. As a general principal, we believe that DRG assignment should be based exclusively on patient characteristics and not on the attributes of the payment system. The DRG definitions should be based on clinical logic and should remain independent of the logic of the payment system.

However, we agree with ProPAC that there are problems with the current definition of DRG 468. Our original expectation was that the patients assigned to DRG 468 would be those who experienced significant unanticipated complications that were not associated with the patient's principal diagnosis and that necessitated performance of a surgical procedure. We expected that these types of patients would be atypical and would have a high use of hospital resources as evidenced by the high payment weight for DRG 468. However, in examining the discharges in DRG 468 and procedures associated with these discharges, we found that there are two additional distinct types of discharges in DRG 468.

The first distinct type of discharge is that of a male patient admitted for a medical problem who, after treatment for the medical problem, experiences urinary retention. A transurethral prostatectomy is performed and the discharge is then grouped to DRG 468.

The second distinct type of discharge is that of a patient admitted for a medical problem who, after treatment for the medical problem, has an unrelated elective or diagnostic procedure performed, for example, a polypectomy or cataract extraction. The

performance of the unrelated procedure results in the discharge being grouped to DRG 468. We believe the high relative weight associated with DRG 468 may provide a financial incentive for hospitals to perform these procedures on patients admitted for unrelated medical reasons.

In order to address these problems in DRG 468, we proposed to add the following two new DRGs to the current list:

- DRG 476—Prostatic OR Procedure Unrelated to Principal Diagnosis. We proposed to assign DRG 476 to those discharges in which one of the following prostatic procedures is performed that is unrelated to the principal diagnosis:
60.2—Transurethral prostatectomy
60.61—Local excision of lesion of prostate
60.69—Other prostatectomy
60.94—Control of postoperative hemorrhage of prostate

- DRG 477—Non-Extensive OR Procedure Unrelated to Principal Diagnosis. We proposed to assign DRG 477 to those discharges in which the only procedure performed is a nonextensive procedure that is unrelated to the principal diagnosis.

Comment: Several commenters expressed support for the refinements that we have made to DRG 468 by adding DRG 476 and DRG 477. While supporting the proposed changes, the commenters also want us to continue looking at ProPAC's proposal to reassign cases in DRG 468 to existing surgical DRGs, using the secondary, rather than principal, diagnoses.

Response: We believe the addition of DRGs 476 and 477 will add to the refinement of the DRG classification system and provide a more equitable system of payment. We will, of course, be monitoring the discharge bills and plan to review the implementation of these two new DRGs during the next fiscal year. We will also continue to study ProPAC's recommendation although we have reservations with this method as explained in detail in the proposed rule (53 FR 19504).

Comment: One commenter noted that Table 6c included procedure code 20.09 (Other myringotomy), which is not an operating room procedure.

Response: The commenter is correct and we are deleting procedure code 20.09 from Table 6c. Based on further review, we have also deleted two other procedure codes from Table 6c: 86.09 (Other incision of skin and subcutaneous tissue) and 86.3 (Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue).

Since neither procedure is currently classified as an OR procedure, neither should have been included in Table 6c to begin with. In addition, we note that in Table 6c, the second column has been corrected by adding procedure code 20.01 (Myringotomy with insertion of tube) after procedure code 15.13, as discussed in the correction notice published July 21, 1988.

In Table 6c in section VI of the addendum to this final rule, we have listed the ICD-9-CM procedure codes for all of the procedures we would consider nonextensive procedures if performed with an unrelated principal diagnosis. These cases will be grouped in DRG 477.

We have modified the titles of DRGs 468, 476 and 477 as follows:

DRG 468—Extensive Operating Room Procedure Unrelated to Principal Diagnosis

DRG 476—Prostatic Procedure Unrelated to Principal Diagnosis

DRG 477—Non-Extensive Operating Room Procedure Unrelated to Principal Diagnosis

8. Changes to the ICD-9-CM Coding System.

As discussed above in section III.B.1. of this preamble, ICD-9-CM is a coding system for the reporting of diagnostic information and procedures performed on a patient. In September 1985, the ICD-9-CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee charged with the mission of maintaining and updating the ICD-9-CM. This includes approving new coding changes, developing errata, addenda, and other modifications to the ICD-9-CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. The NCHS has primary responsibility for the ICD-9-CM diagnoses codes included in Volumes 1 and 2 Diseases: Tabular List and Diseases: Alphabetic Index, while HCFA has primary responsibility for the ICD-9-CM procedure codes included in Volume 3—Procedures: Tabular List and Alphabetic Index.

The Committee encourages participation in the above process by major health-related organizations. In this regard, the Committee holds public

meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for input into coding matters from representatives from recognized organizations in the coding fields, such as the American Medical Record Association, the American Hospital Association, and the Commission on Professional and Hospital Activities, as well as physicians, medical record administrators, and other members of the public. Considering the opinions expressed at the public meetings, the Committee formulates recommendations, which then must be approved by the co-chair agency heads (that is, the Administrator of HCFA and the Director of NCHS) before adoption for general use.

The Committee presented proposals for coding changes at a public meeting held in Washington, DC on December 4, 1987 and finalized the coding changes after consideration of comments received at that meeting and in writing in the 30 days following the meeting. The initial meeting for consideration of coding issues for resolution in FY 1989 was held on April 14, 1988. Copies of the minutes of these meetings may be obtained by writing to the co-chairpersons representing NCHS and HCFA. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Ms. Sue Meads, R.R.A., Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, NCHS, Rm 2-19, Center Building, 3700 East-West Highway, Hyattsville, Maryland 20782.

Questions and comments concerning the procedure codes should be addressed to: Ms. Patricia E. Brooks, Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, HCFA, Office of Coverage Policy, Rm 309, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

The additional new ICD-9-CM codes that have been recommended by the Committee and approved by both agency heads will become effective October 1, 1988. The new ICD-9-CM codes are listed, along with their proposed DRG classifications, in Tables 6a and 6b in section VI of the addendum.

Further, the Committee recommended, and the agency heads approved, the deletion of ICD-9-CM procedure code 48.66 (Hartmann resection of the rectum). This procedure will be classified under ICD-9-CM procedure code 45.75 (Left hemicolectomy), which is classified by the Grouper program as follows:

MDC 6 DRGs 148 and 149

MDC 10 DRGs 292 and 293
MDC 17 DRGs 400, 406, and 407
MDC 21 DRGs 442 and 443

Comment: We received a number of comments concerning the proposed Grouper assignment of the ICD-9-CM diagnoses and procedure codes that will become effective October 1, 1988. As we stated in the proposed rule, the code numbers and their titles have been finalized by the ICD-9-CM Coordination and Maintenance Committee and approved by the heads of both HCFA and NCHS. The proposed notice only solicited comment concerning the Grouper assignment of the codes.

Comment: Several commenters noted errors in Tables 6a and 6b as set forth in section IV of the addendum to the proposed rule (53 FR 19585-19587).

Response: We believe all of these errors were addressed in the correction notice to the May 27, 1988 proposed rule, which was published on July 21, 1988 (53 FR 27535). Since we received many of these comments prior to publication of this correction notice, we are restating the applicable corrections here:

- On page 19585, in Table 6a, the second column is corrected by adding DRG 388 to diagnosis codes 765.00, 765.06, 765.07, and 765.08 and by adding DRG 387 to diagnosis code 765.10.

- On page 19585, in Table 6b, the third column is corrected by changing the DRG for procedure code 20.95 from "3" to "55" and the DRG for procedure code 37.33 from "Non-OR" to "108, 109" and by adding DRG 156 to procedure code 42.25.

Comment: The majority of the commenters on the Grouper assignment of the new procedure code 37.34, (Catheter ablation of lesion or tissues of heart) argued that the ablation through a catheter should be considered an OR procedure and continue to be assigned to DRGs 108 and 109.

Response: We agree that this procedure should still be considered an OR procedure, but would classify it with vascular procedures since open heart surgery is not involved. Therefore, we are assigning procedure code 37.34 to DRG 112 (Vascular Procedures except Major Reconstruction without Pump) and DRG 108 (Other Cardiothoracic or Vascular Procedures with Pump).

Comment: The American College of Cardiology and a number of cardiologists and electrophysiologists objected to the proposed treatment of new procedure codes 37.26 (Cardiac electrophysiologic stimulation and recording studies) and 37.27 (Cardiac mapping) as non-OR procedures since that meant such procedures would have no effect on DRG assignment.

A majority of the commenters believed that the electrophysiologic (EP) studies should be treated as either a cardiac catheterization or an OR procedure for the purpose of DRG assignment. Although generally performed in a catheterization laboratory or radiology suite, rather than in an operating room, EP studies involve significant levels of time and resources in managing patients with potentially life-threatening cardiac arrhythmias. Multiple drug testing in cases that do not ultimately involve surgery can involve stays over 2 weeks in length.

Response: Generally, we continue to classify a new ICD-9-CM code in the same DRG as the non-specific or temporary code previously in use until we can obtain data on the charges in those bills showing the new specific code. EP studies and cardiac mapping, which are identified under temporary code 37.29 (Other diagnostic procedures on the heart), have been used since the early 1980's to determine the appropriate antifibrillation agent to be prescribed for patients with arrhythmias. Accordingly, we believe the cost of such studies is already reflected in the relative weights of both the medical and surgical DRGs in which such cases are currently classified. Therefore, using cases in MDC 5 (Diseases and Disorders of the Circulatory System) in the FY 1987 MEDPAR file, we divided cases in each DRG into two categories, those with procedure code 37.29 and those without. In DRGs 138 and 139 (Cardiac Arrhythmia and Conduction Disorders), where we would expect to find the highest incidence of EP testing and cardiac mapping, procedure code 37.29 is present in less than one-half of one percent of the cases (less than 1,200 out of some 250,000 cases).

To the extent the occurrence of procedure code 37.29 represents the true incidence of EP studies or cardiac mapping, we believe the number of cases is too small to warrant differential payment and that there are sufficient numbers of other cases to average out payments. To the extent that EP studies and cardiac mapping occur much more frequently than our data would suggest, we encourage hospitals to record these codes on their billing forms so that we might conduct a more thorough analysis of these procedures in the future. At the present time, however, we believe it is inappropriate to construct a new DRG or to test these two procedures as OR procedures for an unknown set of cases whose incremental cost has been

reported to us as ranging from \$5,000 to \$21,000.

The recalibrated weights for these DRGs are based upon the total Medicare charges in FY 1987 for all cases in MDC 5, including those in which EP studies or cardiac mapping were performed. Regardless of the procedures coded or represented on the bill, the charges include those of the procedures performed. Those exceptionally expensive cases may fall outside the outlier thresholds, thus qualifying for additional payments as outliers.

We received 34 comments concerning EP studies, 23 of which were from hospitals. Twenty of the comments from hospitals were from teaching hospitals. (The other 11 comments were from individual cardiologists.) Teaching hospitals receive additional payments adjustments to compensate for the increased costs of treating a specialized patient population and funding their teaching programs.

Comment: Two commenters asked for a description of the conforming changes to the DRG Grouper logic in MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) to incorporate the new fifth digit subclassification to denote birthweight in ICD-9-CM categories 764 and 765. Since the DRG assignments shown in table 6A of the proposed rule do not simply follow the assignment of the four digit codes, they wanted to know how the five-digit codes will be shown on the CC list and "major problem" list in MDC 15.

Response: The commenters are correct in their observation that we did not substitute each new set of five-digit newborn diagnosis codes for the corresponding four-digit code whenever it occurs in the MDC 15 Grouper logic. Although the incremental birthweight classification will doubtless provide more specific data on the treatment of "light for dates" and premature neonates, the application of these weight categories to all four-digit diagnosis codes in categories 764 and 765 of the ICD-9-CM produced some improbable categories for DRG assignment.

Following a convention used in the ICD-9-CM Tabular Lists (ICD-9-CM Volume I, page xxiii, DHHS Publication No. (PHS) 80-1260), the fifth digits are required to be added to all four-digit diagnosis codes in categories 764 and 765. A fifth digit of zero denotes an unspecified birthweight; a fifth digit of one through nine specifies increments from less than 500 grams to 2,500 or more grams. The conflicts arise when these weight subclassifications are

applied to the existing definitions for 764 and 765, which were not revised in this addendum to the ICD-9-CM.

For example, category 765 (Disorders relating to short gestation and unspecified low birth weight) is divided into two four-digit codes. The first, 765.0 (Extreme immaturity), usually implies a birthweight less than 1,000 grams or a gestation period of less than 28 completed weeks. The second category, 765.1 (Other preterm infants), usually implies a birthweight of 1,000-2,499 grams or a gestation period of 28-37 completed weeks. Since all five-digit categories apply, we now have a new diagnosis code 765.09 (Extreme immaturity, 2,500+ grams) in which there is an inherent conflict between the clinical picture of extreme immaturity depicted by the first four digits and the birthweight specified by the fifth digit (2,500 or more grams). If we accepted this code without review and assigned it to the DRG in which 765.0 was previously assigned, it would go to DRG 386 (Extreme Immaturity or Respiratory Distress, Neonate). However, we consider it for more likely that this particular code was assigned in error than that an extremely immature infant exhibits of birth weight of 2,500 or more grams. For that reason, diagnosis code 765.09 will be assigned to DRG 470 as ungroupable with this principal diagnosis. Intermediaries will return these cases to the hospital for validation or correction.

We believe that hospitals will consider the clinical scenario implied by the four-digit rubrics before using the new codes that represent increments of birth weight for preterm and "light-for-dates" infants. We will work with the other members of the Coordination and Maintenance Committee to provide coding guidance and, if necessary, to develop revised definitions of the 764 and 765 categories that reflect the five-digit subclassifications. In the meantime, with the exception of diagnosis code 765.09, as described above, we have assigned the newborn codes to the DRGs that correspond most to the newborn actually described by the code.

The specific DRG assignments required conforming changes to the Grouper logic that may not have been apparent to all of the readers of the May 27, 1988 proposed rule. A detailed list of the changes follows:

- The following diagnosis codes are added to the complications and comorbidities list:
 - 765.01 Extreme immaturity, less than 500 grams
 - 765.02 Extreme immaturity, 500-749 grams

- 765.03 Extreme immaturity, 750-999 grams
- 765.04 Extreme immaturity, 1,000-1,249 grams
- 765.05 Extreme immaturity, 1,250-1,499 grams
- 765.06 Extreme immaturity, 1,500-1,749 grams
- 765.07 Extreme immaturity, 1,750-1,999 grams
- 765.08 Extreme immaturity, 2,000-2,499 grams

• We have revised Tables 6d and 6e to reflect conforming changes in the CC Exclusions List resulting from the new diagnosis codes for neonates. Specifically:

—Diagnoses 765.01-765.08 (Extreme immaturity) are excluded as CCs for principal diagnoses 764.00-765.19, 767.8, 767.9 and 779.8.

—Since diagnosis code 765.0 is now obsolete, it is dropped from the excluded CCs for similarly obsolete principal diagnoses 764.0-765.1, and for principal diagnoses 767.8, 767.9 and 779.8.

• The following diagnoses are considered "major problems" for purposes of DRG 387 (Prematurity with Major Problems) and DRG 389 (Full Term Neonate with Major Problems): 764.11-764.18 "Light for dates" with signs of fetal malnutrition 764.21-764.28 Fetal malnutrition without mention of "Light-for dates"

• The following diagnoses are considered "significant problems" for purposes of DRG 390 (Neonate with Other Significant Problems):

764.00-764.08 Light-for-dates without mention of fetal malnutrition

764.10 "Light-for-dates" with signs of fetal malnutrition, unspecified [weight]

764.19 "Light-for-dates" with signs of fetal malnutrition, 2,500+ grams

764.20 Fetal malnutrition without mention of "light-for-dates", unspecified [weight]

764.29 Fetal malnutrition without mention of "light-for-dates", 2,500+ grams

764.90-764.98 Fetal growth retardation, unspecified

9. Other Issues

a. *Cochlear Implants.* In the September 1, 1987 final notice on changes to the DRG classification system (52 FR 33143), we agreed to evaluate the placement of cochlear implant discharges in DRG 49 (Major Head and Neck Procedures). We examined the mean standardized charge for all cochlear implants and separately examined the mean standardized charges for single channel and

multichannel implants. Because we determined that the Medicare data do not indicate that there would be a material difference in the weighting factors if a separate DRG were created for cochlear implants, we did not propose to create a separate DRG.

Comment: We received two comments concerning the classification of cochlear implants in DRG 49. One commenter stated that the payment amount for DRG 49 is not sufficient because it only covers the cost of the cochlear implant device to the hospital and provides no payment for any other services during the inpatient stay. The other commenter reviewed all 69 discharges coded as cochlear implants in FY 1987 and stated that some of the bills were not coded as multichannel implants although contact with the hospital revealed that a multichannel device had been implanted. The commenter eliminated certain discharges from the study because the standardized charges were less than \$6,000, which the commenter believed to be below the charges for all cochlear implants on the market, and eliminated others because the length of stay and principal diagnosis were believed to be incompatible with cochlear implant procedures. This commenter suggested that multichannel cochlear implant cases should be separated from other cochlear implants and assigned to a new DRG or that all cochlear implant discharges be assigned to DRG 2 (Craniotomy for Trauma Age > 17) in MDC 1 (Diseases and Disorders of the Nervous System) because the procedure involves the auditory nerve, one of the 12 cranial nerves.

Response: For FY 1989, the weights for each DRG were established by dividing the mean standardized charges for cases in that DRG by the mean standardized charges for all Medicare cases, using billing data from FY 1987. The standardized charges are derived from the charges submitted by the hospital on the bill for each discharge in FY 1987. We can only assume that what the hospital submits as its charges on each bill are in fact the actual total charges. The hospital is not under any obligation to show charges equal to or greater than its costs for services.

We note, nevertheless, that our data showed that in DRG 49, the mean standardized charge for cases other than cochlear implants was \$14,033. In the study submitted by one commenter, after excluding those discharges that were believed to be incorrect, the mean standardized charges were \$14,610 for all cochlear implants. That means that there is little difference (about 4 percent) between the standardized charges for

cochlear implants and those for all other procedures in DRG 49. Given this slight difference in charges, combined with the fact that cochlear implants represents less than one percent of the cases in DRG 49, we see no compelling reason to move the classification of cochlear implants from DRG 49.

We believe that the commenters' suggestions to move cochlear implants to DRG 2 would also violate a basic premise of the prospective payment system, which is to assign a DRG based on the principal diagnosis rather than the procedure that is performed. Since all of the diagnoses related to hearing disorders which can be ameliorated by cochlear implants are located in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) rather than MDC 1 (Diseases and Disorders of the Nervous System), the movement of the procedure codes for cochlear implants from DRG 49 to DRG 2 would merely produce DRG 468 assignments since the procedure would appear in the Grouper logic to be unrelated to the principal diagnosis for which it is performed.

We will continue to review the classification of cochlear implants. However, as noted above, since only 1 percent of the total cases in DRG 49 are cochlear implants, and the standardized charges for other cases are similar to the standardized charges for other cases in DRG 49, we do not believe a classification change at this time is warranted.

We recognize that hospitals may be experiencing some problems with the coding of cochlear implants. We have notified interested organizations of the need to educate hospital coders and hospital management of the need to use the device-specific code and expect to see explanatory materials printed by these organizations. We have provided materials on coding changes through the intermediaries.

b. *Tissue Plasminogen Activator (TPA).* Prior to publication of the proposed rule, we received inquiries concerning whether HCFA has any plans to pay for tissue plasminogen activator (TPA), a thrombolytic agent used in treating blockages of coronary arteries, in a special manner. Those making inquiries assert that hospitals need to be shielded from the effects of TPA's high price.

We considered this issue and the arguments presented. However, we have determined that TPA should not be singled out for special treatment. That is, we believe that the update factors established in section 1886(b)(3)(B)(i) of the Act, combined with the potential for continuing improvements in hospital

productivity, and annual recalibration of the DRG weights, are adequate to finance appropriate care of Medicare patients. We concluded, as has ProPAC, that a special accommodation for TPA would not be appropriate. (See the May 27, 1988 proposed rule at 53 FR 19654 for a complete description of our position on this matter.)

Comment: Several commenters stated that HCFA should consider providing an adjustment to the prospective payment rate for TPA.

Response: We continue to believe that the update factors provided for in section 1886(b) of the Act as well as the annual recalibration provide sufficient recognition of TPA. Since the recalibration process uses actual hospital charges, the hospital resources directly associated with TPA will be used in the calculation of the DRG weights in the future.

In addition, clinicians continue to debate the issue of which thrombolytic agent of those now available, including TPA, is the best and most effective to use, particularly for the Medicare population. No large mortality study has yet been completed that shows significant differences among drugs in terms of long-term mortality or other significant outcomes. Research is still ongoing with newer thrombolytic agents that appear promising.

A separate payment for a new advance could be counterproductive because it potentially creates an incentive to use the technology in cases in which it may not be appropriate. In addition, a payment would insulate hospitals from the consequences of their actions with respect to resource use. Rather than a special add-on for any new advance that would only benefit hospitals using the advance, the general principles of the prospective payment system permit hospitals to choose which advances are appropriate for the care and services they furnish to Medicare beneficiaries.

Comment: One commenter wrote requesting a special payment adjustment for magnetic resonance imaging (MRI) scans.

Response: As we have stated previously, we do not believe a separate payment adjustment for MRI is warranted. (See 51 FR 20003). We continue to believe that the annual update factor, a portion of which recognizes changes in new technology, and the annual recalibration process are the appropriate means of taking new technologies into account.

As part of our ongoing review process, we looked at the standardized charges in each DRG for FY 1987 after separating the discharges where MRI was coded

from those in which MRI was not coded. In many DRGs the standardized charges for cases with MRI were lower than the standardized charges for similar cases without MRI. There was no consistent pattern in the standardized charges for cases involving MRI across DRGs.

The fact that the standardized charges for cases with MRI were sometimes lower than those for other cases suggests that MRI may in fact be replacing other more expensive technologies and that no payment adjustment may be necessary or appropriate.

Comment: Several commenters raised DRG classification and weighting issues that had not been discussed in the proposed rule and requested that we make several DRG changes. Among the issues raised were the following:

- Analysis of the importance of CC in DRGs not currently partitioned by presence or absence of CC;

- Expansion of DRG 474 (Respiratory System Diagnosis with Tracheostomy) and DRG 475 (Respiratory System Diagnosis with Ventilator Support) to include principal diagnoses from any MDC when ventilator support is used.

- Classification of limb salvage surgery in patients with major arterial occlusive disease in the lower extremities.

- Identification of certain diagnoses that do not require unusual neonate care as "significant problems" for purposes of assigning cases in MDC 15 to DRG 390 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period).

- Appropriateness of the DRG classification and relative weight for bone marrow transplants.

- Classification of extracorporeal shock wave lithotripsy (ESWL) as a non-OR procedure for DRG assignment.

Response: To consider new issues that arise during a comment period, especially those that are not directly related to proposed changes, would require us to make hasty decisions without the benefit of detailed, reasoned analysis or public comments. This is equally true of ongoing evaluations that have not been concluded or did not establish evidence to support a proposed change. Consequently, we do not intend to make a general practice of setting forth new DRG changes in final rules or notices, other than those directly related to changes that were previously proposed. We will, however, where appropriate, place the issues raised on our agenda for study during FY 1989.

We want to assure these commenters that we are not minimizing the issues that they have raised here. Each

represents an area that is being evaluated by HCFA staff. We welcome further suggestions for issues to study and encourage commenters to submit detailed proposals early in the Federal fiscal year so that we are not hampered in our decisionmaking process by time constraints imposed by the statutorily required publication process. That is, in order to meet the new statutory requirement for publication of a proposed notice by May 1 of each year, we must complete our evaluative process by no later than March of each year. Suggestions may be submitted to: Grouper Changes, P.O. Box 26681, Baltimore, Maryland 21207.

Comment: ProPAC reiterated a previous inquiry about the status of our investigation of the DRG assignment of procedure code 58.93 (Implantation of artificial urinary sphincter (AUS)), which was effective October 1, 1986. AUS had previously been classified under procedure code 57.99 (Other operations on bladder, not elsewhere classified (NEC)), which was assigned to DRGs 308 and 309 (Minor Bladder Procedures) and DRGs 442 and 443 (Other Procedures for Injuries).

Response: We stated in the March 13, 1986 proposed notice concerning changes to the DRG classification system (51 FR 8769) that we would continue to classify this procedure in the same DRG as the previous coding assignment. However, we also stated that if data available under the new code indicated a need for reclassification, we would publish the reassignment for public comment as required by § 412.10.

When the Grouper program was amended to accommodate procedure code 58.93 in October 1986, we misspecified the code under which AUS had previously been identified as 58.99 (Other operations on urethra and periurethral tissue NEC), instead of 57.99. As a result, AUS was erroneously assigned to the following DRGs: DRGs 312, 313, and 314 (Urethral Procedures), DRGs 344 and 345 (Other Male Reproductive System OR Procedures, for Malignancy and Except for Malignancy, respectively), and DRG 365 (Other Female Reproductive System OR Procedures). Since we did not publish a discussion of this Grouper change in the final notice of June 3, 1986 (51 FR 20192), the industry correctly assumed that no change was intended and had no reason to verify the assignment of the new code.

HCFA validation of the Grouper program showed 58.93 assigned according to specification, that is, as if AUS were previously coded 58.99. This

error went undetected until late 1987, when both ProPAC and American Medical Systems, a manufacturer, contacted us to question the current assignment.

We have corrected the assignment in the Grouper program that will become effective October 1, 1988 and are taking action to notify Medicare intermediaries to add an adjustment to their claims processing systems to correctly assign 58.93 to DRGs 308, 309, 442, and 443 for discharges occurring in FYs 1986 and 1987. Payment adjustments for these cases are exempt from the requirement in § 412.60(d) that a hospital can only appeal a DRG assignment within 60 days of the date of the notice.

C. Recalibration of DRG Weights

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. Since FY 1986, the DRG weights have been based on charge data. The latest recalibration, which was published as a part of the FY 1988 prospective payment final rule, used hospital charge information from the FY 1986 Medicare provider analysis and review (MEDPAR) file. For a discussion of the options we considered and the reasons we chose to use charge data beginning in FY 1986, we refer the reader to the rules published on June 10, 1985 (50 FR 24372) and September 3, 1985 (50 FR 35652).

We proposed to use the same methodology for the FY 1989 recalibration as we did for FY 1988. That is, we recalibrated the weights based on charge data for Medicare discharges. However, we used the most current charge information available, the FY 1987 MEDPAR file, rather than the FY 1986 MEDPAR file. The MEDPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights were constructed from FY 1987 MEDPAR data, received by HCFA through December 1987, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The MEDPAR file included data for approximately 9.5 million Medicare discharges. The MEDPAR file updated through June 1988 includes data for 9.75 million Medicare discharges and this is the file used to calculate the weights set forth in Table 5 of this final rule.

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

- All the claims were regrouped using the revised DRG classifications

discussed above in section III.B. of this preamble.

- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education costs, disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.

- We then eliminated statistical outliers using the same 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.

- The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average standardized charge per case to determine the weighting factor.

- We established the weighting factor for heart transplants (DRG 103) in a manner consistent with the methodology for all other DRGs except that the heart transplant cases that were used to establish the weight were limited to those Medicare-approved heart transplant centers that have cases in the FY 1987 MEDPAR file.

- 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 Transplant). For this reason, it was necessary to make an adjustment to prevent the relative weight for DRG 302 from including the effect of kidney acquisition costs, since these costs are paid separately from the prospective payment rate. Kidney acquisition charges were subtracted from the total charges for each case involving a kidney transplant prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

- Heart acquisition costs, like kidney acquisition costs, continue to be paid on a reasonable cost basis and are similarly concentrated in a single DRG (DRG 103, Heart Transplant). Accordingly, for the heart transplant cases in the updated MEDPAR file used for recalibration, we subtracted from the total charges of each case an estimate of heart acquisition charges prior to computing the average charge for the DRG and prior to eliminating statistical outliers, identical to the adjustment we make for removing kidney acquisition charges from cases in DRG 302. For additional information about the methodology for estimating heart

acquisition costs, see the September 1, 1987 final rule at 52 FR 33037.

The weights developed according to the methodology described above, using the revised Grouper program, result in an average case weight that is different from the average case weight before recalibration. Therefore, the new weights were normalized by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

When we recalibrated the DRG weights for FY 1986 and FY 1988, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In FY 1988, there were 32 DRGs that contained fewer than 10 cases. We proposed to use that same case threshold in recalibrating the DRG weights for FY 1989. In the FY 1988 recalibration, we computed the weight for the 32 low-volume DRGs by adjusting the original weights of these DRGs by the percent change in the weight of the average case in the remaining DRGs. However, we note that normalization (discussed above) results in holding constant the weight for low-volume DRGs since the adjustment factor is the same as the percent change in the weight of the average case across all DRGs. We proposed to use this same methodology for the FY 1989 recalibration. Using the FY 1987 MEDPAR data set, there are 35 DRGs that contain fewer than 10 cases.

As discussed in the proposed rule at 53 FR 19507, ProPAC, in its Recommendation 15, recommended that, starting with the FY 1989 recalibration, the DRG weights be recalibrated annually on the basis of costs rather than charges. However, ProPAC indicated concern about the current Medicare cost-finding methods for estimating costs because the limitations of the Medicare cost report data may in some cases produce imprecise DRG weights. Therefore, ProPAC recommended that the Secretary verify the accuracy of the cost report data and implement changes as necessary.

While time constraints preclude us from adopting ProPAC's recommendation for FY 1989, we believe that recalibration of the DRG weights using costs does warrant further consideration. We plan to examine the feasibility of developing cost-based DRG relative weights for FY 1990. However, as we have noted previously, we continue to believe at this time that

the disadvantages associated with charge-based weights are compensated for by the fact that for purposes of recalibration, charge data are available on a more timely basis than cost data. For example, for the recalibrated weights for FY 1989, we used FY 1987 Medicare billing data from the MEDPAR file. However, we have yet to obtain a full file of FY 1986 Medicare cost reports. Thus, any cost data we were to use for recalibration would be at least one year and perhaps as much as two years older than the most recent available charge data.

In addition, since costs are not accumulated on an individual case basis, DRG by DRG, it is necessary even in developing cost-based weights to link ancillary charge data from the claims file to cost report data as part of the process of estimating the average costs of cases in each DRG. To maintain consistency and to accurately determine relative resource use, charge data for the same period as the cost data should be used in cost-based recalibration. Therefore, both the charge and cost data that would be used would be significantly older than the most recently available charge data, which we can use by itself to obtain DRG relative weights.

We believe that using old data is inappropriate, particularly given the rapid advances in medical technology and resulting changes in treatment patterns. We further believe that it is in the best interest of the hospitals and Medicare beneficiaries that the resource use associated with these major new medical advances be reflected in the DRG weights as soon as possible. This can be accomplished by the use of charge-based weights computed on an annual recalibration schedule. We are concerned that use of cost-based weights would significantly delay recognition of new technologies or greatly complicate the recalibration process by necessitating a number of special adjustments to take such new technologies into account. Therefore, if we decide to adopt cost-based weights in the future, we believe it is essential that we address the timeliness problem and take steps to ensure that changing technologies are reflected in the DRG relative weights on a timely basis.

Comment: Many commenters expressed support for continuing to use charge data to recalibrate the DRG weighting factors. These commenters expressed the same reservations we had about the timeliness and accuracy of the Medicare cost data. Only two commenters believed that cost data

were more appropriate for recalibrating the DRGs.

Response: As we stated in the proposed notice, we believe the timeliness of the data is the most important consideration in recalibrating the DRG weighting factors. We wish to recognize the effects of new technology on the DRGs as soon as possible. Charge data only lag about a year behind the current fiscal year data compared to cost data, which would be two years old. Also, the time constraints for FY 1989 would prevent us from adopting such a complete change from the present methodology.

As discussed above, we will examine the feasibility of using cost data for future fiscal years and we will consider which type of an adjustment might need to be made to account for ancillary costs on a case-by-case basis.

Comment: One commenter wrote about fluctuation in the heart transplant weight (DRG 103), noting that it has been very volatile during the time since Medicare coverage was first extended to heart transplants and suggesting that such volatility was a function of the data used to establish the weighting factor. Because the weight for DRG 103 has risen considerably since last year to a factor the commenter considers more reflective of the true resource consumption of heart transplant cases, this commenter recommends that the Medicare program should make retroactive adjustments in the payments for heart transplants furnished during FY 1988. Questioning the appropriateness of using charges to recalibrate the weights for a new technology, the commenter finally argues that the heart transplant weighting factor for FY 1989 be established at least 17.2554 in order to cover the average costs of heart transplantation services, as estimated by the commenter based on a sample of ten hospitals with ten Medicare cases each.

Response: We agree that the weighting factor for heart transplants has shifted depending upon the data base used to establish the relative weights. The original weight for heart transplant cases was based on Medicare and non-Medicare charge data for 52 transplants, performed at six hospitals, accumulated under the National Heart Transplant Study (NHTS). The NHTS provided the most reliable and comprehensive compilation of cost data at the time the original weight was developed. For FY 1988 and FY 1989, the weighting factors for heart transplants, as is the case for all DRGs, was based on Medicare billing records. The weight

in effect for FY 1988 was based on data for 55 heart transplant cases in the FY 1986 MEDPAR file. The weight in effect for FY 1989 (see Table 5 of this final rule) is based on data for 47 heart transplant cases in the FY 1987 MEDPAR file. (The transplant cases that were used to establish the FY 1989 weight were limited to those Medicare-approved heart transplant centers that had cases in the FY 1987 MEDPAR file, whereas cases used to establish the FY 1988 weight was not thus limited.) However, in all cases, the relative weight was based on the most recent and reliable data available and was computed in a manner consistent with the methodology for all other DRGs. Hence, we do not agree with the commenter's recommendation that the Medicare program make retroactive adjustments in the payments for heart transplants furnished during FY 1988.

Finally, we note that the weighting factor of 17.2554 suggested by the commenter is based on certain assumptions that would tend to inflate the estimate. Using data from ten institutions in 1987, the commenter argues that such a weight would be required to cover the average costs of heart transplantation services at these facilities. The results are based on the assumption that the facilities would not receive any indirect medical education or disproportionate share payments, and would be paid on the basis of a wage index value of 1.1. Since most heart transplantation centers are large, teaching hospitals located in major metropolitan areas, the suggested weighting factor would, in general, result in overpayments to heart transplant centers. In fact, it is precisely because certain types of procedures tend to be performed more often in certain types of providers that we standardize charges in the recalibration process to remove the effects of differences in area wage levels, indirect medical education costs, and disproportionate share payments.

IV. Changes to the Hospital Wage Index

Section 1886(d)(2)(C)(ii) of the Act required, as a part of the process of developing separate urban and rural standardized amounts for FY 1984, that we standardize the average cost per case of each hospital for differences in area wage levels. Section 1886(d)(2)(H) of the Act required that the standardized urban and rural amounts be adjusted for area variations in hospital wage levels as part of the methodology for determining prospective payments to hospitals for FY 1984. To fulfill both requirements, we

constructed an index that reflects average hospital wages in each urban or rural area as a percentage of the national average hospital wage.

For purposes of determining the prospective payments to hospitals in FY 1984 and 1985, we constructed the wage index using calendar year 1981 hospital wage and employment data obtained from the Bureau of Labor Statistics ES 202 Employment, Wages and Contributions file for hospital workers. Beginning with discharges occurring on or after May 1, 1986, we have been using a hospital wage index based on HCFA surveys of hospital wage and salary data as well as data on paid hours in hospitals. The HCFA hospital wage index was developed in an attempt to overcome the limitation of the BLS data with regard to full-time and part-time employment. The methodology used to compute the first HCFA wage index, which was based on 1982 wage data, was set forth in detail in the September 3, 1985 final rule (50 FR 35661).

In the September 1, 1987 final rule, we made a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels (52 FR 33039). To minimize the impact on the national average hourly wage when the wage data for hospitals in an area are adjusted or when hospitals are reclassified from one area to another, we moved from an area-weighted national average hourly wage index to an hour-weighted wage index. That is, we now compute the national average hourly wage by dividing the total wages for all hospitals in the data base by the total paid hours for all hospitals in the data base.

In the September 1, 1987 final rule, we also updated the wage index by using wage data from 1984. However, we did not base the new wage index solely on the 1984 data. Because adoption of a wage index based solely on 1984 data would have resulted in abrupt, large changes in wage index values for some areas because of economic changes in those areas that had occurred between 1982 and 1984, we adopted a blended wage index that incorporated both 1982 and 1984 wage data. The blended index was based on area wage index values computed from 1982 data on an hour-weighted basis and area wage index values computed from 1984 data on an hour weighted basis, equally weighted to produce average area wage index values.

Although we did not propose to change the methodology for computing the wage index for use in FY 1989, we did propose to base the wage index solely on 1984 wage data. We also made

a number of corrections to the 1984 wage data based on our continuing analysis of those data.

Section 4005(a) of Pub. L. 100-203 enacted a new section 1886(d)(8)(B) of the Act. Under this new provision, for discharges occurring on or after October 1, 1988, hospitals in certain rural counties adjacent to one or more Metropolitan Statistical Areas (MSAs) would be considered to be located in one of the adjacent MSAs if certain standards are met. (These requirements are explained in greater detail in section V.C.2. of this preamble.) Because of this provision, it was necessary to reclassify the wage data for those rural areas as if the hospitals in those areas were located in the adjacent MSAs and to recompute the wage index values for the affected MSAs and rural areas. The table in section V.A. of this preamble indicates in which MSAs hospitals in certain rural counties will be considered to be located for purposes of the wage index adjustment. The wage index tables in section IV of the addendum reflect these revised urban and rural designations.

In accordance with the provisions of section 4004(b) of Pub. L. 100-203, effective October 1, 1988, we proposed to include in the calculation of the wage index certain wage costs for organizations related to hospitals that had received a waiver authorized by section 602(k) of the Social Security Amendments of 1983 (Pub. L. 98-21). For cost reporting periods beginning before October 1, 1986, hospitals that qualified for this waiver were allowed to continue billing for inpatient nonphysician services under part B and to be paid for those services under Part B even though all other hospitals subject to the prospective payment system were required to bill those inpatient nonphysician services under Part A.

The wage costs that are now included in the calculation of the wage index are those for employees of a related organization described above who are directly involved in the delivery and administration of care provided by the related organization to the inpatients of a hospital that received the waiver under section 602(k) of Pub. L. 98-21. Section 4004(b) of Pub. L. 100-203 specifies that these wage costs do not include costs of overhead or home office administrative salaries or any costs not incurred in the MSA in which the hospital is located. We collected the data to implement this provision and have included the data in the calculation of the wage index set forth in this final rule.

We received 33 items of correspondence that commented on the

hospital wage index. These comments and our responses are discussed below.

Comment: Several commenters objected to the use of a wage index based solely on the 1984 wage survey data because they asserted that the data contain numerous errors. In addition, several commenters claimed that the 1984 wage survey data were not sufficiently edited or audited to ensure their accuracy. Because of perceived errors in the 1984 wage index, some commenters recommended continued use of the blended wage index until data are available.

Response: Before publication of the blended wage index that incorporated both 1982 and 1984 wage data from prospective payment hospitals, we performed several edits to ensure the accuracy of the 1984 wage data. These edits were discussed in detail in the September 1, 1987 prospective payment final rule (52 FR 33041) in response to comments received concerning the June 10, 1987 proposed rule.

In addition to the edits performed on the 1984 wage data, we have made additional changes and corrections to the 1984 wage data. Several corrections were based on an analysis of the wage index areas to ensure that each hospital was correctly classified either as rural or urban within a particular MSA. These corrections were made before publication of the May 27, 1988 proposed rule and were reflected therein. Another adjustment to the 1984 wage data reflected in the proposed rule was a result of a special wage survey conducted for hospitals that were granted a waiver under section 602(k) of Pub. L. 98-21 and are, or were, involved with related organizations. This special adjustment to the 1984 wage data was required under section 4004(b) of Pub. L. 100-203. This special wage survey for hospitals granted these waivers resulted in a change to the Rochester, Minnesota MSA wage index value.

The last factor that resulted in changes to the 1984 wage data was a result of providers and intermediaries submitting additional documentation that corrected the figures previously submitted for particular hospitals. Any changes requested by providers or their representatives were verified with the intermediaries. As a result, corrections have been made to the following areas since publication of the May 27, 1988 proposed rule: Abilene, Texas; Dallas, Texas; Baton Rouge, Louisiana; and rural South Carolina and Texas.

We regret that the fact that we continue to make corrections to the data has led some to conclude that the 1984 wage index is not sufficiently accurate

to use without blending it with the 1982 wage index. Let us assure our readers that all of the data being used in the 1984 wage index have been certified as accurate by an officer of the hospitals submitting the forms. However, errors do occur, and we do not stop making corrections to the data just because a provider has already certified such data as correct. But we do apply a fairly stringent test before substituting new hourly wage data for old.

As a result of these changes, however, the national average hourly wage rate increased slightly, thus reducing area wage index values for all areas not affected by the changes. Moreover, we have determined that a change in the wage index is not necessarily neutral with respect to aggregate payment to hospitals, despite the change made last year to the manner in which the national average hourly wage is computed. Therefore, until we can evaluate the relationship between changes in the wage index and changes in aggregate prospective payments, we have decided to postpone adoption of a wage index based solely on 1984 wage data and to continue using the blended wage index. This index is comprised of a simple average of area wage index values computed from 1982 data on an hour-weighted basis and area wage index values computed from 1984 data on an hour-weighted basis, equally weighted to produce average area wage index values. (See 52 FR 33040, September 1, 1987, for a discussion of the computation methodology). Given our concern about the negative impact the adoption of a wage index based solely on 1984 data may have on aggregate hospital payments, we believe it is in the best interest of hospitals, as well as the Medicare program, to continue using the blended wage index for FY 1989.

In addition to the corrections to the 1984 wage data discussed above, we have incorporated the statutorily required changes into both wage indexes. Also, the Executive Office of Management and Budget announced that, effective March 14, 1988, Decatur, AL has become a new MSA, and that, effective December 22, 1987, the city of Sullivan, Missouri has become part of the St. Louis, MO-IL MSA. These changes have been incorporated as well.

In addition to the changes described above, we received information from other hospitals that indicated that their 1984 wage data are incorrect. However, these corrections cannot be made in this final rule because documentation and validation from the intermediaries were not received in time for publication in this final rule. After a hospital requested

change has been verified by the intermediary and evaluated by HCFA, we will notify the regional offices of the appropriate wage index values. Any changes to the wage index values as a result of corrections in which the documentation was not received in time for publication in this final rule will become effective the day after the regional offices are notified of the corrected wage index values.

Comment: Some commenters, including several members of Congress, asserted that Congress intended that the urban and rural wage indexes were not to be revised just because some hospitals in rural counties are considered to be in an adjacent urban area for prospective payment purposes.

Response: Under section 1886(d)(8)(B) of the Act, as enacted by section 4005(a) of Pub. L. 100-203, and as amended by section 411(b)(4) of Pub. L. 100-360, hospitals in rural counties adjacent to one or more urban areas that meet certain criteria are considered to be located in one of those adjacent urban areas. Under the prospective payment system, hospitals are located in one of the following: a large urban area, another urban area, or a rural area. We find no authority in sections 1886(d)(2)(D), and (d)(8)(B) of the Act, or in any other part of section 1886 of the Act to set up an additional category of hospitals, rural for some purposes and urban for others.

We note that the Senate version of section 4005(a) of Pub. L. 100-203 provided that the change in location of hospitals from rural areas to urban areas was not to be considered when calculating the hospital wage index. However, as stated in the Conference Committee Report accompanying Pub. L. 100-203, with respect to section 4005(a) of Pub. L. 100-203, "the conference agreement includes the Senate amendment with modifications." (Emphasis added) (H.R. Rep. No. 495, 100th Cong., 1st Sess. 532 (1987)). One modification was that Pub. L. 100-203 did not include the provision that specified that wage index values were not to be revised when a hospital located in a rural area was considered to be located in an adjacent urban area.

Further, as amended by section 411(b)(4) of Pub. L. 100-360, section 1886(d)(8)(B) of the Act now applies "For purposes of this subsection," meaning for purposes of all the provisions pertaining to the prospective payment system in section 1886(d) of the Act. Thus, if a hospital is considered "urban" for purposes of prospective payments, it is also considered "urban" for purposes of computing the

prospective payment system wage index values.

Comment: Many commenters recommended that HCFA periodically update the wage index. In addition, commenters suggested that the wage data be presented in a manner that permits the hospital and the intermediary to review data submitted to aid in determining if the data are reasonable and accurate.

Response: We agree with the recommendation that the hospital wage index should be updated on a regular basis.

At present we do not have a process in place for obtaining the necessary data on a regular basis. However, we will be investigating the necessity and feasibility of such a process for future updates. We note that section 1886(d)(3)(E) of the Act, as amended by section 4004(a) of Pub. L. 100-203, requires that the wage index be updated not later than October 1, 1990 and at least every 36 months thereafter.

One of the ways we had hoped to update the wage index was with the data from 1986 that were collected from the HCFA Form 339, Exhibit 7, which was designed and developed to enable us to look at the feasibility of developing a wage index that takes into account occupational mix. The collection of the 1986 data is incomplete since the majority of hospitals (more than 60 percent) failed to complete or submit the forms. Also, a preliminary examination of the forms that were submitted suggests that hospitals had numerous problems in completing the forms. We intend in the near future to look into the feasibility of using these data or conducting a new survey in order to update the wage index. In this connection, we will invite the hospital industry to participate in the design and implementation of any new wage survey.

As to presenting data in such a manner as to permit hospitals to review data for accuracy, we have routinely made wage data available upon request, either through the provisions of the Freedom of Information Act or, during the comment period when a revised wage index is newly proposed, on an expedited basis as described in the proposed rule (53 FR 19526-19527).

Comment: One commenter, noting that most MSAs contain fewer than five hospitals, recommended that no hospital should be left out of the calculation of the wage index because of potential data errors or nonavailability of information. If the data are inaccurate or unavailable, the prior year's survey data

should be used and updated by inflation factors.

Response: In the process of collecting both the 1982 and 1984 wage survey forms, we closely monitored the receipt of data from MSAs that contained fewer than four hospitals. To ensure that smaller MSAs were completely represented, we followed up with both hospitals and intermediaries to obtain missing data. For the few hospitals that did not respond, we considered updating missing data or inaccurate data by inflating the prior period's data. However, since the overall response rate in both surveys was so close to 100 percent, and because wages paid by individual hospitals can be volatile from year to year, we elected not to use earlier data. Also, since we do not update the wage index every year, past data from a hospital may be two or more years old. In future updates, we will reconsider this suggestion if survey data appear to be inaccurate or unavailable.

Comment: One commenter suggested that we correct underpayments to all hospitals retroactively for errors in the wage data caused by other hospitals, the intermediaries, or HCFA.

Response: We believe that applying changes to the wage index retroactively would violate the prospective nature of the prospective payment system. Moreover, changes would result in both underpayments and overpayments. That is, if the wage index value is too low for some hospitals, then it is too high for others. In addition, it would be administratively cumbersome to have all intermediaries recompute all processed bills retroactively to reflect small changes in individual area wage indexes.

Depending upon the magnitude of the individual area changes, the national average hourly wage could go up as well as down. An increase in the national average decreases the wage index values for all other areas in which the data remain unchanged. In this situation, all payments would be subject to change. The prevention of such retroactive changes and the consequent uncertainties of payments were two of the reasons for the initial adoption of the Medicare prospective payment system, which replaced the cost reimbursement system.

V. Other Decisions and Changes to the Regulations

A. Physician Attestation (§ 412.46)

Previously, § 412.46(a) required that, as a part of DRG validation, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the

principal diagnosis, secondary diagnoses, and names of major procedures that have been performed. The information must be in writing in the medical record. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's signature:

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

In addition, when the claim is submitted, the hospital must have on file a current signed acknowledgment from the attending physician that the physician has received the following notice:

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

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

HCFA has received a number of requests from hospitals and hospital corporations for permission to install automated systems for executing physician attestations because, with a fully automated system, a physician could record the appropriate information and attest to it from his home or office. Hospitals asserted that the use of fully automated systems is critical for the efficient use of staff, including physician staff, prompt and accurate completion of medical records, and timely submission of claims.

After reviewing materials submitted by various hospitals, we concluded that it would be acceptable for physician attestations to be completed electronically so long as the procedures a hospital establishes are sufficient to achieve the program objectives of the existing requirements. Thus, we proposed that the physician could personally execute the attestation by computer and that the system would contain safeguards to ensure that the physician's identifier is confidential and to enable the physician to determine whether the attestation had been correctly recorded. The physician would be informed of the penalty for making false statements and for allowing others to complete the required attestations using his or her identifier.

Therefore, we proposed to amend § 412.46(a) to provide that a physician attestation may, at the request of a hospital, be completed electronically if the intermediary determines that the hospital's system meets standards established by the Secretary.

We indicated that we expected that two types of physician attestation systems would be approved. The first type involves the use of alpha/numeric identifiers for physicians. First, the physician would gain access to the hospital's records system by entering a physician-specific identification code. Then, the physician would enter diagnosis and procedure information onto a computer and affirm its accuracy.

The second type of physician attestation system involves the use of biometrics. The physician would attest to the diagnoses and the procedure information as discussed above but would gain access to the record system through a computer-assisted device that identifies the physician, for example, by reading his or her fingerprint.

We recognize that there may be other systems available with which we are not familiar and will consider such systems on their merits as we encounter them. This discussion is not intended to be an exhaustive discussion of the possibilities of electronic attestation.

In making this option for electronic signatures available, we anticipate requiring hospitals to take some additional safeguards to ensure that physicians making use of the option are aware of the attestations that have been made and that there is documentation in hard copy to support their attestations. In cases where an alpha-numeric code is used, we would expect a hospital to generate a periodic hard copy list of attestations made by the physician and send it to the physician for his or her signature as a means by which the physician can confirm that the appropriate diagnoses and procedures were reported. In the case of biometric equipment, we would expect the hospital to send the physician a copy of each attestation for his or her records so that there would be a document against which the hospital's reports could be judged.

We note that this option would not be a requirement for physicians. Instead, it is an alternative means of meeting the existing requirement at § 412.46(a). This alternative would be acceptable to us in cases where a hospital and its medical staff determine that they would prefer this alternative and request to use it. Therefore, this change in the regulations would not constitute a new Federal requirement.

We also proposed to make clarifying changes in § 412.46 to explicitly state that the physician attestation and acknowledgment must be dated as well as signed.

The majority of those who commented on this proposal were in favor of the change. However, we also received the following comments:

Comment: Three commenters stated that we should not require that hospitals generate and maintain "hard copies" of the electronically generated attestations. Instead, hospitals should have the option to maintain records in whatever form is most convenient for the period of time required by existing State and Federal laws.

Response: We have not accepted this comment. The proposed alternative attestation provision was developed as a result of hospital requests for a mechanism whereby computers could be used to fulfill a requirement for handwritten signatures. We believe that hard copies are necessary to maintain the integrity of the alternative provision for electronically generated attestations. However, we note that this new alternative is entirely optional. Hospitals that prefer to continue to meet the original requirement for handwritten signatures may do so.

Comment: One commenter asserted that since PROs already conduct DRG validation, which includes the review of physician attestations, PROs should also determine if the hospitals' data system meets established guidelines. If the decision is left with the intermediary, we should require that the intermediary convey its decision to the PRO. Also, we should prohibit PROs from issuing technical denials if a claim's only deficiency is an incomplete or incorrectly completed attestation.

Response: After reviewing the public comments, we have decided that the intermediaries are the entities best suited to verify compliance with the alternative signature requirement and we plan to use them for this purpose. We will continue to evaluate this issue, however, and reserve the option to employ other means of implementing this provision if experience indicates that a change is needed.

The provision for a technical denial if the claim's only deficiency is an incomplete or incorrectly completed attestation was not proposed for revision and we do not anticipate any changes in this area. But we will consider whether we should prohibit PROs from issuing a technical denial if this case warrants action in future rulemaking.

Comment: Three commenters, though in support of the proposed provisions

concerning physician attestation, requested that we reexamine the physician attestation requirements altogether. The commenters stated that they believe that the physician attestation requirement has outlived its utility and that it is a large administrative burden to hospitals and remains offensive to many physicians. Also, one commenter is unconvinced that this requirement is essential to the successful prosecution of fraud and abuse relating to the submission of Medicare claims.

Response: Our experience with physician attestation has been that it provides a valuable tool for validating DRG selections, and we continue to believe that it is an appropriate requirement in the context of the prospective payment system. Our reasoning is fully discussed in the preambles to the regulations in which this requirement was established. (See the January 3, 1984 final rule (49 FR 283) and the August 31, 1984 final rule (49 FR 34734).) We have not developed any plans for discontinuing this requirement.

Comment: One commenter stated that the proposed physician attestation rule that the hospital would have to obtain documentation in hard copy if an alpha-numeric identifier is used is impractical and should be revised because it is inappropriate to discriminate between alpha-numeric identifiers and biometric type electronic signatures. In addition, the commenter asserted that long historical experience with alpha-numeric systems should confirm their utility for this purpose without additional safeguards.

Response: As we noted in the discussion of the proposed changes, we believe that the hard copy requirements set forth in the alternative attestation requirement are necessary to maintain accountability and to assure that any rare instance of inappropriate behavior can be successfully dealt with by the Inspector General or the Department of Justice.

Comment: One commenter recommended that we revise our requirement that the current signed acknowledgment from attending physicians must have been completed within the 12 months prior to the submission of the claim in order to prevent a lapse in hospital recordkeeping. The commenter stated that because a hospital may request a new acknowledgement statement from a physician as early as two months before the 12-month period runs out, in some cases a physician might sign the acknowledgement as early as two months ahead of the end of the 12-month period. This would result in moving the

beginning of the 12-month period up to this new date. To avoid the possibility of a date change every year for every physician, the commenter recommended that we merely allow the physician to sign the acknowledgement early so that we may continue to apply a 12-month period that starts from the same date each year.

Response: We rejected this comment because we did not propose a change in this provision, and we do not believe that it would be appropriate to do so at this time. However, we will consider these comments in connection with future revisions of the regulations.

Comment: We received a number of comments relating to other aspects of our physician attestation requirements requirements that we had not been proposed for revision and which we do not currently contemplate changing.

Response: As we noted in section I.D. of this preamble, we are not discussing in this document any comments that raised issues not specific to the proposals we made. However, we will consider whether the suggestions made by the commenters would merit action in future rulemaking.

B. Increase in the Prospective Payment Rates and Rate-of-Increase Limits (§§ 412.63, 412.73, 412.208, 412.210, and 413.40)

Section 4002(a) of Pub. L. 100-203 amended section 1886(b)(3)(B)(i) of the Act to provide that the applicable percentage increases for prospective payment hospitals for FY 1988 effective with discharges on or after April 1, 1988 are—

- 3.0 percentage points for hospitals located in rural areas;
- 1.5 percentage points for hospitals located in large urban areas; and
- 1.0 percentage points for hospitals located in other urban areas.

However, under 4002(g)(1)(B) of Pub. L. 100-203, for the purposes of determining the standardized amounts for discharges occurring on or after October 1, 1988 (for FY 1989), the applicable percentage increases effective April 1, 1988 are deemed to have been in effect for the entire FY 1988.

Amended section 1886(b)(3)(B)(i) of the Act also sets forth the applicable percentage increases for FY 1989 as—

- The market basket percentage increase minus 1.5 percentage points for hospitals located in rural areas;
- The market basket percentage increase minus 2.0 percentage points for hospitals in large urban areas; and

• The market basket percentage increase minus 2.5 percentage points for hospitals in other urban areas.

In addition, the applicable percentage increase for FY 1990 and each subsequent fiscal year for hospitals in all areas is the market basket percentage increase.

Section 1886(b)(3)(B) of the Act also governs the target rate-of-increase limits for hospitals and units excluded from the prospective payment system. Section 4002(e) of Pub. L. 100-203 amended section 1886(b)(3)(B)(ii) of the Act to provide that the applicable percentage increase for FY 1988 for these hospitals and units is the market basket percentage increase minus 2.0 percentage points. However, section 4002(g)(3) of Pub. L. 100-203 provided that for a hospital's cost reporting period beginning during FY 1988, payment is made as though the applicable percentage increase equals 2.7 percent times the ratio of 315 to 366. This results in an actual applicable percentage increase for FY 1988 of 2.328 percent. However, for purposes of updating the target rate-of-increase limits for FY 1989, the applicable percentage increase for FY 1988 is deemed to have been 2.7 percent for the entire period.

Section 4002(e) of Pub. L. 100-203 amended section 1886(b)(3)(B)(ii) of the Act to provide that for FY 1989 and subsequent fiscal years the applicable percentage increase for excluded hospitals and units is the market basket percentage increase.

The percentage increases applicable in FY 1988 to hospitals both included in and excluded from the prospective payment system were described in the April 5, 1988 notice at 53 FR 11135. In the May 27, 1988 proposed rule (at 53 FR 19510), we proposed to amend §§ 412.63, 412.73, 412.210 and 413.40 (and to make a conforming change at § 412.212(b)) to implement the provisions of section 1886(b)(3)(B) (i) and (ii) of the Act.)

We also proposed to revise §§ 412.62(k), 412.63(k) (previously §§ 412.63(j), 412.208(i), and 412.210(c)) to clarify in the regulations that when we refer to "geographic areas" in the context of adjusting the rates for different area wage levels, we mean urban and rural areas. We received no comments on these proposals.

C. Changes in Geographic Classification (§§ 412.63, 412.208, and 412.210)

Prior to the enactment of Pub. L. 100-203, section 1886(d)(2)(D) of the Act required the Secretary to compute separate average standardized amounts for hospitals located in urban and rural areas. The term "urban area" is defined as an area within a Metropolitan

Statistical Area (MSA). Urban areas in New England are defined as New England County Metropolitan Areas (NECMAs). However, under section 601(g) of Pub. L. 98-21, certain nonurban New England counties were deemed to be parts of urban areas. For purposes of the prospective payment system, we have treated those counties as part of the NECMAs of which they were a part in 1979. The only other exception to the strict use of MSA and NECMA definitions in identifying urban areas has been for a rural county that qualifies for reclassification into an MSA under § 412.63(b)(3). In these two instances, the population of the rural counties deemed to be urban is included in calculating the population of the MSA or NECMA to which the county has been appended for Medicare prospective payment purposes.

1. Establishment of Large Urban Areas

Section 4002(c)(1) of Pub. L. 100-203 amended section 1886(d)(3) of the Act to require the Secretary to compute three average standardized amounts for discharges occurring in a fiscal year beginning on or after October 1, 1987: one for hospitals located in rural areas; one for hospitals located in large urban areas; and one for hospitals located in other urban areas. Section 4002(b) of Pub. L. 100-203 amended section 1886(d)(2)(D) of the Act to define a "large urban area" as an urban area with a population of more than 1,000,000, based on the latest population data published by the Bureau of the Census. In addition, section 4009(i) of Pub. L. 100-203 provides that an NECMA with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Under that section as now amended, urban areas that do not meet the criteria for large urban areas are referred to as "other urban areas."

Based on 1986 population estimates published by the Bureau of the Census, we identified 46 urban areas that meet the criteria to be defined as large urban areas for FY 1988. A list of those areas was set forth in the April 5, 1988 notice at 53 FR 11138. Although we did not propose any changes in these areas for purposes of the May 27, 1988 proposed rule, we stated that if new population estimates are published by the Bureau of the Census before we publish the final rule, we would include any resulting additions to and deletions from the list of large urban areas in that rule. We have been advised by the Bureau of the Census that new population estimates

will not be available in time to be evaluated for this final rule. Therefore, the areas meeting the definition of "large urban areas" for discharges occurring in FY 1989 are the same as the ones listed in the April 5, 1988 notice.

We proposed to amend §§ 412.63 and 412.210 to implement the provision of 1886(d)(3) of the Act. In addition, in Table 4a in section IV of the addendum to the proposed rule, which sets forth the wage index values for urban areas, we specifically designated those urban areas that qualify as large urban areas for the convenience of the reader. We have continued this practice in this final rule (see Table 4a in section IV of the addendum).

Comment: We received one comment stating that Lake County, Illinois is part of the Chicago MSA and should therefore be designated as a large urban area.

Response: Lake County has been designated as a separate MSA by EOMB. While it is part of a Consolidated Metropolitan Statistical Area (CMSA) that also includes the Chicago MSA, for purposes of payment under the prospective payment system, we do not use CMSAs in defining urban areas. CMSAs are made up of two or more Primary Metropolitan Statistical Areas (PMSAs). A PMSA is recognized as a separate urban area because it demonstrates very strong internal economic and social links in addition to its ties with another portion of a CMSA. In defining urban areas under the prospective payment system, we recognize MSAs and PMSAs only.

We believe this is consistent with section 1886(d)(2)(D) of the Act, which defines "urban area" as "an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation." Subsection (a) (that is, section 1886(a) of the Act), which was enacted by section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248), established limits on total hospital inpatient operating costs for cost reporting periods beginning on or after October 1, 1982. Under section 1886(a) of the Act, we defined an urban area as an area within a Standard Metropolitan Statistical Area (SMSA) or NECMA as designated by EOMB. We did not recognize a Consolidated Standard Metropolitan Statistical Area (CSMSA) as a single urban area but defined urban in terms of each SMSA within the CSMSA separately. On June 30, 1983, EOMB began using MSAs, which replaced the SMSA definitions, and we

adopted the MSA definitions in the same manner as the previous SMSA definitions (that is, we do not recognize CMSAs as single urban areas). Therefore, for purposes of defining large urban areas under the prospective payment system, the population criteria are applied to MSAs and PMSAs, which are the same areas used to define labor market areas in developing the HCFA wage index.

2. Revision of Standards for Including a Hospital Located in a Rural County in an Urban Area

Section 4005(a) of Pub. L. 100-203 revised 1886(d)(8) of the Act to provide that, if certain conditions are met, the Secretary would treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute. As specified in section 1886(d)(8)(B) of the Act as enacted by section 4005(a) of Pub. L. 100-203 and amended by section 411(b)(4) of Pub. L. 100-360 (see discussion, below), the conditions that must be met for a hospital located in a rural county adjacent to one or more urban areas to be treated as being located in the urban area to which the greatest number of workers commute are as follows:

- The rural county would otherwise be considered part of an MSA but for the fact that the rural county does not meet the standard established by the Executive Office of Management and Budget (EOMB) relating to the commuting rate of workers between the county and the central county or counties of any adjacent MSA.
- The county would meet the commuting standard if commuting to (and where applicable, from) the central county or central counties of all adjacent MSAs or NECMAs (rather than just to one) were considered.

A county meeting the above commuting standards must also meet the other standards established by EOMB for inclusion in an MSA as an outlying county. In order to meet these requirements, the rural county must have a degree of "metropolitan character." "Metropolitan character" is established by meeting one of the following EOMB standards, which were published in the *Federal Register* on January 3, 1980 (45 FR 956):

- At least 50 percent of the employed workers residing in the county commute to the central county or counties and the population density is at least 25 persons per square mile.
- From 40 percent to 50 percent of the employed workers residing in the county commute to the central county or

counties and the population density is at least 35 persons per square mile.

- From 25 percent to 40 percent of the employed workers residing in the county commute to the central county or counties and the population density is at least 35 persons per square mile. In addition, the county meets at least one of the following conditions:

- The county has a population density of at least 50 persons per square mile.
- At least 35 percent of the population in the county is classified as urban by the Bureau of the Census.
- At least 10 percent of the population or at least 5,000 persons live within the urbanized area of the central county.
- From 15 percent to 25 percent of the employed workers residing in the county commute to the central county or counties² and the county has a population density of at least 50 persons per square mile. In addition, the county meets at least two of the following conditions:
- The county has a population density of at least 60 persons per square mile.
- At least 35 percent of the population in the county is classified as urban by the Bureau of the Census.
- Between 1970 and 1980, the population must have increased by at least 20 percent.
- At least 10 percent of the population or at least 5,000 persons live within the urbanized area of the central county.

The determination as to whether a county qualifies for inclusion in an MSA is made based on data from the Bureau of the Census.

For purposes of payment under the prospective payment system, as required by section 1886(d)(8)(B) of the Act, we proposed that a hospital located in a rural county that qualifies under this provision would be deemed to be located in the MSA to which the greatest number of workers in the rural county commute. In addition, we proposed that the area wage indexes would be recomputed to reflect the reclassification of these counties as urban and, consequently, part of the urban wage area.

We noted that in determining whether a county meets the criteria for being

designated an outlying county of an MSA that were published in the January 3, 1980 *Federal Register* notice (and summarized in this document, above), EOMB first determines the county's commuting rate to the central county or counties of individual MSAs and then determines, based on that rate, which additional criteria the county must meet for MSA status. Thus, for example, if a county's commuting rate is less than 15 percent to the central county or counties or the sum of the employed workers commuting from the outlying county to the central county or counties and the employed workers commuting from the central county or counties to the outlying county is less than 20 percent of the employed workers living in the outlying county, the county cannot qualify for MSA status under any criteria. If the commutation rate is from 15 percent to 25 percent and the population density is at least 50 persons per square mile, the county must meet at least two out of the following four additional criteria: a population density of at least 60 persons per square mile; at least 35 percent of the population classified as urban; 1970-1980 population growth of at least 20 percent; and a significant portion of the population lives within the urbanized area of the central county.

Since the purpose of amended section 1886(d)(8) of the Act is to recognize all other criteria for MSA designations except for the alternative commuting standard, we followed the EOMB and Bureau of the Census procedures for evaluating urban status. That is, we first determined which rural counties adjacent to one or more urban areas would meet the alternative standard specified in section 1886(d)(8)(B) of the Act, and then evaluated whether each of the counties that meet the alternative standard also meet the required additional criteria applicable to the rural county's level of commuting.

In the proposed rule at 53 FR 19512, we listed the counties that meet the standards established under section 1886(d)(8)(B) of the Act. The final list of these counties is set forth below following the comments and responses concerning this provision. Hospitals located in the counties on the list will be considered to be located in the specified adjacent urban area beginning October 1, 1988.

Section 1886(d)(8)(C) of the Act requires that the effect of this provision be budget neutral; that is, the statute requires that a proportional adjustment to the standardized amount for urban hospitals would be made to ensure that total aggregate payments made in the

² Also accepted as meeting this commuting requirement are:

(a) The number of persons working in the county who live in the central county(ies) is equal to at least 15 percent of the number of employed workers living in the county; or

(b) The sum of the number of workers commuting to and from the central county(ies) is equal to at least 20 percent of the number of employed workers living in the county.

prospective payment system would be neither greater nor less than aggregate payments that would otherwise be made. In addition, section 1886(d)(8)(C) of the Act requires that aggregate payments to those rural hospitals not affected by this provision remain constant. Thus, appropriate adjustments to the standardized amounts set forth in Tables 1a, 1b, and 1c in section IV of the addendum to the proposed rule were made to reflect the budget neutrality requirement.

In the conference report that accompanied Pub. L. 100-203, Congress specified "that the effect of this provision shall be limited to the treatment, for payment purposes, of the hospitals located in qualifying rural counties; the boundaries and population size of the adjacent urban areas shall not be altered." (H.R. Rep. No. 495, 100th Cong., 1st Sess. 532 (1987).) Accordingly, even though a hospital located in a qualifying rural county would be deemed a part of an adjacent MSA for payment purposes, we did not propose to include the population of that county in the MSA for purposes of determining whether the MSA is a large urban area (that is, an MSA with a population of at least 1,000,000 or an NECMA with a population of at least 970,000).

As noted above, other than those exceptions required by law, we have made only one exception to the strict use of MSA and NECMA definitions in identifying urban areas. Under current § 412.63(b)(3), a hospital classified as rural is deemed to be urban and receives the urban Federal payment amount if the county in which it is located meets the following criteria:

- At least 95 percent of the perimeter of the rural county is contiguous with urban counties.
- The county was reclassified from an urban area to a rural area after April 20, 1983.
- At least 15 percent of employed workers in the county commute to the central county of one of the adjacent MSAs or NECMAs.

This provision was added to the regulations by the September 3, 1986 final rule (51 FR 31469) under the Secretary's authority pursuant to section 1886(d)(5)(C)(iii) of the Act " * * * to provide by regulation for such other exceptions and adjustments * * * as the Secretary deems appropriate * * *"

Since implementation of this exception, only one hospital in one county (Shiawassee, MI) has qualified under this provision. Because this hospital would be deemed to be in an urban area under the new statutory requirements in section 1886(d)(8)(B) of the Act, we believe there is no reason to

retain our special exception as set forth in current § 412.63(b)(3). Therefore, we proposed to eliminate that provision under the Secretary's authority in section 1886(d)(5)(C)(iii) of the Act " * * * to provide by regulation for such other exceptions and adjustments * * * as the Secretary deems appropriate * * *" because it has been effectively included in a statutory requirement.

Comment: Three commenters challenged our interpretation of the language included in section 1886(d)(8)(B) of the Act, as enacted by section 4005(a)(1)(D) of Pub. L. 100-203 that established the criteria for considering hospitals located in certain rural counties as located in urban areas. One commenter stated that in determining the commutation rate to the rural county from the adjacent MSAs, all counties in the MSA should be considered since the language in the law did not specify central counties only. Two commenters stated that since the law specified a 15 percent commuting criteria, this percentage replaces all other commuting standards established by EOMB.

Response: We agree that a literal reading of section 1886(d)(8)(B) of the Act as initially enacted could permit these interpretations. However, section 411(b)(4) of Pub. L. 100-360, which was enacted on July 1, 1988, included a technical amendment to section 1886(d)(8)(B) of the Act, which had been added by section 4005(a)(1)(D) of Pub. L. 100-203. The language concerning the specific commuting criteria was replaced by the following: "the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas)."

Therefore, our application of EOMB standards is consistent with the law, which requires that we consider aggregate commuting to (and, if applicable, from) the central county or counties of all adjacent MSAs when applying EOMB standards for inclusion of a county in an MSA (or NECMA) as an outlying county.

We are revising § 412.63(b)(3) to reflect the revised language in section

1886(d)(8)(B) of the Act as amended by section 411(b)(4) of Pub. L. 100-360.

Comment: Two commenters objected to the fact that we used commuting percentages based on 1980 census data in determining whether a rural county would qualify for urban status. These commenters suggested that since these data do not reflect current commuting patterns, a special census should be performed on a county-specific basis to provide updated commuting data.

Response: The Congress intended in section 1886(d)(8)(B) of the Act as amended by section 411(b)(4) of Pub. L. 100-360 to revise, for purposes of determining prospective payments to hospitals, the way EOMB standards are applied for identifying outlying counties by allowing consideration of aggregate commuting rates to and from the central counties of all adjacent MSAs in applying those standards. This is the only modification to EOMB's standards and the application of those standards that was intended by this provision. Indeed, the amendment to section 1886(d)(8)(B) of the Act contained in section 411(b)(4) of Pub. L. 100-360 specifies the use of EOMB standards as published January 3, 1980. These standards were developed specifically for the purpose of designating and defining MSAs following the 1980 Census.

Therefore, since EOMB uses commuting data from the 1980 census in identifying those counties that currently qualify as outlying counties of MSAs, it would not be appropriate to use a different set of data in determining which counties would also qualify as outlying counties under this provision. The decennial census data EOMB uses to identify outlying counties are not updated between censuses but are used for the entire ten-year period until data obtained from the next census are computed. Therefore, until the future census data (that is, the 1990 census data) become available, we will continue to use the same 1980 census data used by EOMB.

Similarly, in determining the total commuting percentage for a county, we rounded the number to two decimal places to determine which commuting category would apply to the county. For example, a county with total commuting to adjacent MSAs of 39.99 percent would fall into the 25 percent to 40 percent commuting category. This number (39.99 percent) would not be rounded up to 40 percent. This is consistent with the rounding policy used by EOMB in making its MSA determinations.

Comment: We received many comments specifically requesting reclassification of certain rural counties that we had not identified as qualifying counties under our proposed rule. Generally, these commenters believe their counties qualified for urban status under section 1886(d)(8)(B) of the Act and requested reclassification as qualifying counties for urban status.

Response: While we are not addressing each specific comment separately in this final rule, we have reviewed all the relevant census data for the counties named in the comments to determine whether they qualify for urban status. The final list of qualifying counties is set forth below.

We have performed an extensive review of the census data for all rural counties adjacent to MSAs and believe that all qualifying counties have been identified. A hospital located in a qualifying county listed in this final rule will begin receiving payment at the urban rate beginning with discharges on October 1, 1988. In Table 4, the counties are listed as part of the labor market area comprising the MSA to which the greatest number of workers commute.

We are notifying each commenter directly with an explanation of why the county the commenter was seeking to have included in this provision has not been included in the list of qualifying counties.

Comment: We received a comment from a hospital located in Fredericksburg, Virginia, which is an independent city and not part of a county and which the commenter believes should be included in our list of qualifying areas. The commenter points out that under EOMB standards, an independent city located in Virginia is regarded as being included in the county from which it was originally formed. Since Fredericksburg was originally formed from Spotsylvania County, which qualifies under the criteria in section 1886(d)(8)(B) of the Act, Fredericksburg should also qualify.

Response: We agree with the commenter and are treating hospitals in Fredericksburg City as being located in Washington, DC-MD-VA MSA. We did consider Fredericksburg to be part of Spotsylvania County when the proposed list of qualifying counties was developed, although we did not specifically include it on the list. In order to clarify this issue, we have added Fredericksburg City to the list of qualifying counties. We note that the addition of Decatur, AL as an urban area effective on March 14, 1988 has led to the inclusion of Limestone County, AL to our list of qualifying counties. The following is the final list of counties that

qualify under section 1886(d)(8)(B) of the Act.

Rural county	MSA
Limestone, AL.....	Decatur, AL.
Marshall, AL.....	Huntsville, AL.
Charlotte, FL.....	Sarasota, FL.
Indian River, FL.....	Fort Pierce, FL.
Christian, IL.....	Springfield, IL.
Macoupin, IL.....	St. Louis, MO-IL.
Mason, IL.....	Peoria, IL.
Clinton, IN.....	Lafayette, IN.
Henry, IN.....	Anderson, IN.
Owen, IN.....	Bloomington, IN.
Jefferson, KS.....	Topeka, KS.
Allegan, MI.....	Grand Rapids, MI.
Barry, MI.....	Battle Creek, MI.
Cass, MI.....	Benton Harbor, MI.
Ionia, MI.....	Lansing-East Lansing, MI.
Lenawee, MI.....	Ann Arbor, MI.
Shiawassee, MI.....	Flint, MI.
Tuscola, MI.....	Saginaw-Bay City-Midland, MI.
Van Buren, MI.....	Kalamazoo, MI.
Clinton, MO.....	Kansas City, KS-MO.
Cass, NE.....	Omaha, NE.
Caswell, NC.....	Danville, VA.
Currituck, NC.....	Norfolk-Virginia Beach-Newport News, VA.
Harnett, NC.....	Fayetteville, NC.
Genesee, NY.....	Rochester, NY.
Columbiana, OH.....	Beaver County, PA.
Morrow, OH.....	Mansfield, OH.
Preble, OH.....	Dayton-Springfield, OH.
Van Wert, OH.....	Lima, OH.
Lawrence, PA.....	Beaver County, PA.
Cherokee, SC.....	Greenville-Spartanburg, SC.
Bedford, VA.....	Roanoke, VA.
Fredericksburg City, VA.....	Washington, DC-MD-VA.
Isle of Wight, VA.....	Norfolk-Virginia Beach-Newport News, VA.
Spotsylvania, VA.....	Washington, DC-MD-VA.
Jefferson, WI.....	Milwaukee, WI.
Walworth, WI.....	Milwaukee, WI.
Jefferson, WV.....	Washington, DC-MD-VA.
Lincoln, WV.....	Charleston, WV.

Comment: We received comments suggesting alternatives whereby a rural hospital could be reclassified as urban and that the Secretary use the general exceptions authority provided under section 1886(d)(5)(C) of the Act to adopt these alternative criteria.

Response: Under section 411(b)(4)(A) of the recently enacted Medicare Catastrophic Act of 1988 (Pub. L. 100-360) Congress amended section 1886(d)(8)(B) of the Act to ensure its intended narrow applicability by specifying that a county must meet all other standards for designating MSAs and that the only variance from the established standards is the inclusion of commuting "to (and if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas."

We believe that the statutory language cited above underscores Congress' acceptance of the MSA standards and precludes us from relaxing those standards to enable more hospitals to benefit from urban

designation. Since Congress has already explicitly decided the manner in which certain hospitals would be reclassified as urban for purposes of the prospective payment system, we believe that the use of our exceptions authority to modify those criteria on a case-by-case basis would contradict the intent of Congress in enacting this provision.

3. Multicampus Hospitals

Some hospitals receiving payment under the prospective payment system are multicampus hospitals; that is, they consist of two or more separately located inpatient hospital facilities. We had received inquiries concerning how we determine the prospective payment rate for these hospitals when the various individual hospital facilities are located in areas with different prospective payment rates or wage indexes.

Section 1886(d)(3)(D) of the Act, as amended by section 4002(c)(1)(D) of Pub. L. 100-203, provides that prospective payment rates are established "for hospitals located * * * in a large urban area or other urban area * * *" and "for hospitals located in a rural area * * *." That is, the prospective payment rate is based on the geographic location of the hospital at which the discharge occurs rather than on any other location, such as, for example, the location of the headquarters of the multicampus facility that owns and operates the various individual hospital facilities, or the location of the main hospital facility. Therefore, we proposed to amend § 412.63 to provide that a multicampus hospital that is participating in the Medicare program as a single provider must be paid prospective payment rates that are determined by the geographic location of each individual hospital facility within the multicampus hospital.

Comment: A few commenters expressed concern that our proposal to pay multicampus hospitals on the basis of the geographic location of each respective campus does not consider operational difficulties imposed by attempting to make payment on two separate bases to a hospital with a single Medicare billing number that files a single, fully combined cost report. The commenters expressed concern that our proposed policy is silent with respect to the calculation of the respective disproportionate share hospital adjustments, where such adjustments are applicable. Another comment noted that administering this policy may be costly.

Response: We recognize that this policy, as described in the proposed rule, presents difficulties in

implementation. Therefore, we are implementing this policy prospectively, with discharges occurring on or after October 1, 1988. With respect to the operational difficulties raised by the commenter, including the method for calculating disproportionate share payments, we are currently ascertaining the number of multiple-site providers. After this information has been obtained, we will develop a system to permit intermediaries to differentiate separate campuses of a hospital, and to pay each campus according to the applicable rate for its geographic area. We note that since section 1886(d)(5)(F) of the Act requires that hospitals be differentiated by urban or rural location, eligibility for disproportionate share payments, as well as the calculation of the payments, must be determined according to the urban or rural location of an individual hospital campus.

With respect to the additional costs of administering this policy, we believe that the program benefits resulting from hospitals being paid appropriately, and in particular according to the law as enacted, outweigh the costs inherent in administering this policy.

D. Establishment of a Regional Floor (§ 412.70)

Section 4002(d) of Pub. L. 100-203 amended section 1886(d)(1)(A)(iii) of the Act to establish a "regional floor" for the prospective payment rate applicable to a hospital. In accordance with this section, hospitals payments are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the Census region in which they are located. This provision is effective for discharges occurring on or after April 1, 1988 and before October 1, 1990 and was described in the April 5, 1988 notice at 53 FR 11134.

In implementing this provision and determining which regions qualify for the regional floor, we compared the total of the labor-related and nonlabor-related portions of each standardized amount in each region with the total of the labor-related and nonlabor-related portions of the national standardized amount. In structuring the comparison in this way, we are following the explication of this provision contained in the Conference Committee Report accompanying Pub. L. 100-203 (H.R. Rep. No. 495, 100th Cong., 1st Sess. 525 (1987)), as well as the amendment to the provision contained in section 411(b)(1)(G) of Pub. L. 100-360.

Based on the updated payment rates published in the April 5, 1988 notice, we

determined that for discharges occurring on or after April 1, 1988 and before October 1, 1988, rural hospitals in Census regions I, II, III, and IV and hospitals in large urban areas and other urban areas in Census regions I and IV will receive greater payments using the national/regional blend than the national average standardized amount. Therefore, for discharges occurring on or after April 1, 1988 and before October 1, 1988, the Federal portion of the payment for these hospitals is comprised of 85 percent of the national average standardized amount and 15 percent of the applicable regional average standardized amount rather than 100 percent of the national average standardized amount. We proposed to amend § 412.70 to implement the provisions of 1886(d)(1)(A)(iii) of the Act.

Based on the updated payment rates set forth in this final rule, we have determined that there is only one change to the areas for which the regional floor is applicable. Hospitals in large urban areas and other urban areas in region VI are affected by the regional floor. Therefore, for discharges occurring on or after October 1, 1988 and before October 1, 1989, rural hospitals in regions I, II, III, and IV and hospitals in large urban areas and other urban areas in regions I, IV, and VI will receive greater payments using the national/regional blend than the national average standardized amount. Thus, for discharges occurring on or after October 1, 1988 and before October 1, 1989, the Federal portion of the payment for these hospitals will be comprised of 85 percent of the national average standardized amount and 15 percent of the applicable regional average standardized amount rather than 100 percent of the national average standardized amount.

E. Payment for Outlier Cases (§§ 412.82 and 412.84)

Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made to hospitals for atypical cases known as "outliers." These are cases that have either an extremely long length of stay or extraordinarily high costs when compared to the other discharges classified in the same DRG.

Section 1886(d)(5)(A)(iii) of the Act specifies that the outlier payments should approximate the marginal cost of care beyond the outlier threshold. In the September 1, 1983 interim final rule, we established the ratio of marginal cost to average cost at 60 percent (48 FR 39776).

For day outliers, an additional per diem payment is made for each covered day of care beyond the length of stay

threshold. The per diem payment is equal to 60 percent of the average per diem Federal rate for the DRG, which is calculated by dividing the wage-adjusted Federal rate for the DRG by the geometric mean length of stay for the DRG. This amount is multiplied by the applicable Federal blend percentage. After the end of the transition period, the Federal portion is 100 percent of the payment rate except for sole community hospitals, which continue to receive payment equal to 75 percent of the hospital-specific portion and 25 percent of the Federal regional portion.

For cost outliers, the additional payment is equal to 60 percent of the difference between the hospital's charges for the discharge, adjusted to cost, and the cost threshold. We currently determine the cost of the discharge to be equal to 66 percent of the billed charges for covered services based on the average ratio of operating costs to charges for Medicare discharges nationwide. The resulting cost estimate is further adjusted to exclude an estimate of indirect medical education costs and payments to hospitals that serve a disproportionate share of low-income patients. As with day outliers, the resulting amount is then multiplied by the applicable Federal blend percentage.

Our analysis indicates that while our payment policy for outliers effectively reduces the risk faced by hospitals in treating cases that are outside the normal range of cases in terms of duration or costliness, additional compensation would be justified for the most expensive cases, particularly those long-stay cases with extremely high costs. On the other hand, some cases that currently qualify for additional payment as day outliers are not extraordinarily costly.

In the June 10, 1987 proposed rule (at 52 FR 22089), we proposed to make two changes to the outlier regulations in order to more appropriately compensate hospitals for outlier cases. First, we proposed that a marginal cost factor of 80 percent be applied to cost outlier cases. Thus, outlier payment for these cases would be equal to 80 percent of the difference between the adjusted charges for the case and the cost threshold. Second, we proposed that day outlier cases whose adjusted charges exceeded the cost threshold also be paid 80 percent of the difference between the adjusted charges for the case and the cost threshold.

In the September 1, 1987 final rule (52 FR 33048), we announced our decision to delay implementation of any changes to the outlier policy. While the evidence

showed that the proposed changes would increase the effectiveness of outlier payment and most commenters supported an outlier policy that pays a higher fraction of outlier payments for extremely costly cases, many were concerned about the impact of the proposed changes and recommended that changes in the outlier policy be delayed until further study could be completed.

Given these concerns, we decided to delay implementation of any changes to the outlier payment policy and to continue our research on the impacts of alternative outlier payment methodologies, including the use of a hospital-specific rather than a national cost-to-charge ratio in computing cost outlier payments.

In the May 27, 1988 proposed rule, we proposed the following changes to the outlier policy to be effective for discharges on or after October 1, 1988. We would amend §§ 412.82 and 412.84 and add a new § 412.86 to implement these changes.

1. Marginal Cost Factor for Cost Outliers

We proposed for discharges occurring on or after October 1, 1988, to pay cost outlier cases at a marginal cost factor of 80 percent of adjusted charges beyond the cost outlier threshold (except for burn outlier cases, which are being paid using a marginal cost factor of 90 percent for discharges occurring on or after April 1, 1988 and before October 1, 1989).

2. Higher of Day or Cost Outlier Payment

For the first five years of the prospective payment system, we have paid even the most expensive day outliers at a per diem amount that is based on the average payment for all discharges assigned to that DRG. For some of the cases that currently qualify as day outliers, the per diem rate paid does not adequately compensate the hospital for its marginal costs. This is especially true for exceptionally costly day outlier cases (which are not addressed by the day outlier payment methodology). In such cases, the daily costs beyond the length of stay threshold may vastly exceed the day outlier per diem amount, and that daily discrepancy is multiplied by each additional day of the stay.

Thus, for those day outlier cases that have adjusted charges exceeding the cost threshold, we proposed to make outlier payment equal to the greater of 60 percent of the per diem Federal rate for each day beyond the length of stay threshold or 80 percent of the difference

between adjusted charges and the cost threshold.

3. Hospital Specific Cost-to-Charge Ratios

We proposed to use hospital-specific cost-to-charge ratios to adjust charges for the purpose of computing cost outlier payments. The use of hospital-specific cost-to-charge ratios should greatly enhance the accuracy with which outlier cases are identified and outlier payments are computed, since there is wide variation among hospitals in these cost-to-charge ratios. The increased emphasis on cost in computing outlier payments heightens the need to use reasonably reliable factors to estimate costs from charges. Therefore, we believe the use of hospital-specific cost-to-charge ratios is essential to ensure that outlier payments are made for cases that have extraordinarily high costs, and not merely high charges.

We proposed that the intermediary would compute a cost-to-charge ratio for each hospital using cost data from the hospital's latest settled cost report and charge data for discharges during the same period from the billing file maintained by the intermediary. The intermediary would compute the hospital-specific cost-to-charge ratios based on the ratio that follows:

$$\frac{\text{Medicare Inpatient Operating Costs (from cost report)}}{\text{Medicare Covered Charges (from billing file)}}$$

For hospitals that have not yet filed their first Medicare cost report with their fiscal intermediary or for which the intermediary is unable to compute a reasonable cost-to-charge ratio, we computed statewide average cost-to-charge ratios for urban hospitals and for rural hospitals, which appear in Table 8 of section IV of the addendum to this final rule. We proposed that these average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes cost-to-charge ratios lower than 0.36 or greater than 1.24. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We believe that ratios falling outside this range are unreasonable, in that they are probably due to faulty data reporting or entry, and should not be used to identify and pay for cost outliers.

We proposed that hospital-specific cost-to-charge ratios would be computed annually before the beginning of each Federal fiscal year, based on each hospital's latest settled cost report. The

intermediary would enter the appropriate ratio for each hospital into the Pricer program used by the intermediary to calculate payments and this ratio would be used for discharges occurring during that Federal fiscal year.

We proposed to continue our policy that outlier payments would be final and not subject to recalculation based on later data that would affect the hospital specific cost-to-charge ratios, indirect medical education adjustment factors, or disproportionate share adjustment factors. This policy was first set forth in the September 1, 1983 final rule (48 FR 39779) and at that time codified at § 405.454(m)(5). This section was subsequently redesignated as § 413.64(k)(1)(ii) in a final rule with comment period published on September 30, 1986 (51 FR 34790). However, in a final rule with comment period published on January 21, 1988 (53 FR 1621), when this section was further redesignated as § 412.116(e), we inadvertently deleted from that section the sentence that specified that outlier payments are based on submitted bills and represent final payment. As a part of the proposed rule, we corrected that paragraph to include the deleted sentence.

4. Outlier Thresholds and Size of the Outlier Pool

As explained above, 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)(3)(B) of the Act correspondingly requires that the standardized amounts be reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates in any year.

In the September 1, 1987 final rule, we set the outlier thresholds so as to result in estimated outlier payments equal to 5.0 percent of total prospective payments (that is, estimated outlier payments plus regular prospective payments per discharge, excluding indirect medical education payments and disproportionate share hospital payments) for FY 1988 (52 FR 33065). These same thresholds were estimated to result in outlier payments of 5.1 percent of total DRG payments based on the rates as updated for discharges occurring on or after April 1, 1988 and

adjusted to reflect the use of a 90 percent marginal cost factor for burn-related outliers. The urban and rural outlier offsets averaged out to produce this 5.1 percent outlier "pool".

Section 1886(d)(3)(B) of the Act requires that, effective with discharges occurring on or after October 1, 1986, each national and regional standardized amount be reduced for hospitals located in urban areas and for hospitals located in rural areas based on the estimated proportion of total DRG payments attributable to outlier payments for hospitals in urban areas and for hospitals in rural areas, respectively. Consequently, instead of the uniform five percent reduction factor applying equally to all the standardized amounts, there are now two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Rates for urban hospitals, which are projected to receive outlier payments in excess of five percent of total DRG payments, are reduced by that larger percentage (instead of by five percent). Rates for rural hospitals, which are projected to receive outlier payments of less than five percent of total DRG payments, are reduced by that lower percentage (instead of by five percent).

Under section 1886(d)(5)(A)(iv) of the Act, we proposed to set the outlier thresholds for FY 1989 so as to result in estimated outlier payments equal to five percent of total prospective payments. In our proposed rule of May 27, 1988, we stated that this would require that the day outlier threshold be set at the lesser of 24 days or 3.0 standard deviations beyond the geometric mean length of stay for the DRG and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or \$27,000.

ProPAC recommended that thresholds be adjusted so that 40 to 50 percent of outlier payments would be paid according to the cost outlier methodology. (The previous payment split was approximately 85 percent to day outliers and 15 percent to cost outliers.) Under the proposed thresholds, 60 percent of outlier payments would be made according to the cost outlier methodology. This shift is consistent, however, with ProPAC's recommendation that there be greater emphasis on cost rather than length of stay as a criterion for paying for outliers, and is also reflective of an 80 percent marginal cost factor for cost outliers, rather than the 60 percent factor presumed by ProPAC. Also, in view of

the fact that, compared to current thresholds, the increase in the proposed cost threshold is significantly greater than the increase in the proposed day threshold, we decided not to raise the cost threshold further, as would have been necessary to hold the proportion of outlier payments made on the basis of the cost methodology to 50 percent.

Moreover, since we proposed to pay day outliers exceeding the cost threshold on the basis of the methodology that generates the higher payment, much of the 60 percent of payments that would be made according to the cost outlier methodology is accounted for by day outlier cases that would actually receive more payment under the proposed policy than they would under the current policy. Our estimate is that 85 percent of outlier payments under the proposed policy would be generated by day outlier cases.

Since the proposed policy would result in higher payment for many outlier cases (those for which payments using the cost outlier methodology are higher than payments using the day outlier methodology), it requires that the thresholds be increased.

The substantial increases in both the day and the cost outlier thresholds stem not only from the combined effects of all the proposed changes to outlier payment policy set forth above, but also from continued slight increases in the Medicare length of stay and hospital charge increases in excess of the increase in the hospital market basket.

ProPAC agrees with us that the outlier payment policy should be refined to better protect hospitals from the risk of extremely costly cases (Recommendation 18). Our proposed changes are also consistent with ProPAC's recommendations to pay day outliers exceeding the cost threshold on the basis of the greater of the day or the cost outlier amounts and to utilize hospital-specific cost-to-charge ratios for identifying and paying cost outliers.

We did not, however, propose to adopt ProPAC's recommendation to increase the outlier pool from five percent to the maximum six percent allowed under the law. We stated our belief that it is desirable to maintain the outlier pool at a level below the maximum permissible by law at this time, because it allows proportionately greater payment for typical cases. Furthermore, our research shows only a marginal reduction in risk associated with moving to a six-percent outlier pool. We specifically requested comments on the appropriate size of the outlier pool.

We note that ProPAC also recommended that a corrective adjustment be made if outlier payments in a year are different from the amount financed by the offsets to the urban and rural rates. Although the data indicate that outlier payments fell short of the estimates in the first years of the prospective payment system, this situation seems to have reversed in recent years. In light of our estimate in the May 27, 1988 Federal Register that outlier payments in FY 1988 would be about 5.5 percent of total prospective payments, as compared to a 5.1 percent outlier pool, adopting this recommendation would have resulted in a 0.4 percent reduction to the standardized amounts. Since the update factor applied to the standardized amounts is prescribed by law, we have no authority to make such an adjustment.

5. Differential Urban and Rural Thresholds

Under current policy, the same outlier thresholds are applicable to urban and rural hospitals. Since rural hospitals generally have less complex and costly cases, they have fewer outlier cases. Presently, only approximately 2.5 percent of payments to rural hospitals are additional payments for outlier cases. Although rural hospitals have a smaller outlier pool (and proportionately higher payments for typical cases), this means that, as a proportion of total prospective payments, they receive less outlier protection than do urban hospitals. At the same time, rural hospitals have fewer inpatient cases and, as a result, are more vulnerable to large losses on individual cases. Moreover, an expensive outlier case has a greater financial effect on a small rural hospital than on the average urban hospital.

In order to provide additional outlier protection to rural hospitals, we considered establishing lower thresholds for rural hospitals than for urban hospitals. Although we decided not to propose this change, we specifically requested comments on the appropriateness of replacing the current combination of uniform thresholds and differential urban and rural outlier offsets with a policy of uniform offsets and differential thresholds for hospitals paid the urban rate and hospitals paid the rural rate. Such a policy would, in order to comport with statutory constraints, require an increase in the proportion of payments to rural hospitals attributable to outlier payments, a corresponding reduction in the rural standardized amounts, and

lower thresholds for hospitals paid the rural rate so as to identify and pay for more outlier cases in rural hospitals.

6. Burn Outliers

In the April 5, 1988 notice (53 FR 11137), we discussed the provisions of section 4008(d)(1)(A) of Pub. L. 100-203, which changed the marginal cost factor from 60 percent to 90 percent for both day and cost outliers in DRGs related to burn cases. These provisions are effective for discharges occurring on or after April 1, 1988 and before October 1, 1989 for outlier cases classified in the six DRGs relating specifically to burn cases:

DRG	Name
456.....	Burns, Transferred to Another Acute Care Facility.
457.....	Extensive Burns without OR Procedure.
458.....	Non-Extensive Burns with Skin Graft.
459.....	Non-Extensive Burns with Wound Debridement or Other OR Procedure.
460.....	Non-Extensive Burns without OR Procedure.
472.....	Extensive Burns with OR Procedure.

As part of the May 27, 1988 proposed rule, we proposed to amend §§ 412.82 and 412.84 to implement the provisions of section 4008(d)(1) of Pub. L. 100-203.

ProPAC supported the intent of section 4008(d) of Pub. L. 100-203, which temporarily increases outlier payments for burn DRGs. However, ProPAC's preliminary analysis indicated that the increase in outlier payments is appropriate only for those cases treated in specialized burn centers and units. ProPAC has examined this topic further and submitted its report and recommendations to Congress in July 1988, and to the Secretary (as part of ProPAC's comments on the May 27, 1988 proposed rule) as required by section 4008(d)(2)(B) of Pub. L. 100-203.

While we recognize ProPAC's concern that outlier cases result in a more serious impact to specialized burn centers and units than to general hospitals treating burn cases, we generally do not believe it appropriate to create a new class of hospital (that is, burn hospitals and burn units) simply for the purpose of targeting outlier payments.

We are currently in the process of reviewing ProPAC's report and recommendations to determine if any changes in the burn outlier policy may be appropriate for FY 1990. We will comment in greater detail on ProPAC's report and recommendations once our analysis has been completed. However, we believe that our proposed changes in outlier policies would serve to improve

payments for burn outliers. Within the context of the prospective payment system, we generally believe that solutions to problems should be found on a systematic basis, rather than through making special adjustments for individual cases or small groups of cases.

Comment: Several commenters suggested that the size of the outlier payment pool be increased from five percent to the legal maximum of six percent in order to finance a reduction in the outlier thresholds. Other commenters recommended that we maintain the five percent pool.

Response: Increasing the size of the outlier pool to six percent in order to reduce the outlier thresholds would increase the number of outlier cases, but it would also proportionately reduce the basic payment for all cases. Moreover, as noted above, our research has indicated that increasing the outlier pool to six percent would produce only a marginal decrease in the risk faced by hospitals under the prospective payment system. In light of the numerous outlier policy changes that we are already making, we believe that it is desirable at this time to maintain a smaller outlier pool than the maximum six percent because it allows proportionately greater payment for typical cases.

We note that some commenters, while in favor of an increase in the outlier pool, wanted this to be accomplished with no corresponding additional offsets to the rates. This would represent the addition of program funds to the prospective payment system above and beyond the update factor and, because it would violate the constraint that outlier thresholds be set so as to ensure equality between outlier offsets and estimated outlier payments, is not permitted under the law. The law requires that outlier payments be financed out of the total payments made under the prospective payment system. Thus, any increase in the amount of outlier payments can only be accomplished at the expense of funds available for typical cases.

Based on the most recent MEDPAR data, we now estimate that the outlier thresholds proposed on May 27, 1988 and which we are finalizing in this document would require an outlier pool equal to 5.4 percent of total payments under the prospective payment system (rather than the 5.0 percent estimated in the May 27, 1988 proposed rule). To maintain the 5.0 percent outlier pool and all other features of the outlier policy as proposed would require further increasing the outlier thresholds to the mean length of stay for the DRG plus 25 days or 3.0 standard deviations for day

outliers and \$29,000 or twice the Federal rate for cost outliers. Therefore, in light of commenters' concerns with the increase in the outlier thresholds and the desirability of financing a reduction in the thresholds with an increase in the pool, we have modified the final outlier payment policy in two ways. First, we have decided to revise the marginal cost factor for cost outlier cases to 75 percent rather than the 80 percent proposed. While this marginal cost factor represents a slight reduction in the protection afforded to the most expensive outlier cases, we anticipate that it will still substantially reduce the risk faced by hospitals from extremely costly cases. The second change we have made in the final outlier policy is to maintain the outlier pool at 5.1 percent rather than reduce it to 5.0 percent, as proposed. With these changes, together with all other features of the proposed outlier policy and the more recent MEDPAR data, there will be a slight increase in the outlier thresholds relative to those proposed. While the day outlier threshold remains the same as that proposed (that is, the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations), it was necessary to increase the cost threshold to the greater of twice the Federal rate for each DRG or \$28,000 (instead of \$27,000 as proposed).

Comment: A number of commenters stated that the estimated outlier payment split of 60 percent according to the cost outlier methodology and 40 percent according to the day outlier methodology was too abrupt a change from the previous payment split of 15 percent for cost outliers and 85 percent for day outliers. These commenters generally agreed with ProPAC's recommendation that there be gradual movement from the current payment split to a share of between 40 to 50 percent for cost outliers.

Response: The 60 percent cost and 40 percent day outlier split discussed in the proposed rule is based on the methodology used to pay the outlier cases, not on the qualifying criteria. While under the revised policy more cases may be paid using the cost outlier methodology because it yields the higher payment, our simulation of FY 1989 outlier payments based on the FY 1987 MEDPAR data indicates that the percentage of cases that qualify as day outliers is about 83 percent. Those cases are expected to receive over 85 percent of outlier payments in FY 1989. An estimated 17 percent of outlier cases are cost outlier cases, and these cases are expected to receive about 15 percent of

outlier payments. The following table illustrates this finding in greater detail:

Type of outlier case	Percent- age of outlier cases	Percent- age of outlier payments
Meets day threshold only.....	57.0	27.4
Meets day and cost thresh- olds, paid using day methodology.....	10.6	18.4
Meets day and cost thresh- olds, paid using cost methodology.....	15.0	39.6
Subtotal—All cases meeting day thresh- old.....	82.6	85.4
Meets cost threshold only.....	17.4	14.6
Total.....	100.0	100.0

When the FY 1988 outlier thresholds were established, it was estimated that about 85 percent of payments would be made for day outliers and about 15 percent for cost outliers. Our most recent estimates suggest that day outliers account for 80 percent of FY 1988 outlier payments and cost outliers for 20 percent. Accordingly, as illustrated above, the percentage of payments for day outliers under the revised outlier policy will increase relative to that under the policy in effect in FY 1988. More significantly, the final outlier policy adjusts the payment methodology for day outlier cases to ensure that high cost day outliers are paid more appropriately.

Comment: Several commenters expressed concern that the large increase in both the day and cost outlier thresholds would eliminate payment for many cases that are currently paid as outliers.

Response: As we stated in the proposed rule (at 53 FR 19515) and have reconfirmed based on the most recent MEDPAR data, the increase in the outlier thresholds stems partly from both a continuation of the slight increases in Medicare length of stay and the large increases in hospital charges. Thus, even with no change in outlier payment policy, there would have been an increase in the outlier thresholds.

Moreover, while it is true that the number of cases for which outlier payments are made will decrease because of the increase in outlier thresholds, we believe that this policy more accurately reflects the Congressional intent for outlier payments—to protect against extreme losses imposed by exceptionally costly cases under the prospective payment system. Research conducted by the RAND Corporation and by the Congressional Research Service

indicates that under the policy in effect during the first five years of the prospective payment system, a substantial proportion of outlier payments has been made for cases that, even with no outlier policy, would not have resulted in extreme losses to the hospital. The changes in the outlier policy represent an attempt to focus more outlier payments on the cases that impose extreme losses. To accomplish that objective within the context of a fixed outlier payment pool requires that fewer cases receive outlier payment. The result, however, is that the overall risk faced by hospitals under the prospective payment system is reduced, because they are less vulnerable to the most extreme occurrences.

It should be pointed out that the objective of outlier payment is *not* to insure hospitals against losses on any given case. Under the prospective payment system, it is assumed that a certain proportion of cases at any hospital will have costs that are greater than the payment received, but that these deficits will, on average, be counterbalanced by many other cases for which payments are in excess of costs. Outlier payments were incorporated into the prospective payment system in recognition of the fact that for some extremely costly cases the payment deficit might not be counterbalanced by the payment surplus on other cases treated in that year, which could impose short-term financial hardship on a hospital. We believe that the revised outlier policy addresses this objective more effectively than does the current policy.

Comment: Several commenters pointed out that, due to a shortage of skilled nursing beds in some areas, hospitals in those areas tend to have more day outliers. Increased emphasis on cost outliers would put these hospitals at a disadvantage due to factors beyond their control.

Response: We have been aware of this problem for some time. Research conducted by the Urban Institute indicates that the frequency of day outliers is significantly related to the availability of skilled nursing beds and other factors related to the availability of other sources of care in the hospital's market area. However, the increased emphasis on costs in determining outlier payments has not eliminated day outliers by any means. We expect that over 27 percent of outlier payments under the new policy will be for day outliers that do not exceed the cost outlier threshold. Approximately 18 percent will be "dual" outliers (exceeding both the day and cost

thresholds) that receive higher payment under the day outlier formula than under the cost outlier formula. An additional 40 percent will be dual outliers that under this new policy will receive higher payment under the cost outlier formula—thus receiving more payment than they would have under the old policy. Thus, the increased emphasis on costs only shifts payment from the least expensive day outliers to the most expensive day outliers.

We recognize that many of the cases affected by local shortages of skilled nursing beds are among these least expensive day outlier cases. The difficulty in addressing the problem presented by these cases is that there is no reliable way of distinguishing between them and other cases that have similar costs and lengths of stay but are not affected by skilled nursing bed shortages under either the final outlier policy for FY 1989 or the previous policy. We will continue our investigation into this issue.

Comment: Two commenters stated that separate outlier thresholds should be established for hospitals in Puerto Rico because of their lower costs. These lower costs will, in effect, prevent Puerto Rico hospitals from qualifying for cost outlier payments, since the cost outlier thresholds are set at a high level that is reflective of the cost experience of mainland hospitals located outside of Puerto Rico.

Response: Section 1886(d)(9)(D) of the Act (added by section 9304 of Pub. L. 99-509) specifies that certain provisions (including outlier payments) applicable to subsection (d) hospitals "shall apply to subsection (d) Puerto Rico hospitals * * * in the same manner and to the extent as they apply to subsection (d) hospitals * * *." In view of this requirement, we use the same day and cost outlier thresholds for Puerto Rico hospitals as for all other subsection (d) hospitals.

In determining whether a case qualifies as a cost outlier, the threshold amount is adjusted by the hospital's wage index value. This has the effect of taking into account the general cost environment in which the hospital operates. While the commenters stated that the amount of even the wage-adjusted threshold will prevent Puerto Rico from qualifying for many cost outliers, this situation, to the extent that it occurs, may be similar to the situation of many other hospitals.

There are also differences in hospitals' costs among different regions located outside of Puerto Rico, but different outlier thresholds have never been provided in recognition of these

differences. Also, under the outlier policy, cases may still qualify as day outliers and be paid accordingly. In those situations in which a case qualifies as both a day and a cost outlier, the higher outlier amount will be paid, just as it is for hospitals not located in Puerto Rico.

In addition to outliers, Congress also incorporated in the prospective payment system as it applies to Puerto Rico other features that are identical to the features applicable to the prospective payment system outside of Puerto Rico. Some of these features may work to the advantage of Puerto Rico hospitals. For example, Congress provided that Puerto Rico hospitals will be entitled to additional payments for the indirect costs of medical education and as disproportionate share hospitals, even though the formulas for computing these adjustments would be different (and perhaps result in lower adjustments) if they were based solely on data and circumstances relevant to hospitals in Puerto Rico.

Comment: Several commenters suggested that the marginal cost factor for cost outliers be maintained at the current 60 percent, rather than increased to the proposed 80 percent, in order to finance a reduction in the thresholds. One commenter recommended a marginal cost factor of 100 percent.

Response: The purpose of the proposed increase in the marginal cost factor is to focus more outlier payments on the most costly cases. Research conducted by the RAND Corporation and by ProPAC demonstrated that the discrepancy between costs and payments is substantially larger for cost outliers than for day outliers. We take this as an indication that the marginal cost factor for these cases should be greater than the current 60 percent figure.

The retention of the 60 percent marginal cost factor for cost outliers in order to finance a reduction in the proposed thresholds would result in less payment for the most costly cases and more payment for cases that are not as costly and do not present as much of a risk to hospitals. We believe that this would be contrary to our objective of improving the efficiency with which the outlier payment methodology addresses the risk faced by hospitals under the prospective payment system. On the other hand, there is no analytic basis for equating marginal cost with average cost, which is what a 100-percent marginal cost factor would do. We have, however, as noted above, increased the marginal cost factor to 75 percent instead of the proposed 80 percent. We believe this change will both reduce the

risk associated with the most costly cases and avoid significant increases in the thresholds above those proposed.

Comment: One commenter recommended the retention of a national average cost-to-charge ratio for computing cost outliers.

Response: As explained in the proposed rule (53 FR 19514), the use of hospital-specific cost-to-charge ratios should greatly enhance the accuracy with which exceptionally costly outlier cases are identified and outlier payments are computed, given the wide variation among hospitals in their cost-to-charge ratios. Moreover, preliminary research suggests that, in general, the types of hospitals that have high profits per case under the basic prospective payment rates tend to have lower cost-to-charge ratios than the types of hospitals that have lower profits under the basic rates. This means that use of national cost-to-charge ratios to compute cost outlier payments results in a transfer of payments to hospitals that are doing well from hospitals that are doing less well. To the extent that a hospital's financial performance is related to the incidence of outliers, the use of a national cost-to-charge ratio would produce results counter to those we wish to achieve by modifying outlier policy.

One of the major criticisms of the outlier policy we proposed for FY 1988 (52 FR 22089) was its emphasis on the cost outlier methodology in conjunction with the use of a national cost-to-charge ratio. We agreed with the commenters at that time that a national cost-to-charge ratio was inappropriate in an outlier policy that attempted to target outlier payments to the most costly cases and, for that reason, decided to defer adoption of the proposed policy.

Comment: A number of commenters expressed concern about the timeliness of the data we are using to compute the hospital-specific cost-to-charge ratios. Because the latest settled cost reports may be as much as three years old, commenters were concerned that there could be significant fluctuations in the ratios and that the data would not reflect current cost-to-charge ratios. Some commenters suggested that we use the latest filed cost report and others stated that we should update the ratios more than once a year.

Response: We believe that the hospital-specific cost-to-charge ratios should be developed using the most current and accurate data available. While the latest filed cost report represents the most current data, we have found that Medicare costs are generally overstated on the filed cost report and are subsequently reduced as

a result of audit. Therefore, we believe the latest settled cost report represents the most accurate available data for computing the hospital-specific cost-to-charge ratios.

We do, however, believe that as cost reports are settled by the intermediaries, it would be appropriate to recompute the cost-to-charge ratio to ensure that the ratios used to calculate cost outlier payments are as up to date as possible. Therefore, we are instructing the intermediaries to update the hospital-specific cost-to-charge ratios effective with discharges 30 days after the date the Notice of Amount of Program Reimbursement (NPR) is issued for the latest cost reporting period. Similarly, when a revised NPR is issued as a result of a final determination on an appeal and the revised NPR affects costs or charges or both that are used in computing the hospital-specific cost-to-charge ratio, then that ratio may be updated after the 30-day delay discussed above. We note that if the revised ratio is lower than the one currently in effect, it will still be implemented after the 30-day delay.

Our data indicate that charges have been increasing at a faster rate than costs. This is evidenced by the national cost-to-charge ratio which has declined from 72 percent at the beginning of the implementation of the prospective payment system to the current ratio of 66 percent (which was based on cost data from the first year of operation of the prospective payment system). In addition, our analysis of cost reports from the second year of operation of the prospective payment system indicates that the national cost-to-charge ratio has dropped further, to 64 percent. Therefore, we do not believe that hospitals will be disadvantaged by using data from the latest settled cost report rather than from a more recent as filed cost report data to compute hospital-specific cost-to-charge ratios.

Comment: One commenter objected to the parameters that we established for reasonable hospital-specific cost-to-charge ratios. The commenter stated that it was inequitable because if one hospital had a ratio that falls just above the lower parameter of 0.36, we would use that ratio, while, if another hospital has a ratio just below the parameter (for example, 0.35), it would receive the sometimes substantially higher statewide ratio.

Response: The range of reasonable cost-to-charge ratios represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We believe that ratios falling outside this

range are unreasonable and are probably due to faulty data reporting or entry. Therefore, they should not be used to identify and pay cost outliers. We believe that 3.0 standard deviations represents an appropriate range and that the accuracy of cost-to-charge ratios falling outside that range is questionable. Rather than using a national cost-to-charge ratio for those instances in which reasonable hospital-specific cost-to-charge ratios cannot be determined, we believe that statewide ratios are more appropriate, since they better reflect variations in rate-setting controls among states.

The situation described by the commenter would occur no matter what parameters we would establish. There would always be instances in which ratios fall just outside either end of the acceptable range. However, we believe it is necessary to establish these parameters to ensure that only reasonable ratios are used to identify and pay cost outliers.

Comment: Two commenters expressed concern that certain public hospitals that have all-inclusive per diem charge structures will be disadvantaged by an outlier policy that places greater emphasis on cost outliers than day outliers. All-inclusive rate structure hospitals generally only receive day outliers since their charge structures are based on a per diem rate that does not reflect the intensity of ancillary services provided for each case. With an increase in the day outlier thresholds, these hospitals would qualify for fewer outlier payments than previously. The commenters suggested that a special provision be established for paying outliers to all-inclusive rate hospitals. One commenter stated that these hospitals should not be required to contribute fully to the outlier pool and also that they should receive an add-on to their DRG payments to reinstate the portion of the outlier offset representing cost outlier payments that they would have received under previous policy as day outlier payments.

Response: As explained above, more than 80 percent of the outlier cases and almost 85 percent of outlier payments will be made for day outliers under the outlier policy adopted in this final rule. While the number of days covered by outlier payments will be reduced somewhat because of the higher thresholds, all hospitals will continue to be protected against excessive losses on their extremely long-stay cases. Therefore, unless all-inclusive rate hospitals have day outliers that are predominantly at the low end of the

range, they will not be more disadvantaged than other hospitals.

The Medicare program does not require hospitals, public or otherwise, to use an all-inclusive per diem charge structure. As such, we do not believe it is appropriate to establish special payment procedures to accommodate hospitals that have adopted this type of charge structure. In addition, we do not believe it is appropriate to provide an add-on to payments made to these hospitals to reflect the fact that they will not receive cost outlier payments. There are many hospitals nationwide that do not experience outlier cases to the extent that other hospitals do. However, the offsets to the rates necessary to finance outlier payments are uniform for all urban hospitals and for all rural hospitals, regardless of the extent to which individual hospitals receive outlier payments. Furthermore, it would be impossible to calculate the appropriate amount to refund to these hospitals, because their all-inclusive rate structure would not permit this type of calculation.

Comment: One commenter recommended that with the increased emphasis on cost outliers, cost outlier payments should be made automatically by the fiscal intermediary without requiring hospitals to request such payments. This would be consistent with how day outliers are paid.

Response: While more cases will be paid using the cost outlier methodology, the majority of those cases will be expensive day outlier cases that are paid using the cost outlier methodology because it generates the higher payment. Since these cases are day outliers, payment would be automatic and, as such, it is unnecessary to revise our policy that hospitals must request payment for cases qualifying as cost outliers.

Comment: Two commenters noted that there were no provisions in the proposed notice to account for the impact that the recently enacted Medicare Catastrophic Coverage Act (Pub. L. 100-360) will have on outlier payments.

Response: The proposed notice did not address the potential effects of the implementation of Pub. L. 100-360 on either prospective payment hospitals or hospitals and units excluded from the prospective payment system because the enactment date followed publication of the proposed rule. In establishing the rates, weights, outlier thresholds and target amounts for FY 1989 set forth in the addendum to this final rule, however, we have now taken into consideration the reductions in

payments to hospitals by beneficiaries resulting from the elimination of a day limitation on Medicare inpatient hospital services, as required by section 104(c) of Pub. L. 100-360. We refer the reader to section V.M. of this preamble for a detailed discussion of the impact of the catastrophic coverage provisions on Medicare hospital payments.

Comment: We received comments from various segments of the hospital industry, as well as ProPAC, recommending that we take account of past overpayments to and underpayments from the outlier pool in future outlier payments.

Response: It has been our practice under the prospective payment system not to reflect overpayments and underpayments in future payments. Adopting this suggestion would bring us a step backward toward the cost reimbursement methodology, where there was a settlement at the end of a hospital's cost reporting year to reconcile interim payments with reimbursement due. The prospective payment system, on the other hand, is a future oriented system where changes in hospital practices and circumstances are reflected on a continuing, albeit lagged, basis.

We believe that by estimating outlier payments based on the latest and most accurate data available, we have met the statutory requirement that thresholds be set so as to ensure projected outlier payments equal between five and six percent of estimated prospective payments in a given fiscal year.

As we have explained in previous prospective payment rules (at 50 FR 35708, 51 FR 31523, and 51 FR 33047), we believe that we have consistently met our statutory obligation under sections 1886(d)(3)(B) and 1886(d)(5)(A)(iv) of the Act to ensure that the rate offsets used to finance outlier payments were equal to the estimated proportion of total prospective payments that were expected to be additional payments for outliers, and that the thresholds be set so as to yield outlier payments of five to six percent of estimated total DRG-based payments. We have consistently used the most recent Medicare discharge data available to estimate total prospective payments and outlier payments as a percentage thereof. Any discrepancy between the estimated outlier payment proportion (which is, in turn, equal to a weighted average of the urban and rural outlier offsets) and the actual outlier payment proportion is attributable entirely to behavioral and other changes that we are unable to predict and that affect length of stay and

hospital charges between the year from which data is drawn to set outlier thresholds and estimate outlier payments and total prospective payments and the year for which the payment rates and outlier thresholds are applicable.

As noted above, making adjustments to the standardized amounts to reflect past outlier payment experience that varies from our estimates would not be in accordance with current law, which specifies the amount of the update to the standardized amounts. In addition, based on the most complete billing data, we now estimate that for FY 1988 outlier payments will, in fact, be about 5.9 percent, thus exceeding the 5.1 percent outlier pool by 0.8 percent. Accordingly, to adopt this recommendation would require a reduction in the applicable standardized amounts of nearly one percent.

Comment: In the proposed rule we invited comments concerning the appropriateness of establishing differential outlier thresholds for hospitals paid the urban rate and hospitals paid the rural rate. Most of those commenting on this issue believe that it would be an appropriate issue to pursue but that further study is necessary before implementation. One commenter stated that it is appropriate that rural hospitals receive proportionately lower outlier payments than urban hospitals since rural hospitals generally do not have the facilities and technology to treat the more difficult cases.

Response: We appreciate the comments on this matter. We will continue to study this issue to determine if differential outlier thresholds are appropriate.

Comment: Some commenters were concerned that the increased emphasis on cost outliers in the proposed policy would provide an incentive for hospitals to increase their charges and to manipulate their charge structures.

Response: Cost outliers are identified by, and the amount of cost outlier payment determined by, comparing the charges for the case, adjusted by a cost-to-charge ratio, to the cost outlier threshold. Since both the cost-to-charge ratio (whether national or hospital-specific) and the threshold are constant for the payment period, the payment received by the hospital can be increased by increasing charges. In addition, hospitals can conceivably change their charge structures, just as is the case at present, to maximize their outlier payments.

Although concern over this type of incentive is appropriate, we believe that there are several factors that will

mitigate its effects. First, increases in a hospital's overall charges relative to costs will be reflected in the cost-to-charge ratio assigned to the hospital in the future. This is one of the strong arguments for the use of hospital-specific cost-to-charge ratios. Second, many hospitals are restricted in their ability to arbitrarily increase their charges by the fact that they must deal with other third-party payers, some of which base their payments on charges. Also, several States place restrictions on hospital charge increases. Third, a general acceleration in hospital charge increases can be incorporated into the setting of thresholds in future years, which would limit the potential benefit to hospitals.

Fourth, outlier payments comprise a small percent of total hospital payments under the prospective payment system, diluting the incentive for hospitals to disrupt their operations by drastically and continually manipulating charges.

It must be pointed out that this incentive to manipulate charges is not new; in fact, any measure of cost (including length of stay) that is based on an indicator that is within the control of the provider provides an incentive to manipulate that indicator. As previously stated, we will continue to investigate potential improvements in the measurement of case level costs.

Comment: One commenter suggested that we adopt an "insurance model" that incorporates a fixed-loss style (variable) threshold, rather than the fixed threshold that currently applies. This would equalize the loss that hospitals have to bear for cases in different DRGs before they could begin to receive outlier payments.

Response: The proposed changes in the outlier payment methodology are intended to more explicitly recognize the insurance aspects of outlier payment. A fixed loss style threshold would seem to be consistent with that approach, and we have begun investigating the formulation of that type of threshold for cost outliers and evaluating the impact of such a change.

Currently, hospitals must bear greater losses in cases in relatively low-weight DRGs than in cases in relatively high weight DRGs before they can begin to receive cost outlier payments (that is, the "deductible" is not uniform across DRGs). The equalization of deductibles across DRGs is one option that has been considered in the development of a revised outlier payment policy. At this time, however, we do not have enough information on the specific form of such a change or on its impact to include it in our current policy. As we continue our research on outlier payment

methodology, we will attempt to learn more about this option.

Comment: Some commenters asserted that the proposed changes in outlier payments are contrary to the original premise of the prospective payment system, thus representing a retreat to cost-based reimbursement.

Response: While it is true that the prospective payment system overall is intended to sever the connection between the payment received by a hospital and its own current costs, outlier payments, by their very nature, have always been an exception. Outliers are defined as exceptionally long or costly cases, and payment for these cases is made in recognition of their status as partial exceptions to the prospective payment mechanism. Under section 1886(d)(5)(A)(iii) of the Act, an outlier payment is based on our best estimate of the marginal cost of care beyond the outlier threshold and thus by legislation is tied to the cost of the case.

The previous use of length of stay as the predominant criterion for identifying outlier cases was based on our own desire to sever the link between cost and payment. Both HCFA and ProPAC have since further examined the measurement of case-level costs through the adjustment of case-level charges. Although this measure is not perfect, it is widely agreed that it is superior to length of stay for identifying cases that are extremely atypical relative to the average case. It is entirely consistent with the objectives of the prospective payment system to improve the effectiveness of outlier payments, which is the primary motivation for the changes that we proposed and are finalizing in this document. However, we will continue to investigate potential improvements in the measurement of case-level costs.

7. Implementation of Revised Outlier Policy

In order to provide sufficient time to those hospitals that may be disadvantaged by the changes we are making to outlier policy, the revised outlier policy (not including the changes made concerning burn outliers for which the statute mandates an effective date of April 1, 1988) will become effective with discharges occurring on or after November 1, 1988. The FY 1988 outlier policy will remain in effect for discharges occurring on or after October 1, 1988 and before November 1, 1988, with thresholds updated based on the most recent data. The FY 1988 policy incorporates an outlier pool of 5.1 percent, which will be maintained throughout FY 1989. In order to ensure

that the level of outlier payments is consistent with the outlier pool during the interim period before implementation of the revised outlier policy, it is necessary to adjust the current outlier thresholds. During the period October 1, 1988 through October 31, 1988, the day outlier threshold is set at the geometric mean length of stay for each DRG plus the lesser of 22 days or 2.0 standard deviations, and the cost outlier threshold is set at the greater of 2.0 times the prospective payment rate for each DRG or \$23,750.

Effective with discharges occurring on or after November 1, 1988, the day outlier threshold will be set at the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations, and the cost outlier threshold will be set at the greater of 2.0 times the prospective payment rate for each DRG or \$28,000.

F. Payments to Sole Community Hospitals (§ 412.92)

Section 4005(c) of Pub. L. 100-203 amended section 1886(d)(5)(C)(ii) of the Act to extend through cost reporting periods beginning before October 1, 1990, the time period allowed for a sole community hospital (SCH) to qualify for a payment adjustment for a cost reporting period during which the hospital experiences, due to circumstances beyond its control, a significant (that is, more than a five percent) decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period. We proposed to revise § 412.92(e) to reflect this change.

In addition, section 4005(c) of Pub. L. 100-203 also amended section 1886(d)(5)(C)(ii) of the Act to extend the payment adjustment discussed above to those hospitals that meet the criteria to qualify as SCHs but do not receive payment under the prospective payment system as an SCH (that is, payment equal to 75 percent of the hospital-specific portion and 25 percent of the Federal regional portion). Therefore, if a hospital meets the criteria to qualify as an SCH, it may file for the volume decline adjustment regardless of whether it is being paid as an SCH. Of course, in order to receive the volume adjustment, the hospital must meet all the criteria necessary to qualify for a volume adjustment. This provision is effective for cost reporting periods beginning on or after October 1, 1987.

If a hospital wishes to take advantage of this payment adjustment, we proposed that the hospital would have to submit a request for SCH status to a HCFA regional office. The hospital's application must clearly state that it is

seeking SCH status solely to qualify for the volume adjustment and that it does not wish to be paid under the prospective payment system as an SCH. For this purpose, the hospital must meet all criteria for classification of an SCH that are set forth in § 412.92(a).

We proposed that once HCFA's regional office has determined that a hospital meets the criteria to qualify as an SCH for the payment adjustment only, it would notify the hospital and the hospital's intermediary. The hospital would then submit to the intermediary documentation demonstrating the size of the decrease in discharges, explaining the circumstances giving rise to the decline in discharges and how they were beyond the hospital's control. The hospital's submission to the intermediary must be made within 180 days from the date of the notice from the HCFA regional office. The hospital must also furnish evidence of the actions it took to control costs in the face of the circumstances cited and the resulting decline in discharges.

HCFA determines the volume adjustment under the provisions of § 412.92. We proposed to clarify that section to conform with our current practice that HCFA makes its determination within 180 days from the date HCFA receives the hospital's request and all other necessary information from the intermediary. In addition, we stated that this volume adjustment determination is subject to review under Subpart R of Part 405.

Thus, we proposed to revise § 412.92(e) to extend the time period for the payment adjustment and add a new § 412.92(f) to provide for the payment adjustment for a hospital that qualifies as an SCH although it chooses not to be paid on the basis of a hospital-specific/Federal regional blend.

Section 4005(c)(2)(B) of Pub. L. 100-203 requires the Secretary to take appropriate steps to ensure that no more than \$5 million is paid for FY 1988 and no more than \$10 million is paid for FY 1989 to hospitals that qualify for SCH payment adjustments under this special provision. Accordingly, we will monitor expenditures under this provision to ensure that they do not exceed the amounts specifically authorized.

We also note that ProPAC has recommended that we issue guidelines, before FY 1989 begins, for interpreting the criteria used by our regional offices to designate sole community hospitals, so as to promote greater uniformity in their application (Recommendation 11). ProPAC also recommends that we evaluate whether the criteria can be improved to better identify sole

providers of care to isolated populations.

We agree with ProPAC that it is desirable to have as much uniformity as possible in interpreting the criteria for determining sole community hospital status. Our analysis of the sole community hospital criteria is an ongoing process and we will continue to evaluate these criteria in order to achieve as much uniformity as possible in their application. However, the Secretary's current criteria, as set forth in the regulations at § 412.92, and the process for making sole community hospital determinations are the result of long experience with various criteria as well as with centralized and decentralized procedures for determining sole community status. See the proposed rule (53 FR 19518) for a detailed discussion of the history of the sole community hospital provision.

Based on our experience with sole community hospital criteria and the decision making process, we believe the criteria and process for making sole community hospital determinations are appropriate and provide the proper balance between uniform standards and recognition of local conditions. We have received very little criticism of the current system from hospitals. Nevertheless, we stated in the proposed rule that we will continue to study ProPAC's recommendations and the analyses performed by their contractor to assure that our criteria are appropriate for determining which hospitals are the sole source of care for Medicare beneficiaries. Moreover, in light of ProPAC's concern about the lack of interpretive guidelines, we proposed to incorporate into the regulations our definition of a service area and also an explanation of what a hospital must provide to the intermediary to document that no more than 25 percent of the residents of its service area were admitted to other like hospitals for care. This policy was first discussed in the preamble of the September 1, 1983 final rule (48 FR 39781).

First, a hospital that seeks to qualify as a sole community hospital under § 412.92 (a)(2)(i) or (a)(2)(ii), under which no more than 25 percent of the residents of the hospital's service area are admitted to other like hospitals for care, must submit to its intermediary admissions data documenting the boundaries of its service area. The term "service area" means the area from which a hospital draws at least 75 percent of its inpatients.

A hospital may delineate its service area by identifying the zip codes of all its inpatients for the cost reporting

period ending before the date it applies for SCH status. The lowest number of zip codes accounting for at least 75 percent of its inpatients would then constitute its service area. Alternatively, the boundaries of a hospital's service area as established by a statewide health planning agency may be used as long as the hospital can demonstrate that 75 percent of its inpatients are drawn from that area for the cost reporting period ending before it applies for SCH status.

In order to document that no more than 25 percent of the residents of its service area were admitted to other like hospitals for care, we proposed that a hospital would also gather and submit applicable admissions data by patient origin from all other hospitals located within its service area or, if larger, within 50 miles of the requesting hospital. That a hospital can develop its data using inpatients from the total population or from the Medicare population was previously discussed in the January 3, 1984 final rule (49 FR 272) and is already reflected in § 412.92(a)(2)(i) of the regulations. We did not propose to modify this provision. We expect that intermediaries can assist hospitals applying for SCH status by making available Medicare discharge data by patient origin for neighboring hospitals.

Similarly, we did not propose any revision to the stated policy that, if a hospital has fewer than 50 beds, it can be deemed to meet this criterion (that no more than 25 percent of the residents of its service area were admitted to other like hospitals for care) if its intermediary certifies that the hospital would have met this criterion were it not for the fact that some Medicare beneficiaries or residents of the hospital's service area were forced to seek care outside the service area due to the unavailability of certain specialty services at the hospital with fewer than 50 beds.

We proposed to add the term "service area" and its definition to § 412.92(c) and to add information that the hospital must provide to the intermediary to § 412.92(b).

In addition, we proposed to clarify certain terms used in the regulations text. In § 412.92(a)(2)(i), we proposed to add "who become hospital inpatients" after the word "residents" and after the word "beneficiaries." In § 412.92(c)(1), we proposed to replace the first sentence with the following: "The term 'miles' means the shortest distance measured in miles over improved roads." The rest of that definition remains unchanged.

We are finalizing these provisions as proposed. In addition, we wish to clarify a point with respect to the special payment adjustment on the basis of a decrease in discharges. As is the case for all hospital requests for an exemption, exception, or adjustment, the hospital must submit its request for a volume adjustment to its intermediary no later than 180 days from the date on the intermediary's notice of amount of program reimbursement. This policy was first discussed in the preamble of the September 1, 1983 final rule (48 FR 39782). In order that there be no confusion on this issue, we are revising §§ 412.92 (e)(2)(i) and (f)(2)(i) to reflect this policy.

Comment: One commenter protested our proposal to use zip codes to define service area in determining whether a hospital draws at least 75 percent of its inpatients from its inpatients from its service area. The commenter stated that defining a service area consisting of the lowest number of zip codes from which a hospital draws at least 75 percent of its inpatients is inequitable because it does not address differences in zip code, population, size or geographic considerations. The commenter also questioned our apparent preference for documenting the admitting patterns by using general resident admissions rather than Medicare admissions.

Response: We agree that the zip code method of defining a service area has limitations and, for this reason, suggested it only as one alternative methodology. We noted in the proposed rule at 53 FR 19518 that, "Alternatively, the boundaries of a hospital's service area as established by a statewide health planning agency may be used as long as the hospital can demonstrate that 75 percent of its inpatients are drawn from that area for the cost reporting period ending before it applies for SCH status." Thus, a hospital may use either method to define its service area. Since not all States have health planning agencies that define each hospital's service area, we offered the zip code methodology as one means available to every hospital. The important consideration is that a hospital be able to define its service area as the area from which it draws 75 percent of its inpatient admissions, as stated in the regulations text at § 412.92(c)(3).

With regard to the comment on documenting utilization using general inpatient admissions, rather than Medicare inpatient admissions, we believe that the percentage of general resident admissions drawn to a hospital is a more accurate measure of its true

SCH status than the percentage of Medicare admissions. However, we are also aware that in some instances it is very difficult for a hospital to secure complete data on total general resident admissions. Therefore, in the January 3, 1984 Final Rule (49 FR 27), we noted that because of this difficulty, we would " * * * permit hospitals an option of demonstrating the required utilization using either total patient population or Medicare beneficiaries." Therefore, to further clarify that hospitals may use either population base to satisfy the criterion, we are deleting "if data on general resident utilization are not available," from § 412.92(a)(2)(i) of the regulations.

Comment: One commenter pointed out an inconsistency between an SCH criterion as presented in the regulatory text and as discussed in preamble language. That is, the regulatory text at § 412.92(a)(2)(i) states that we will measure whether more than 25 percent of the residents who become inpatients or 25 percent of the Medicare inpatients within a hospital's service area are admitted to other like hospitals for care. However, the preamble of the May 27, 1988 proposed rule states that this requirement can be satisfied if the hospital submits patient origin data from all other hospitals located within the larger of its service area or a 50-mile radius. The commenter noted that the regulatory text would require a hospital to identify every person within its service area or the 50-mile radius who was admitted to any hospital for treatment. Under the preamble language, a hospital seeking SCH status would have to show only that it admitted 75 percent of all the inpatients admitted to any hospital located within the larger of its service area or a 50-mile radius. The commenter also asked about what assistance is available from HCFA if neighboring hospitals are uncooperative in providing data on admissions to their facilities.

Response: We agree with the commenter that the language is confusing. We also recognize the difficulty of identifying every resident or Medicare beneficiary who became an inpatient during a particular period of time. Therefore, we are revising § 412.92(a)(2)(i) to clarify that a hospital seeking SCH status must show that during the cost reporting period ending before it files for SCH status, it admitted at least 75 percent of all the hospitalized residents or 75 percent of all the Medicare beneficiaries who were admitted to any like hospital located within the larger of the requesting

hospital's service area or a 50-mile radius.

We also recognize that there are some instances in which a hospital may experience difficulty in collecting the data to show the percentage of patients it admits from its service area. That is, not every State has a statewide planning agency that furnishes a patient origin data. Also, neighboring hospitals may not be cooperative in furnishing such information to hospitals seeking SCH status. In addition, not all intermediaries have the capability to furnish patient origin data by zip code. We are therefore offering to assist hospitals to making available data from Medicare's central office records. Hospitals seeking this assistance should address their requests to their intermediary.

The hospital must furnish its full name, address and Medicare provider number and state that it is requesting patient origin data so that it may qualify as an SCH. The hospital must furnish a complete listing of zip codes within its service area and it must provide the full name, address and, if available, the Medicare provider number of every other hospital located within the larger of its service area or a 50-mile radius. It must also furnish the beginning and ending date of its most recently completed cost reporting period.

After the intermediary verifies the information furnished and forwards the hospital's request to HCFA's central office, HCFA will respond as rapidly as possible and will provide a count by zip code of the number of Medicare discharges from each of the identified hospitals for the one year period representing the requesting hospital's most recently completed cost reporting period. No patient identifying information will be provided, only counts of discharges by zip code for each hospital.

Hospitals should be aware that if they fail to achieve SCH status based on HCFA-furnished data on Medicare patient origin, they may not substitute other patient origin data for the same time period to demonstrate that the hospital seeking SCH status admitted at least 75 percent of all Medicare beneficiaries who were admitted to this hospital and all like hospitals within its service area or, if larger, a 50-mile radius. That is, once a hospital elects to have HCFA furnish the patient origin data, only HCFA's data will be considered in the determination. This limitation is intended to minimize the administrative burden of having HCFA produce patient origin data for hospitals that have not exhausted other sources of such data.

Comment: One commenter questioned whether it would continue to be treated as an SCH in view of its county's deemed urban status under the provisions of section 1886(d)(8)(B) of the Act, as added by section 4005(a) of Pub. L. 100-203.

Response: Section 4005(a) of Pub. L. 100-203 amended section 1886(d)(8)(B) to provide that "The Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas [which meets certain criteria] as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if * * *." Under the regulations at § 412.92(a), hospitals granted SCH status on October 1, 1983 or later must be located in a rural area. Therefore, if the hospital was approved under the provisions at § 412.92(a), then we believe it can no longer be classified as an SCH effective October 1, 1988, the effective date of its urban status under section 1886(d)(8)(B). However, the regulations at § 412.92(b)(4) state that a hospital that was approved as an SCH before October 1, 1983 or a hospital whose application was submitted by October 1, 1983 and subsequently approved will continue to be an SCH until it voluntarily cancels its status or unless there is a change in the circumstances under which it was approved. Based on this provision, several hospitals in urban areas continue to be classified as SCHs. Therefore, if the hospital to which the commenter refers was approved under the provisions of § 412.92(b)(4), we see no impediment to its continuing to be classified as an SCH despite it now being in an area deemed to be urban.

Comment: Several commenters made specific suggestions for redefining the criteria to qualify for SCH status and for modifying the payment methodology for SCHs. Included as suggestions were designating as an SCH any hospital located in a county in which there are no other hospitals or any hospital located a specified number of miles or minutes from another hospital. The commenters also suggested that the basic payment to SCHs should be based on the amount that they would be paid if they were not classified as SCHs plus a percentage of the difference between costs and prospective payments when costs exceed payments.

Response: With regard to the commenters' suggestions on redefining and simplifying the criteria to qualify for SCH status, we agree that the current standards are cumbersome and difficult to define clearly. We hope to publish revised and simplified standards in the

future. While we will certainly keep the commenters' proposed criteria in mind, adoption of some of the suggestions would appear to result in inequitable treatment of hospitals. For example, if we designated as an SCH any hospital located in a county in which there is no other hospital, the situation could arise in which a hospital is the only one in the county despite the existence of another hospital located in close proximity just over a nearby county line. We do not believe that such a hospital could truly be called a "sole" community hospital.

Similarly, we foresee difficulty in designating SCHs based on travel time from another hospital since travel time is contingent upon, for example, time of day, traffic congestion, and weather conditions. We favor redefining the SCH criteria solely on the basis of miles from another hospital as suggested by the commenters, but we are not prepared to propose revisions at this time.

In regard to the commenters' suggestion that we revise the payment methodology for SCHs, the current methodology is established by law. Therefore, we have no discretion with respect to the method under which prospective payments are made to SCHs. We note, however, that one of the provisions of Pub. L. 100-203 addresses, in part, the commenters' suggestion. That is, section 4005(c) of Pub. L. 100-203 amended section 1886(d)(5)(c)(ii) of the Act to permit a hospital that meets the criteria to qualify as an SCH, but chooses not to be paid under the prospective payment system as an SCH, to also qualify for the special payment adjustment available to SCHs whose volume of discharges declines more than five percent from the previous year. As a result, if a hospital meets the criteria to qualify as an SCH and experiences a decrease of five percent or more in total inpatient discharges due to circumstances beyond its control, the hospital may receive the volume decline adjustment regardless of whether it is being paid as an SCH. The amount of the adjustment is limited to no more than the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

Comment: In its comments on our proposed rule, ProPAC reiterated several of its previous suggestions and recommendations (see 53 FR 19523), many of which we have responded to elsewhere in this section of the preamble. Additional ProPAC comments not addressed elsewhere are: (1) HCFA should limit the time allowed to act on a hospital's SCH designation application; (2) the Secretary should provide more

supporting evidence for its definition of hospital market area; (3) HCFA should attempt to clarify further the SCH designation criteria to promote greater uniformity in the implementation of procedures; and (4) the Secretary should undertake a study and provide technical assistance to the public to evaluate the effectiveness of the current SCH protections.

Response: With respect to the issue of a time constraint for acting on a hospital's application for SCH designation, the HCFA regional offices act as quickly as possible given their personnel and budget constraints. However, the requesting hospital often submits incomplete or insufficient data in support of its request. As a result, the regional office must go back to the hospital in an effort to obtain sufficient documentation to justify a decision. This process can be time-consuming for reasons beyond the control of the regional office. Therefore, we are not proposing time limits for HCFA regional offices. Rather, we will continue to work with ProPAC, regional office personnel, and the hospital industry in an effort to streamline the application process and expedite each hospital's request as rapidly as possible.

With respect to the remaining issues, we agree with ProPAC that further study of our definition of hospital market area, our criteria for determining SCH status, and the effectiveness of the current SCH protections is required. Our analysis of the SCH provisions is an ongoing process, and we will continue to study and work with other interested parties to ensure that our criteria are appropriate for determining which hospitals are the sole source of care for Medicare beneficiaries, and that sufficient protections are in place to provide beneficiary access to inpatient hospital services.

G. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a referral center. Prior to the enactment of Pub. L. 100-203, one of the criteria under which a rural hospital could qualify as a referral center was to have 500 or more beds available for use. Section 4005(d) of Pub. L. 100-203 amended section 1886(d)(5)(C)(i)(I) of the Act to reduce the bed size criterion from 500 or more beds to 275 or more beds, effective with discharges on or after April 1, 1988.

In the April 5, 1988 notice, at (53 FR 11136), we discussed our policy concerning which beds in a hospital should be counted in evaluating whether

a rural hospital meets the new bed size criterion. We stated that, in determining whether a hospital has 275 or more beds, we count only beds available for use within the subsection (d) hospital (that is, we do not count beds located in an excluded psychiatric unit, rehabilitation unit, or newborn nursery).

As further clarification of our policy in implementing the provisions of Pub. L. 100-203 concerning rural referral centers, we proposed that the method for determining the number of beds for indirect medical education purposes be used for counting available beds for rural referral center purposes. That is, we would use the definition at § 412.118(b) to determine if a hospital has 275 or more available beds to qualify it as a rural referral center. For rural referral center purposes, in the May 27, 1988 proposed rule, we proposed to look at the hospital's most recently completed cost reporting period in making this determination. For example, for cost reporting periods beginning on or after October 1, 1988 and before October 1, 1989, we proposed to apply the definition at § 412.118(b) for determining the number of beds for indirect medical education payment purposes to the hospital's cost reporting period that began on or after October 1, 1986 and before October 1, 1987. This is consistent with the time period used to count a hospital's number of discharges to qualify as a rural referral center under § 412.96(c)(2).

In the April 5, 1988 notice, we also stated that rural referral centers should be paid the standardized amounts for hospitals located in other urban areas rather than the standardized amounts for hospitals located in large urban areas. As a part of the May 27, 1988 proposed rule, we proposed to amend § 412.96 to implement the provisions of section 1886(d)(5)(C)(i)(1) of the Act.

Comment: One commenter urged us to take action to address the special needs of referral centers located in urban areas.

Response: In the September 3, 1985 final rule (50 FR 35678), we noted that we would obtain and review cost data from urban hospitals to determine whether urban referral centers should receive any payment adjustment. We have reviewed these data and determined that there is no justification for a payment adjustment at this time. Large urban hospitals in general continue to enjoy favorable operating margins under the prospective payment system. In cases in which hospitals receive more in prospective payment revenues than their Medicare operating costs, we do not believe it is necessary or reasonable to provide additional

adjustments. We will continue to monitor the data in future years to determine if the situation changes.

Comment: We received many comments concerning our policy about which beds should be counted in determining whether a rural hospital meets the bed size criterion necessary to receive special treatment as a rural referral center. The commenters objected to our decision announced in the April 5, 1988 notice (at 53 FR 9339) to use the same procedure for counting beds for rural referral center purposes as is used for counting beds for indirect medical education payment purposes. The commenters also uniformly criticized our proposal in the May 27, 1988 proposed rule (at 53 FR 19519) to count these beds as of the close of the most recently completed cost reporting period. Virtually all commenters who wrote about rural referral centers asserted that we should instead determine the actual number of beds available for use on the effective date of the hospital's classification as a rural referral center.

Response: Based on the comments received, we have reconsidered our policy. The commenters brought to our attention several scenarios that we had not envisioned. Therefore, we are modifying our policies to take into consideration increases in bed count that have occurred since the close of the most recently completed cost reporting period for any of the following reasons:

- Merger of two or more hospitals;
- Reopening of acute care beds in areas previously closed for renovation;
- Transfer of acute care beds previously classified as part of an excluded unit to areas of the hospital subject to the prospective payment system; or
- Expansion of the number of acute care beds available for use and permanently maintained for lodging inpatients (that is, not beds in corridors or other temporary beds).

For purposes of determining a hospital's number of beds for classification as a rural referral center, we will use the bed count as determined from the hospital's most recently completed cost report unless the hospital submits convincing written documentation with its application that its bed count has changed since the close of the most recently completed cost reporting period for one of the reasons cited above. Such convincing evidence may include, but is not limited to: written approval by the State licensing agency to expand the number of beds (together with proof, as discussed below, that an increase in

beds has actually occurred); notice from HCFA agreeing to transfer beds in previously excluded units to the prospective payment system; and documentation of a legitimate merger of two hospitals.

We continue to believe that newborn nursery beds, custodial care beds, and beds in units excluded from the prospective payment system should not be included in determining whether a hospital meets the 275-bed criterion. Also, we will count only licensed beds actually available for use, that is, beds in place, staffed and available to receive patients for inpatient lodging.

As part of our review of each request for rural referral center status based on bed count, we will determine the number of beds as shown on the hospital's most recently submitted cost report. If the number of beds (or that number of beds plus any beds added for one of the reasons listed above, for example, through an expansion or a merger) is below 275, the hospital must explain the discrepancy and document how and why the cost report bed count varies from the number now claimed. If beds have actually been added or put back into service (other than through transfer of a unit from excluded status to prospective payment status), we would expect to see a corresponding increase in staffing and other variable costs. Hospitals are expected to submit documentation (for example, lists of personnel added) in support of their claims of added beds.

Being licensed by a State agency to maintain up to a certain number of beds is not by itself proof of a bed count if the most recently submitted cost report shows that a smaller number of beds was actually available. It is common for a hospital to maintain a fewer number of beds than it is actually licensed to maintain for inpatient care. We believe Congressional intent was to extend the rural referral center adjustment only to those hospitals that are legitimately maintaining 275 or more available prospective payment beds. Therefore, we will carefully review each request to ensure that only those hospitals that are actually maintaining 275 or more prospective payment beds are approved as rural referral centers. It should also be noted that bed counts may be subject to onsite verification by the intermediary or HCFA personnel.

We wish to reiterate that it is the responsibility of a hospital to demonstrate that its bed count has changed if the hospital's count of beds is different from that shown on the most recently submitted cost report. In the absence of verifiable evidence, HCFA regional office personnel will determine

the bed count by using the count as shown on the last submitted cost report.

Using the bed count criteria previously published, some hospitals filed for and were denied rural referral center status during the 90-day period granted to implement this revision in the law. Since we are now revising the method of counting beds in this final rule, hospitals whose applications were denied should resubmit their applications within 60 days from the effective date of this final rule, together with all evidence available in support of their bed count and a copy of the previous denial, to the appropriate HCFA regional office. If review using the revised standards results in approval for status as a rural referral center, the effective date will be retroactive to April 1, 1988, as specified in section 4005(d) of Pub. L. 100-203, but in no instance can status as a rural referral center precede the date that the hospital actually had 275 available beds as defined above.

All other hospitals that believe that they meet these revised standards should submit their applications using the usual rural referral center filing time frames; that is, the application must be submitted during the 90-day period preceding the start of the hospital's cost reporting period and, if approved, status as a rural referral center becomes effective with the start of the hospital's next cost reporting period following the application.

Comment: One commenter objected to our not counting recovery room and labor and delivery room beds toward meeting the rural referral center bed size criterion of 275 or more beds just because the commenter's State licensing agency does not license them.

Response: We believe it is common practice for State licensing agencies not to license or include in a hospital's bed count those beds located in recovery or labor and delivery rooms. Moreover, Medicare policy has historically not counted beds in recovery rooms or labor and delivery rooms in determining a hospital's bed size, because patients in these beds are normally there for only brief periods of time, and during these times, the patient's assigned bed is usually held for him or her. Like beds in other ancillary departments, such as x-ray and radiology departments, these beds are not available for extended patient lodging. Thus, regardless of whether these beds are or are not licensed by the State, they are not counted toward meeting the 275-bed requirement.

A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two

mandatory criteria (number of discharges and case-mix index) and at least one of three optional criteria (medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, currently a hospital is classified as a rural referral center if its—

- Case mix index is at least equal to the lower of the median case mix index for urban hospitals in the census region in which the hospital is located, excluding hospitals with approved teaching programs, or the median case mix index for all urban hospitals nationally; and
- Number of discharges is at least 5,000 discharges per year or, if less, the median number of discharges for urban hospitals in the census region in which the hospital is located. (We note that the number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining referral center status. In determining the proposed national and regional case-mix index values, we proposed to follow the same methodology we used in the November 24, 1986, final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, we proposed that the national case-mix index value include all urban hospitals nationwide and that the regional values would be the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.118).

These values are based on discharges occurring during FY 1987 (October 1, 1986, through September 30, 1987) and include bills posted to HCFA's records through December 1987. Therefore, in addition to meeting other criteria, we proposed that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1988, a hospital's case-mix index value for FY 1987 would have to be at least—

- 1.1764; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.118) calculated by HCFA for the census region in which the hospital is located as indicated in the table below.

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT).....	1.1370
2. Middle Atlantic (PA, NJ, NY).....	1.1124
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	1.1624
4. East North Central (IL, IN, MI, OH, WI).....	1.1307
5. East South Central (AL, KY, MS, TN).....	1.1186
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	1.1501
7. West South Central (AR, LA, OK, TX).....	1.1795
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	1.1950
9. Pacific (AK, CA, HI, OR, WA).....	1.1929

Based on the latest data available (through June 1988), the final national case-mix index value is 1.1782 and the median case-mix index value by region are set forth in the table below.

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT).....	1.1393
2. Middle Atlantic (PA, NJ, NY).....	1.1130
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	1.1655
4. East North Central (IL, IN, MI, OH, WI).....	1.1310
5. East South Central (AL, KY, MS, TN).....	1.1208
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	1.1511
7. West South Central (AR, LA, OK, TX).....	1.1828
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	1.1964
9. Pacific (AK, CA, HI, OR, WA).....	1.1944

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing the FY 1987 case-mix index values in Table 3c in section IV of the addendum to this final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

Comment: One commenter stated that it was inequitable that existing rural referral centers have to maintain a case-mix index higher than 50 percent of all urban hospitals in the country. The commenter also suggested that the current "grandfather period" for rural referral center status be extended for another three years.

Response: The criteria used to determine the case-mix index standards were established in section 1886(d)(5)(C)(i) of the Act. That section states that the regional case-mix index standards will be equal to the median case-mix index for hospitals (other than

hospitals with approved teaching programs) located in an urban area in the same region. The regional standards in the May 27, 1988, proposed rule and those published in this final rule comply with section 1886(d)(5)(C)(i) of the Act. The national case-mix index standard is based on the median case-mix index of all urban hospitals nationwide.

Section 9302(d) of Pub. L. 99-509 introduced the grandfather provision to which the commenter refers. It stated that any hospital that was classified as a rural referral center on the date of enactment of that law shall continue to be classified as a rural referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989. Thus, any hospital that was classified as a rural referral center as of October 21, 1986 (the date of enactment of Pub. L. 99-509) is guaranteed this status through its cost reporting period beginning before October 1, 1989. We do not know whether Congress will extend the grandfather provision beyond that date. However, since we believe that it is important for existing rural referral centers to demonstrate continuing compliance with the generally applicable legislated measurements of rural referral center status, we would oppose the extension of the grandfather provision.

Comment: One commenter suggested that, rather than have a single category of "all or nothing" rural referral centers, we implement a five-tiered adjustment for all rural hospitals. Under the commenter's proposal, HCFA would rank each rural hospital by its case-mix index. Hospitals whose case-mix index equals or exceeds the median case-mix index of urban non-teaching hospitals in the same census region would receive the full urban standardized amount. Those whose case-mix index falls within the 40th through 49th percentiles would be paid based on 80 percent of the urban standardized amount and 20 percent of the rural standardized amount. Those whose case-mix index falls within the 30th through 39th percentiles would be paid based on 70 percent of the standardized amount of the urban and 30 percent of the rural, and so forth. Under the commenter's plan, hospitals would not be required to apply for this type of adjustment; instead HCFA would notify each hospital of its ranking and payment status.

Response: The commenter has presented an interesting concept, but one that we believe is not administratively feasible. Also, we believe that the suggested concept is not

in keeping with the Congressional intent that only large, technologically sophisticated hospitals serving as resource centers for patients from wide geographic areas should be approved rural referral centers. The commenter's suggestion would provide adjustments for all rural hospitals except those falling below the 10th percentile in a case-mix index ranking. Furthermore, we do not believe it was the intent of Congress for the prospective payment system to provide tiered rates to rural hospitals. Rather, Congress stated that the prospective payment system was eventually to pay a specific amount for each discharge based on a case's classification into a specific diagnostic-related group regardless of the hospital's location. Therefore, we are not adopting the commenter's suggestion.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(i)(II) of the Act, the national standard is set at 5,000 discharges. We proposed to update the regional standards, which are based on discharges for urban hospitals during the third year of the prospective payment system (that is, October 1, 1985 through September 30, 1986), which is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we proposed that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1988, a hospital's number of discharges for its cost reporting period that began during FY 1987 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located as indicated in the table below.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT).....	6,730
2. Middle Atlantic (PA, NJ, NY).....	8,063
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	6,125
4. East North Central (IL, IN, MI, OH, WI).....	7,381
5. East South Central (AL, KY, MS, TN).....	5,782
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	5,102
7. West South Central (AR, LA, OK, TX).....	4,393
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	6,142

Region	Number of discharges
9. Pacific (AK, CA, HI, OR, WA).....	4,797

Based on the latest discharge data available, the final median number of discharges by census region are set forth in the table below.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT).....	6,749
2. Middle Atlantic (PA, NJ, NY).....	8,145
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	6,489
4. East North Central (IL, IN, MI, OH, WI).....	7,289
5. East South Central (AL, KY, MS, TN).....	5,782
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	5,633
7. West South Central (AR, LA, OK, TX).....	4,393
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	7,182
9. Pacific (AK, CA, HI, OR, WA).....	4,570

We note that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1988, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1987 would have to be at least 3,000.

Comment: Several commenters asserted that the proposed discharge standards for qualification as a rural referral center do not accurately reflect the decline in occupancy being experienced by many rural hospitals. The commenters suggested that the discharge standards should be lowered considerably.

Response: Section 1886(d)(5)(C)(i) of the Act specifically provides for the national discharge criterion of 5,000 discharges annually and the regional standards that are based on the median number of discharges for urban hospitals in the census region in which the hospital is located (and the upper limit of the discharge standard for osteopathic hospitals of 3,000). The standards published in this final rule conform to the requirements of section 1886(d)(5)(C)(i) of the Act. We do not believe we have authority to impose standards other than those legislated.

H. Disproportionate Share Adjustment (§ 412.106)

Section 4003 (b), (c), and (d) of Pub. L. 100-203 amended section 1886(d) of the Act to provide for several changes to the rules that govern the disproportionate share adjustment. We proposed to revise § 412.106 to implement these provisions, which are all effective

beginning with discharges on or after October 1, 1988.

First, section 4003(b)(1) of Pub. L. 100-203 amended section 1886(d)(5)(F)(iii) of the Act to increase from 15 percent to 25 percent the disproportionate share payment adjustment factor for a hospital that qualifies as a disproportionate share hospital under § 412.106(b)(1)(ii), that is, the hospital has 100 or more beds; is located in an urban area; and receives more than 30 percent of net inpatient revenues from State and local government sources for the care of indigent patients not eligible for Medicare or Medicaid.

Second, section 4003(b)(2) of Pub. L. 100-203 amended section 1886(d)(5)(F)(iv)(I) of the Act to eliminate the 15 percent cap on the payment adjustment factor for a hospital that qualifies as a disproportionate share hospital under either § 412.106 (b)(1)(i)(A) or (b)(2); that is, the hospital has a disproportionate patient percentage (as defined in § 412.106(a)(1)) of at least 15 percent, has 100 or more beds, and is located in an urban area; or the hospital has a disproportionate patient percentage of at least 15 percent, has 500 or more beds, and is located in a rural area.

Third, section 4003(c) of Pub. L. 100-203 amended sections 1886(d)(2)(C)(iv) and 1886(d)(5)(F)(i) of the Act to extend payment of the disproportionate share adjustment through discharges that occur before October 1, 1990. Prior to enactment of Pub. L. 100-203, the payment adjustment for disproportionate share hospitals was to be made only through discharges occurring before October 1, 1989.

In addition, section 1886(d)(5)(F) of the Act as amended by section 4009(j)(3)(A) of Pub. L. 100-203 clarifies that "net" inpatient revenue is the denominator when determining whether a hospital meets the requirement that 30 percent of its inpatient revenue is from State and local government sources for the care of indigent patients. Because regulations at § 412.106(b)(1)(ii) refer to total inpatient care revenue, we proposed to revise this section to clarify that we would use net inpatient revenue rather than gross inpatient revenue in determining whether a hospital qualifies for a disproportionate share adjustment under this provision.

Net inpatient revenues are defined as gross inpatient revenues minus allowances. Allowances represent reductions in revenue for amounts not expected to be realized as revenues. These include allowances for bad debts, charity care, and courtesy discounts and third party contractual allowances.

Comment: We received one comment from a Medicare intermediary that discussed the impact that elimination of the 15 percent cap on disproportionate share payments would have on some hospitals. The intermediary asserted that eight of the hospitals it services would receive disproportionate share payments of between 31 and 44 percent of its DRG-based payments.

Response: We recognize that eliminating the cap on the disproportionate share payment will result in significant additional payments for a number of hospitals. However, sections 4003 (b)(2) and (e) of Pub. L. 100-203 specifically require that effective with discharges on or after October 1, 1988, the cap on disproportionate share payments is eliminated.

Comment: One commenter objected to the use of net inpatient revenues in determining whether a hospital meets the requirement that 30 percent of its inpatient revenues are from State and local government sources for the care of indigent patients. Because of the disparity in the percentage of revenue reductions to gross revenue across the country depending on the type of payment system used by the various state programs, the use of net revenues is an inconsistent measure.

Response: While gross inpatient revenues may be a more consistent measure for determining the percentage of inpatient revenues from State and local government sources for indigent patient care, section 1886(d)(5)(F)(i)(II) of the Act is very specific that "net" inpatient revenues is to be used as the denominator when computing this percentage. That section was amended by section 4009(j)(3)(A) of Pub. L. 100-203 specifically to require that we use "net" inpatient revenues.

I. Classification of Capital-Related Costs and Direct Medical Education Costs (§ 412.113)

The prospective payment system was enacted by section 601 of the Social Security Amendments of 1983 (Pub. L. 98-21) with the intention of curtailing the high rate of increase in hospital inpatient operating expenditures. The term "operating costs of inpatient hospital services" was defined to include all inpatient routine and ancillary costs except for capital-related costs. Payment for capital related costs continues to be determined on a reasonable cost basis. The cost of approved medical educational activities is also excluded from the definition of "operating costs."

In order to ensure that reclassification of costs included in or excluded from the prospective payment system was minimized, we added the "consistency rule" to the regulations governing the prospective payment system. It most recently was set forth at § 412.113 (a)(1) and (b). The consistency rule required that the classification of these capital-related and direct medical education costs remain constant for each hospital during the prospective payment transition period. This rule was necessary since a portion of the prospectively determined payment during the transition to fully Federal standardized rates was based upon a hospital's own cost experience (that is, the hospital-specific rate). Continued use of the same classifications was instituted to avoid paying for the same costs under both payment methodologies; that is, once in the hospital-specific rate where they are included in base year costs and once in pass-through costs if the classification of cost changed during the transition.

We believe that the "consistency rule" for capital-related and direct medical education cost classifications has been effective during the transition period. The rule has been particularly important in identifying situations where there were gross and monetarily substantial misclassifications of those costs in the period before implementation of the prospective payment system. This was especially true for medical education cost misclassifications. As a result of application of the consistency rule, both hospitals and HCFA have sought revisions on a case-by-case basis to ensure that the same costs are not paid for under both payment methodologies (that is, on a reasonable cost basis as a pass-through item and under the prospective payment system as part of the hospital specific rate) and to ensure appropriate payments for such costs are consistent with the modification of base year costs rules at § 412.72.

With the expiration of the transition period, prospectively determined payment is now based on national and regional standardized rates that do not depend upon an individual hospital's cost experience. Thus, restrictions on the classification of capital-related and direct medical education costs are no longer necessary. Therefore, we proposed eliminate this requirement so that it would not be confusing to hospitals in future cost reporting periods.

Comment: Commenters supported elimination of the consistency rule, which required that classification of capital-related and direct medical

education costs remain constant for each hospital during the prospective payment transition period. Several commenters asked that we stipulate the effective date of the expiration of the consistency rule.

Response: As noted in the preamble of the proposed rule at 53 FR 19520, the consistent application of classification for capital-related and direct medical education costs is no longer necessary due to the expiration of the prospective payment transition period. We are simply deleting the language from the regulations text concerning the consistency rule to avoid further confusion. However, just as the regulations previously required, consistency for capital related costs must be applied only to cost reporting periods beginning before October 1, 1986 and for direct medical education costs only for cost reporting periods beginning before October 1, 1987.

J. Elimination of Interim Payments for Indirect Medical Education Costs (§ 412.116)

Previously, under § 412.116, payments for indirect medical education costs were on the basis of 26 equal biweekly payments, subject to a year-end adjustment. Because the Pricer program used by intermediaries to calculate payments already computes the indirect medical education interim payments on a bill-by-bill basis, we proposed to pay for indirect medical education costs on a bill-by-bill basis, effective with discharges on or after October 1, 1988. This is consistent with the way in which payments are made for the disproportionate share adjustment. Thus, we proposed to delete § 412.116(d) from the regulations.

Comment: Several commenters objected to the elimination of periodic interim payments for indirect medical education costs because of the negative effects the proposal would have on the cash flow of teaching hospitals. Another commenter suggested that it be made clear that the indirect medical education payment made on a bill-by-bill basis are interim payments subject to adjustment at settlement.

Response: We do not believe in general that teaching hospitals will experience a substantial cash flow problem as a direct result of this change in policy. Furthermore, the advantages of paying for indirect medical education costs on a bill-by-bill basis are so compelling that we plan to implement it beginning with discharges on or after October 1, 1988. By linking the payment mechanism to the Pricer program, bill-by-bill payments will ensure more accurate payments, administrative

expediency, and payments consistent with the Medicare inpatient services being furnished and billed by teaching hospitals. It is important to note, however, that, as appropriate, the Pricer must be updated during the year whenever changes in the parameters used in the Pricer program occur. Thus, if there is a change from the prior year in the intern and resident to-bed ratio, the new figure must be reflected in Pricer to ensure that the indirect medical education payments are as accurate as possible for the current cost reporting period. At the end of a hospital's fiscal year, any necessary adjustments in the indirect medical payment will be made at final settlement of the cost report.

K. Indirect Medical Education Costs (§ 412.118)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that operate medical education programs receive an additional payment for the indirect costs of medical education. The regulations governing the calculation of this additional payment are set forth at § 412.118. Each hospital's additional indirect medical education payment is determined by multiplying the hospital's total DRG revenue (that is, wage-adjusted DRG payments and outlier payments) by the applicable education adjustment factor.

Section 4003(a) of Pub. L. 100-203 revised section 1886(d)(5)(B)(ii) of the Act to reduce the education adjustment factor used to determine the indirect medical education payment from approximately 8.1 percent to approximately 7.7 percent for discharges occurring on or after October 1, 1988 and before October 1, 1990. The 8.1 percent and 7.7 percent are approximations because the true education adjustment factor is applied on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear relationship; that is, each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in payments.

For discharges occurring on or after October 1, 1988 and before October 1, 1990, the indirect medical education factor equals the following:

$$1.89 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}} \right)^{.405} - 1 \right]$$

For discharges occurring on or after October 1, 1990, the indirect medical education factor equals the following:

$$1.43 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}} \right)^{.5795} - 1 \right]$$

We proposed to amend § 412.118 (c) and (d) to implement the provisions of section 1886(d)(5)(B)(ii) of the Act.

Comment: Several commenters objected to the reduction of the effective indirect medical education payment factor from approximately 8.1 percent to approximately 7.7 percent. One commenter said that this payment factor should not be reduced until HCFA implements a severity-of-illness factor to reflect more accurately the costs of these resource-intensive Medicare cases.

Response: This reduction was mandated by section 4003(a) of Pub. L. 100-203, and HCFA had no discretion in implementing the change.

L. Ceiling on Rate of Hospital Cost Increases (§ 413.40)

Payment to hospitals and hospital units that are excluded from the prospective payment system is on a reasonable cost basis, subject to the rate-of-increase limits established by section 1886(b) of the Act. These excluded hospitals and hospital units receive payment for the inpatient hospital services they furnish on the basis of reasonable cost up to a ceiling. The ceiling is determined by a per discharge rate based upon each hospital's or excluded hospital unit's average cost per case in a particular year (that is, the base year) which is then updated annually by an applicable percentage increase. The per discharge rate is referred to as the target amount, and the percentage update is referred to as the target rate or rate-of-increase limit. By using each hospital's or hospital unit's historical cost to establish a target amount for future periods, the choice of an appropriate and representative base period becomes an important factor that must be carefully defined and uniquely maintained for each excluded hospital or hospital unit for all future cost reporting periods.

Section 1886(b)(3) of the Act provides for the use of a particular 12-month cost reporting period as the base period that is to serve as the basis of future period's cost per case (that is, the target amount) after updating by the applicable percentage increase. That particular period is the hospital's or hospital unit's first 12-month cost reporting period beginning on or after October 1, 1981. Section 1886(b)(5) of the Act gives the

Secretary the authority to determine the applicable 12-month period to use as the base period for hospitals or hospital units that have a cost reporting period of other than 12-months' duration. This policy is set forth in regulations at § 413.40(b).

We have experienced increasingly frequent requests from hospitals to change their original base year to a later period of time when the hospital or unit does not have consecutive 12-month cost reporting periods after October 1, 1982, the earliest period to which the limits apply. In addition, we have received requests for the selection of a new base year for an excluded hospital or excluded hospital unit when it has experienced a break in providing patient services, or its participation in the Medicare program has been interrupted. We have also been asked to explain the difference in treatment for exclusion of new hospitals as compared to the treatment of new excluded hospital units.

Hospitals have used the provisions of § 413.40(b)(2) to argue for use of later 12-month cost reporting periods for base years when the first 12-month cost reporting period is not followed immediately by another 12-month period. We recognize that the statute requires the target amount to be applied to 12-month cost reporting periods, or in the case of any hospital having a cost reporting period of other than a 12-month period, a 12-month period determined by the Secretary. Rather than either prohibiting cost reporting periods of other than 12-months' duration due to financial or administrative reasons or requiring that hospitals combine data from multiple cost reporting periods in order that the target rate-of-increase limits be applied on a 12-month basis, we believe it is more appropriate to continue to apply the rate-of-increase ceiling to all cost reporting periods, of whatever duration, beginning during each Federal fiscal year. Therefore, we proposed to revise section 413.40(b)(2) to clarify that ceilings would apply to any cost reporting period following a base period established under § 413.40(b)(1) that began on or after October 1, 1982, or, if later, after the hospital's exemption from the target amount expires unless the exception provided in § 413.40(b)(3) applies to such periods that are shorter than 12 months duration.

An excluded hospital or hospital unit may leave the Medicare program due to temporary closure or termination of its provider agreement. Questions have arisen regarding whether there is a need to establish a new base period or whether a "new provider" exemption period is available in those cases. In order to avoid such confusion, we proposed to revise § 413.40(b)(1) by deleting the word "initial" in the first sentence. We proposed to include a provision that the ceiling, once established, remains applicable to an excluded hospital unit or hospital regardless of intervening cost reporting periods during which the excluded hospital or hospital unit may not be subject to its target amount as a result of other provisions of the law or regulations, or nonparticipation in the Medicare program. This clarification is needed due to the number of excluded hospitals and particularly distinct part units that may be excluded one year, subject to the prospective payment system in a subsequent year (owing, for example, to failure to continue to meet all the criteria for exclusion), and then excluded again in the next year. Such fluctuation from excluded status to prospective payment system status and back again is not considered sufficient reason to establish a new base period.

The authority to establish distinct part units of hospitals is provided for under section 1886(d)(1)(B)(iv) of the Act. Regulations specifically setting forth criteria for establishing distinct part units are contained in §§ 412.25 through 412.29 and 412.32. Distinct part units are excluded from the prospective payment system and are subject to the ceiling on the rate of hospital cost increases. Due to the fact that a majority of the distinct part units was created as a result of the prospective payment system, many hospitals have requested exemptions for newly created distinct part units as new hospitals under § 413.40(f)(1). In that section, a new hospital is defined as a " * * * 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 a previous ownership, or both, for less than three full years."

A distinct part unit is not equivalent to a hospital within the meaning of the regulations. A distinct part unit is

basically a subprovider within a hospital for which the hospital has decided to separately report costs. Unless the hospital as a whole is new within the meaning of § 413.40(f)(1), a distinct part unit within a hospital would not qualify for an exemption under § 413.30(f).

The base period established under § 413.40(b)(1) for a newly established distinct part unit is the first 12-month cost reporting period for which the unit was approved as meeting the requirements necessary to be an excluded distinct part unit and costs of the unit were reported separately to Medicare. As a result of the unique situation created by the establishment of distinct part units, we proposed to modify § 413.40(f) to specifically state that a distinct part unit does not qualify for an exemption under the rate of increase ceiling provision as a new hospital.

Comment: One commenter suggested that the provision in section 1886(b)(4)(A) of the Act that provides authority to grant exceptions, exemptions, and adjustments could be used to allow for new base periods and a three-year exemption for new units. The commenter believes that there are circumstances, such as change of ownership, under which a new base period should be used, and that units face the same start-up costs and other problems as do new hospitals.

Response: We believe the commenter does not recognize the context of section 1886(b)(4)(A) of the Act. That section gives administrative authority to make exceptions and adjustments to a hospital for either a subsequent cost reporting period or the base period, and to allow exemption from the target amount (that is, determination of a base period cost per case). Both actions presuppose that a base period is already determined. In any case, the requirement for establishing a base period only once under section 1886(b)(3)(A) of the Act is not modified. In our opinion, the authority to make such adjustments and exemptions strengthens the rationale that the Congressional intent in this statutory provision is to set the base year only once since either the target amount or allowable costs in a later period can be adjusted if circumstance arise like those pointed out by the commenter.

Additionally, we do not agree that a three-year exemption should apply to new units of previously operating hospitals as it does to new hospitals. These units do not face the same start-up cost problems or other difficulties that an entire new hospital would face. These units are created within the

confines of already existing facilities that have usually provided the services before it was decided to separately report that operation. Thus, unit start-up costs cannot readily be compared to a fully new hospital's start-up costs. As another commenter pointed out, most hospitals now having distinct part units offered the services previously, and their organization as separate units reflects the need for identification for Medicare purposes rather than an expansion of services.

Comment: The one comment received on our proposal to clarify establishing the base year for hospitals and hospital units under the rate-of-increase ceiling rules supported our changes but asked for general reformation of the rate-of-increase system in light of the significant changes in programs, organizations, and treatment modes during the past six years.

Response: We believe that the system does provide adequate flexibility to consider and address fluctuations in the provider environment under the exception and adjustment provisions of the rate-of-increase ceiling rules. When events create cost distortions that render the target amount unresponsive to circumstances, the targets can be reviewed and, if warranted, adjustments can be made. We believe this process is working effectively, and that even as more types of excluded hospitals or excluded units are incorporated into the prospective payment system in the future, the target amount system will continue to be appropriate.

M. The Medicare Catastrophic Coverage Act of 1988

Under section 101(b) of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360), which was enacted July 1, 1988, essentially unlimited inpatient hospital days will be available for Medicare beneficiaries effective for discharges occurring on or after January 1, 1989. (We note that the inpatient psychiatric day limitation is unchanged.) Before enactment of Pub. L. 100-360, a beneficiary was entitled to 90 days of inpatient hospital services during each spell of illness. In addition, a beneficiary could draw from a lifetime reserve of 60 days if that beneficiary's inpatient hospital days exceeded 90 days in a spell of illness. Previously, a hospital could bill the beneficiary or the beneficiary's third party insurer for inpatient hospital services furnished to a beneficiary whose inpatient hospital benefits were exhausted either before entering the hospital or, following admission, during the outlier portion of an inpatient stay (see § 412.42(e)).

Hospitals and hospital associations expressed concern to Congress that they would be financially disadvantaged by not being permitted to bill beneficiaries or their third party insurers for inpatient hospital services that before enactment of Pub. L. 100-360 were not covered because beneficiaries had exhausted their inpatient hospital benefits. (These noncovered days were not reflected in the cost base used to establish the prospective payment rates and thus are not recognized in those rates.)

Therefore, Congress provided, in section 104(c)(1) of Pub. L. 100-360, that the Secretary in establishing the prospective payment rates, outlier thresholds, and DRG weighting factors for FY 1989 must, to the extent the Secretary determines to be appropriate, take into consideration any reductions in payments by Medicare beneficiaries to prospective payment hospitals due to the elimination of a day limitation on inpatient hospital services caused by the provisions of section 101(b) of Pub. L. 100-360. In addition, section 104(c)(2) of Pub. L. 100-360 requires that, for cost reporting periods beginning on or after October 1, 1988, the Secretary, in increasing the target amounts for hospitals excluded from the prospective payment system, must, on a hospital-specific basis, take into consideration the same reduction in payments to excluded hospitals.

1. Prospective Payment System Hospitals

We have determined that the prospective payment system will automatically adjust to the expansion of inpatient hospital benefits under Pub. L. 100-360. This is because increased payments will occur automatically as DRG payments are made for entire stays, including the outlier portions thereof, that previously would not have been covered due to a beneficiary's exhaustion of covered inpatient hospital days.

The following chart compares the prospective payments that hospitals receive before and after implementation of catastrophic coverage:

Situation	Pre-Catastrophic	Post-Catastrophic
Beneficiary exhausts inpatient hospital benefits prior to entering hospital.	No DRG payment. No outlier payment. Ancillary services are covered and billable payments under Part B for Part B enrollees.	No exhaustion of benefits: Hospital will receive regular DRG payment plus any applicable outlier payment.

Situation	Pre-Catastrophic	Post-Catastrophic
Beneficiary has at least one covered day remaining upon admission to the hospital, but exhausts inpatient hospital benefits while in the hospital.	Regular DRG payment made. Outlier payments made only for covered outlier days. Ancillary services for noncovered outlier days are covered and billable under Part B for Part B enrollees.	No exhaustion of benefits: Hospital will receive regular DRG payment plus any applicable outlier payments for the balance of the stay.

Thus, as demonstrated above, the prospective payment system will automatically expand to reflect the additional payments for previously noncovered stays and noncovered days of a stay. Aggregate payments to hospitals will automatically reflect changes in the volume of Medicare discharges resulting from the elimination of the day limitation on inpatient hospital benefits, just as is currently the case. The additional discharges occurring as a result of the expansion of benefits will be covered and paid for automatically as are all other discharges under the prospective payment system. Hence, we have determined that no adjustment to the standardized payment amounts is necessary to accommodate the additional discharges furnished to Medicare beneficiaries who previously would have been financially liable for such care because they had exhausted their Medicare inpatient hospital benefits prior to admission.

On the other hand, there will be additional days of inpatient care—those occurring during the outlier portion of a hospital stay—for which the hospital would previously have been permitted to bill beneficiaries because such care was not reflected in the data base used to establish the prospective payment rates. Because such care will, in general, be covered after January 1, 1989, it is necessary to make an adjustment to the prospective payment system in order to ensure that such care is financed out of additional Federal monies rather than through the updated standardized amounts and outlier funds.

Based on FY 1987 data currently available regarding noncovered days of hospital care furnished to Medicare beneficiaries under the existing benefit structure, we estimate that outlier payments for such days will be about one percent of total DRG payments. However, to reflect these additional payments by increasing the

standardized amounts by one percent would then require that the outlier offsets to those rates or the outlier thresholds be increased to ensure that total outlier payments are between five and six percent of total DRG payments and do not exceed the outlier offset. Moreover, our current estimate is likely to be overstated to the extent that some proportion of hospital days will continue to be noncovered even after implementation of Pub. L. 100-360 for reasons other than the current limit on inpatient hospital benefits. Therefore, we have determined that it is inappropriate to incorporate an adjustment into the rates at the present time.

Instead, it is possible to estimate outlier payments and outlier offsets on the basis of days covered under the current inpatient benefit structure as reflected in the FY 1987 MEDPAR data base, knowing that the proportion of days eligible for outlier payments will increase as expanded coverage begins on January 1, 1989 and that a higher proportion of DRG payments will thus be attributable to outlier payments as a result of such expansion of benefits.

In light of the increases in the outlier thresholds that are already necessitated by the changes in outlier payment policy described in section V.E. of this preamble, we believe the latter approach is appropriate for FY 1989 and preferable to further possible increases in the outlier thresholds. Accordingly, while the outlier offsets to the standardized amounts average 5.2 percent for FY 1989, we expect that outlier payments will comprise about 6.2 percent of total DRG payments during that same year. This inequality constitutes our adjustment to account for the reductions in beneficiary payments to prospective payment hospitals owing to the elimination of the day limitation on inpatient hospital services provided for in section 101(b) of Pub. L. 100-360.

The adjustment described above eliminates the need to increase the prospective payment rates at present. Moreover, the DRG relative weights are already based on the average total charges, rather than average covered charges, for all cases in each DRG. Consequently, the weighting factors established in accordance with the methodology described in section III.C. of this preamble contain no distortions resulting from the potentially different incidence across DRGs of inpatient hospital care furnished to beneficiaries who have exhausted their inpatient hospital benefits. Hence, no adjustment to the relative weights is needed to take

into account the elimination of the day limitation on inpatient hospital care resulting from implementation of Pub. L. 100-360.

In conclusion, in order to ensure that payment for additional days of care resulting from implementation of Pub. L. 100-360 reflects new funds and not merely a redistribution of the same funds that would have been paid out prior to the implementation of Pub. L. 100-360, we have used only currently covered days and covered charges in modeling our payment simulations for purposes of establishing outlier thresholds, despite the fact that effective January 1, 1989 essentially all inpatient hospital days and charges will be covered. This approach will prevent the outlier thresholds increasing to finance the additional outlier payments that will be made as a result of the expansion in benefits. This means that, to the extent that hospitals are furnishing care to patients who previously would have exhausted their inpatient hospital benefits, they will receive more outlier payments than we will account for in our outlier threshold simulations.

We note that the prospective payment rates reflect total payment due a hospital for a nonoutlier case. The rates themselves are not reduced by amounts paid or expected to be paid by beneficiaries for applicable deductible and coinsurance amounts, although payments due a hospital as a result of cost report settlement are reduced by deductible and coinsurance amounts paid by beneficiaries. Thus, to the extent that after implementation of the catastrophic coverage provisions, beneficiaries face fewer deductibles and no coinsurance for inpatient hospital stays, the prospective payments to which a hospital is entitled will be reduced by those smaller beneficiary liabilities and actual Medicare payments will increase.

2. Hospitals and Units Excluded from the Prospective Payment System

We will allow hospitals and hospital units excluded from the prospective payment system to apply for increases to their target rates to correct any distortion due to higher costs caused by the expansion of inpatient hospital benefits. We are revising § 413.40 to implement this policy. We note that this policy is an exception to our general rule, as discussed in detail in section II of this preamble and set forth in regulations at § 413.40(g) and (h), that excluded hospitals subject to the target rates may not receive exceptions or adjustments unless they actually exceed their target rates. The adjustment under

section 104(c)(2) of Pub. L. 100-360 will be available to any hospital that experiences a distortion due to increased costs caused by elimination of the inpatient entitlement limitation, whether or not the hospital actually exceeds its target rate. This is because any distortion will be due to the effect of section 104(c)(2) of Pub. L. 100-360, and essentially is unrelated to the actions of any individual hospital—it is a circumstance that could potentially affect all hospitals to some degree.

As a result, we are adding a new paragraph (i) to § 413.40 of the regulations. The new provisions allow a hospital to request a target amount adjustment directly from its intermediary. The target amount will be adjusted for the impact of any reduction in Medicare payments that the hospital experienced because of the previous inpatient day benefit limitation. The adjustment will be based on the estimated incremental costs of care historically furnished to Medicare beneficiaries after they had exhausted benefits during an inpatient stay.

A hospital may request an adjustment from its intermediary after the effective date of this regulation (that is, October 1, 1988) but no later than 180 days after the closing date of the hospital's first cost reporting period beginning on or after October 1, 1988. In order for its request to be considered, a hospital must submit a written request for an adjustment to its target amount under authority of this provision along with the following supporting documentation:

- A statement from the hospital regarding whether it wishes the adjustment to be based on its historical experience in either its base year or its last cost reporting period beginning before October 1, 1988. (If this period is not of at least 12 months' duration, multiple consecutive cost reporting periods comprising at least 12 months must be used.)

- The hospital's cost report or reports for the period selected by the hospital to serve as the basis for the adjustment.

- Billing data for the period that serves as the basis for the adjustment documenting the following:

- The number of hospital inpatient days furnished to Medicare beneficiaries for which no payment was made because the beneficiary had exhausted Part A hospital benefits. (Excluded from the count are days for stays that were not covered in their entirety, since such stays will be paid as discharges after January 1, 1989.)
- The ancillary charges for services furnished on the days after the beneficiary had exhausted Part A hospital benefits, as counted above.

Upon receipt of a request for an adjustment by a hospital that supplies the required information, the intermediary will verify the data submitted by the hospital regarding beneficiary status and exhaustion of inpatient hospital entitlement. (Medical necessity of acute care for inpatient days following exhaustion of entitlement will be assumed.)

In order to adjust the target amount, the intermediary will—

- Estimate the total inpatient operating costs for services furnished to Medicare beneficiaries, including the costs of services furnished after a beneficiary had exhausted benefits;

- Take the ratio of the above-determined costs to the Medicare allowable inpatient operating costs for the period from which the provider's data is derived; and

- Apply this ratio to the otherwise applicable target amount for cost reporting periods beginning on or after October 1, 1988.

The intermediary will determine the amount of any appropriate adjustment and notify the hospital of its determination within 90 days of the date of receipt of the request.

The following example illustrates the target amount adjustment:

1. Medicare allowable inpatient operating costs in base year or last cost reporting period beginning before October 1, 1988.....	\$600,000
2. Estimated routine costs of inpatient days furnished to Medicare beneficiaries after exhaustion of Part A hospital benefits: 50 days of care multiplied by \$400 Medicare allowable inpatient operating cost per diem	\$20,000
3. Estimated costs for ancillary services furnished after Medicare beneficiaries had exhausted Part A hospital benefits (estimated by applying departmental cost-to-charge ratios from the cost report to the ancillary charges).....	\$10,000
4. Incremental costs of care furnished to Medicare beneficiaries after exhaustion of Part A hospital benefits (Line 2 plus Line 3).....	\$30,000
5. Total inpatient operating costs for Medicare beneficiaries notwithstanding exhaustion of Part A hospital benefits (Line 1 plus Line 4).....	\$630,000
6. Ratio of total inpatient operating costs for Medicare beneficiaries to covered Medicare inpatient operating costs (Line 5 divided by Line 1).....	1.05
7. Target amount applicable to cost reporting period beginning on or after October 1, 1988.....	\$4,500.00

8. Adjusted target amount for cost reporting period beginning on or after October 1, 1988 (Line 6 multiplied by Line 7)..... \$4,725.00

VI. Other ProPAC Recommendations

As required by law, we reviewed the March 1, 1988 report submitted by ProPAC and gave its recommendations careful consideration in conjunction with the proposals set forth in the proposed rule. We also responded to the individual recommendations in that proposed rule. The comments we received on our treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our responses to that recommendation, we have not repeated the recommendation and response in the discussion below. Recommendations 1 through 5 concerning the update factors are discussed in Appendix B of this document. Recommendation 11 concerning sole community hospital criteria is discussed in section V.F. of this preamble. Recommendation 15 concerning recalibration of the DRG weights is discussed in section III.C. of this preamble. Recommendation 16 concerning improvements to DRG 468 is discussed in section III.B. of this preamble, and Recommendations 17 and 18 concerning payment for outlier cases are discussed in section V.E. of this preamble. The remainder of the recommendations are discussed below.

A. Adjustments to the Prospective Payment System Payment Formula

1. Capital Institutional Neutrality (Recommendation 7)

Recommendation: Until capital costs are incorporated into an all-inclusive prospective payment rate, the Secretary should provide supplemental payments to hospitals that have contracts with other facilities (for example, other hospitals and clinics) for capital costs incurred at those other facilities. Currently, Medicare does not pay for these costs.

Response in the Proposed Rule: We do not accept this recommendation. As we indicated in response to this recommendation last year (52 FR 18854, May 19, 1987), the prospective payment rates represent the full rebundled costs to hospitals of providing services. Under the prospective payment system, hospitals are responsible for the full costs of providing inpatient services.

whether they are furnished inhouse or by arrangement.

In developing the prospective payment rates, we incorporated all operating costs of providing services. We also included both the costs of purchased services performed outside the hospital and formerly billed separately by the supplier of services and the costs of services furnished "under arrangements," that is, where the services were furnished by an outside supplier, but billed by the hospital as Part A services. No attempt was made to distinguish operating and capital components of these services furnished by entities other than the hospital. A hospital's own direct costs are appropriately disaggregated into capital and operating costs. While there is a capital component to many items and services purchased by the hospital for use in patient care or provided under arrangements, the charges made for such services do not distinguish the capital from the operating component of such services. It was charges for purchased services that were used to establish the rebundling adjustment to the Federal rates and that were used by the intermediary as the basis for modifying base-year costs to incorporate the effect of the rebundling requirement in the hospital-specific rate. (No similar adjustment was necessary for services furnished "under arrangements" since the allowable costs of these services was already reflected in hospital cost reports used in determining the prospective payment rates.) Therefore, we believe the prospective payment rates already reflect the full costs of services, and that any additional amount to cover the capital costs of services provided outside the hospital would constitute a duplicate payment.

Comment: One commenter took issue with our rejection of ProPAC's recommendation that hospitals be paid an additional amount to cover the capital-related costs of services purchased by the hospital from outside vendors. The commenter noted that while the capital-related costs of services furnished to inpatients of one hospital by another hospital had been taken into account when costs were rebundled to calculate standardized amounts, this was not the case for services purchased from nonhospital suppliers.

Response: We have not been advised of any empirical evidence that hospitals now have any greater opportunity to purchase services that involve capital-related cost components than they had when the prospective payment rates

were originally established. Since hospitals have always had and used such options, capital-related costs were included in charges for services obtained for inpatients in the prospective payment base year just as they are currently. These costs are, therefore, reasonably represented in the current prospective payment rates and were described in the documents explaining the construction of those rates (48 FR 39766; September 1, 1983 and 49 FR 326; January 3, 1984). Thus, contrary to ProPAC's and the commenters' allegations, the costs of the capital-related components of purchased services, including those purchased for nonhospital suppliers, are clearly reflected in the standardized amounts. In fact, to make supplemental payments for these capital costs as suggested, the standardized amounts would have to be reduced for those estimated supplemental payments to assure not only that total payments are not duplicated but, in addition, that the Medicare program is not actually providing an incentive for hospitals to purchase services for inpatients rather than securing the in-hospital capability to provide them when it's more efficient to do so.

In addition to these specific concerns related to capital items, this approach could be used to lobby for additional or supplemental payments for any new service, product, or treatment that did not exist in the base year. Indeed, the same argument has been presented with respect to new diagnostic tools and costly medications that were not available in the base year. We believe that making supplemental or additional pass-through payments in addition to those specifically provided under applicable statutes is antithetical to the intent of the law in establishing a standard price for similar cases, regardless of the specific services furnished to individual patients or the manner in which the hospital obtains those services.

2. Labor Market Area Definitions (Recommendation 9)

Recommendation: ProPAC states that it continues to believe that the current hospital labor market area definitions are seriously flawed and that they can be improved substantially with currently available data. ProPAC recommends that the Secretary should adopt improved definitions of hospital labor market areas. For urban areas, the Secretary should modify the current MSAs to distinguish between central and outlying areas. The central areas should be defined using urbanized areas as designated by the Census Bureau. For

rural areas, the Secretary should distinguish between urbanized rural counties and other rural counties within each State. Urbanized rural counties should be defined as counties with a city or town having a population of 25,000 or greater. The implementation of improved definitions should not result in any change in aggregate hospital payments. Furthermore, these definitions should not affect the assignment of hospitals to urban or rural areas for purposes of determining standardized amounts.

Response in the Proposed Rule: We appreciate the effort and analysis that ProPAC has devoted to trying to better define labor market areas for purposes of applying the wage index. However, we continue to believe that defining labor market areas on the basis of urbanized and nonurbanized areas within areas classified as urban and rural would create administrative problems. In our response to this same recommendation in the April 1, 1987 ProPAC report for FY 1988 (52 FR 22093, June 10, 1987), we raised a number of concerns that still trouble us.

First, we continue to be concerned with the Census Bureau's definition of urbanized areas. Because the boundaries are based on population density and defined to the census tract level, urbanized areas follow boundaries that do not coincide with street addresses, zip codes, or other identities with which hospitals, intermediaries or we are routinely familiar. In addition, the actual boundaries of urbanized areas are volatile and subject to dramatic change where extensive development occurs. However, the Census Bureau routinely draws the boundaries for urban areas only once each decade following the decennial census. Hence, we would anticipate numerous cases in which hospitals would argue that their location has changed from a nonurbanized area to an urbanized area because of development since the last census. We have already received a great deal of criticism from hospitals on the use of dated census information with regard to our implantation of section 1886(d)(8)(B) of the Act (the reclassification of certain rural areas). This boundary issue, along with the increase in boundaries resulting from classifying hospitals according to four labor market area classifications, would multiply the number of cases in which hospitals perceive that they are being disadvantaged.

Second, we continue to have concern regarding the accuracy with which hospitals would be assigned to urbanized areas. As we noted in the

September 1, 1987 final rule (52 FR 33055), the census tract is not a part of the data we routinely receive from hospitals, nor is it data with which hospitals or intermediaries are familiar. To assign hospitals to classifications below the county level would require this information.

Third, while ProPAC's suggested refinements to labor market areas would most likely recognize greater wage variations than are currently indicated, we note that these wage differentials are highly correlated with and thus are already taken into account in some degree through the indirect medical education and disproportionate share adjustments for hospitals, and the special treatment for rural referral centers. In addition, constructing the wage index for labor market areas as redefined by ProPAC would dictate recalculation of the indirect medical education and disproportionate share adjustments in order to ensure that we would not be aggravating payment disparities among groups of hospitals. Such recalculation would require legislation.

It is not clear that the labor market areas recommended by ProPAC are any more reflective of the markets in which hospitals compete for labor than the current system. We agree that use of more labor market areas would result in a wage index with greater explanatory power with regard to hospital wage levels. In fact, maximum explanatory power would be achieved by using a hospital-specific wage index. However, under the prospective payment system, we are concerned with hospital level cost differences rather than wage level differences. It is anticipated under the prospective payment system that hospitals with high wages substitute nonlabor inputs for labor inputs in order to keep overall costs down.

We recognize that the current system of MSAs used for defining labor market areas has shortcomings. We look forward to continuing to work with ProPAC to develop a classification methodology that better reflects labor market areas and that overcomes the administrative problems discussed above.

Comment: We received comments expressing concern that the Secretary did not accept the ProPAC recommendation to revise labor market area definitions for use in establishing the wage index. One commenter asserted that revising labor market area definitions to take into account urban core and ring differences and urbanized and nonurbanized rural area differences were both feasible and effective in reducing variance. In support of the

contention that it is feasible to distinguish hospital urbanized and nonurbanized area locations, the commenter supplied a step-by-step methodology for determining whether hospitals are located within urbanized areas.

Response: We appreciate the commenter's constructive suggestions as to how one can classify hospitals on the basis of location in an urbanized area. However, we still do not accept the recommendation to define labor market areas below the county level. Our policy is that such further subclassification of hospitals would be confusing and difficult to administer, and would likely create numerous situations in which hospitals perceive that they have been disadvantaged. Contrary to the assertion of the commenter, we do not believe the benefits of adopting revised labor market definitions would far outweigh the disadvantage. While we acknowledge that the system of defining labor market areas on the basis of MSA location has shortcomings, the payment effects of these shortcomings are largely overcome for hospitals in the urban core by the indirect medical education and disproportionate share hospital adjustments. Nonetheless, we will further analyze the ProPAC recommendations during the coming year and we will study whether any changes are appropriate.

B. Quality of Care

Evaluation of Peer Review Organization (PRO) Review and Quality of Care (Recommendation 12)

Recommendation: The Secretary should review and synthesize the findings of the PROs over the past four years. A major comprehensive evaluation of PROs and their impact on quality of care should follow. The evaluation should focus on issues of access to and use of services, patterns of denials, and instances of poor quality care. Issues related to expenditure control and efficient administration of PRO contract requirements should be secondary to broader quality-of-care evaluative goals. The assessment should also evaluate and compare criteria used to make judgments about when care is appropriate. Finally, this major study should assist the Secretary in developing and implementing mechanisms for expanded PRO review of episodes of care that are patient-oriented rather than institution-oriented.

Response in the Proposed Rule: While we agree conceptually with the purpose of a longitudinal study of PRO review findings, we do not believe that such a study is feasible given the transitional

nature of the PRO program during the targeted time period. The PRO program was implemented simultaneously with the prospective payment system in 1984, and, in 1986, its focus changed from utilization review to quality review.

Major changes have been made to improve the review methodology both through our program policies and as a result of legislative mandates. As a result, we do not have a consistent data base on which to perform longitudinal analysis. In addition, we have not collected data on individual case reviews; we have summary data only. This further limits our data analysis techniques. In the next PRO contract scope of work, we are implementing a new data collection system that will include disaggregated data, which will significantly improve our ability to perform a longitudinal analysis.

We have contracted with the Institute of Medicine (IOM) to assess the current state of the art in quality review. IOM will evaluate the procedures, costs, and adequacy of quality assurance mechanisms and examine the availability of reliable and clinically valid criteria and standards to judge quality of care. A comprehensive report of the IOM study outlining findings, conclusions, and recommendations will be prepared for Congress.

The second part of the ProPAC recommendation concerns the evaluation of PRO criteria. ProPAC believes that the Secretary should review the development, use, and application of criteria related to medical necessity and appropriateness.

All PROs are required to submit their criteria to HCFA 45 days before implementation and to submit any changes to these criteria 30 days before implementation. All criteria are then reviewed by HCFA central office and regional office medical personnel. After this review, the strengths and weaknesses of the criteria are discussed with the PROs, and the PROs are then required to make appropriate revisions to these criteria. In addition, both the HCFA regional offices and an independent contractor, SystemeMetrics, Inc. (the so called "SuperPRO") review a sample of PRO cases using the PRO's approved criteria to assure that the criteria are applied appropriately and that the medical determinations are accurate. In addition, over the next year, the "SuperPRO" will analyze the PRO criteria and make recommendations for changes.

We also agree that the PRO program should focus on outcomes of care. To that end, we are developing uniform, accurate screening procedures using

clinical data abstracted from the individual medical records. Under this process, we will review an array of diagnostic information, including objective positive physician findings and information on the course of hospitalization. This will permit assessment of the severity of illness at admission and the care a person receives while a patient, as well as monitoring the outcome. The data generated from this process will be used to systematically identify for indepth review physicians and providers with aberrant practice patterns.

We are in agreement with ProPAC's recommendation that the appropriate mix of cases in all areas should be examined along with the number of reviews and type of tools needed to identify quality problems. A number of activities have taken place in the past year in this regard. A zero based analysis of PRO reviews was performed prior to the development of the new PRO contract scope of work (which is effective for contracts entered into or renewed on or after October 1, 1988) to refine the mix of reviews in order to assure that activities are focused appropriately. In addition, we convened a task force composed of PRO and HCFA representatives that further refined and improved the HCFA inpatient hospital generic quality screens. We believe that the improved quality screens will improve the identification of quality problems. We also convened a task force to develop a model quality intervention plan to ensure that the PROs will take more consistent actions to improve quality of care when problems are identified.

In the new PRO contract scope of work, PROs will review a sample of posthospital care furnished before a readmission that occurred within 31 days of discharge from a hospital. To make that review more meaningful, work groups were convened in early 1987 to develop generic quality screens to help in the identification of quality problems in skilled nursing facilities, home health care, and outpatient surgery areas.

Also, we are in the process of providing some PROs with added funds to conduct pilot studies. These studies will test varying review methodologies in an attempt to identify the most efficient and effective way to identify cases for review. Examples of the areas that will be studied are review of short stays, deaths within 20 days of hospital discharge, and services furnished by skilled nursing facilities and home health agencies.

Comment: One commenter stated that the Secretary has rejected ProPAC's call

for review and synthesis of PRO findings and a comprehensive evaluation of PROs and their impact on quality of care. The commenter stated that the Secretary supported this position by citing a series of ongoing activities and the lack of a consistent data base for longitudinal analysis. While the commenter agrees that there are limitations in available data, the commenter does not believe that consistent longitudinal data are a prerequisite to the type of evaluation that was recommended.

The commenter stated that other activities, such as those being undertaken on a pilot basis, or between HCFA and individual PROs, or through the "SuperPRO," do not constitute acceptable substitutes for a major evaluation of the results of the PRO program. The commenter expressed belief that such an evaluation would assist those undertaking the IOM study cited by the Secretary. For these reasons, the commenter continues to believe that the Secretary should undertake (or contract for) a major evaluation of findings concerning the PRO program.

Response: We continue to believe that a lack of longitudinal data does prevent us from making the kind of evaluation requested. We also believe that data that measures outcomes of encounters with the health care delivery system are the true measure of the effectiveness of PROs. Realizing this, we set about defining our data needs. As a result, we are in the process of conducting studies to determine which clinical data should be collected to enable us to measure these outcomes over time. The resultant data would also be used by PROs to identify potential problem cases and aberrant practice patterns, which are the objectives of the PRO program.

C. Patient Classification and Case-Mix Measurement Coding Improvements (Recommendation 14)

Recommendation: The Secretary should formalize a more timely, systematic, and consultative approach to consider ICD-9-CM codes for new diagnoses, procedures, devices, and other treatments. When new codes are considered and created, both coding specialists and clinical specialists should be involved. ProPAC continues to believe that the Secretary's guidelines prohibiting the use of Chapter 16 codes as principal diagnoses should be reviewed because the prohibition has, in some cases, impeded appropriate DRG assignment of important diagnoses. (Chapter 16 of the ICD-9-CM system is a compendium of symptoms, signs, ill-defined conditions, and abnormal

findings of laboratory and investigative procedures. Chapter 16 rules contradict the usual guidelines of the ICD-9-CM coding system concerning the sequence of principal and secondary diagnoses.)

Response in the Proposed Rule: We disagree with ProPAC's assertion that the current system for coding changes is not timely, systematic, and consultative. Each fiscal year, we publish the process for coding changes and we request public comment concerning problems and recommendations. We also publish notices in the *Federal Register* to announce the time, place and proposed agenda for regularly scheduled public meetings concerning coding changes. During calendar year 1987, we held meetings in April, July, and December.

Prior to all public meetings, the ICD-9-CM Coordination and Maintenance Committee (the Committee) thoroughly researches the topics on the agenda. This committee is composed of individuals trained in the coding of medical records in addition to physicians, nurses, and others familiar with the Medicare prospective payment system. In addition to the thorough review by this committee, outside organizations are also contacted for consultation. At the public meetings, presentations may be given by qualified experts on particular topics of interest.

While this may appear to be a lengthy time process, we have received many public comments that the timeframes are not sufficient for hospitals to implement or adopt coding changes.

One of the reasons for length of time between meetings is to permit the public to provide additional comments on the proposals presented at the public meetings. In addition to those who regularly attend the public meetings, we also send summaries of the Committee meetings to an additional 200 organizations and individuals. Included among this group are coding specialists as well as physicians. As a result of this distribution, we receive additional comments from those unable to attend the meetings. While the last public meeting is held in December, written comments are accepted until January 31.

The time we allot to this process is necessary to permit us time to consider the volume of input from outside groups before we make a final decision on changing a code. To accurately edit, index, and print the errata for the three volumes of ICD-9-CM, we must have some lead time. In addition, final coding changes may necessitate changes in DRG classification that would require revisions in the Grouper program.

By statute, the prospective payment rates and update factors that are to be

effective for a given Federal fiscal year (that is, on or after October 1) must be published in the *Federal Register* by the preceding May 1 with 60 days allowed for public comment. Since coding changes affect the DRGs that are used in computing final payment for inpatient services, we must finalize coding changes before the May 1 publication date. In order to finalize changes by May 1, we begin formulation of the final proposed code revisions on February 1. By February 15, final clearance begins within HCFA and the National Center for Health Statistics (NCHS). Approval must be obtained by all relevant staff before submission to the HCFA Administrator and NCHS Director. By March 1, revisions have received final approval, and work is completed in April on the tabular and indexing of the Addendum that will contain the new and revised codes. Publication of the Addendum occurs sometime in August. The Addenda for FY 1986 and FY 1987 contained 50 new and revised codes and 100 new and revised codes, respectively.

A great deal of background work goes into a proposal before it is presented at a public meeting. The ICD-9-CM Coordination and Maintenance Committee thoroughly researches the topics on the agenda. This committee is composed of people trained in the coding of medical records in addition to physicians, nurses and others familiar with the prospective payment system. In addition to the review by this committee, technical advice is solicited from clinical specialists. Examples of groups who have provided technical advice include the American Society for Gastrointestinal Endoscopy, North American Society for Pacing and Electrophysiology, the National Association of Children's Hospitals and Related Institutions, and the National Association for Sleep Disorders. Physician specialists regularly attend the public meetings and make presentations on medical procedure and technology. The results are better revisions to the ICD-9-CM.

In its recommendation ProPAC noted what it considered to be two areas of continuing coding problems, acute myocardial infarctions (AMIs) and partial joint replacements.

We agree, with ProPAC, that problems still exist with the coding of AMIs. The diagnosis codes are contained in volumes 1 and 2 of the ICD-9-CM and therefore are the primary responsibility of NCHS. NCHS has been reviewing the problems with the codes throughout the year. Several proposals have been presented by the public and NCHS at the public meetings.

However, the proposals have not adequately distinguished between patients admitted with an AMI and patients not admitted for treatment of an AMI but whose diagnosis is an AMI because of the "eight week rule." Under the eight week rule, a diagnosis of AMI must be coded under some circumstances if the patient has had an infarction within eight weeks of the admission.

HCFA will continue to work with NCHS to improve the guidelines and code definitions. Any comments from the public on improving Chapter 16 and any other coding questions concerning volumes 1 and 2 of ICD-9-CM should be sent to: Ms. Sue Meads, Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, National Center for Health Statistics, Room 2-19 Center Building, 3700 East-West Highway, Hyattsville, MD 20782.

We will also continue to examine the necessity of codes for partial joint replacements. Since this is an issue related to procedure codes within volume 3 of ICD-9-CM, HCFA has the lead responsibility for making any changes. This topic was on the agenda for the July meeting and will be addressed during the next year. Any concerns with the coding of procedures in volume 3 of the ICD-9-CM should be sent to: Ms. Patricia Brooks, Health Care Financing Administration, Office of Coverage Policy, Room 309, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Comment: We also received comments on the process of code revisions by the Committee. All of these comments were supportive. Some commenters praised the clinicians who at the public meetings provided background information on the need for coding changes.

Two commenters qualified their statements with a request that the process become more timely. They specifically addressed the longstanding need for an improvement in the ICD-9-CM diagnoses codes for acute myocardial infarction (AMI). One commenter, ProPAC, pointed out that although deficiencies in the AMI codes had been on the committee's agenda since July 1987, it will be October 1989 before new codes could be implemented and June 1991 before charge data are available for analysis.

Response: Officials of HCFA and NCHS have met to specifically address the development of new or expanded diagnoses codes for acute myocardial infarction (AMI) by the Coordination and Maintenance Committee. We believe that the cooperation

demonstrated by these representatives will result in a viable proposal for new codes at the next public meeting in December 1988. With the audience's input and written follow-up, the AMI codes could be implemented in October 1989. We anticipate that this will result in additional improvements through the conforming changes, which will be made to the guidelines, and indexing for the use of all diagnoses codes in the Circulatory System chapter of ICD-9-CM. Optimally, all changes would be made at the same time to ensure the continuity of the data over time.

VII. Other Required Information

A. Effective Dates

The effective date of this final rule (including the addendum and appendixes) is October 1, 1988. The following changes are applicable October 1, 1987: §§ 412.53 (c)(6) and (f) and 413.40(c)(3)(i)(C). The following changes are applicable beginning with cost reporting periods beginning on or after October 1, 1987: §§ 412.73(c)(5)(i) and 412.92(f). The following changes are applicable for discharges occurring on or after April 1, 1988: §§ 412.70 (c)(6) and (d)(5), 412.82(d), 412.84(k), and 412.96 (b)(1)(ii) and (d). The following changes are applicable beginning with cost reporting periods beginning on or after October 1, 1988: §§ 412.73(c)(5)(ii) and 413.40 (c)(3)(i)(D) and (h)(3). The following changes are applicable for discharges occurring on or after November 1, 1988: §§ 412.80(a), 412.82(c), 412.84 (a), (g), (h), and (j), and 412.86.

B. Waiver of 30-Day Delay in the Effective Date

We ordinarily provide for a 30-day delay in the effective date of a substantive final rule. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date. As discussed in detail above, we published a proposed rule on May 27, 1988 that included all the issues in this final rule except for one issue raised by Pub. L. 100-360, which was enacted on July 1, 1988. We provided for a 60-day period for public comment. In developing this final rule, we considered all comments received in response to that proposed rule.

The regulations published in final in this rule implement specific statutory provisions and most of the provisions in these regulations are applicable to discharges occurring on or after October 1, 1988 as required by law. In general, these regulations are beneficial to most

of the prospective payment hospitals, as well as to hospitals and hospital units excluded from the prospective payment system. If we were to provide for a 30-day delay in the effective date of these changes, hospitals would be deprived of the full benefits of this final rule. Thus, a 30-day delay in the effective date would be contrary to the public interest. For these reasons, we find good cause to waive the normal 30-day delay in the effective date.

C. Waiver of Prior Public Comment Period

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** for a substantive rule to provide a period for public comment. However, we may waive that procedure if we find good cause that notice and comment are impractical, unnecessary, or contrary to the public interest.

As discussed in detail above, we published a proposed rule on May 27, 1988 that included all the issues in this final rule except for one issue raised by Pub. L. 100-360, which was enacted on July 1, 1988. As explained in detail in section V.M. of this preamble, above, section 104(c)(1) of Pub. L. 100-360 provided that the Secretary in establishing the prospective payment rates, outlier thresholds, and DRG weighting factors for FY 1989 must, to the extent the Secretary determines to be appropriate, take into consideration any reductions in payments to prospective payment hospitals due to the elimination of a day limitation on inpatient hospital services caused by the provisions of section 101(b) of Pub. L. 100-360. In addition, section 104(c)(2) of Pub. L. 100-360 requires that, for cost reporting periods beginning on or after October 1, 1988, the Secretary, in increasing the target amounts for hospitals excluded from the prospective payment system, must take into consideration, on a hospital-specific basis, the same reduction in payments to excluded hospitals.

In addition, section 411(b)(4) of Pub. L. 100-360 amended section 1886(d)(8)(B)(ii) of the Act and thereby revised a provision of the proposed rule concerning the criteria under which hospitals in certain rural counties may be deemed to be located in an adjacent urban area. This provision is also effective for discharges occurring on or after October 1, 1988.

The regulations published in final in this rule implement these two statutory provisions as Congress intended. The changes made by section 411(b)(4) of Pub. L. 100-360 are technical in nature and we are merely conforming the text of the regulations to the new statutory

language. The changes made to implement the provisions of section 104(c)(1) and (c)(2) of Pub. L. 100-360 are effective on October 1, 1988 and result in increased payments to prospective payment hospitals and allow hospitals excluded from that system to request a special adjustment to their target amounts under the rate-of-increase ceiling. For these reasons, we believe that it is both unnecessary and contrary to the public interest to delay implementation of the statutory provisions until the process of publishing both proposed and final rules can be completed. Therefore, we find good cause to waive proposed rulemaking and to issue these regulations as final. Nonetheless, we are providing a 60-day period for public comment only on these issues as indicated in the beginning of this preamble.

Because of the large number of items of correspondence we normally receive concerning regulations, we are not able to acknowledge or respond to the comments individually. However, if we decide that changes are necessary as a result of our consideration of timely comments, we will issue a final rule and respond to the comments in the preamble of that rule.

D. Paperwork Reduction Act

This final rule does not impose information collection requirements. Consequently, it need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501-3511).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Health facilities, Medicare.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare.

42 CFR Chapter IV is amended as follows:

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

Subchapter B—Medicare Programs

I. Part 405, Subpart C is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

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

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

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

B. In § 405.310, paragraph (m)(2) is revised to read as follows:

§ 405.310 Particular services excluded from coverage.

* * * * *

(m) *Services to hospital inpatients.*—

* * * * *

(2) *Exception.* Physicians' services that meet the criteria of § 405.550(b) for payment on a reasonable charge basis, and services of an anesthetist employed by a physician that meet the conditions of § 405.553(b)(4), are not excluded.

* * * * *

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, 1122, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1320a-1, 1395g(e), 1395hh, and 1395ww).

B. In Subpart A, § 412.2, paragraphs (c)(1) and (c)(3) are amended by changing "413.55(b)" to "413.53(b)," the introductory text in paragraph (e) is republished, and a new paragraph (e)(6) is added to read as follows:

Subpart A—General Provisions

§ 412.2 Basis of payment

* * * * *

(e) *Additional payments to hospitals.*

In addition to payments based on the prospective payment rates, hospitals will receive payments for the following:

* * * * *

(6) Serving a disproportionate share of low-income patients, as provided in § 412.106.

C. Subpart C is amended as follows:

Subpart C—Conditions for Payment Under the Prospective Payment System

1. In § 412.46, paragraph (a) is revised; paragraphs (b), (c), and (d) are redesignated as paragraphs (c), (d), and (e), respectively; a new paragraph (b) is added; and newly redesignated paragraph (c) is revised to read as follows:

§ 412.46 Medical review requirements; DRG validation.

(a) *Physician attestation.* The attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. The information must be in writing in the medical record, and, except as provided in paragraph (b) of this section, the physician must sign the statement. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's dated signature:

"I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge."

(b) *Alternative signature requirement.* The attending physician's signature, along with the other information required in paragraph (a) of this section, may be provided by electronic means through a hospital data system if the intermediary determines that the hospital data system meets the guidelines established by HCFA.

(c) *Physician acknowledgement.* In addition, when the claim is submitted, the hospital must have on file a current signed and dated acknowledgement from the attending physician that the physician has received the following notice:

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

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

2. Section 412.50(b) is revised to read as follows:

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(b) HCFA does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b) of this chapter and services of an anesthetist employed by a physician reimbursable under § 405.553(b)(4) of this chapter.

D. Subpart D is amended as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

1. Section 412.62 is amended by republishing the introductory texts of paragraph (f)(1), and (f)(1)(ii), and revising paragraphs (f)(1)(ii)(B) and (k) to read as follows:

§ 412.62 Federal rates for fiscal year 1984.

(f) *Geographic classifications.* (1) For purposes of paragraph (e) of this section, the following definitions apply:

(ii) The term "urban area" means—

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

(k) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (j) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

2. Section 412.63 is amended by revising paragraph (b)(3) and by adding new paragraphs (b)(4) and (b)(5); revising paragraph (c)(4) and adding a new paragraph (c)(6); revising paragraphs (f) and (g); redesignating paragraphs (h), (i), and (j) as paragraphs (i), (j), and (k), respectively; adding a new paragraph (h); revising the introductory texts of newly redesignated

paragraphs (j) and (j)(1) and paragraph (j)(1)(i); and revising newly redesignated paragraph (k) to read as follows:

§ 412.64 Federal rates for fiscal years after Federal fiscal year 1984.

(b) *Geographic classifications.* * * *

(3) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs or NECMAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs or NECMAs. These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the *Federal Register* on January 3, 1980 (45 FR 956), and available from HCFA, East High Rise Building, Room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.

(4) For purposes of this section, any change in an MSA of NECMA designation is recognized on the October 1 following the effective date of the change.

(5) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs.

(c) *Updating previous standardized amounts.* * * *

(4) For fiscal year 1987 through 1990 HCFA standardizes the average standardized amounts by excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(6) For fiscal year 1988 and thereafter, HCFA computes average standardized amounts for hospitals located in large urban areas, other urban areas, and rural areas. The term "large urban area" means an MSA with a population of more than 1,000,000 or an NECMA, with a population of more than 970,000 based on the most recent available population data published by the Bureau of the Census.

(f) *Applicable percentage change for fiscal year 1988.* (1) The applicable percentage change for fiscal year 1988 is—

(i) For discharges occurring on or after October 1, 1987 and before November 21, 1987, zero percent;

(ii) For discharges occurring on or after November 21, 1987 and before April 1, 1988, 2.7 percent; and

(iii) For discharges occurring on or after April 1, 1988 and before October 1, 1988—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1988 (for Federal fiscal year 1989), the applicable percentage change for fiscal year 1988 is deemed to have been—

(i) 3.0 percent for hospitals located in rural areas;

(ii) 1.5 percent for hospitals located in large urban areas; and

(iii) 1.0 percent for hospitals located in other urban areas.

(g) *Applicable percentage change for fiscal year 1989.* The applicable percentage change for fiscal year 1989 is the percentage increase in the market basket index (as described in § 413.40(c)(3)(ii))—

(1) Minus 1.5 percentage points for hospitals located in rural areas;

(2) Minus 2.0 percentage points for hospitals in large urban areas; and

(3) Minus 2.5 percentage points for hospitals in other urban areas.

(h) *Applicable percentage change for fiscal year 1990 and following.* The applicable percentage change for FY 1990 and each subsequent fiscal year for hospitals in all areas is the percentage increase in the market basket index (as described in § 413.40(c)(3)(ii)).

* * *

(j) *Computing Federal rates for large urban, other urban, and rural hospitals.* For each discharge classified within a DRG, HCFA establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate, for each region, as follows:

(1) For hospitals located in a large urban or other urban area in the United States or that region respectively, the rate equals the product of—

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

* * *

(k) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Federal rates computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average hospital wage level.

D. Subpart E is amended as follows:

Subpart E—Determination of Transition Period Payment Rates

1. Section § 412.70 is amended by revising paragraph (c)(5), adding a new paragraph (c)(6), revising paragraph (d)(4), and adding a new paragraph (d)(5) to read as follows:

§ 412.70 General description.

* * *

(c) *Amount of blended portions.*

* * *

(5) The appropriate Federal prospective payment rate is a combined regional and national rate and changes with the Federal fiscal year. For Federal fiscal year 1984, which begins October 1, 1983, the Federal prospective payment rate is 100 percent regional. For Federal fiscal years 1985 and 1986, which begin October 1, 1984 and October 1, 1985, respectively, the combined rate is 75 percent regional and 25 percent national. For Federal fiscal year 1987, which begins October 1, 1986, the combined rate is 50 percent regional and 50 percent national. Effective with Federal fiscal year 1988, which begins October 1, 1987, the Federal prospective payment rate is 100 percent national except as provided in paragraph (c)(6) of this section.

(6) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

* * *

(d) *Blended portions for new hospitals.*

* * *

(4) For discharges occurring on or after October 1, 1987, the prospective payment rate equals the appropriate Federal national rate except as provided in paragraph (d)(5) of this section.

(5) For discharges occurring on or after April 1, 1988 and before October 1, 1990, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

2. Section 412.73 is amended by revising paragraph (c)(5) and adding a new paragraph (c)(6) to read as follows:

412.73 Determination of the hospital specific rate

* * *

(c) *Updating base-year costs*

* * *

(5) *For Federal fiscal year 1988.* (i) For purposes of determining the prospective payment rates for sole community hospitals under § 412.92(d) for cost reporting periods beginning in Federal fiscal year 1988 (that is, on or after October 1, 1987 and before October 1, 1988), the base-year cost per discharge is undated as follows:

(A) for the first 51 days of the hospital's cost reporting period, by zero percent.

(B) for the next 132 days of the hospital's cost reporting period, by 2.7 percent.

(C) for the remainder of the hospital's cost reporting period, by—

(1) 3.0 percent for hospitals located in rural areas;

(2) 1.5 percent for hospitals located in large urban areas; and

(3) 1.0 percent for hospitals located in other urban areas.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1989 (that is, beginning on or after October 1, 1988 and before October 1, 1989), the update factor for the cost reporting period beginning during Federal fiscal year 1988 is deemed to have been—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(6) *For Federal fiscal years 1989 and following.* For Federal fiscal years 1989 and following, the update factor is determined using the methodology set forth in § 412.63(g) and (h).

* * *

E. Subpart F is amended as follows:

Subpart F—Payment for Outlier Cases

1. Section § 412.80 is amended by revising the introductory text of

paragraph (a)(1) and paragraphs (a)(1)(ii) and (a)(2) to read as follows:

§ 412.80 General provisions.

(a) *Basic rule.* (1) Except as provided in paragraph (a)(2) of this section concerning transferring hospitals, HCFA provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by HCFA, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the following conditions is met:

(ii) the beneficiary's length of stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a cost-to-charge ratio as described in § 412.84(h), exceed the greater of the following:

(2) *Outlier cases in transferring hospitals.* HCFA provides cost outlier payments to a transferring hospital that does not receive payment under § 412.2(b) for discharges specified in § 412.4(d)(2), if the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a cost-to-charge ratio as described in § 412.84(h), exceed the greater of the criteria specified in paragraph (a)(1)(ii) of this section.

2. In § 412.82, paragraph (c) is revised; paragraph (d) is redesignated as paragraph (e); and a new paragraph (d) is added to read as follows:

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

(c) Except as provided in paragraph (d) of this section or § 412.86, the per diem payment made under paragraph (a) of this section is derived by first taking 60 percent of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate determined under Subpart D of this part by the mean length-of-stay for that DRG. The resulting amount is then multiplied by the applicable Federal portion of the blend as follows:

Cost reporting periods beginning on or after	Federal portion (percent)
October 1, 1983.....	25
October 1, 1984.....	50
October 1, 1985.....	50
The first seven months of the cost reporting period.....	50
The remaining five months of the cost reporting period.....	55

Cost reporting periods beginning on or after	Federal portion (percent)
October 1, 1986.....	75
October 1, 1987.....	100

(d) For discharges occurring on or after April 1, 1988 and before October 1, 1989, the per diem payment made under paragraph (a) of this section for the DRGs related to burn cases, which are identified in the most recent annual notice of prospective payment rates published in accordance with § 412.8(b), is derived under the provisions of paragraph (c) of this section except that the calculation is made using 90 percent of the average per diem payment of the applicable DRG.

3. In § 412.84, paragraphs (a) and (g) are revised; paragraphs (h) and (i) are redesignated as paragraphs (i) and (j), respectively; a new paragraph (h) is added; newly redesignated paragraph (j) is revised; and a new paragraph (k) is added to read as follows:

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

(a) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with § 412.80(a)(1)(ii).

(g) The intermediary bases the cost of the discharge on the billed charges for covered inpatient services adjusted by a cost-to-charge ratio as described in paragraph (h) of this section. The cost is adjusted further to exclude an estimate of indirect medical education costs, and payments for hospitals that serve a disproportionate share of low-income patients, and to include the reasonable charges for nonphysician services billed by an outside supplier in accordance with § 489.23(c)(3) of this chapter.

(h) The cost-to-charge ratio used to adjust covered charges is computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters. HCFA sets forth these parameters and the Statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under § 412.8(b).

(j) Except as provided in paragraph (k) of this section, the additional amount is

derived by first taking 75 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)(1)(ii). The resulting amount will then be multiplied by the applicable Federal portion of the blend as indicated in § 412.82(c).

(k) For discharges occurring on or after April 1, 1988 and before October 1, 1989, the additional payment amount for the DRGs related to burn cases, which are identified in the most recent annual notice of prospective payment rates published in accordance with § 412.8(b), is computed under the provisions of paragraph (i) of this section except that the payment is made using 90 percent of the difference between the hospital's adjusted cost for the discharge and the threshold criteria.

4. A new § 412.86 is added to read as follows:

§ 412.86 Payment for extraordinarily high-cost day outliers.

If a discharge that qualifies for an additional payment under the provisions of § 412.82 has charges adjusted to costs that exceed the cost outlier threshold criteria for an extraordinarily high-cost case as set forth in § 412.80(a)(1)(ii), the additional payment made for the discharge is the greater of—

(a) The applicable per diem payment computed under § 412.82 (c) or (d); or

(b) The payment that would be made under § 412.84 (i) or (j) if the case had not met the day outlier criteria threshold set forth in § 412.80(a)(1)(i).

F. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

§ 412.90 [Amended]

1. In § 412.90(h), the phrase "October 1, 1988" is revised to read "October 1, 1990".

2. In § 412.92, the introductory texts of paragraphs (a) and (a)(2) are republished and paragraph (a)(2)(i) is revised; paragraphs (b)(1)(ii) and (b)(1)(iii) are redesignated as paragraphs (b)(1)(iv) and (b)(1)(v), respectively; new paragraphs (b)(1)(ii) and (b)(1)(iii) are added; paragraphs (b)(2), (b)(3), and (b)(4) are redesignated as paragraphs (b)(3), (b)(4), and (b)(5) respectively; new paragraph (b)(2) is added; newly redesignated paragraph (b)(4) is [amended] by redesignating paragraph (b)(4)(ii) as paragraph (b)(4)(iii), and adding a new paragraph (b)(4)(ii); the introductory text of paragraph (c) is republished, paragraph (c)(1) is revised, and a new paragraph (c)(3) is added;

paragraph (d)(2) is revised; the title of paragraph (e) and paragraph (e)(1) are revised; the introductory texts of paragraphs (e)(2) and (e)(3) are revised; paragraphs (e)(3)(i), (e)(3)(ii), and (e)(3)(iii) are redesignated as paragraphs (e)(3)(i)(A), (e)(3)(i)(B), and (e)(3)(i)(C), respectively; new introductory text for paragraph (e)(3)(i) and paragraphs (e)(3)(ii) and (e)(3)(iii) are added; paragraph (f) is redesignated as paragraph (g); a new paragraph (f) is added; and newly redesignated paragraph (g)(1) is revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

(a) *Criteria for classification as a sole community hospital.* HCFA classifies a hospital as a sole community hospital if it is located in a rural area (as defined in § 412.62(f)), and meets one of the following conditions:

(2) The hospital is located between 25 and 50 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 50-mile radius of the hospital, or, if larger, within its service area;

(b) *Classification procedures—(1) Request for classification as a sole community hospital.* * * *

(ii) If a hospital is seeking sole community hospital classification under paragraph (a)(2)(i) or (a)(2)(ii) of this section, the hospital must include the following information with its request:

(A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.

(B) The hospital must provide patient origin data from all other hospitals located within a 50 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.

(iii) (A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 50 mile radius of the hospital or, if larger, within

the hospital's service area, the hospital may request that HCFA provide this information.

(B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the intermediary and HCFA in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.

(2) *Effective dates of classification.*

(i) Sole community hospital status is effective 30 days after the date of HCFA's written notification of approval to the provider.

(ii) When a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses an HCFA denial of sole community hospital status and no further appeal is made, the sole community hospital status is effective as follows:

(A) If the hospital's application was submitted prior to October 1, 1983, its status as a sole community hospital is effective at the start of the cost reporting period for which it sought exemption from the cost limits.

(B) If the hospital's application for sole community hospital status was filed on or after October 1, 1983, the effective date is 30 days after the date of HCFA's original written notification of denial.

(iii) When a hospital is granted retroactive approval of sole community hospital status by a court order or a PRRB decision and the hospital wishes its sole community hospital status terminated before the date of the court order or PRRB determination, it must submit written notice to the HCFA regional office within 90 days of the court order or PRRB decision. A written request received after the 90-day period is effective no later than 30 days after the request is submitted.

(iv) A hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of HCFA's approval of the classification.

(4) *Cancellation of classification.*

(ii) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(c) *Terminology.* As used in this section—

(1) The term "miles" means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road which is maintained by a local, State, or Federal government entity and which is available for use by the general public.

(3) The term "service area" means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital.

(d) *Determining prospective payment rates for sole community hospitals.*

(2) *Adjustments to payments.* A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in number of discharges or a significant increase in inpatient operating costs, as described in paragraphs (e) and (g) of this section respectively.

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease.* (1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1990, HCFA provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement—

(3) HCFA determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates (including outlier payments determined under Subpart F of this part

and additional payments made for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.118).

(i) In determining the adjustment amount, HCFA considers—

(ii) HCFA makes its determination within 180 days from the date HCFA receives from the intermediary the hospital's request and all other necessary information.

(iii) The HCFA determination is subject to review under Subpart R of Part 405 of this chapter.

(f) *Additional payments to other hospitals experiencing a significant volume decrease.* (1) For cost reporting periods beginning on or after October 1, 1987 and before October 1, 1990, HCFA provides for a payment adjustment for a hospital that qualifies as a sole community hospital but is not receiving payment as a sole community hospital under paragraph (d) of this section for any cost reporting period during which the hospital experiences, due to circumstances beyond its hospital's control, a decrease of more than five percent in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply that figure by 12 to estimate the total number of discharges for a 12-month cost reporting period. The payment adjustment is determined under the provisions of paragraph (e)(3) of this section.

(2) To qualify for a payment adjustment under paragraph (f)(1) of this section, a hospital must complete the following:

(i) No later than 180 days from the date of the intermediary's Notice of Amount of Program Reimbursement, the hospital must submit to the HCFA regional office a request for sole community hospital status for the purpose of the payment adjustment only furnishing the documentation as may be necessary to demonstrate that the hospital meets the criteria in paragraph (a) of this section.

(ii) Within 180 days from the date on the notice from the regional office indicating that sole community hospital status has been granted for purposes of the payment adjustment only, the hospital submits to the intermediary documentation demonstrating the size of

the decrease in discharges and the resulting effect on per discharge costs and shows that the decrease is due to circumstances beyond the hospital's control.

(g) *Payment adjustment for new inpatient facilities or services—(1) General rule.* If a sole community hospital experiences a significant increase in inpatient operating costs resulting from new inpatient services or facilities that were not available in the hospital during its base period and that are necessary for patient care, HCFA may adjust payments made to the hospital to ensure that it is receiving reasonable compensation, as defined in paragraph (g)(2) of this section, for the operating costs of the new inpatient facilities or services (including special care units).

3. In § 412.96, introductory text is added to paragraph (b), paragraphs (b)(1) and (d) are revised, and paragraph (e) is removed and reserved to read as follows:

§ 412.96 Special treatment: Referral centers.

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.* The hospital meets either of the following criteria:

(1) The hospital is located in a rural area (as defined in § 412.63(b)) and has the following number of beds, as determined under the provisions of § 412.118(b), available for use:

(i) Effective for discharges occurring before April 1, 1988, the hospital has 500 or more beds.

(ii) Effective for discharges occurring on or after April 1, 1988, the hospital has 25 or more beds during its most recently completed cost reporting period unless the hospital submits written documentation with its application that its bed count has changed since the close of its most recently completed cost reporting period for one or more of the following reasons:

(A) Merger of two or more hospitals.

(B) Reopening of acute care beds previously closed for renovation.

(C) Transfer to the prospective payment system of acute care beds previously classified as part of an excluded unit.

(D) Expansion of acute care beds available for use and permanently maintained for lodging inpatients, excluding beds in corridors and other temporary beds.

(d) *Payment to rural referral centers.* Effective for discharges occurring on or

after April 1, 1988, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments per discharge based on the applicable other urban payment rates as determined in accordance with § 412.63, as adjusted by the hospital's area wage index.

(e) [Reserved]

4. In § 412.106, the introductory text of paragraph (a)(1) is republished; paragraph (a)(1)(i) is revised; the introductory text of paragraph (a)(2) is revised; a new paragraph (a)(5) is added; and the introductory text of paragraph (b)(1), and paragraphs (b)(1)(ii), (b)(2), and (c) are revised to read as follows:

§ 412.106 Special treatment: Hospitals that serve as a disproportionate share of low-income patients.

(a) *Basic rule.* (1) Unless a hospital elects the option concerning the period of time used for counting the number of patient days (that is, the hospital's cost reporting period rather than the Federal fiscal year), as described in paragraph (a)(2) of this section, a hospital's disproportionate patient percentage is the sum of the following, expressed as a percentage:

(i) Number of covered patient days associated with discharges occurring during each month of the Federal fiscal year in which the hospital's cost reporting period begins of those patients who are entitled during that month to both Medicare Part A and Supplemental Security Income benefits under title XVI of the Act (excluding those patients receiving State supplementation only), summed for the months of the Federal fiscal year, and divided by the number of patient days associated with discharges occurring during that same Federal fiscal year of those patients entitled to Medicare Part A.

(2) For purposes of making the calculation in paragraph (a)(1)(i) of this section, a hospital may elect to have the count of the number of patient days made on the basis of covered patient days associated with discharges occurring during each month of its cost reporting period, rather than by Federal fiscal year, if the hospital furnishes to its intermediary, in machine-readable tape format as prescribed by HCFA, data on its Medicare Part A patients for its cost reporting period.

(5) For purposes of making the calculation in paragraph (a)(1) of this section, patient days are determined by counting those days attributable only to

areas of the hospital subject to the prospective payment system. Patient days attributable to areas or units of the hospital excluded from the prospective payment system are not included in the count of patient days.

(b) *Criteria for classification*—(1) *General rule.* For discharges occurring on or after May 1, 1986 and before October 1, 1990, a payment adjustment (as described in paragraph (c) of this section) is made for each hospital that meets one of the following criteria:

(ii) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for indigent care furnished to patients who are not covered by Medicare or Medicaid.

(2) *Special rule for certain rural hospitals.* For discharges occurring on or after October 1, 1986 and before October 1, 1990, a payment adjustment (as described in paragraph (c) of this section) is made for each hospital that, during its cost reporting period, has a disproportionate patient percentage that is at least equal to 15 percent, if the hospital is located in a rural area and has 500 or more beds.

(c) *Payment adjustment.* For discharges occurring on or after October 1, 1988, if a hospital meets one of the criteria in paragraph (b) of this section, the hospital's total DRG revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under Subpart F of this part but excluding additional payments made under the provisions of this subpart or § 412.118, is increased by the disproportionate share payment adjustment factor, determined as follows:

(1) If the hospital meets the criteria of paragraph (b)(1)(i)(A) of (b)(2) of this section, the disproportionate share payment adjustment factor is 2.5 percent plus one-half the difference between the hospital's disproportionate patient percentage and 15 percent.

(2) If the hospital meets the criteria of paragraph (b)(1)(i)(B) of this section, the disproportionate share payment adjustment factor is five percent.

(3) If the hospital meets the criteria of paragraph (b)(1)(i)(C) of this section, the disproportionate share payment adjustment factor is four percent.

(4) If the hospital meets the criteria of paragraph (b)(1)(ii) of this section, the

disproportionate share payment adjustment factor is 25 percent.

G. Subpart H is amended as follows:

Subpart H—Payments to Hospitals Under the Prospective Payment System

1. In § 412.113, paragraphs (a)(1) and (b) are revised to read as follows:

§ 412.113 Payments determined on a reasonable cost basis.

(a) *Capital related costs.* (1) *Payment.* Subject to the reductions described in paragraph (a)(2) of this section, payment for capital-related costs (as described in § 413.130 of this chapter) is determined on a reasonable cost basis.

(b) *Direct medical education costs.* Payment for the cost of approved medical educational activities as defined in § 413.85 of this chapter is made on a reasonable cost basis (except with respect to activities defined in § 413.85(d) of this chapter). For cost reporting periods beginning on or after July 1, 1985, but before July 1, 1986, payment for these reasonable costs is limited as described in § 413.85(a) of this chapter.

2. In § 412.116, paragraph (a) is revised; paragraph (d) is removed; paragraphs (e) and (f) are redesignated as paragraphs (d) and (e), respectively; and newly redesignated paragraph (d) is revised to read as follows:

§ 412.116 Method of payment.

(a) *General rule.* Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made as described in § 413.64 (a), (c), (d), and (e) of this chapter.

(d) *Outlier payments.* Payments for outlier cases (described in Subpart F of this part) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

3. In § 412.118, the title and paragraph (c) are revised; the text of paragraph (d)(1) is removed and paragraph (d)(2) is redesignated as paragraph (d)(1); newly redesignated paragraph (d)(1) is amended by revising the introductory text and paragraphs (d)(1)(i) and (d)(1)(iii); and a new paragraph (d)(2) is added to read as follows:

§ 412.118 Determination of indirect medical education adjustment.

(c) *Measurement for teaching activity.* The factor representing the effect of teaching activity on inpatient operating costs is equal to the following:

(1) For discharges occurring on or after May 1, 1988 and before October 1, 1990, the factor equals .405.

(2) For discharges occurring on or after October 1, 1990, the factor equals .5795.

(d) *Determination of education adjustment factor.* (1) For discharges occurring on or after October 1, 1988 and before October 1, 1990, each hospital's education adjustment factor is calculated as follows:

(i) *Step one*—A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent interns and residents to beds, as determined under paragraph (a)(1) of this section, is raised to an exponential power equal to the factor set forth in paragraph (c)(1) of this section.

(iii) *Step three*—The factor derived from completing steps one and two is multiplied by 1.89.

(2) For discharges, occurring on or after October 1, 1990, each hospital's education adjustment factor is calculated as follows:

(i) *Step one*—A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent interns and residents to beds, as determined under paragraph (a)(1) of this section, is raised to an exponential power equal to the factor set forth in paragraph (c)(2) of this section.

(ii) *Step two*—The factor derived from step one is reduced by 1.00.

(iii) *Step three*—The factor derived from completing steps one and two is multiplied by 1.43.

H. Subpart K is amended as follows:

Subpart K—Prospective Payment System for Hospitals Located in Puerto Rico

1. In § 412.208, the introductory text of paragraph (f)(1) is republished; paragraph (f)(1)(ii) is redesignated as paragraph (f)(1)(iii); a new paragraph (f)(1)(ii) is added; and paragraph (i) is revised to read as follows:

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(f) *Geographic classification.* (1) For purposes of this paragraph (e) of this section, the following definitions apply:

(ii) The term "large urban area" means an MSA with a population of more than 1,000,000.

(i) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Puerto Rico rates computed under paragraph (h) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels, by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

2. In § 412.210, paragraphs (a)(2)(b), the introductory text of paragraph (c), paragraph (c)(1), the introductory texts of paragraphs (d) and (d)(1), paragraph (d)(1)(i), and paragraph (e) are revised to read as follows:

§ 412.210 Puerto Rico rates for fiscal years after fiscal year 1988.

(a) *General rule.* * * *

(2) The rate is determined for hospitals located in large urban, other urban, or rural areas within Puerto Rico, as described in paragraphs (b) through (e) of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.208(f)(1) apply.

(2) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greatest number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs.

These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the Federal Register on January 3, 1980 (45 FR 956), and available from HCFA, East High Rise Building, Room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.

(3) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment

rate is based on the geographic location of the hospital at which the discharge occurs.

(c) *Updating previous standardized amounts.* HCFA computes separate average standardized amounts for hospitals in large urban, other urban, and rural areas within Puerto Rico equal to the respective average standardized amount computed for fiscal year 1988 under § 412.208(e)—

(1) Increased by the applicable percentage changes determined under § 412.63 (g) and (h); and

(d) *Computing Puerto Rico rates for large urban, other urban, and rural hospitals.* For each discharge classified within a DRG, HCFA establishes for the fiscal year a Puerto Rico prospective payment rate as follows:

(1) For hospitals located in a large urban or other urban area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large urban or other urban area; and

(e) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Puerto Rico rates computed under paragraph (d) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average hospital wage level.

§ 412.212 [Amended]

3. In § 412.212, the reference to "§ 412.63(i)(1)(i)" in paragraph (b)(1) is revised to read "412.63(j)(1)(i)" and the reference to "§ 412.63(i)(2)(i)" in paragraph (b)(2) is revised to read "§ 412.63(j)(2)(i)".

III. Part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a-1, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, and 1395ww).

B. In § 413.30, paragraph (c) is revised to read as follows:

§ 413.30 Limitations on reimbursable costs.

(c) *Provider requests regarding applicability of cost limits.* A provider may request a reclassification, exception, or exemption from the cost limits imposed under this section. In addition a hospital may request an adjustment to the cost limits imposed under this section. The provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the provider of HCFA's decision. The time required for HCFA to review the request is considered good cause for the granting of an extension of the time limit to apply for a Board review, as specified in § 405.1841 of this chapter. HCFA's decision is subject to review under Subpart R of Part 405 of this chapter.

C. In § 413.40, paragraphs (a)(2), (b)(1), and (b)(2) are revised; the introductory text of paragraph (c)(3)(i) is republished; paragraphs (c)(3)(i)(C), (c)(3)(i)(D), (e), (f)(1), (g)(1), and (h)(1)(iii) are revised; and a new paragraph (i) is added to read as follows:

§ 413.40 Ceiling on rate of hospital cost increases.

(a) *Introduction.* * * *

(2) *Applicability.* (i) This section is not applicable to—

(A) Hospitals reimbursed in accordance with section 1814(b)(3) of the Act or under State reimbursement control systems that have been approved under section 1886(c) of the Act and Subpart C of Part 403 of this chapter; or

(B) Hospitals that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(d) of the Act and Part 412 of this chapter.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section is applicable to hospitals excluded from the prospective payment system in accordance with § 412.23 of this chapter, subprovider psychiatric and rehabilitation units (distinct parts) excluded from the prospective payment system in accordance with §§ 412.25 through 412.32 of this chapter, and those hospitals eligible for special treatment under the prospective payment system

as described in § 412.94(b) of this chapter.

(b) *Cost reporting periods subject to the rate of increase ceiling*—(1) *Base period.* Each hospital's ceiling is based on allowable inpatient operating costs per case incurred in the 12-month cost reporting period immediately preceding the first cost reporting period subject to ceilings established under this section, except that, when the immediately preceding cost reporting period is a short reporting period (fewer than 12 months) the first 12-month period subsequent to that short period is the base period. The ceiling established under this procedure remains applicable for a hospital or excluded distinct part hospital unit, as described in §§ 412.25 through 412.32 of this chapter, in spite of intervening cost reporting periods during which the hospital or excluded distinct part hospital unit is not subject to the target amount as a result of other provisions of the law or regulations, or nonparticipation in the Medicare program, unless the hospital or excluded distinct part hospital unit qualifies as a new hospital or excluded distinct part hospital unit under paragraph (f) of this section.

(2) *Periods subject to the ceiling.* Ceilings established under this section are applied to all cost reporting periods that—

(i) Begin on or after October 1, 1982; and

(ii) Immediately follow the base period established under paragraph (b)(1) of this section unless the exception in paragraph (b)(3) of this section is applicable.

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

(3) *Target rate percentage.* * * *

(i) The applicable target rate percentage is determined as follows:

(C) *Federal fiscal year 1988.* The applicable target rate percentage for cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988 is 2.3238 percent. For purposes of updating the target rates for cost reporting periods beginning on or after October 1, 1988, the target rate percentage for cost reporting periods beginning during FY 1988 is deemed to have been 2.7 percent.

(D) *Federal fiscal year 1989 and following:* The applicable target rate percentage for cost reporting periods beginning during FY 1989 and in all fiscal years thereafter is the percentage increase in the hospital market basket

(as described in paragraph (c)(3)(ii) of this section).

(e) *Hospital requests regarding applicability of the rate of increase ceiling.* A hospital may request an exemption from, or exception or adjustment to, the rate of cost increase ceiling imposed under this section. The hospital's request must be made to its fiscal intermediary no later than 180 days from the date on the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the hospital's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the hospital of HCFA's decision. The time required for HCFA to review the request is considered good cause for the granting of an extension of the time limit to apply for review by the Provider Reimbursement Review Board, as specified in § 405.1841(b) of this chapter. HCFA's decision is subject to review under Subpart R of Part 405 of this chapter.

(f) *Exemptions*—(1)(i) *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. The first cost reporting period beginning at least two years after the hospital accepts its first patient is the base period in accordance with paragraph (b) of this section.

(ii) A newly-established distinct part unit that is excluded from the prospective payment system under the provisions of §§ 412.25 through 412.32 of this chapter does not qualify for the exemption afforded to a new hospital under paragraph (f)(1)(i) of this section unless the distinct part unit is located in a hospital that, if it were subject to the provisions of this section, would qualify as a new hospital under paragraph (f)(1)(i) of this section. The first 12-month cost reporting period under which a newly-established excluded distinct part unit exists is the base period used to establish a target amount.

(g) *Exceptions*—(1) *General procedure.* HCFA may adjust a hospital's operating costs (as described in paragraph (b)(1) of this section) upward or downward, as appropriate, under circumstances as specified in paragraphs (g)(2) and (3) of this section. HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary. HCFA may grant an exception only if a hospital's operating costs exceed the rate of increase ceiling imposed under this section.

(h) *Adjustments.* * * *

(1) *Capability of cost reporting periods.* * * *

(iii) HCFA may adjust the amount of operating costs, under paragraph (c)(1) of this section, to take into account factors such as a change in the inpatient hospital services that a hospital provides, that are customarily provided directly by similar hospitals, or the manipulation of discharges to increase reimbursement. A change in the inpatient hospital services provided could result from changes that include, but are not limited to, opening or closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department. HCFA may grant an adjustment only if a hospital's operating costs exceed the rate of increase ceiling imposed under this section.

(i) *Target amount revisions for Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360)* (1) *General rule.* For cost reporting periods beginning on or after October 1, 1988, HCFA may adjust a hospital's target amount to take into account any distortion in operating costs between the hospital's base period and the period subject to the rate of increase ceiling due to the elimination of Part A inpatient hospital benefit limitations under section 101 of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360).

(2) *Request for adjustment.* A hospital must request an adjustment no later than 180 days after the close of its first cost reporting period beginning on or after October 1, 1988. A request for adjustment must include the following:

(i) A statement from the hospital specifying that adjustment is to be based on its historical experience in—

(A) Its base period; or

(B) Its last cost reporting period beginning before October 1, 1988. (If this

period is not at least 12 months in duration, multiple consecutive cost reporting periods comprising at least 12 months must be used.)

(ii) The hospital's cost report or reports for the period selected by the hospital under paragraph (i)(2)(i) of this section to serve as the basis for the adjustment.

(iii) Billing data for the cost reporting period selected under paragraph (i)(2)(i) of this section as the basis for the adjustment documenting the following:

(A) The number of hospital inpatient days furnished to Medicare beneficiaries for which no payment was made because the beneficiary had exhausted Medicare Part A hospital benefits during an inpatient hospital stay. (Excluded from the count are days for stays that were not covered in their entirety.)

(B) The ancillary charges for services furnished on the days counted in paragraph (i)(2)(iii)(A) of this section.

(3) *Amount of adjustment.* The adjustment is based on the estimated incremental costs of care historically furnished to Medicare beneficiaries after they had exhausted their benefits during an inpatient hospital stay.

IV. Part 489 is amended as follows:

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

A. The authority citation for Part 489 is revised to read as follows:

Authority: Secs. 1102, 1861, 1864(m), 1866, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa(m), 1395cc, and 1395hh).

§ 489.23 [Removed]

B. Subpart B is amended by removing § 489.23.

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

Dated: September 23, 1988.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: September 27, 1988.

Otis R. Bowen,

Secretary.

(Note: The following addendum and appendixes will not appear in the Code of Federal Regulations.)

Addendum—Schedule of Standardized Amounts Effective With Discharges on or After October 1, 1988, and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 1988

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 including those services furnished in Puerto Rico. We are also setting forth the new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals and hospital units excluded from the prospective payment system.

For hospital cost reporting periods beginning on or after October 1, 1988, except for sole community hospitals and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will be comprised of 100 percent of the Federal rate. Except for hospitals affected by the regional floor, the Federal portion of a hospital's prospective payment rate is based on 100 percent of the national rate.

Sole community hospitals are 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 (section 1886(d)(5)(C)(ii) of the Act). Hospitals in Puerto Rico are paid on the basis of a rate per discharge composed of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act). Hospitals affected by the regional floor are paid on the basis of 85 percent of the Federal national rate and 15 percent of the Federal regional rate.

As discussed below in section II, we are making changes in the determination of the prospective payment rates. The changes, to be applied prospectively, will affect the calculation of the Federal rates. Section III sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the final rule are presented at the end of this addendum in section IV.

II. Changes to Prospective Payment Rates For Hospitals for FY 1989

The basic methodology for determining prospective payment rates is set forth at § 412.63, except for hospitals located in Puerto Rico. The basic methodology for determining the prospective payment rates for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below we discuss the manner in which we are changing some of the factors or methodology used for determining the prospective payment rates. The Federal and Puerto Rico rate changes will be effective with discharges occurring on or after October 1, 1988. As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and

weighting factors for discharges in FY 1989.

In summary, the standardized amounts set forth in Tables 1a, 1b, and 1c of section IV of this addendum were:

- Restandardized to reflect the revision to the indirect medical education and disproportionate share hospital adjustment factors.
- Except for the amounts in Table 1c, adjusted to generate and preserve program savings from the reduction in indirect medical education payments.
- Adjusted to ensure budget neutrality as provided in section 4005(a)(1)(C) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203).
- Adjusted by the revised urban and rural outlier offsets
- Updated by—
 - The market basket percentage increase minus 1.5 percentage points for hospitals located in rural areas;
 - The market basket percentage increase minus 2.0 percentage points for hospitals in large urban areas; and
 - The market basket percentage increase minus 2.5 percentage points for hospitals in urban areas other than large urban areas.

A. Calculation of Adjusted Standardized Amounts

1. Standardization and Restandardization of Base-Year Costs or Target Amounts

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

Section 1886(d)(9)(B)(i) of the Act required that Medicare target amounts be determined for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs or, for Puerto Rico, adjusted target amounts, from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections

1886(d)(2)(C) and 1886(d)(9)(B)(ii) of the Act required that the updated base-year per discharge costs and, for Puerto Rico, the updated target amounts, respectively, be standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients. Restandardization for the revised indirect medical education and disproportionate share hospital adjustment factors is performed at the individual hospital level because the original adjustments are performed on a hospital-specific basis and it is those adjustments that must be replaced.

Since all adjustments for variation in hospital operating costs or target amounts except those for the indirect medical education and disproportionate share hospitals had already been

accounted for consistent with the construction of the standardized amounts, no revision was made at the hospital level for those factors. That is, the adjustments for differences in case mix, wages, and cost-of-living reflected in the FY 1989 standardized amounts are identical to those reflected in the FY 1988 standardized amounts. Therefore, the discussion below is limited to the changes in standardization for indirect medical education and disproportionate share hospitals necessitated by the provisions of section 4003 of Pub. L. 100-203.

a. Indirect Medical Education Costs. Section 1886(d)(2)(C)(i) of the Act requires that the updated FY 1984 amounts be standardized for indirect medical education costs. Section 1886(d)(9)(B)(ii)(I) is the parallel requirement for development of the Puerto Rico rates from updated FY 1987 target amounts. Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional

payment for the indirect costs of medical education.

Section 4003(a) of Pub. L. 100-203 revised section 1886(d)(5)(B)(ii) of the Act to reduce the indirect medical education adjustment factor used to determine the indirect medical education payment from approximately 8.1 percent to approximately 7.7 percent for discharges occurring on or after October 1, 1988 and before October 1, 1990. (These factors are approximations because the adjustment factor is applied on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship, that is, each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in costs.) For discharges occurring on or after October 1, 1988 and before October 1, 1990, the indirect medical education factor equals the following:

$$1.89 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}} \right)^{.405} - 1 \right]$$

Section 1895(b)(1)(B) of the Tax Reform Act of 1986 (Pub. L. 99-514), enacted October 22, 1986, provides that "If the formula under paragraph (5)(B) [of section 1886(d) of the Act] for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula." Accordingly, since the indirect medical education adjustment factor has been changed by section 4003(a) of Pub. L. 100-203, the base-year costs and target amounts have been readjusted (restandardized) using the new formula.

The restandardization is accomplished by multiplying each affected hospital's base-year cost or target amount per discharge by 1.0 plus the hospital's indirect medical education adjustment factor computed using the formula in effect prior to the enactment of Pub. L. 100-203 and then dividing the product by 1.0 plus the hospital's revised indirect medical education adjustment factor computed using the formula required by section 1886(d)(5)(B)(ii) of the Act as amended by section 4003(a) of Pub. L. 100-203.

b. Costs for Hospitals that Serve a Disproportionate Share of Low-Income

Patients. Prior to enactment of Pub. L. 100-203, sections 1886(d)(2)(C)(iv) and 1886(d)(9)(B)(ii)(IV) of the Act provided that, effective with discharges occurring on or after October 1, 1986 and before October 1, 1989, the updated hospital costs and target amounts per case be standardized for the estimated additional payments made to hospitals that serve disproportionate shares of low-income patients. That is, the law requires us to remove the effects of the payments made to disproportionate share hospitals from the costs used to establish the standardized amounts.

Section 4003 (b) and (c) of Pub. L. 100-203 amended section 1886(d) of the Act to provide the following changes to the disproportionate share adjustment:

- The adjustment is extended to discharges occurring before October 1, 1990.
- For hospitals that qualify for a disproportionate share adjustment because they receive more than 30 percent of their net inpatient revenues from State and local government sources for the care of indigent patients, and adjustment is raised from 15 percent to 25 percent.
- For hospitals with 100 or more beds that are located in urban areas and for hospitals with 500 or more beds that are

located in rural areas, the 15 percent cap on the amount of the payment adjustment is eliminated.

In establishing the standardized amounts for FY 1987 and FY 1988, we adjusted each disproportionate share hospital's inpatient operating cost or target amount per discharge by adding 1.0 to the applicable disproportionate share payment factor and dividing the hospital's cost or target amount per discharge by that number. In this way, we removed the effect of payment adjustments for disproportionate share hospitals from the standardized amounts as required under section 1886(d)(2)(C)(iv) of the Act.

The changes to the disproportionate share adjustment will result in higher adjustment factors than were taken into account in standardizing the costs used to establish the standardized amounts. Thus, it is now necessary to restandardize the base-year costs and target amounts to remove the effects of disproportionate share payments computed in accordance with the revised formula. In order to accomplish the restandardization, we first multiplied each affected hospital's base-year cost or target amount per discharge by 1.0 plus the applicable disproportionate share payment factor

computed under the law as in effect prior to enactment of Pub. L. 100-203 and used to standardize the costs for FY 1988. This eliminated the effects of prior standardization for disproportionate share payments. We then divided the product of this calculation by the disproportionate share payment adjustment factor computed using the most recent data available to reflect the elimination of the 15 percent cap on disproportionate share adjustments and other changes required by section 4003(c) of Pub. L. 100-203.

2. Wage Index Values for Puerto Rico

As discussed in section IV of the preamble to this final rule, we are continuing to use the blended HCFA wage index which is based on 1982 and 1984 wage data. However, since the FY 1988 wage index values for areas in Puerto Rico were based solely on 1984 (and were not a blend of indexes based on 1982 and 1984 data), any changes in Puerto Rico wage index values are attributable only to the corrections we have made to the 1984 wage data based on our continuing analysis of the data, as discussed in section IV of the preamble to this final rule. Since the Puerto Rico standardized amounts are based on target amount data from relatively few hospitals, standardized by the Puerto Rico wage index values based on 1984 data, it is necessary to restandardize the target amount data to reflect changes in the wage values for Puerto Rico in order for the standardized amounts to be accurately adjusted for differences in area relative wage levels.

3. Computing Urban and Rural Averages Within Geographic Areas

In determining the prospective payment rates for FY 1984, section 1886(d)(2)(D) of the Act required that the average standardized amounts be determined for hospitals located in urban and rural areas of the nine census divisions and the nation, respectively. Under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge for FY 1988 must be determined for hospitals located in urban and rural areas in Puerto Rico.

For FY 1989, except for hospitals in Puerto Rico and those hospitals that are affected by the regional floor, the Federal rates will be comprised of 100 percent of the national rate (section 1886(d)(1)(A)(iii) of the Act). The Federal rate for hospitals affected by the regional floor is based on 85 percent of the national rate and 15 percent of the regional rate. Section 1886(d)(5)(C)(ii) of the Act specifies that a sole community hospital's Federal rate is based on 100 percent of the regional rate. Hospitals in

Puerto Rico are paid a blend of 75 percent of the applicable Puerto Rico standardized amount and 25 percent of a national standardized payment amount.

Table 1a contains the three national standardized amounts that are applicable to most hospitals. Table 1b sets forth the 27 regional standardized amounts that are applicable to sole community hospitals and to hospitals subject to the regional floor. Under section 1886(d)(9)(A)(ii) of the Act as amended by section 4002(c) of Pub. L. 100-203, effective October 1, 1987, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national rural standardized amount, the national large urban standardized amount and the national other urban standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is set forth in Table 1c. This table also includes the three Puerto Rico standardized amounts that would be applicable to most hospitals in Puerto Rico.

The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that we now apply separate update factors for the purposes of determining large urban and other urban rates.

We stated in the addendum to the proposed rule that the Executive Office of Management and Budget (EOMB) may announce revised listings of the Metropolitan Statistical Area (MSA) and New England County Metropolitan Area (NECMA) designations that are used in calculating the standardized amounts. We also stated that if EOMB makes the announcement before we issue the final rule, we would list the revised MSA/NECMA designations in the addendum to the final rule. We also stated that consistent with Medicare policy, as codified by this final rule, the changes in designation will be effective for discharges occurring on or after October 1, 1988.

Since publication of the proposed rule, EOMB has announced a new MSA, Decatur, AL, which comprises the counties of Morgan and Lawrence and has Decatur as its central city. This new MSA was created by Alabama Metropolitan Statistical Area Act (Pub. L. 100-258), enacted March 14, 1988. In addition, EOMB announced that the boundary of the St. Louis, MO-IL MSA has been changed to include the part of the City of Sullivan in Crawford County, MO. This boundary change was

required by section 530 of the Treasury, Postal Service and General Government Appropriations Act of 1988 (Pub. L. 100-202), enacted December 22, 1987.

4. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A) of the Act, as amended by section 4002(c) of Pub. L. 100-203, we are updating the large urban, other urban, and rural average standardized amounts using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act, as amended by section 4002(a) of Pub. L. 100-203. The percentage increase to be applied is mandated under that section of the law as the estimated percentage increase in the hospital market basket minus—

- 1.5 percentage points for hospitals located in rural areas;
- 2.0 percentage points for hospitals located in large urban areas; and
- 2.5 percentage points for hospitals located in other urban areas.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care.

When the proposed rule was published, the increase in the hospital market basket for FY 1989 was estimated at 4.8 percent. Therefore, the proposed applicable percentage increases were—

- 3.3 percent for hospitals located in rural areas;
- 2.8 percent for hospitals located in large urban areas; and
- 2.3 percent for hospitals in other urban areas.

The most recent forecast of the market basket increase for FY 1989 is 5.4 percent. Therefore, the percentage increases applicable for FY 1989 are—

- 3.9 percent for hospitals located in rural areas;
- 3.4 percent for hospitals located in large urban areas; and
- 2.9 percent for hospitals located in other urban areas.

In accordance with section 1886(b)(3)(B)(i) of the Act, we also proposed that the hospital-specific rate (which after the first 51 days of cost reporting periods beginning on or after October 1, 1987 applies only to sole community hospitals) be updated by the applicable percentage increase for hospitals located in a large urban, other urban, or rural area based on the location of the sole community hospital.

Although the update factors for FY 1989 are set by law, we were required by section 1886(e)(3)(B) of the Act to

report to Congress no later than March 1, 1988 on our initial recommendation of update factors for FY 1989 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have published this report as Appendix B of the proposed rule. Our final recommendation on the update factors (which is required by sections 1886(e)(4) and (e)(5)(A) of the Act) is set forth in Appendix B of this final rule.

Comment: We received a number of comments concerning the inadequacy of the updates to the standard payment amounts for FYs 1988 and 1989. Specifically, commenters stated that these increases are inadequate to keep pace with hospital inflation levels.

Response: The update factors applicable to the standard payment amounts for FY 1988 and FY 1989 were mandated by Congress under section 4002 of Pub. L. 100-203. Thus, the Secretary has no discretion in applying the update factors to the standard payment amounts other than in developing the hospital market basket inflation forecasts.

Comment: We received a few comments requesting clarification of how the standardized amounts that went into effect on April 1, 1988, were computed.

Response: The updates effective April 1, 1988 were applied to the standard payment rates in effect for the period September 1, 1987 through November 21, 1988, which had reflected a zero percent update. Because of the changes to the outlier payment methodology for burn cases, and the implementation of differential update factors effective April 1, 1988, it was also necessary to recompute the outlier offsets to the standard amount in order to reflect the resulting change in the distribution of outlier payments. We therefore removed the previous outlier offsets from the standard payment amounts and applied the revised outlier offsets. In addition, section 4003(d)(1)(B) of Pub. L. 100-203 required that total payments made under section 1886 of the Act after reflecting changes in outlier payments for cases in burn-related DRGs be neither greater nor less than total payments that would have been made in the absence of this provision. Therefore, it was necessary to apply a budget neutrality adjustment of .997697 to the standardized amounts.

Comments: We received a number of comments stating that our hospital market basket inflation projection was understated because of the way we measured increases in the wage component of the market basket.

Specifically, commenters were concerned that the wage component of the market basket, which is comprised of external, as well as internal, price proxies, does not adequately account for the fact that hospital wages are increasing faster than other industry wages. The commenters recommended that only internal proxies such as the Bureau of Labor Statistics Employment Cost Index (ECI) for hospitals be used in the market basket forecasts. ProPAC also recommended that we review our forecasting methodology and address the issue of hospital wage forecasts.

Response: The rebased hospital market basket was established in FY 1987 and we have not proposed any changes to the market basket forecasting methodology for FY 1989. The methodology we used to forecast the market basket inflation for FY 1989 is consistent with that outlined in the September 3, 1986, *Federal Register* at 51 FR 31461. We do not believe it is appropriate to make changes to specific market basket components without also examining all of the other components of the market basket. While changing the proxy measures used in the wage component of the market basket may result in a higher inflation forecast for that component, it is also possible that further analysis of the appropriateness of the forecasting measures used in the other components of the market basket could result in lower forecasts being developed. Therefore, we do not believe it is appropriate to adopt changes to various components of the market basket and that any revisions should be made only in conjunction with a complete rebasing of the market basket. Absent rebasing, we believe it is important that the model we use in developing the market basket forecasts be carried forward over a period of years so that forecasts will be consistent from year to year.

We agree that the issue of appropriate wage proxies warrants further consideration and we acknowledged in the September 3, 1986 *Federal Register* that the ECI for hospitals may provide a better measure for forecasting hospital wage increases in the future. As of this date, we do not believe there is enough historical data available to permit reliable forecasts because the ECI is a newly developed measure. (We will, however, consider incorporating the ECI measure into the market basket once sufficient data are available.)

Comment: We received one comment critical of separate update factors for hospitals located in large urban areas. The commenter asserted that an update factor for hospitals located in large urban areas that is greater than the

update factor for hospitals located in other urban areas is grossly unfair to other hospitals nationwide.

Response: Because a separate update factor for hospitals in large urban areas is mandated by Congress, we have no choice but to implement the requirement.

5. Other Adjustments to the Average Standardized Amounts

a. Indirect Medical Education Section 1886(d)(3)(C)(ii) of the Act provides that, effective for discharges occurring on or after October 1, 1986, the average standardized amounts be further reduced, taking into consideration the effects of the standardization for indirect medical education costs as described in section II.A.1.a. of this addendum. The required adjustment is to ensure that the program savings that would be achieved through standardizing for indirect medical education on one basis and computing indirect medical education payments on another basis are preserved. The first such adjustment was implemented for the standardized amounts effective October 1, 1986. (See the September 3, 1986 final rule (51 FR 31521).) Section 1886(d)(3)(C)(ii) of the Act, as amended by section 4003(a)(2) of Pub. L. 100-203, now requires a revision of the adjustment due to the revision of the adjustment factor for computing indirect medical education payments effective October 1, 1988.

Specifically, for each geographic area (regional and national, large urban, other urban, and rural), total payments including indirect medical education and disproportionate share hospital adjustments, based on payment rates for FY 1989, standardized for a curvilinear indirect medical education factor (of approximately 7.7 percent) and for disproportionate share, shall be neither more nor less than the estimated total of payments, including indirect medical education adjustment payments, that would have been made based on rates standardized for an 11.59 percent linear indirect medical education factor and paid out at approximately 8.3 percent on a curvilinear basis. The adjustment is performed on a regional basis in order to reflect congressional intent that the necessary calculations will not redistribute payments among the regions.

Through this adjustment, Congress is ensuring that total prospective payments, on a regional basis, taking into consideration the restandardization of rates for disproportionate share payments and for a revised indirect medical education payment factor of

approximately 7.7 percent on a curvilinear basis, will equal payments that would have resulted with rates standardized for an 11.59 percent indirect medical education adjustment factor, and payments computed using an indirect medical education factor of approximately 8.3 percent applied on a curvilinear basis. Since the first such adjustment already ensures system savings equal to those that would have been achieved by a reduction in indirect medical education payments from 11.59 percent on a linear basis to about 8.7 percent on a curvilinear basis, the only further adjustment necessary is to achieve the incremental savings that would result from a further reduction in indirect medical education payments from approximately 8.7 percent to about 8.3 percent, both on a curvilinear basis. Therefore, under section 1886(d)(3)(C)(ii) of the Act, for FY 1989, we adjusted the large urban, other urban, and rural regional and national standardized amounts to account for indirect medical education.

Because there is no specific reference in the Act to making this adjustment for hospitals in Puerto Rico, this adjustment was not made to the Puerto Rico standardized amounts. It is reflected, however, in the discharge-weighted national average standardized amount applicable to Puerto Rico.

The factors applied to the standardized amounts are shown in the table below:

	Large urban and other urban	Rural
1. New England (CT, ME, MA, NH, RI, VT).....	0.99702	0.99951
2. Middle Atlantic (PA, NJ, NY).....	0.99610	0.99917
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	0.99862	0.99976
4. East North Central (IL, IN, MI, OH, WI).....	0.99771	0.99979
5. East South Central (AL, KY, MS, TN).....	0.99779	0.99998
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	0.99754	0.99989
7. West South Central (AR, LA, OK, TX).....	0.99887	0.99998
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	0.99804	0.99995
9. Pacific (AK, CA, HI, OR, WA).....	0.99853	1.00000
10. National.....	0.99754	0.99982

b. Rural Hospitals Deemed to be Urban. Section 1886(d)(8)(B) of the Act, as added by section 4005(a) of Pub. L. 100-203, provides that certain rural hospitals will be deemed urban effective with discharges occurring on or after October 1, 1988. Section 1886(d)(8)(C) of

the Act specifies two payment conditions that must be met. First, the FY 1989 urban standardized amounts are to be adjusted so as to ensure that total aggregate payments under the prospective payment system after implementation of this provision are equal to the aggregate prospective payments that would have been made absent the provision. Second, the rural standardized amounts are to be adjusted to ensure that aggregate payments to rural hospitals not affected by this provision neither increase nor decrease as a result of implementation of this provision. The following adjustment factors, necessary to achieve the requisite budget neutrality constraints, were applied to the proposed standardized amounts:

Urban	Rural
.99924.....	1.00075

The following adjustment factors were applied to the final standardized amounts.

Urban	Rural
.99924.....	1.00088

c. Outliers. Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act correspondingly requires that the urban and rural standardized amounts, respectively, be separately reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments for hospitals located in urban areas and those located in rural areas. Section 1886(d)(9)(B)(iv) of the Act requires that the urban and rural standardized amounts be reduced by the proportion of estimated total payments made to hospitals in Puerto Rico attributable to estimated outlier payments.

Consequently, instead of the uniform reduction factor applying equally to all the standardized amounts, there are now two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Furthermore, sections 1886(d)(5)(A)(iv) and 1886(d)(9)(i) of the Act direct 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 the September 1, 1987, final rule, we set the outlier thresholds so as to result in estimated outlier payments equal to five percent of total prospective payments. We also set the same outlier thresholds and offsets for the Puerto Rico prospective payment standardized amounts as we had for hospitals located outside Puerto Rico. Therefore, for FY 1988, we set the day outlier threshold at the lesser of 18 days of 2.0 standard deviations and the cost outlier threshold at the greater of \$14,000 or 2.0 times the prospective payment rate for the DRG. The outlier adjustments for FY 1988 were .94441 for the urban rates and .97485 for the rural rates.

These adjustments were modified effective for discharges occurring on or after April 1, 1988 to .9441 for urban rates and .9746 for rural rates, with a budget neutrality factor of .997697, for the increase to 90 percent in the marginal cost fact for burn outliers in accordance with section 4008(d)(1)(A) of Pub. L. 100-203. (See the April 5, 1988, notice (53 FR 11137).) These thresholds and offsets were estimated to yield outlier payments of 5.1 percent of total prospective payments.

We proposed to set the outlier thresholds so as to result in estimated outlier payments equal to five percent of total prospective payments. Therefore, for FY 1989, we proposed to set the day outlier threshold at the geometric means length of stay plus the lesser of 24 days or 3.0 standard deviations and the cost outlier threshold at the greater of \$27,000 or 2.0 times the prospective payment rate for the DRG.

The proposed outlier adjustment factors for FY 1989 are as follows:

OUTLIER REDUCTION FACTORS

Urban	Rural
.9446.....	.9781

Based on the final outlier policy as modified (see detailed discussion in section V.E. of the preamble to this final rule), the outlier pool is maintained at 5.1 percent.

The final outlier adjustment factors for FY 1989 are as follows:

OUTLIER REDUCTION FACTORS

Urban	Rural
.9437.....	.9777

The final outlier thresholds are as follows: For discharges on or after October 1, 1988 and before November 1,

1988, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 22 days or 2.0 standard deviations and the cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or \$23,750. For discharges on or after November 1, 1988, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations and the cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or \$28,000. Both these sets of thresholds are expected to yield aggregate outlier payments across all hospitals equal to 5.1 percent of total DRG-based payments.

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. Tables 1a, 1b, and 1c, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that would be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico.

1. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section IV of the preamble to this final rule, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a and 4b 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 are taken account of in the adjustment for area wages above. For FY 1989, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

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

Alaska—all areas.....	1.25
Hawaii:	
Oahu.....	1.225
Kauai.....	1.175
Maui.....	1.20
Molokai.....	1.20
Lanai.....	1.20
Hawaii.....	1.15

The above factors are based on data obtained from the U.S. Office of Personnel Management.

C. DRG Weighting Factors

As discussed in section III 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 resource utilization of cases in each DRG relative to that of the average Medicare case.

Table 5 of section IV of this addendum contains the weighting factors that we will use for discharges occurring in FY 1989. These factors have been recalibrated as explained in section III of the preamble.

D. Calculation of Prospective Payment Rates for FY 1989

General Formula for Calculation of Prospective Payment Rates for FY 1989

Prospective Payment Rate for all hospitals located outside Puerto Rico except sole community hospitals = Federal Portion

Prospective Payment Rate for Sole Community Hospitals = 75 percent of the hospital-specific portion + 25 percent of the Federal portion

Prospective Payment Rate for Puerto Rico Hospitals = 75 percent of the Puerto Rico rate + 25 percent of a discharge-weighted average of the large urban, other urban, and rural national rates

1. Federal Portion

For discharges on or after October 1, 1988, and before October 1, 1989, except for sole community hospitals and hospitals located in Puerto Rico, the hospital's rate is comprised exclusively of the Federal rate. The Federal rate is comprised of 100 percent of the Federal national rate except for those hospitals located in regions affected by the regional floor, whose Federal rate equals 85 percent of the Federal national rate and 15 percent of the Federal regional rate. For sole community hospitals, the 25 percent Federal portion is based entirely on the Federal regional rate. The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban, other urban, or rural (see Tables 1a and 1b, section IV of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4a and 4b, section IV of this addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Sum the amount from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3).

Step 5—Multiply the final amount from step 4 by the weighting factor corresponding to the appropriate DRG (see Table 5, section IV of this addendum).

Step 6—For sole community hospitals, multiply the result in step 5 by 25 percent. The result is the Federal portion of the FY 1989 prospective payment for a given discharge for a sole community hospital.

2. Hospital-Specific Portion (Applicable Only to Sole Community Hospitals)

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:

$$\frac{\text{Base year costs per discharge}}{\text{1981 case-mix index}} \times \frac{\text{update factor}}{\text{factor}} = \text{Hospital-specific rate}$$

For sole community hospitals, the hospital-specific portion equals 75 percent of the hospital-specific rate for all cost reporting periods beginning on or after October 1, 1983. For each subsequent cost reporting period, the hospital-specific portion is derived as follows:

Hospital-Specific Rate x Update Factor x Blending Percentage x DRG Weight

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 1989 Cost Reporting Periods. For cost reporting periods beginning on or after October 1, 1988, we proposed to increase the hospital-specific rates by—

- 3.3 percent (market basket percentage increase minus 1.5 percentage points) for hospitals located in rural areas;
- 2.8 percent (market basket percentage increase minus 2.0 percentage points) for hospitals located in large urban areas; and
- 2.3 percent (market basket percentage increase minus 2.5 percentage points) for hospitals located in other urban areas.

As required by section 1886(b)(3)(B) of the Act (as amended by section 4002 of Pub. L. 100-203), these were the same percentage increases by which we proposed to change the Federal rates for FY 1989.

Because the most recently forecasted market basket increase for FY 1989 is 5.4 percent, we are increasing the hospital-specific rates by—

- 3.9 percent (market basket percentage increase minus 1.5 percentage points) for hospitals located in rural areas;
- 3.4 percent (market basket percentage increase minus 2.0 percentage points) for hospitals located in large urban areas; and
- 2.9 percent (market basket percentage increase minus 2.5 percentage points) for hospitals located in other urban areas.

Comment: We received two comments requesting clarification of the appropriate update to the hospital-specific rate for sole community hospitals that are also rural referral

centers, which receive 25 percent of their payments at the Federal other urban rate.

Response: In accordance with section 4002(g)(2)(C) of Pub. L. 100-203, the applicable percentage increase to the hospital-specific rates for sole community hospitals is provided for under section 4002(a) of Pub. L. 100-203. Under that section the percentage increase is applied based on the location of the hospital (that is, rural, large urban, or other urban). Therefore, for purposes of updating the hospital-specific portion of a sole community hospital's payment rate, the update is applied based on the hospital's location. The fact that a sole community hospital is also a rural referral center and receives 25 percent of its payment at the Federal regional other urban rate does not affect the update to its hospital-specific rate.

B. Calculation of Hospital-Specific Portion. For sole community hospital cost reporting periods beginning on or after October 1, 1988, the hospital-specific portion of a hospital's payment for a given discharge would be calculated by—

*Step 1—*Multiplying the hospital's hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 3.9 percent for hospitals located in rural areas, 3.4 percent for hospitals located in large urban areas, and 2.9 percent for hospitals located in other urban areas);

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

*Step 3—*Multiplying the result in step 2 by 75 percent. (The result is the hospital-specific portion of the FY 1989 prospective payment for a given discharge for a sole community hospital.)

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or after October 1, 1988 and Before October 1, 1989.

a. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

*Step 1—*Select the appropriate adjusted average standardized amount considering the large urban, other urban,

or rural designation of the hospital (see Table 1c, section IV of the addendum).

*Step 2—*Multiply the labor-related portion of the standardized amount by the appropriate wage index (see Tables 4a and 4b, section IV of the addendum).

*Step 3—*Sum the amount from step 2 and the nonlabor portion of the standardized amount.

*Step 4—*Multiply the result in step 3 by 75 percent.

*Step 5—*Multiply the amount from step 4 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section IV of the addendum).

b. National Rate. The national prospective payment rate is determined as follows:

*Step 1—*Multiply the labor-related portion of the national average standardized amount (see Table 1c, section IV of the addendum) by the appropriate wage index.

*Step 2—*Sum the amount from step 1 and the nonlabor portion of the national average standardized amount.

*Step 3—*Multiply the result in step 2 by 25 percent.

*Step 4—*Multiply the amount from step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section IV of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. 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 under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience, trended forward by the applicable update factors. 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 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 cost reporting periods beginning on or after October 1, 1988, section 1886(b)(3)(B)(ii) of the Act, as amended by section 4002(e) of Pub. L. 100-203, provides that the applicable percentage increase is the market basket percentage increase. Also, under section 4002(g)(3)(C) of Pub. L. 100-203, the hospital target amount for the cost reporting period beginning in FY 1988 is deemed to have been increased by 2.7 percent (rather than 315/366 multiplied

by 2.7, which was the actual target rate of increase applicable for this period). Therefore, in order to determine a hospital's target amount for its cost reporting period beginning in FY 1989, the following steps apply:

- Increase the hospital target amount for its reporting period which began in FY 1987 by 2.7 percent;
- Increase the result of step one by the market basket percentage increase for FY 1989.

The most recent forecasted hospital market basket increase for FY 1989 is 5.4 percent. Therefore, the applicable percentage increase is also 5.4.

IV. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983, initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 3c, 4a, 4b, 5, 6a, 6b, 6c, 6d, 6e, 7a, 7b, and 8 are

presented below. The tables are as follows:

Table 1a—National Adjusted Standardized Amounts, Labor/Nonlabor
Table 1b—Regional Adjusted Standardized Amounts, Labor/Nonlabor
Table 1c—Adjusted Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 3c—Hospital Case-Mix Indexes for Discharges Occurring in FY 1987
Table 4a—Wage Index for Urban Areas
Table 4b—Wage Index for Rural Areas
Table 5—Diagnosis-Related Groups
Table 6a—New Diagnosis Codes
Table 6b—New or Revised Procedure Codes
Table 6c—Elective Diagnostic and Other Nonextensive Procedures Unrelated to Principal Procedures that Group to DRG 477
Table 6d—Additions to the CC Exclusions List
Table 6e—Deletions from the CC Exclusions List
Table 7a—Length-of-Stay Percentiles Using FY 1988 DRG Classification (Grouper V5.0)
Table 7b—Length-of-Stay Percentiles Using FY 1989 DRG Classification (Grouper V6.0)
Table 8—Statewide Average Cost-to-Charge Ratios for Urban and Rural Hospitals

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This section contains the tables referred to in this preamble.

Table 1a -- NATIONAL ADJUSTED STANDARDIZED AMOUNTS,
LABOR/NONLABOR

Large Urban		Other Urban		Rural	
Labor- related	Nonlabor- related	Labor- related	Nonlabor- related	Labor- related	Nonlabor- related
2374.22	840.95	2351.10	832.75	2219.89	614.82

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Table 1b -- REGIONAL ADJUSTED STANDARDIZED AMOUNTS,
LABOR/NONLABOR

	Large Urban		Other Urban		Rural	
	Labor- related	Nonlabor- related	Labor- related	Nonlabor- related	Labor- related	Nonlabor- related
1. New England (CT, ME, MA, NH, RI, VT)	2492.76	877.87	2468.48	869.32	2459.67	729.25
2. Middle Atlantic (PA, NJ, NY)	2239.44	833.05	2217.63	824.94	2358.50	687.99
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2390.57	767.55	2367.29	760.07	2251.81	597.80
4. East North Central (IL, IN, MI, OH, WI)	2520.39	907.78	2495.85	898.94	2281.73	664.15
5. East South Central (AL, KY, MS, TN).19	2294.31	695.00	2271.96	688.23	2231.78	557.45
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2391.22	827.47	2367.93	819.41	2169.19	595.56
7. West South Central (AR, LA, OK, TX)	2384.08	762.35	2360.87	754.92	2080.31	547.70
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2292.60	817.28	2270.27	809.33	2114.98	634.06
9. Pacific (AK, CA, HI, OR, WA)	2230.84	932.77	2209.12	923.68	2046.07	709.66

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Table 1c -- ADJUSTED STANDARDIZED AMOUNTS FOR
PUERTO RICO, LABOR/NONLABOR

	Large Urban		Other Urban		Rural	
	Labor- related	Nonlabor- related	Labor- related	Nonlabor- related	Labor- related	Nonlabor- related
Puerto Rico	2109.03	377.31	2088.51	373.63	1483.55	274.62

National	<u>Labor- related</u>	<u>Nonlabor- related</u>
	2326.77	780.76

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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[illegible]

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 : CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040032	00.9519	040107	01.0550	050051	01.0349	050110	01.1212	050170	01.2938	050170	01.2938
040033	00.8613	040108	00.9330	050052	01.1297	050111	01.2054	050172	01.1727	050172	01.1727
040035	00.9496	040109	01.1746	050053	01.1942	050112	01.3187	050173	01.2366	050173	01.2366
040036	01.1639	040114	01.6273	050054	01.1773	050113	01.1844	050174	01.1587	050174	01.1587
040037	01.0489	040115	01.0141	050055	01.2066	050114	01.3125	050175	01.1801	050175	01.1801
040039	00.8804	040116	01.1656	050056	01.1681	050115	01.2790	050177	01.3218	050177	01.3218
040040	00.9766	040118	01.0583	050057	01.2346	050116	01.1443	050179	01.1532	050179	01.1532
040041	01.1553	040119	01.1932	050058	01.2352	050117	01.1443	050180	01.3405	050180	01.3405
040042	01.2206	040122	01.0110	050060	01.3161	050118	01.1352	050181	01.1945	050181	01.1945
040043	00.9671	040123	00.8567	050061	01.2117	050119	00.8513	050183	01.1083	050183	01.1083
040044	00.9669	040124	01.0555	050063	01.2619	050121	01.1124	050186	01.1842	050186	01.1842
040045	00.9425	040126	00.9846	050065	01.3002	050122	01.3857	050187	01.1527	050187	01.1527
040047	01.0063	040128	00.8907	050066	01.1847	050124	01.2872	050188	01.2872	050188	01.2872
040048	01.1509	040130	01.1666	050067	01.1385	050125	01.1478	050189	00.9874	050189	00.9874
040050	01.0511	050002	01.1764	050068	01.0795	050126	01.2755	050190	01.2257	050190	01.2257
040051	00.8993	050004	01.1535	050069	01.3932	050127	01.2509	050191	01.3040	050191	01.3040
040053	00.9998	050006	01.1698	050070	01.1624	050128	01.3297	050192	01.0054	050192	01.0054
040054	01.0857	050007	01.3783	050071	01.1599	050129	01.4718	050193	01.2857	050193	01.2857
040055	01.2504	050008	01.2765	050072	01.2268	050131	01.1810	050194	01.2139	050194	01.2139
040058	00.9284	050009	01.3227	050073	01.1490	050132	01.2122	050195	01.2134	050195	01.2134
040060	00.9861	050011	01.1709	050074	00.9571	050133	01.1753	050196	01.1795	050196	01.1795
040062	01.1487	050013	01.9363	050075	01.2201	050134	01.2332	050197	01.6740	050197	01.6740
040063	01.2939	050014	01.1724	050076	01.4399	050135	01.4927	050199	01.4927	050199	01.4927
040064	00.9781	050015	01.2401	050077	01.4627	050136	01.2398	050201	01.0352	050201	01.0352
040066	00.9531	050016	01.1049	050078	01.1945	050138	01.1804	050202	01.2028	050202	01.2028
040067	01.0361	050017	01.6328	050079	01.2449	050139	01.4070	050204	01.4118	050204	01.4118
040069	01.0222	050018	01.1181	050080	01.1222	050140	01.2104	050205	01.1104	050205	01.1104
040070	00.9548	050019	00.9183	050081	01.4206	050141	01.2037	050207	01.1937	050207	01.1937
040071	01.1809	050021	01.1291	050082	01.2343	050143	01.1652	050208	01.1763	050208	01.1763
040072	01.0263	050022	01.3316	050084	01.3652	050144	01.1946	050211	01.2481	050211	01.2481
040074	01.0435	050024	01.1327	050086	01.1496	050145	01.3177	050212	01.1085	050212	01.1085
040075	01.1096	050025	01.4615	050087	01.2771	050146	01.2444	050213	01.1931	050213	01.1931
040076	00.9710	050026	01.3338	050088	01.1251	050147	00.6597	050214	01.3500	050214	01.3500
040077	00.9056	050028	01.2480	050089	01.1949	050148	01.1001	050215	01.1654	050215	01.1654
040078	01.2142	050029	01.1908	050090	01.1912	050149	01.1653	050217	01.1654	050217	01.1654
040080	00.9798	050030	01.1562	050091	01.2023	050150	01.2080	050219	01.2680	050219	01.2680
040081	00.8784	050032	01.1140	050092	01.0918	050151	01.2347	050220	01.0928	050220	01.0928
040082	01.1769	050033	01.3075	050093	01.4484	050152	01.2301	050221	01.2210	050221	01.2210
040084	01.0541	050034	01.1496	050095	01.1156	050153	01.2301	050222	01.1663	050222	01.1663
040085	01.0170	050036	01.2379	050096	01.1529	050154	01.4672	050224	01.2664	050224	01.2664
040087	00.9833	050038	01.2364	050097	01.1904	050155	01.1838	050225	01.1667	050225	01.1667
040088	01.1673	050039	01.4377	050099	01.3996	050156	01.1705	050226	01.4171	050226	01.4171
040090	00.9488	050040	01.1244	050100	01.6759	050158	01.4515	050228	01.2258	050228	01.2258
040091	01.0882	050041	01.1344	050101	01.2553	050159	01.1934	050229	01.2172	050229	01.2172
040093	01.0607	050042	01.1652	050102	01.2586	050161	01.1733	050230	01.2068	050230	01.2068
040095	00.9795	050043	01.5202	050103	01.3312	050164	01.2589	050231	01.3467	050231	01.3467
040098	01.1740	050045	01.1157	050104	01.2329	050166	01.0435	050232	01.5514	050232	01.5514
040100	01.0803	050046	01.1022	050107	01.2421	050167	01.2774	050233	01.1450	050233	01.1450
040105	01.0074	050047	01.5079	050108	01.3257	050168	01.3860	050234	01.1921	050234	01.1921
040106	01.0433	050049	01.1498	050109	01.8622	050169	01.3664	050235	01.3089	050235	01.3089

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050236	01.1697	050308	01.4251	050381	00.9313	050451	00.9737	050542	01.0711
050238	01.2033	050309	01.2055	050382	01.3623	050454	01.6698	050543	01.1701
050239	01.2692	050310	01.0973	050383	01.0812	050455	01.4948	050544	01.1651
050240	01.2393	050312	01.3379	050385	01.2003	050456	01.3141	050545	00.8189
050241	01.1455	050313	01.1169	050387	00.9867	050457	01.4034	050546	00.9793
050242	01.2782	050315	01.2368	050388	00.9475	050458	00.7623	050547	00.9489
050243	01.2628	050317	01.1861	050390	01.2119	050459	01.2538	050549	01.4060
050245	01.3695	050318	00.9620	050391	01.1679	050464	01.6342	050550	01.2607
050248	01.0876	050319	01.2455	050392	01.0226	050467	01.2025	050551	01.2625
050251	01.0772	050320	01.1096	050393	01.2744	050468	01.2752	050552	01.1426
050253	01.2029	050324	01.5887	050394	01.3726	050469	00.9540	050557	01.2173
050254	01.1502	050325	01.1948	050395	01.1469	050470	01.0661	050559	01.2159
050256	01.5362	050326	01.2535	050396	01.4297	050471	01.4945	050560	01.0983
050257	01.2158	050327	01.4997	050397	01.0432	050472	01.2016	050561	01.1095
050258	01.2768	050328	01.1739	050401	01.2163	050476	01.2141	050562	01.1090
050260	01.0763	050329	01.2136	050404	01.0911	050477	01.1373	050564	01.1469
050261	01.1082	050331	01.2502	050406	01.0432	050478	01.1400	050565	01.1532
050262	01.5029	050333	01.0881	050407	01.1716	050481	01.2544	050566	00.9507
050263	01.1890	050334	01.2067	050410	01.0856	050482	01.0202	050567	01.2828
050264	01.2592	050335	01.0921	050411	01.2168	050483	01.2118	050568	01.1835
050267	01.3725	050336	01.2397	050413	01.3121	050485	01.4126	050569	01.2661
050268	01.2115	050337	01.1109	050414	01.0825	050486	01.3080	050570	01.4575
050269	01.1750	050338	01.9344	050417	01.1450	050488	01.2058	050571	01.2479
050270	01.2251	050342	01.1725	050418	01.0670	050489	01.1527	050573	01.4057
050272	01.2437	050343	01.1355	050419	01.1654	050491	01.2454	050575	01.0851
050273	00.9347	050345	01.2793	050420	01.1987	050492	01.1265	050577	01.2816
050274	00.9385	050348	01.3629	050421	01.2230	050494	01.0349	050578	01.0913
050276	01.0836	050349	00.9388	050423	01.0321	050496	01.5332	050579	01.2391
050277	01.2137	050350	01.2764	050424	01.4488	050497	00.8454	050580	01.1103
050278	01.2689	050351	01.3885	050425	01.2021	050498	01.1883	050581	01.2198
050279	01.1419	050352	01.0977	050426	01.1178	050502	01.6337	050583	01.5509
050280	01.2037	050353	01.5300	050427	00.9289	050503	01.2923	050584	01.1489
050281	01.2743	050355	01.9817	050430	00.9028	050506	01.2422	050585	01.2399
050282	01.2212	050357	01.4623	050431	01.0984	050510	01.1350	050586	01.1286
050283	01.2459	050359	01.0939	050432	01.2676	050512	01.1424	050587	01.2430
050286	01.0628	050360	01.1913	050433	00.9827	050515	01.3007	050589	01.2149
050289	01.5442	050361	00.9200	050434	01.0430	050516	01.2587	050590	01.1986
050290	01.3493	050362	01.0490	050435	01.1642	050517	01.1408	050591	01.1566
050291	01.2163	050363	01.1157	050436	01.0514	050522	01.1829	050592	01.2422
050292	01.1483	050366	01.1632	050438	01.3698	050523	01.1434	050593	01.1024
050293	00.9903	050367	01.2323	050440	01.1185	050526	01.1299	050594	02.0687
050295	01.2587	050369	01.1720	050441	01.5793	050527	01.1915	050597	01.1489
050296	01.1100	050371	01.0023	050442	01.1727	050528	01.1444	050598	01.1974
050298	01.0784	050372	01.1218	050443	00.9420	050530	01.2143	050599	01.3189
050299	01.2564	050373	01.1024	050444	01.1403	050531	01.2004	050601	01.1815
050300	01.2305	050376	01.3245	050446	00.9367	050534	01.1904	050603	01.3764
050301	01.1827	050377	01.0378	050447	01.2971	050535	01.2519	050604	01.1855
050302	01.2738	050378	01.0564	050448	00.9929	050537	01.2644	050605	01.0769
050305	01.3100	050379	01.0196	050449	01.1943	050539	01.2673	050607	01.1692
050307	01.3352	050380	01.5160	050450	00.8636	050541	01.3753		

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050608	01.1211	060011	01.1976	060068	01.1372	070030	01.1440
050609	01.2478	060012	01.3181	060070	01.1401	070031	01.2629
050613	00.9933	060013	01.2568	060071	01.2702	070033	01.1926
050615	01.1980	060014	01.4121	060072	00.9533	070034	01.2275
050616	01.0949	060015	01.3480	060073	00.9044	070035	01.2947
050618	01.0043	060016	01.2132	060074	01.1121	070036	01.2653
050619	01.2326	060017	01.2328	060075	01.1746	070038	01.0237
050622	01.1271	060018	01.1673	060076	01.2575	080001	01.3118
050623	01.1779	060019	01.2249	060077	00.9715	080002	01.1190
050625	01.3705	060020	01.3287	060083	01.0622	080003	01.1918
050630	01.0477	060022	01.4964	060085	00.9374	080004	01.2262
050633	01.2028	060023	01.3362	060087	01.1099	080005	01.1147
050635	01.2244	060024	01.4097	060088	01.0408	080006	01.0545
050636	01.2233	060026	01.3203	060090	00.9835	080007	01.1822
050637	01.1803	060027	01.2456	060092	00.9989	090001	01.3017
050638	00.9246	060028	01.3785	060093	00.9264	090002	01.0460
050641	01.1216	060029	01.0242	060096	01.1525	090003	01.2090
050643	00.9872	060030	01.2017	060097	00.6840	090004	01.3580
050644	01.1445	060031	01.3956	060098	01.1531	090005	01.2314
050649	01.0188	060032	01.3642	060099	00.8597	090006	01.2170
050650	01.2302	060033	01.2368	060101	01.6978	090007	01.0869
050651	01.2054	060034	01.2206	070001	01.6608	090008	01.1229
050660	01.2451	060035	01.1680	070002	01.5232	090009	01.1323
050661	01.0623	060036	01.1344	070003	01.2272	090010	01.0663
050662	00.9860	060037	00.9806	070004	01.1499	090011	01.5813
050663	01.1209	060038	01.1024	070005	01.3081	100001	01.2650
050666	00.8808	060039	01.1011	070006	01.1831	100002	01.2920
050667	01.1278	060041	00.9621	070007	01.2336	100004	01.1071
050668	01.3447	060042	01.0339	070008	01.1527	100005	01.0520
050669	00.7866	060043	00.9797	070009	01.1747	100006	01.3931
050671	01.0349	060044	01.2176	070010	01.4015	100007	01.6316
050672	00.6935	060045	01.0210	070011	01.2085	100008	01.3859
050674	01.2315	060046	01.1347	070012	01.1597	100009	01.3594
050675	01.2920	060047	01.1120	070013	01.1890	100010	01.2392
050676	00.8918	060049	01.0478	070014	01.1745	100011	01.0087
050677	01.2285	060050	01.1561	070015	01.1986	100012	01.2625
050678	01.1640	060051	01.2635	070016	01.2357	100013	00.9408
050679	01.0716	060052	00.8813	070017	01.2677	100014	01.1574
050680	01.0881	060053	00.8727	070018	01.2017	100015	01.1480
060001	01.4102	060054	01.2432	070019	01.1758	100016	01.0388
060003	01.1623	060055	00.9474	070020	01.2570	100017	01.2634
060004	01.0695	060056	00.9740	070021	01.2100	100018	01.2598
060005	01.4011	060057	01.2130	070022	01.5728	100019	01.2644
060006	01.2493	060058	01.0012	070023	01.2030	100020	01.2008
060007	01.1534	060060	01.0845	070024	01.1931	100021	01.1920
060008	01.1715	060062	00.9969	070025	01.5018	100022	01.4026
060009	01.2324	060063	01.0602	070026	01.1403	100023	01.1877
060010	01.4590	060064	01.2589	070027	01.2435	100024	01.1880
		060065	01.1956	070028	01.3361	100025	01.4227
		060066	01.0251	070029	01.2115	100026	01.3427
		060067	01.0367				

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100083	01.1214	100147	01.0232	100217	01.0985	100276	01.1411	110054	01.1902
100084	01.1216	100149	01.1541	100218	01.1286	100277	01.0751	110055	00.9572
100085	01.1715	100150	01.2482	100219	01.2143	110001	01.0990	110056	00.9252
100086	01.1990	100151	01.5300	100220	01.4893	110002	01.1839	110059	01.0561
100087	01.5416	100152	01.1840	100221	01.6017	110003	01.1595	110061	00.8721
100088	01.3046	100154	01.3359	100222	01.1379	110004	01.2374	110062	00.9532
100089	01.1680	100156	01.0555	100223	01.2399	110005	01.1466	110063	01.0171
100090	01.1297	100157	01.3379	100224	01.1936	110006	01.1848	110064	01.1879
100092	01.1516	100159	01.0137	100225	01.1634	110007	01.2933	110065	01.0664
100093	01.2597	100160	01.0592	100226	01.1680	110008	01.0034	110066	01.1866
100098	00.9954	100161	01.2672	100227	01.1422	110009	01.0164	110069	01.0545
100099	01.1627	100162	01.2298	100228	01.1557	110010	01.8287	110070	00.9424
100100	01.1660	100164	00.9936	100229	01.2040	110011	01.1098	110071	00.9361
100102	01.0572	100165	00.9328	100230	01.1478	110013	01.0033	110072	00.9332
100103	00.9617	100166	01.2684	100231	01.4852	110014	01.0751	110073	01.0056
100105	01.1780	100167	01.1745	100232	01.0630	110015	01.0456	110074	01.1968
100106	01.0898	100168	01.2320	100234	01.1834	110016	01.2068	110075	01.0790
100107	01.1504	100169	01.5019	100235	01.2051	110017	00.9189	110076	01.2582
100108	01.0158	100170	01.2013	100236	01.2551	110018	01.1162	110077	00.9553
100109	01.1572	100172	01.1682	100237	01.7069	110020	01.1181	110078	01.4300
100110	01.2033	100173	01.1970	100238	01.2007	110023	01.1260	110079	01.0709
100112	00.9705	100174	01.3936	100239	01.3183	110024	01.1918	110080	01.0439
100113	01.6378	100175	01.0739	100240	00.7524	110025	01.1541	110081	01.0152
100114	01.2434	100176	01.6689	100241	01.0354	110026	00.9777	110082	01.6958
100115	01.1021	100177	01.1738	100242	01.1828	110027	01.0289	110083	01.2266
100117	01.2009	100179	01.3485	100243	01.1845	110028	01.3716	110085	01.1357
100118	01.1374	100180	01.2782	100244	01.1745	110029	01.1365	110086	01.1598
100120	01.1849	100181	01.0896	100246	01.1921	110030	01.1362	110087	01.1457
100121	01.0918	100183	01.1564	100248	01.4440	110031	01.1320	110088	00.8578
100122	01.1202	100185	01.0640	100249	01.0938	110032	01.1380	110089	01.1828
100124	01.1521	100186	01.2540	100252	01.1625	110033	01.1275	110091	01.0533
100125	01.1730	100187	01.1638	100253	01.2407	110034	01.2261	110092	01.0533
100126	01.1924	100189	01.1943	100254	01.2449	110035	01.1439	110093	00.9940
100127	01.3279	100191	01.2211	100255	01.1895	110036	01.4023	110094	00.9063
100128	02.0680	100194	01.1930	100256	01.2401	110037	01.1121	110095	01.2218
100129	01.1832	100195	01.1454	100258	01.2541	110038	01.2026	110096	01.0257
100130	01.1835	100196	01.2414	100259	01.1442	110039	01.1499	110097	00.9930
100131	01.1726	100199	01.1688	100260	01.1865	110040	00.9876	110098	00.9250
100132	01.1971	100200	01.2143	100262	01.2268	110041	01.1188	110099	00.9002
100134	00.9198	100203	01.2268	100263	01.1824	110042	01.0043	110100	01.0577
100135	01.4317	100204	01.3858	100264	01.2480	110043	01.3650	110101	00.9785
100137	01.1561	100206	01.1481	100265	01.1640	110044	01.1265	110103	00.9932
100138	00.9980	100207	01.2155	100266	01.1231	110045	01.0165	110104	01.0595
100139	01.1437	100208	01.2043	100267	01.1706	110046	01.1692	110105	01.1462
100140	01.0709	100209	01.2553	100268	01.1524	110047	00.9518	110107	01.4244
100142	01.0590	100210	01.4801	100269	01.2058	110048	01.0794	110108	00.9354
100143	00.9901	100211	01.2115	100270	00.9145	110049	00.9272	110109	00.9550
100144	01.0542	100212	01.1989	100271	01.3351	110050	01.0110	110111	01.0046
100145	01.1761	100213	01.2966	100273	00.9290	110051	00.9299	110112	00.9095
100146	01.0265	100214	01.3223	100275	01.1584	110052	00.8919	110113	01.0012

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140130	01.1555	140187	01.2370	140250	01.1867	150027	01.0606
140131	01.1682	140188	00.9894	140251	01.1927	150029	01.1798
140132	01.2927	140189	01.1034	140252	01.2134	150030	01.1503
140133	01.2156	140190	01.0006	140253	01.1553	150031	01.0976
140134	01.2063	140191	01.1576	140254	01.2554	150032	01.5987
140135	01.1308	140192	01.1076	140255	01.1214	150033	01.3435
140136	01.0299	140193	00.9755	140256	01.1214	150034	01.0791
140137	01.0917	140194	01.2707	140257	00.9810	150035	01.1565
140138	01.1524	140195	01.0478	140258	01.0976	150036	01.0300
140139	01.0766	140196	01.2477	140259	01.8194	150037	01.1267
140140	01.0747	140200	01.1704	140260	01.1236	150038	01.1459
140141	01.0154	140201	01.0762	140261	01.3833	150039	01.0164
140142	01.1322	140202	01.2213	140262	01.0699	150040	01.1471
140143	01.0868	140203	01.0946	140263	01.1515	150041	01.1304
140144	01.0476	140204	01.2213	140264	01.1515	150042	01.0878
140145	01.1353	140205	01.0980	140265	01.3550	150043	01.1425
140146	00.9625	140206	01.1774	140266	01.2294	150044	01.3053
140147	01.0604	140207	01.3257	140267	01.1910	150045	01.3340
140148	01.3634	140208	01.0262	140268	01.1491	150046	01.1659
140149	01.2576	140209	01.1308	140269	01.1491	150047	01.0094
140150	01.2174	140210	01.0579	140270	01.0812	150048	01.1424
140151	01.0645	140211	01.1383	140271	01.2102	150049	01.0991
140152	01.1194	140212	01.0643	140272	01.2226	150050	01.1932
140153	01.0991	140213	00.9263	140273	01.2102	150051	01.1424
140154	01.2046	140214	01.1776	140274	00.9070	150052	01.0866
140155	01.0110	140215	01.0324	140275	01.1036	150053	01.0328
140156	01.2138	140216	01.1862	140276	01.1556	150054	01.4378
140157	01.1293	140217	01.0899	140277	01.3308	150055	02.0030
140158	01.2204	140218	01.3517	140278	01.2123	150056	01.0864
140159	01.0232	140219	00.9656	140279	01.1952	150057	01.1086
140160	01.1768	140220	01.3990	140280	01.1032	150058	01.0869
140161	01.1935	140221	01.0432	140281	01.2045	150059	01.0760
140162	00.9995	140222	00.9552	140282	01.1385	150060	01.0760
140163	01.1459	140223	01.3517	140283	01.2144	150061	01.1086
140164	01.0727	140224	01.2627	140284	01.1032	150062	01.0983
140165	01.0630	140225	01.1938	140285	01.1952	150063	01.0627
140166	01.0307	140226	01.0079	140286	01.0663	150064	01.1446
140167	00.9845	140227	01.4415	140287	01.1654	150065	01.0864
140168	01.3254	140228	01.1539	140288	01.2977	150066	01.0344
140169	01.2294	140229	00.9517	140289	01.0135	150067	01.1239
140170	01.1238	140230	00.9650	140290	01.1518	150068	01.0993
140171	01.1259	140231	01.3529	140291	01.1475	150069	01.1270
140172	00.9660	140232	01.1615	140292	01.4712	150070	01.2172
140173	01.2294	140233	01.1615	140293	01.1670	150071	01.0857
140174	01.1238	140234	00.8883	140294	01.1817	150072	01.3076
140175	01.1259	140235	01.2423	140295	01.0516	150073	01.1682
140176	01.2219	140236	01.1170	140296	01.3917	150074	01.1565
140177	01.2944	140237	01.0058	140297	01.0591	150075	01.0531
140178	01.1146	140238	01.0564	140298	01.2053	150076	01.1455
140179	01.2586	140239	00.9887	140299	01.2053	150077	01.1455
140180	01.1796	140240	01.1525	140300	01.1101	150078	01.0402
140181	01.1051	140241	00.8249	140301	01.3541	150079	01.0447
140182	01.1051	140242	00.8249	140302	01.1871	150080	01.0255
140183	01.1051	140243	00.8249	140303	01.1871	150081	01.0255
140184	01.1051	140244	00.8249	140304	01.1871	150082	01.1289
140185	01.1051	140245	00.8249	140305	01.1871	150083	01.1289
140186	01.1051	140246	00.8249	140306	01.1871	150084	01.1289
140187	01.1051	140247	00.8249	140307	01.1871	150085	01.1289
140188	01.1051	140248	00.8249	140308	01.1871	150086	01.1289
140189	01.1051	140249	00.8249	140309	01.1871	150087	01.1289
140190	01.1051	140250	00.8249	140310	01.1871	150088	01.1289
140191	01.1051	140251	00.8249	140311	01.1871	150089	01.1289
140192	01.1051	140252	00.8249	140312	01.1871	150090	01.1289
140193	01.1051	140253	00.8249	140313	01.1871	150091	01.1289
140194	01.1051	140254	00.8249	140314	01.1871	150092	01.1289
140195	01.1051	140255	00.8249	140315	01.1871	150093	01.1289
140196	01.1051	140256	00.8249	140316	01.1871	150094	01.1289
140197	01.1051	140257	00.8249	140317	01.1871	150095	01.1289
140198	01.1051	140258	00.8249	140318	01.1871	150096	01.1289
140199	01.1051	140259	00.8249	140319	01.1871	150097	01.1289
140200	01.1051	140260	00.8249	140320	01.1871	150098	01.1289
140201	01.1051	140261	00.8249	140321	01.1871	150099	01.1289
140202	01.1051	140262	00.8249	140322	01.1871	150100	01.1289
140203	01.1051	140263	00.8249	140323	01.1871	150101	01.1289
140204	01.1051	140264	00.8249	140324	01.1871	150102	01.1289
140205	01.1051	140265	00.8249	140325	01.1871	150103	01.1289
140206	01.1051	140266	00.8249	140326	01.1871	150104	01.1289
140207	01.1051	140267	00.8249	140327	01.1871	150105	01.1289
140208	01.1051	140268	00.8249	140328	01.1871	150106	01.1289
140209	01.1051	140269	00.8249	140329	01.1871	150107	01.1289
140210	01.1051	140270	00.8249	140330	01.1871	150108	01.1289
140211	01.1051	140271	00.8249	140331	01.1871	150109	01.1289
140212	01.1051	140272	00.8249	140332	01.1871	150110	01.1289
140213	01.1051	140273	00.8249	140333	01.1871	150111	01.1289
140214	01.1051	140274	00.8249	140334	01.1871	150112	01.1289
140215	01.1051	140275	00.8249	140335	01.1871	150113	01.1289
140216	01.1051	140276	00.8249	140336	01.1871	150114	01.1289
140217	01.1051	140277	00.8249	140337	01.1871	150115	01.1289
140218	01.1051	140278	00.8249	140338	01.1871	150116	01.1289
140219	01.1051	140279	00.8249	140339	01.1871	150117	01.1289
140220	01.1051	140280	00.8249	140340	01.1871	150118	01.1289
140221	01.1051	140281	00.8249	140341	01.1871	150119	01.1289
140222	01.1051	140282	00.8249	140342	01.1871	150120	01.1289
140223	01.1051	140283	00.8249	140343	01.1871	150121	01.1289
140224	01.1051	140284	00.8249	140344	01.1871	150122	01.1289
140225	01.1051	140285	00.8249	140345	01.1871	150123	01.1289
140226	01.1051	140286	00.8249	140346	01.1871	150124	01.1289
140227	01.1051	140287	00.8249	140347	01.1871	150125	01.1289
140228	01.1051	140288	00.8249	140348	01.1871	150126	01.1289
140229	01.1051	140289	00.8249	140349	01.1871	150127	01.1289
140230	01.1051	140290	00.8249	140350	01.1871	150128	01.1289
140231	01.1051	140291	00.8249	140351	01.1871	150129	01.1289
140232	01.1051	140292	00.8249	140352	01.1871	150130	01.1289
140233	01.1051	140293	00.8249	140353	01.1871	150131	01.1289
140234	01.1051	140294	00.8249	140354	01.1871	150132	01.1289
140235	01.1051	140295	00.8249	140355	01.1871	150133	01.1289
140236	01.1051	140296	00.8249	140356	01.1871	150134	01.1289
140237	01.1051	140297	00.8249	140357	01.1871	150135	01.1289
140238	01.1051	140298	00.8249	140358	01.1871	150136	01.1289
140239	01.1051	140299	00.8249	140359	01.1871	150137	01.1289
140240	01.1051	140300	00.8249	140360	01.1871	150138	01.1289
140241	01.1051	140301	00.8249	140361	01.1871	150139	01.1289
140242	01.1051	140302	00.8249	140362	01.1871	150140	01.1289
140243	01.1051	140303	00.8249	140363	01.1871	150141	01.1289
140244	01.1051	140304	00.8249	140364	01.1871	150142	01.1289
140245	01.1051	140305	00.8249	140365	01.1871	150143	01.1289
140246	01.1051	140306	00.8249	140366	01.1871	150144	01.1289
140247	01.1051	140307	00.8249	140367	01.1871	150145	01.1289
140248	01.1051	140308	00.8249	140368	01.1871	150146	01.1289
140249	01.1051	140309	00.8249	140369	01.1871	150147	01.1289
140250	01.1051	140310	00.8249	140370	01.1871	150148	01.1289
140251	01.1051	140311	00.8249	140371	01.1871	150149	01.1289
140252	01.1051	140312	00.8249	140372	01.1871	150150	01.1289
140253	01.1051	140313	00.8249	140373	01.1871	150151	01.1289
140254	01.1051	140314	00.8249	140374	01.1871		

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160009	01.1209	160066	01.1013	160123	01.1075	170032	01.0481	170090	00.9516
160012	01.0828	160067	01.1415	160124	01.1279	170033	01.1505	170092	01.0148
160013	01.2754	160068	01.0789	160126	01.1079	170034	00.9630	170093	00.9731
160014	01.0674	160069	01.3093	160129	01.0228	170035	00.9645	170094	00.9995
160016	01.1999	160070	01.0193	160130	01.1510	170036	00.9719	170095	01.0845
160018	01.0098	160071	01.2020	160131	01.1259	170037	01.1223	170097	00.9955
160020	01.0615	160072	01.0749	160132	01.2093	170038	01.0232	170098	01.0851
160021	01.0788	160073	00.9492	160133	01.1266	170039	01.0525	170099	01.1280
160023	01.1411	160074	01.0059	160134	00.9408	170040	01.3293	170100	00.8350
160024	01.1731	160075	01.0451	160135	00.9349	170041	01.0132	170101	01.0549
160025	01.1796	160076	00.9351	160138	01.0790	170043	01.0738	170102	00.9800
160026	01.1095	160077	01.0205	160140	01.0288	170044	01.1129	170103	01.1831
160027	01.1414	160079	01.2222	160141	00.9496	170045	01.0593	170104	01.2632
160028	01.1657	160080	01.0937	160142	01.1554	170046	00.9722	170105	01.0330
160029	01.2558	160081	01.1173	160143	01.0116	170049	01.1858	170106	00.9978
160030	01.2274	160082	01.4432	160145	01.0873	170050	00.9622	170108	01.0732
160031	01.0876	160083	01.3910	160146	01.2767	170051	01.0006	170109	01.0621
160032	01.0516	160085	01.2213	160147	01.2448	170052	01.0084	170110	00.9288
160033	01.2394	160086	00.9905	160151	01.1044	170053	01.0209	170112	00.9422
160034	01.0305	160088	01.0035	160152	01.0376	170054	01.0775	170113	01.0729
160035	01.0631	160089	01.1501	160153	01.4167	170055	01.0277	170114	01.1085
160036	01.1388	160090	01.0600	170001	01.1406	170056	00.9851	170115	01.0554
160037	01.0950	160091	01.2676	170002	01.1801	170057	01.0006	170116	01.1416
160038	01.1895	160092	01.0198	170003	01.0867	170058	01.0021	170117	01.0238
160039	01.0058	160093	00.9837	170004	01.0663	170060	01.0058	170119	00.9034
160040	01.2259	160094	01.1354	170005	00.9649	170061	01.1058	170120	01.1528
160041	01.1060	160095	01.0869	170006	01.1783	170062	00.9435	170121	00.8150
160043	01.0743	160097	01.1300	170007	01.1339	170063	00.9656	170122	01.6000
160044	01.2255	160098	01.1065	170008	00.9730	170064	01.0416	170123	01.3379
160045	01.3875	160099	01.0452	170009	01.1409	170066	00.9217	170124	01.0063
160046	01.0233	160101	01.1127	170010	01.0965	170067	00.9638	170125	00.9236
160047	01.2273	160102	01.2826	170011	01.1525	170068	01.1598	170126	00.9427
160048	01.0668	160103	00.9349	170012	01.3564	170069	01.0028	170128	01.0349
160049	00.9884	160104	01.0757	170013	01.2731	170070	00.9527	170130	01.4044
160050	01.0901	160106	01.2131	170014	01.0875	170072	00.9393	170131	01.1433
160051	01.1147	160107	01.0841	170015	01.0448	170073	01.1070	170133	01.2337
160052	01.1167	160108	01.1577	170016	01.4512	170074	01.1058	170134	01.0345
160053	01.1431	160109	01.1055	170017	01.1050	170075	00.8905	170137	01.1444
160054	01.0509	160110	01.3435	170018	01.0592	170076	01.0726	170138	01.1515
160055	01.0540	160111	01.1176	170019	01.1950	170077	00.9359	170139	01.0401
160056	00.9992	160112	01.2400	170020	01.1915	170079	00.9180	170140	01.0225
160057	01.1548	160113	01.0318	170021	00.9958	170080	00.9890	170142	01.1829
160058	01.4826	160114	01.0063	170022	01.1688	170081	01.0131	170143	01.1370
160059	01.2093	160115	01.0872	170023	01.2985	170082	00.9023	170144	01.3151
160060	01.0608	160116	01.1180	170024	00.9830	170084	00.9715	170145	01.1002
160061	01.0431	160117	01.2614	170025	01.1994	170085	00.9982	170146	01.2464
160062	01.0325	160118	01.1045	170026	01.0422	170086	01.4121	170147	01.1901
160063	01.2111	160119	00.8887	170027	01.1619	170087	01.2718	170148	01.1953
160064	01.2093	160120	01.0342	170030	00.9741	170088	01.0120	170150	01.0738
160065	01.0832	160122	01.0819	170031	01.0054	170089	00.9475	170151	01.0031

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
170152	00.9284	180041	01.0066	180117	00.9721	190041	01.3180	190124	01.2187
170159	00.9381	180042	01.0137	180118	00.9845	190043	01.3288	190125	01.1869
170160	00.9094	180043	01.0042	180120	00.9289	190044	01.0058	190127	01.0949
170164	01.2252	180044	01.0072	180121	00.9545	190045	01.1636	190128	01.0296
170166	01.0246	180045	01.1355	180122	00.9758	190046	01.2855	190130	00.9358
170168	01.0641	180046	00.9852	180123	01.1448	190047	01.0922	190131	01.0627
170170	01.1285	180047	00.9364	180124	01.2309	190048	01.0546	190132	01.1220
170171	01.0769	180048	01.1094	180125	00.9397	190049	01.0194	190133	01.0657
170172	00.9648	180049	01.1069	180126	01.0880	190050	00.9837	190134	00.8520
170173	00.9657	180050	01.1347	180127	01.1084	190051	01.1491	190135	01.3479
170174	00.9131	180051	01.2145	180128	01.0401	190053	01.2530	190136	00.9738
170175	01.1182	180053	00.9511	180129	00.9302	190058	00.9878	190137	00.9514
170176	01.2470	180054	01.0759	180130	01.1935	190059	01.0209	190138	00.7576
170178	01.0354	180055	01.0200	180132	01.1015	190060	01.1941	190139	01.0651
180001	01.1290	180056	01.1097	180133	01.0962	190064	01.2314	190140	00.9834
180002	01.0043	180058	00.8651	180134	01.1777	190065	01.3686	190141	01.0089
180004	01.1024	180059	00.9295	180135	01.1909	190067	01.0281	190142	00.9617
180005	01.0026	180060	00.9110	180137	01.2567	190071	00.9861	190144	01.1026
180006	00.8942	180062	00.9087	180138	01.1304	190073	00.8567	190145	00.9393
180007	01.2207	180063	00.9409	190001	00.9544	190075	01.1851	190146	01.3385
180009	01.0948	180064	01.0496	190002	01.3797	190077	01.0134	190147	00.8971
180010	01.4897	180065	00.9747	190003	01.1778	190078	01.0591	190148	00.8759
180011	00.9975	180066	01.0092	190004	01.1603	190079	01.0713	190149	01.0662
180012	01.1358	180067	01.3928	190005	01.1457	190081	00.9425	190151	01.1309
180013	01.1801	180069	00.9783	190006	01.0971	190083	00.9203	190152	01.1354
180014	01.4139	180070	00.9757	190007	01.0047	190086	01.1039	190155	00.9694
180015	01.0611	180072	01.1135	190008	01.3520	190088	01.0297	190156	00.9214
180016	01.1715	180075	00.9454	190009	01.1031	190089	01.1206	190157	00.9244
180017	01.1842	180078	00.9382	190010	01.0428	190090	01.0476	190158	01.0848
180018	01.1465	180079	00.9607	190011	01.0586	190092	01.1724	190160	01.0274
180019	01.0993	180080	01.0922	190012	01.0672	190095	00.9335	190161	01.0920
180020	00.9698	180081	01.1952	190013	01.1280	190098	01.2284	190162	01.1621
180021	00.9510	180085	01.2185	190014	00.9819	190099	01.0291	190163	00.9662
180023	00.8506	180087	01.0625	190015	00.9819	190101	00.9892	190164	01.0701
180024	00.9801	180088	01.3562	190017	01.1160	190102	01.2589	190165	01.0026
180025	01.1047	180092	01.0597	190018	01.2153	190103	00.8708	190166	00.9470
180026	01.0297	180093	01.2207	190019	01.2475	190106	00.9738	190167	01.1345
180027	01.0480	180094	00.9645	190020	01.0573	190109	01.0380	190169	00.9747
180028	00.9292	180095	01.0737	190023	00.9192	190110	00.9845	190170	00.9833
180029	01.0929	180099	00.9619	190025	01.1231	190111	01.3328	190173	01.2252
180030	01.0068	180100	01.1407	190026	01.2448	190112	01.2010	190175	01.1529
180031	01.0238	180101	01.1091	190027	01.2344	190113	01.1358	190176	01.3735
180032	00.8971	180102	01.1968	190029	01.0805	190114	01.0052	190177	01.0983
180033	01.0894	180103	01.4164	190033	00.9265	190115	01.2166	190178	00.9611
180034	00.9996	180104	01.2548	190034	01.1441	190116	01.1008	190179	01.0337
180035	01.2316	180105	00.8462	190035	01.2552	190117	01.0306	190180	01.0746
180036	01.0313	180106	00.8392	190036	01.4180	190118	00.9969	190182	01.0375
180037	01.1363	180108	00.8733	190037	01.0116	190119	01.0260	190183	01.0369
180038	01.1198	180115	00.9879	190039	01.3326	190120	00.9147	190184	00.9055
180040	01.5731	180116	01.1905	190040	01.2995	190122	01.1208	190185	01.1619

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
190186	00.9387	200039	01.2486	210039	01.1350	220041	01.1184
190187	01.0461	200040	01.0740	210040	01.2520	220042	01.1033
190188	00.9904	200041	01.1110	210043	01.1406	220045	01.1766
190189	01.1143	200043	00.8360	210044	01.1854	220046	01.2807
190190	01.0999	200044	01.1456	210045	01.0204	220048	01.1238
190191	01.1657	200047	01.1551	210046	01.0343	220049	01.1572
190193	01.1847	200049	00.9181	210047	01.0890	220050	01.0407
190194	01.0701	200050	01.1100	210048	01.1252	220051	01.2126
190195	01.0487	200051	01.0427	210049	01.2030	220052	01.1849
190196	00.9629	200052	01.0587	210050	00.9375	220053	01.1578
190197	01.1987	200053	01.0470	210051	01.1889	220055	01.1636
190198	01.0756	200054	01.0571	210052	00.3486	220057	01.1631
190199	01.3790	200055	01.2286	210053	01.1137	220058	01.0840
190200	01.1667	200056	01.1395	210054	01.1471	220059	01.1211
190201	01.1472	210001	01.2475	210055	01.2794	220061	01.2084
190202	01.1618	210002	01.15635	210056	01.2055	220062	00.8926
190203	01.3324	210003	01.1878	210057	01.18158	220063	01.1060
190204	01.1568	210004	01.1983	210058	01.1254	220064	01.1823
190205	01.2096	210005	01.2147	220001	01.1858	220065	01.1242
190206	01.2759	210006	01.0608	220002	01.3055	220066	01.2308
190207	01.1051	210007	01.3959	220003	01.0051	220067	01.1372
200001	01.2213	210008	01.1763	220004	01.1527	220068	00.6849
200002	01.0385	210009	01.3532	220005	01.1322	220070	01.1405
200003	01.0131	210010	01.1233	220006	01.1935	220071	01.6082
200005	00.8876	210011	01.1922	220008	01.1812	220072	01.1060
200006	01.1341	210012	01.2113	220009	01.1176	220073	01.1826
200007	01.0173	210013	01.1985	220010	01.1393	220074	01.0877
200008	01.2157	210015	01.1891	220011	01.2148	220075	00.7511
200009	01.5575	210016	01.4138	220012	01.2154	220076	01.1615
200012	01.0577	210017	01.0531	220015	01.1743	220077	01.4476
200013	01.1758	210018	01.2228	220016	01.1561	220079	01.1127
200015	01.2217	210019	01.3103	220017	01.1963	220080	01.1257
200016	01.0287	210021	01.1620	220018	01.1155	220081	01.0302
200017	01.1830	210022	01.2204	220019	01.1407	220082	01.1530
200018	01.1216	210023	01.1828	220020	01.1447	220083	01.1614
200019	01.2315	210024	01.1935	220022	01.0590	220084	01.1935
200020	01.1041	210025	01.1182	220023	01.1633	220086	01.4787
200021	01.1283	210026	01.1585	220024	01.1535	220087	00.9199
200023	00.9752	210027	01.1635	220025	01.1152	220088	01.3944
200024	01.1540	210028	01.0762	220026	01.2170	220089	01.2006
200025	01.1947	210029	01.2869	220028	01.2160	220090	01.1123
200026	01.0662	210030	01.0156	220029	01.1214	220092	01.1704
200027	01.0623	210031	01.5133	220030	01.1000	220094	01.1386
200028	01.0533	210032	01.0607	220031	01.5085	220095	01.1105
200031	01.1536	210033	01.1211	220033	01.1778	220097	01.0987
200032	01.2408	210034	01.1410	220034	01.0785	220098	01.1638
200033	01.3746	210035	01.1034	220036	01.0924	220099	01.0952
200034	01.1768	210036	01.1873	220037	01.3606	220100	01.2437
200037	01.1148	210037	01.1796	220038	01.1262	220101	01.2039
200038	01.0232	210038	01.1793	220040	01.1204	220102	00.9463

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230030	01.2610	230096	01.0856	230154	00.9954	230227	01.1851	240028	01.1109
230031	01.2488	230097	01.1900	230155	00.9593	230228	01.1639	240029	01.0902
230032	01.6049	230098	01.1482	230156	01.4568	230230	01.2958	240030	01.3234
230034	01.0510	230099	01.1368	230157	01.1727	230231	00.9593	240031	01.0206
230035	01.1490	230100	01.1194	230158	00.9970	230232	01.0293	240033	00.9579
230036	01.2153	230101	01.0890	230159	01.1848	230235	00.9749	240036	01.2565
230037	01.0475	230102	01.1872	230161	00.8416	230236	01.2309	240037	01.1102
230038	01.5306	230103	01.0676	230162	00.9603	230237	01.1512	240038	01.3789
230039	01.2406	230104	01.3555	230163	00.9643	230239	01.0727	240040	01.1230
230040	01.1918	230105	01.3801	230165	01.4828	230241	01.0720	240041	01.1635
230041	01.1115	230106	01.0928	230167	01.1835	230244	01.1732	240043	01.1903
230042	01.1165	230107	00.9926	230169	01.1622	230253	01.0789	240044	01.1105
230043	00.8334	230108	01.1774	230171	01.1052	230254	01.1763	240045	01.0863
230046	01.5146	230110	01.1485	230172	01.1806	230256	01.0685	240046	01.2921
230047	01.1142	230111	00.9795	230173	01.1182	230257	01.0519	240047	01.2692
230051	00.9464	230113	00.9356	230174	01.1450	230259	01.0893	240048	01.2326
230053	01.3423	230114	00.9354	230175	00.9116	230264	01.1450	240049	01.5377
230054	01.3312	230115	01.0150	230176	01.1024	230265	01.0587	240050	01.1497
230055	01.0534	230116	00.9299	230178	01.0977	230266	01.1235	240051	00.9556
230056	00.9668	230117	01.6573	230179	00.9408	230269	01.1445	240052	01.1942
230057	00.9485	230118	01.2034	230180	01.0866	230270	01.1112	240053	01.3686
230058	01.0631	230119	01.0136	230181	01.1405	230273	01.2121	240055	01.1597
230059	01.3664	230120	01.0600	230184	01.1218	230275	01.0753	240056	01.3114
230060	01.1262	230121	01.1359	230186	01.0845	230276	00.9391	240057	01.5898
230062	00.9947	230122	01.2086	230188	01.0395	230277	01.1455	240058	00.9943
230063	01.1658	230123	00.9406	230189	00.9571	240001	01.3490	240059	01.0525
230065	01.1976	230124	01.0471	230190	01.1331	240002	01.5004	240061	01.4131
230066	01.1678	230125	01.2979	230191	00.9019	240003	01.1038	240062	01.1527
230067	00.9005	230127	01.1359	230193	01.1571	240004	01.3128	240063	01.3052
230068	01.2291	230128	01.2827	230194	01.1094	240005	00.9929	240064	01.1766
230069	01.0830	230129	01.6445	230195	01.2527	240006	01.1511	240065	00.9614
230070	01.2479	230130	01.3203	230197	01.0927	240007	01.0883	240066	01.2378
230071	00.6994	230132	01.2027	230199	01.0814	240008	01.0465	240069	01.0999
230072	01.1292	230133	01.1015	230201	01.0132	240009	01.1241	240071	01.1118
230075	01.2043	230134	01.0877	230203	00.7816	240010	01.8460	240072	01.0358
230076	01.1933	230135	01.1558	230204	01.2340	240011	01.0449	240073	01.0075
230077	01.6079	230137	01.0565	230205	01.1598	240013	01.2629	240074	01.0333
230078	01.0581	230138	00.8999	230207	01.1063	240014	01.0933	240075	01.1613
230080	01.1667	230140	01.0329	230208	01.3352	240016	01.2893	240076	01.1347
230081	01.0484	230141	01.3502	230211	00.9425	240017	01.1721	240077	01.0031
230082	01.1464	230142	01.1296	230212	01.0905	240018	01.1713	240078	01.3210
230084	01.0666	230143	01.2385	230213	01.0096	240019	01.3716	240079	01.0948
230085	01.1268	230144	01.1272	230216	01.2442	240020	01.1439	240080	01.2209
230086	01.0211	230145	01.1432	230217	01.1048	240021	01.0288	240081	01.2767
230087	01.0870	230146	01.1323	230219	00.9272	240022	01.1243	240082	01.2814
230089	01.2006	230147	01.1813	230221	01.2109	240023	01.0677	240083	01.1410
230090	01.3636	230149	01.1021	230222	01.1527	240024	01.1374	240084	01.2731
230092	01.1955	230150	01.4906	230223	01.2018	240025	01.1409	240085	00.9065
230093	01.1529	230151	01.2878	230224	01.0401	240026	01.3057	240086	01.0960
230095	01.0820	230153	01.1279	230225	01.1561	240027	01.0565	240087	01.1720

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
240088	01.3707	240143	00.9822	250009	01.0930	250071	01.0134	250132	00.9798
240089	01.0033	240144	01.0097	250010	01.0138	250072	01.1253	250133	00.8667
240090	01.0199	240145	00.9331	250012	00.9250	250073	00.9200	250134	01.0707
240091	00.9985	240146	01.0082	250014	00.9937	250075	00.9494	250136	00.9751
240093	01.2901	240148	00.9480	250015	01.0193	250076	00.8994	250137	00.8677
240094	01.0662	240150	00.9981	250016	00.8548	250077	00.9016	250138	00.9989
240096	01.0606	240152	01.0457	250018	00.8858	250078	00.9016	250139	00.9235
240097	01.0816	240153	01.0390	250019	01.1506	250079	01.2163	250140	00.8795
240098	00.9873	240154	00.9730	250020	00.9709	250081	01.1237	260001	01.4001
240099	01.1171	240155	00.9894	250021	00.9079	250082	01.0907	260002	01.1778
240100	01.1928	240156	00.9645	250023	00.9025	250084	00.8708	260003	00.9908
240101	01.0496	240157	01.0475	250024	00.9344	250086	01.1056	260004	01.0812
240102	00.9524	240158	01.1581	250025	00.9828	250088	00.9812	260005	01.1767
240103	01.0357	240160	01.0256	250026	00.9045	250089	01.0120	260006	01.1333
240104	01.2029	240161	01.0371	250027	00.9439	250091	01.0450	260007	01.1575
240105	00.9697	240162	01.1017	250029	00.8872	250093	00.9903	260008	01.1616
240106	01.2363	240163	01.0644	250030	00.9030	250094	00.9320	260009	01.1499
240107	01.0390	240165	00.9958	250031	01.0600	250095	01.1221	260010	01.1708
240108	00.9930	240166	01.1377	250032	01.1540	250097	01.1067	260011	01.2364
240109	01.0435	240167	00.9545	250033	00.8710	250098	01.0267	260012	00.9316
240110	01.1259	240169	00.9323	250034	01.3179	250099	01.0798	260013	01.0718
240111	01.0712	240170	01.0953	250035	00.9091	250100	01.1595	260014	01.3897
240112	01.0434	240171	01.0534	250036	00.9672	250101	00.8930	260015	01.0330
240114	00.9996	240172	01.0337	250037	00.9489	250102	01.0812	260016	01.1790
240115	01.2044	240173	01.0129	250038	00.9222	250104	01.0927	260017	01.2295
240116	00.9908	240175	00.9487	250039	00.9309	250105	00.8927	260018	01.0131
240117	01.1273	240176	01.0254	250040	01.0656	250107	01.3505	260019	00.9991
240118	00.9593	240177	00.9937	250042	01.0446	250108	01.1661	260020	01.3684
240119	00.9009	240179	01.0237	250043	00.8622	250109	00.8794	260021	01.2492
240121	00.9531	240180	01.0503	250044	00.8622	250110	00.9280	260022	01.2949
240122	01.0857	240183	01.0931	250045	00.9869	250111	00.9340	260023	01.2226
240123	01.0523	240184	01.0036	250046	00.9673	250112	00.8945	260024	01.0850
240124	01.0596	240187	01.1829	250047	00.8857	250113	00.9408	260025	01.1928
240125	01.0584	240192	00.9669	250048	01.2856	250114	00.8485	260026	01.0904
240127	01.0686	240193	01.0081	250049	00.9183	250117	00.9549	260027	01.3123
240128	01.1126	240196	01.3590	250050	00.9185	250118	01.0503	260029	01.1369
240129	01.0437	240200	00.9014	250051	00.8609	250119	01.0588	260030	01.1546
240130	01.0106	240201	00.9502	250052	00.8609	250120	00.9297	260031	01.3667
240131	01.2738	240205	00.8611	250053	01.0359	250121	00.9065	260032	01.4307
240132	01.2316	240206	00.8365	250054	01.0792	250122	01.0639	260033	01.1919
240133	01.1134	240207	01.1676	250055	01.0038	250123	01.1235	260034	01.0437
240134	01.0582	240210	01.2605	250056	00.8291	250124	00.9956	260035	00.9596
240135	00.5975	240211	01.3946	250057	00.9950	250125	01.1235	260036	01.0591
240136	01.0521	250002	00.8657	250058	01.0379	250126	00.8988	260037	01.1869
240137	01.0558	250003	00.8814	250059	00.9088	250127	01.0481	260039	01.1197
240138	01.0048	250004	01.2618	250060	01.0178	250128	00.9955	260040	01.3322
240139	01.0746	250005	01.0034	250061	00.9054	250129	01.0204	260041	01.0333
240140	00.9224	250006	00.9548	250062	01.0838	250131	01.0289	260042	01.1037
240141	01.0036	250007	01.0333	250063	00.8632			260044	01.0521
240142	01.1483	250008	00.8649	250064	01.1066			260047	01.2000

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NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 : CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
280104	01.0071	300010	01.0940	310036	01.1458	310096	01.3666	320062	00.8725
280105	01.2071	300011	01.1586	310037	01.2108	310105	01.0902	320063	01.1507
280106	01.1532	300012	01.1939	310038	01.4110	310108	01.1715	320065	01.1001
280107	01.0937	300013	01.0633	310039	01.1748	310110	01.1595	320067	00.9390
280108	01.0520	300014	01.2154	310040	01.0932	310111	01.1649	320068	01.0269
280109	00.3394	300015	01.0638	310041	01.2042	310112	01.1436	320069	01.1452
280110	01.0805	300016	01.1592	310042	01.0952	310113	01.1834	320070	00.9113
280111	01.1805	300017	01.1959	310043	01.1485	310115	01.1857	320074	01.1602
280114	01.0127	300018	01.2126	310044	01.1867	310116	01.1956	320076	01.0516
280115	01.0495	300019	01.1593	310045	01.1808	310118	01.1197	320077	00.8598
280116	00.8748	300020	01.1048	310047	01.2671	310119	01.1798	330001	01.1522
280117	01.2168	300021	01.0933	310048	01.1928	310120	01.0895	330002	01.2163
280118	01.1778	300022	01.1216	310049	01.1559	310121	00.9435	330003	01.2265
280119	00.7819	300023	01.1644	310050	01.1291	310122	00.9435	330004	01.1886
280122	00.9001	300024	01.1535	310051	01.2395	320001	01.3146	330005	01.4396
280123	00.6741	300028	01.1170	310052	01.1791	320002	01.1834	330006	01.2331
290001	01.3677	300029	01.1956	310054	01.2716	320003	01.1571	330007	01.1835
290002	00.9580	300032	00.9429	310056	01.1296	320004	01.1140	330008	01.1029
290003	01.3341	300033	01.0042	310057	01.2376	320005	01.1927	330009	01.0417
290005	01.1750	300034	01.3581	310058	01.0401	320006	01.1592	330010	01.1192
290006	01.0242	310001	01.4225	310059	00.8493	320009	01.2269	330011	01.1421
290007	01.4026	310002	01.6632	310060	01.1823	320010	01.2286	330012	01.3171
290008	01.1309	310003	01.1306	310061	01.1270	320011	01.0439	330013	01.7433
290009	01.2844	310005	01.1707	310062	00.9862	320012	00.9939	330014	01.1601
290010	01.1186	310006	01.1442	310063	01.2280	320013	01.0193	330015	01.2301
290011	01.0229	310008	01.2300	310064	01.1976	320014	00.9235	330016	01.0164
290012	01.2418	310009	01.1370	310067	01.1314	320016	01.0329	330019	01.0675
290013	00.9769	310010	01.1996	310068	01.1568	320017	01.2156	330020	01.0034
290014	01.0124	310011	01.1795	310069	01.1095	320018	01.2060	330022	01.0150
290015	00.9253	310012	01.2708	310070	01.2021	320019	01.2620	330023	01.1839
290016	01.0940	310013	01.2088	310071	01.1223	320021	01.5798	330024	01.4776
290018	00.8192	310014	01.3702	310072	01.1560	320022	01.2416	330025	01.0386
290019	01.1868	310015	01.2460	310073	01.1729	320023	01.1203	330027	01.1918
290020	00.9014	310016	01.1499	310074	01.2076	320030	01.0597	330028	01.1666
290021	01.4162	310017	01.2229	310075	01.1844	320031	00.9229	330029	01.2281
290022	01.4897	310018	01.1042	310076	01.2433	320032	00.9981	330030	01.0077
290027	01.0445	310019	01.4462	310077	01.5063	320033	01.0892	330033	01.2584
290029	00.8944	310020	01.1455	310078	01.1389	320035	00.9552	330034	01.1257
290031	01.0707	310021	01.1746	310081	01.1428	320037	01.1702	330036	01.0724
290032	01.1871	310022	01.1538	310083	01.1262	320038	01.1385	330037	01.1069
290033	01.0093	310024	01.1911	310084	01.1775	320046	01.0636	330038	01.0632
290034	00.7590	310025	01.0893	310085	01.1846	320048	01.1397	330039	01.0305
300001	01.2355	310026	01.1466	310086	01.1633	320049	01.0600	330041	01.2022
300002	01.0781	310027	01.1498	310087	01.1521	320053	01.0371	330043	01.1324
300003	01.4957	310028	01.0796	310088	01.1402	320056	00.9115	330044	01.1989
300005	01.2284	310029	01.5850	310090	01.2034	320057	01.1513	330045	01.1754
300006	01.0526	310031	02.1510	310091	01.1725	320058	00.9359	330046	01.2389
300007	01.0462	310032	01.1313	310092	01.1718	320059	01.0370	330047	01.1385
300008	01.1297	310033	01.1231	310093	01.0905	320060	00.9707	330048	01.1745
300009	01.1960	310034	01.1614	310094	01.0548	320061	01.0947	330049	01.2271

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CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 : CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
340028	01.2420	340098	01.4777	340162	01.1376	350056	00.9390
340030	01.6563	340099	01.1448	340164	01.1785	350058	00.9912
340031	01.1261	340100	01.1809	340166	01.2181	350060	00.9818
340032	01.2954	340101	01.1625	340167	00.7978	350061	01.0291
340034	01.3008	340104	01.0202	350001	00.8961	350063	00.9470
340035	01.0956	340105	01.2519	350002	01.4296	350064	00.9744
340036	01.0501	340106	01.1167	350003	01.0533	350065	00.9595
340037	01.2201	340107	01.2426	350004	01.5794	350066	00.9488
340038	01.2124	340109	01.2240	350005	01.1234	350067	00.8601
340039	01.1445	340111	01.2179	350006	01.1467	360001	01.1409
340040	01.5298	340112	00.9994	350007	00.9516	360002	01.1637
340041	01.1804	340113	01.7503	350008	00.9306	360003	01.2539
340042	01.1308	340114	01.2387	350009	01.1345	360006	01.4816
340044	00.9931	340115	01.2979	350010	01.1098	360007	00.9940
340045	01.0768	340116	01.4451	350011	01.5569	360008	01.0977
340047	01.5872	340119	01.1615	350012	01.0098	360009	01.1797
340049	00.6637	340120	01.1006	350013	01.0042	360010	01.0899
340050	01.1283	340121	01.0040	350014	00.9779	360011	01.2756
340051	01.2667	340122	01.0480	350015	01.4978	360012	01.2418
340052	00.9729	340123	01.1502	350016	01.1122	360013	01.0927
340053	01.4157	340124	01.0303	350017	01.1812	360014	01.1222
340054	01.0221	340125	01.3761	350018	00.9307	360015	01.3486
340055	01.2419	340126	01.2098	350019	01.3153	360016	01.2323
340060	01.0934	340127	01.1751	350020	01.2145	360017	01.3627
340061	01.4967	340129	01.1155	350021	01.0556	360018	01.2628
340063	01.1085	340129	01.1984	350023	00.9741	360019	01.1703
340064	01.0566	340131	01.2650	350024	00.9756	360020	01.1392
340065	01.1285	340132	01.2291	350025	01.0181	360021	01.1810
340067	00.9924	340133	01.1287	350027	01.0048	360022	01.0944
340068	01.1786	340135	01.0229	350029	00.8978	360024	01.0804
340069	01.6087	340136	01.0406	350030	01.1009	360025	01.1105
340070	01.2478	340137	01.0639	350031	01.0637	360026	01.1142
340071	01.0470	340138	01.1778	350032	01.1321	360027	01.3443
340072	01.0912	340141	01.2688	350033	00.9435	360028	01.1933
340073	01.2404	340142	01.1709	350034	00.9323	360029	01.0883
340075	01.1368	340143	01.2982	350035	00.8622	360030	01.0997
340076	01.0453	340144	01.1491	350036	00.9212	360031	01.1212
340079	00.9495	340145	01.1288	350038	00.9092	360032	01.1598
340080	01.0286	340146	00.9327	350039	00.9343	360034	01.0947
340084	01.0770	340147	01.1706	350041	00.9259	360035	01.3575
340085	01.2447	340148	01.2386	350042	00.9850	360036	01.1379
340087	01.0524	340151	01.0417	350043	01.1568	360037	01.5163
340088	01.1165	340153	01.9124	350044	00.8987	360038	01.2349
340089	00.9749	340154	00.8734	350047	00.9845	360039	01.1509
340090	01.1245	340155	01.3316	350048	00.9441	360040	01.1334
340091	01.4750	340156	00.8783	350049	01.0155	360041	01.1560
340093	01.0582	340157	01.2169	350050	00.8646	360042	01.0767
340094	01.2409	340158	01.0745	350051	00.8785	360044	01.1689
340096	01.1120	340159	01.1003	350053	00.9676	360045	01.3154
340097	01.0071	340160	01.0760	350055	00.8391	360046	01.0365

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CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360047	01.0345	360056	00.9390	360067	01.1407	360099	01.0891
360048	01.3587	360058	00.9912	360068	01.2108	360099	01.0891
360049	01.1173	360060	00.9818	360069	01.0273	360099	01.0891
360050	01.0636	360061	01.0291	360070	01.2038	360099	01.0891
360051	01.3086	360063	00.9470	360071	01.2045	360099	01.0891
360052	01.9552	360064	00.9744	360072	01.1414	360099	01.0891
360053	01.1601	360065	00.9595	360074	01.2118	360099	01.0891
360054	01.1697	360066	00.9488	360075	01.2934	360099	01.0891
360055	01.1873	360067	00.8601	360076	01.1681	360099	01.0891
360056	01.1407	360068	01.1409	360077	01.2649	360099	01.0891
360057	01.1637	360069	01.1637	360078	01.1535	360099	01.0891
360058	01.1311	360070	01.2539	360079	01.4977	360099	01.0891
360059	01.2136	360071	00.9940	360080	01.1636	360099	01.0891
360061	01.0100	360072	01.3983	360081	01.1733	360099	01.0891
360062	01.3983	360074	01.0185	360082	01.2133	360099	01.0891
360063	01.3164	360075	01.2108	360083	01.0859	360099	01.0891
360064	01.3164	360076	01.1252	360084	01.3010	360099	01.0891
360065	01.2108	360077	01.1181	360085	01.5125	360099	01.0891
360066	01.1252	360078	01.0273	360086	01.1219	360099	01.0891
360067	01.1181	360079	01.2038	360087	01.1780	360099	01.0891
360068	01.2814	360080	01.1636	360088	01.0239	360099	01.0891
360069	01.0273	360081	01.1733	360089	01.0718	360099	01.0891
360070	01.2038	360082	01.2133	360090	01.1553	360099	01.0891
360071	01.2045	360083	01.0859	360091	01.2329	360099	01.0891
360072	01.1414	360084	01.3010	360092	01.1221	360099	01.0891
360074	01.2118	360085	01.5125	360093	01.0613	360099	01.0891
360075	01.2934	360086	01.1219	360094	01.0707	360099	01.0891
360076	01.1681	360087	01.1780	360095	01.1999	360099	01.0891
360077	01.2649	360088	01.0239	360096	01.1689	360099	01.0891
360078	01.1535	360089	01.0718	360098	01.2154	360099	01.0891
360079	01.4977	360090	01.1553	360099	01.0891	360099	01.0891

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360100	01.1542	360156	01.1003	370002	01.0019	370064	00.9962	370146	01.0122
360101	01.3385	360157	01.1209	370004	01.0888	370065	01.1834	370148	01.2304
360102	01.1917	360161	01.1500	370005	00.9415	370069	01.0317	370149	01.2091
360103	01.2020	360162	01.1049	370006	01.1575	370071	00.9181	370153	01.0337
360104	00.9324	360163	01.4040	370007	01.1616	370072	00.9344	370154	00.9611
360106	01.1523	360164	01.0842	370008	01.1714	370076	01.1388	370156	00.9824
360107	01.1005	360165	01.0905	370011	00.9404	370077	01.1160	370157	00.9932
360108	01.0758	360166	00.9713	370012	00.9251	370078	01.3733	370158	01.0118
360109	01.0488	360167	00.8854	370013	01.3673	370079	00.9644	370159	01.1076
360112	01.3618	360168	00.9529	370014	01.1142	370080	01.0343	370161	01.0528
360113	01.1690	360169	00.9850	370015	01.1089	370082	00.9284	370163	00.9700
360114	01.0101	360170	01.0922	370016	01.2345	370083	01.0548	370165	01.0456
360115	01.1505	360171	01.0391	370017	00.9527	370084	01.0064	370166	00.9700
360116	01.0361	360172	01.1832	370018	01.2146	370085	00.9281	370168	00.8947
360118	01.2259	360174	01.0560	370019	01.0336	370086	01.0670	370169	01.0414
360119	01.0713	360175	01.1161	370020	01.1477	370089	01.2145	370170	01.0475
360120	00.8304	360176	01.1387	370021	00.9680	370090	00.9095	370171	01.0325
360121	01.0768	360177	01.0281	370022	01.1392	370091	01.3913	370172	00.9335
360122	01.1580	360178	01.1268	370023	01.1360	370092	00.9687	370173	01.1078
360123	01.1233	360179	01.1545	370025	01.2343	370093	01.4533	370174	00.8251
360124	01.1835	360180	01.8771	370026	01.2843	370094	01.1888	370176	01.1164
360125	01.0835	360184	01.0556	370028	01.4653	370095	01.0195	370177	00.9395
360126	01.1709	360185	01.1175	370029	01.1454	370096	01.1822	370178	00.9905
360127	00.9896	360186	00.9499	370030	01.1012	370097	01.2186	370179	00.9745
360128	01.1033	360187	01.1726	370032	01.1914	370099	00.9749	370180	01.1544
360129	00.9980	360188	01.1194	370033	01.0540	370100	00.9758	370182	00.8845
360130	01.0829	360189	01.1603	370034	01.1213	370103	01.0615	370183	01.0196
360131	01.1121	360192	01.2227	370035	01.3977	370105	01.8340	370184	01.2952
360132	01.0833	360193	01.1876	370036	00.9824	370106	01.2599	380001	01.3229
360133	01.2596	360194	01.0969	370037	01.5216	370107	00.9622	380002	01.1980
360134	01.3218	360195	01.1455	370038	01.0136	370108	01.0428	380003	01.1737
360135	01.0911	360197	01.0575	370039	01.1301	370110	00.9777	380004	01.6312
360136	00.9971	360200	01.0829	370040	01.0772	370112	00.9699	380005	01.1307
360137	01.3995	360203	01.0973	370041	01.0150	370113	01.0849	380006	01.2017
360139	01.0597	360204	01.0784	370042	00.9042	370114	01.4106	380007	01.4047
360140	01.0031	360210	01.1114	370043	00.9130	370117	01.0608	380008	01.0590
360141	01.2739	360211	01.0863	370045	01.0318	370121	01.1414	380009	01.5330
360142	01.0469	360212	01.2507	370046	01.0060	370122	00.8477	380010	01.1765
360143	01.1578	360213	01.0709	370047	01.1093	370123	01.1284	380011	01.0806
360144	01.1762	360218	01.2196	370048	00.9804	370125	00.9462	380013	01.0805
360145	01.2793	360230	01.2232	370049	01.1509	370126	01.0475	380014	01.1551
360147	01.1614	360231	01.0824	370050	00.9636	370130	01.0140	380017	01.5203
360148	01.1713	360232	01.1067	370051	01.0011	370131	00.9531	380018	01.4734
360149	01.0500	360234	01.1468	370054	01.1045	370133	01.0030	380019	01.2539
360150	01.1447	360236	01.0952	370056	01.1970	370136	00.9450	380020	01.2586
360151	01.1827	360238	01.0575	370057	01.1592	370138	00.9541	380021	01.1864
360152	01.2820	360239	01.1457	370059	01.1237	370139	01.0071	380022	01.1770
360153	01.0819	360240	01.2339	370060	01.0763	370140	00.9581	380023	01.2090
360154	01.0880	360241	00.7709	370061	00.9500	370141	01.2807	380024	01.1956
360155	01.1168	370001	01.4936	370063	01.0302	370144	01.2318	380025	01.2599

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
380026	01.1497	380094	00.9955	390052	01.0613	390110	01.1573
380027	01.1350	390001	01.1362	390054	01.1391	390111	01.5966
380029	01.0349	390002	01.1110	390055	01.4787	390112	01.1036
380030	00.9929	390003	01.1110	390056	01.1458	390113	01.1510
380031	00.9332	390004	01.1835	390057	01.2054	390114	00.9870
380033	01.4595	390005	01.0229	390058	01.2382	390115	01.1612
380035	01.2369	390006	01.4436	390059	01.2665	390116	01.2050
380036	01.0608	390007	01.1357	390060	01.1130	390117	01.0759
380037	01.1475	390008	01.1476	390061	01.2186	390118	01.0349
380038	01.2014	390009	01.3086	390062	01.1328	390119	01.1671
380039	01.2048	390010	01.0838	390063	01.4343	390121	01.1837
380040	01.0954	390011	01.1719	390064	01.2034	390122	01.0777
380041	00.8054	390012	01.1411	390065	01.1768	390123	01.1840
380042	01.0573	390013	01.1411	390066	01.1731	390125	01.1204
380043	00.9588	390014	01.0377	390067	01.3663	390126	01.1497
380044	01.0032	390015	01.0591	390068	01.1688	390127	01.1116
380045	01.1234	390016	01.1038	390069	01.1440	390128	01.1229
380047	01.3714	390017	01.0617	390070	01.1314	390130	00.9909
380048	00.9250	390018	01.1412	390071	01.0965	390131	01.1874
380050	01.2052	390019	01.0602	390072	01.0101	390132	01.0317
380051	01.2543	390020	01.0912	390073	01.1607	390133	01.2573
380052	01.1618	390021	01.0945	390074	01.2031	390135	01.1617
380055	01.1870	390022	01.1423	390075	01.1553	390136	01.1483
380056	00.9856	390023	01.1399	390076	01.1621	390137	01.0858
380059	00.9821	390024	00.7777	390077	01.2017	390138	01.2183
380060	01.2609	390025	00.8025	390078	01.0163	390139	01.3663
380061	01.3957	390026	01.2331	390079	01.6289	390142	01.4217
380062	00.9793	390027	01.4134	390080	01.1600	390143	00.9042
380063	01.1224	390028	01.5028	390081	01.2000	390145	01.1097
380064	01.1643	390029	01.3855	390083	01.1100	390146	01.1511
380065	01.1706	390030	01.0639	390084	01.0112	390147	01.1271
380066	01.1510	390031	01.1208	390086	01.0792	390148	01.0826
380068	01.0847	390032	01.1556	390088	01.2563	390149	01.1895
380069	01.0294	390034	01.0686	390090	01.4813	390150	01.1347
380070	01.0041	390035	01.1634	390091	01.0851	390151	01.2775
380071	01.1965	390036	01.1721	390092	01.0905	390152	01.0583
380072	00.9161	390037	01.1776	390093	01.0972	390153	01.1669
380075	01.2146	390039	01.0715	390095	01.1903	390154	01.1114
380077	01.0148	390040	01.0516	390096	01.1704	390155	01.2559
380078	01.1092	390041	01.1141	390097	01.2590	390156	01.1807
380079	01.1645	390042	01.1829	390098	01.4780	390157	01.1024
380081	00.9397	390043	01.0437	390100	01.5189	390158	01.2358
380082	01.2122	390044	01.3892	390101	01.1849	390159	01.1602
380083	01.1480	390045	01.2084	390102	01.2149	390160	01.1602
380084	01.2454	390046	01.2989	390103	01.0256	390161	01.0057
380087	01.0294	390047	01.3417	390104	01.1109	390162	01.1818
380088	01.1451	390048	01.1140	390106	01.0117	390163	01.1348
380089	01.2699	390049	01.2661	390107	01.1627	390164	01.4339
380090	01.2523	390050	01.4627	390108	01.2018	390165	01.0545
380091	01.2415	390051	01.8492	390109	01.1472	390166	01.1328

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390231	01.2356	420009	01.2035	420073	01.1731	430043	01.0622
390232	01.1157	420010	01.0253	420074	00.9962	430044	00.9192
390233	01.2166	420011	01.0756	420075	00.9980	430047	01.0685
390234	01.1879	420014	01.0698	420076	00.9724	430048	01.0735
390235	01.5222	420015	01.1141	420078	01.3552	430049	00.9136
390236	01.0864	420016	01.2168	420079	01.3122	430051	00.9412
390237	01.4190	420017	00.9319	420080	01.1811	430054	00.9254
390238	00.8481	420018	01.4119	420081	00.9692	430056	00.9066
390242	01.1390	420019	01.1153	420082	01.1921	430057	00.9624
390244	00.9005	420020	01.1334	420083	01.1615	430060	00.9494
390245	01.2221	420022	01.0162	420084	00.7577	430062	00.8793
390246	01.1280	420023	01.1621	420085	01.1796	430064	00.9740
390247	01.0485	420026	01.6453	420086	01.1790	430065	00.9308
390249	01.0884	420027	01.1258	420087	01.3307	430066	00.9644
390252	00.8436	420028	00.9927	420088	01.1415	430072	01.0629
390256	01.5484	420029	02.1404	420089	01.1975	430073	01.0541
390258	01.1492	420030	01.0606	430004	01.0570	430076	01.0501
390260	01.1767	420031	00.9289	430005	01.1765	430077	01.2437
390261	01.6014	420032	00.9654	430007	01.0002	430079	01.0194
390262	01.2848	420033	01.1858	430008	01.1732	430080	00.8632
390263	01.2995	420035	00.6451	430009	01.1126	430081	00.9423
390265	01.2020	420036	01.1473	430010	01.0724	430082	00.9136
390266	01.1771	420037	01.1776	430011	01.2367	430083	00.8590
390267	01.1240	420038	01.0240	430012	01.2750	430084	00.8370
390268	01.1257	420039	01.0867	430013	01.1203	430085	00.9369
390270	01.1271	420040	01.2131	430014	01.1865	430086	00.9089
390272	00.8601	420042	01.0622	430015	01.0703	430087	00.8594
390275	00.7808	420043	01.1355	430016	01.2584	430088	01.0668
390276	00.5520	420044	01.1060	430017	01.1490	440001	01.0316
410001	01.1522	420048	01.0064	430018	00.9360	440002	01.3382
410002	01.0774	420049	01.0517	430020	00.9863	440003	01.0938
410004	01.2056	420050	00.9240	430022	00.8745	440005	00.9941
410005	01.2662	420051	01.4068	430023	00.9757	440006	01.1737
410006	01.2063	420053	01.0520	430024	01.0028	440007	00.9786
410007	01.3687	420054	01.0714	430025	00.9922	440008	00.9864
410008	01.0746	420055	01.0291	430026	00.9720	440009	00.9852
410009	01.1888	420056	01.1553	430027	01.5128	440010	01.0128
410010	00.9905	420057	01.0918	430028	00.9783	440011	01.1428
410011	01.1320	420059	01.1120	430029	00.9386	440012	01.1737
410012	01.3409	420061	01.0522	430030	01.0711	440014	00.9533
410013	01.1128	420062	01.0678	430031	00.9454	440015	01.4750
410014	01.1210	420064	01.0495	430033	01.1009	440016	00.9947
410016	01.0189	420065	01.2018	430034	01.0430	440017	01.3046
410018	01.0760	420066	00.9598	430036	01.0507	440018	01.1377
420002	01.2074	420067	01.0997	430037	00.8996	440019	01.3729
420003	01.1192	420068	01.1677	430038	01.0743	440020	00.9928
420004	01.5904	420069	01.0662	430039	00.9543	440022	01.1135
420005	01.0607	420070	01.1613	430040	00.9647	440023	00.9223
420006	01.1374	420071	01.2020	430041	00.9544	440024	01.1012
420007	01.3842	420072	00.8734	430042	00.9628	440025	01.0771

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
440102	01.0428	440175	01.0245	450037	01.2552	450101	01.2543
440103	01.0679	440176	01.1311	450039	01.1475	450102	01.4069
440104	01.3120	440177	00.9326	450040	01.4161	450104	01.1376
440105	00.8724	440178	01.1254	450042	01.4336	450107	01.2433
440109	01.0624	440180	00.9294	450043	01.2098	450108	01.0445
440110	01.0265	440181	01.0484	450044	01.4673	450109	01.0856
440111	01.1181	440182	00.8983	450045	01.2133	450110	01.2125
440113	01.0259	440183	01.2017	450046	01.2859	450111	01.2560
440114	01.0437	440184	01.1030	450047	01.1254	450112	01.1906
440115	01.0717	440185	01.0050	450048	01.0344	450113	01.0987
440117	00.8729	440186	00.9999	450049	01.0344	450115	01.0742
440120	01.1837	440187	00.9365	450050	01.0339	450116	01.2208
440121	01.1133	440189	01.2760	450051	01.5750	450118	01.2390
440125	01.2049	440191	01.0734	450052	01.1219	450119	01.2132
440128	00.9185	440192	01.0236	450053	01.0329	450121	01.2081
440130	01.0931	440193	00.9807	450054	01.4136	450122	00.9662
440131	01.0391	440194	01.0504	450055	01.1560	450123	01.1515
440132	00.9722	440196	00.9709	450056	01.3579	450124	01.4347
440133	01.3100	440197	01.2357	450057	01.2145	450126	01.1822
440134	01.0747	440200	00.9826	450058	01.3243	450127	00.9962
440135	01.1248	440203	00.9657	450059	01.1961	450128	01.1732
440136	01.0382	440204	01.0457	450060	01.1701	450130	01.3421
440137	01.0296	440205	01.0326	450063	01.0024	450131	01.1999
440141	00.8898	450002	01.2237	450064	01.3197	450132	01.3422
440142	00.8789	450004	01.0378	450065	01.0406	450133	01.2090
440143	00.9634	450005	01.0001	450066	01.4058	450134	01.1748
440144	00.9715	450007	01.2009	450068	01.3384	450135	01.3859
440145	00.9456	450008	01.2387	450070	01.0611	450137	01.1884
440146	00.9202	450010	01.2084	450072	01.1130	450140	00.9603
440147	00.9379	450011	01.2286	450073	01.0833	450141	01.0089
440148	00.9883	450013	01.3597	450074	01.1109	450142	01.1905
440149	00.9930	450014	01.0327	450076	01.1435	450143	01.0444
440150	01.1855	450015	01.3840	450077	00.9842	450144	01.1319
440151	01.0934	450016	01.4249	450078	01.0608	450145	01.0337
440152	01.2963	450018	01.3327	450079	01.2961	450146	00.8990
440153	00.8957	450019	01.1695	450080	01.1728	450147	01.1918
440154	00.8317	450020	01.0555	450081	01.1150	450148	01.2268
440156	01.2196	450021	01.5576	450082	01.0369	450149	01.2313
440157	00.8702	450022	00.9897	450083	01.3209	450150	01.0853
440159	01.1208	450023	01.3990	450084	01.1296	450151	01.0653
440160	00.9890	450024	01.1877	450085	01.0805	450152	01.2845
440161	01.4261	450025	01.3911	450087	01.2480	450153	01.3490
440162	00.9870	450027	01.1209	450089	01.1641	450154	01.1891
440166	01.2364	450028	01.2513	450092	01.1512	450155	01.2543
440167	01.1741	450029	01.1867	450094	01.1566	450157	01.1015
440168	01.0049	450031	01.1569	450095	01.0814	450160	00.8491
440170	01.0563	450032	01.1722	450096	01.3892	450162	01.4035
440171	00.9842	450033	01.4777	450097	01.3011	450163	01.0732
440173	01.1304	450034	01.3614	450098	01.0350	450164	00.9921
440174	00.9360	450035	01.2990	450099	01.1163	450165	01.0562

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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[illegible]

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 : CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450694	01.1008	460010	01.6772	490004	01.1843	490069	01.1699	500001	01.2988
450696	01.2454	460011	01.1293	490005	01.2787	490071	01.1745	500002	01.2953
450697	01.2304	460012	01.4155	490006	01.1613	490073	01.1616	500003	01.2344
450698	00.9086	460013	01.3728	490007	01.5710	490074	01.2685	500005	01.5042
450700	00.9887	460014	01.0217	490008	01.0246	490075	01.1478	500007	01.2419
450701	00.6984	460015	01.2033	490009	01.4564	490077	01.1295	500008	01.9887
450702	01.2096	460016	00.9249	490010	01.0392	490078	00.9163	500009	01.2748
450703	01.0625	460017	01.2387	490011	01.1799	490079	01.1059	500010	01.2024
450704	01.1367	460018	00.8652	490012	01.0225	490083	00.7715	500011	01.1916
450705	00.9030	460019	01.0264	490013	01.0617	490084	01.0536	500012	01.3852
450706	01.2122	460020	00.9939	490014	01.3962	490085	01.0696	500014	01.4848
450709	01.1361	460021	01.1972	490015	01.2044	490088	01.0761	500015	01.2445
450711	01.3468	460022	00.9393	490017	01.1685	490089	01.0359	500016	01.3448
450712	00.8230	460023	01.1584	490018	01.1054	490090	01.1163	500017	01.1437
450713	01.2058	460024	01.0109	490019	01.1417	490091	01.2220	500019	01.1422
450715	01.1934	460025	00.9444	490020	01.0338	490092	01.0708	500020	01.2144
450716	01.1248	460026	00.9901	490021	01.1151	490093	01.1837	500021	01.3139
450717	01.2036	460027	00.9560	490022	01.1774	490094	01.1011	500023	01.1107
450718	01.1336	460029	00.9470	490023	01.1373	490095	01.1968	500024	01.2986
450719	01.1723	460030	01.0185	490024	01.0432	490097	01.1036	500025	01.8929
450722	00.9847	460032	00.9920	490027	01.0370	490098	01.1160	500026	01.2474
450723	01.2104	460033	00.9323	490028	01.1385	490099	00.9750	500027	01.4689
450724	01.3384	460035	00.9170	490029	01.0954	490100	01.2153	500028	00.9814
450725	01.1139	460036	00.9470	490030	01.1459	490101	01.0726	500029	00.9389
450726	00.9772	460037	00.9546	490031	01.0680	490104	00.8145	500030	01.3141
450727	01.1896	460039	00.8948	490032	01.5694	490105	00.8637	500031	01.1670
450728	01.1110	460041	01.1674	490033	01.1676	490106	00.8854	500033	01.2310
450729	01.0256	460042	01.2785	490035	01.0514	490107	01.0984	500034	01.0654
450730	01.1512	460043	01.1971	490037	01.0965	490108	00.8593	500035	01.3172
450732	01.0618	460044	01.1211	490038	01.1068	490109	00.9760	500036	01.2075
450733	01.2228	460046	01.0998	490040	01.1403	490110	01.0448	500037	01.0762
450734	01.0771	470001	01.1485	490041	01.1449	490111	01.0617	500039	01.1899
450735	00.9073	470003	01.6120	490042	01.1013	490112	01.3759	500040	01.1214
450736	00.8995	470004	01.0794	490043	01.1645	490113	01.0879	500041	01.1833
450737	00.7386	470005	01.1939	490044	01.1647	490114	01.0365	500042	01.2201
450739	01.1898	470006	01.1434	490045	01.1334	490115	01.0576	500043	01.1373
450740	00.9575	470008	01.1317	490046	01.2298	490116	01.0241	500044	01.7290
450741	00.8762	470010	01.0926	490047	01.1155	490117	00.9668	500045	01.1189
450742	01.1629	470011	01.2452	490048	01.2128	490118	01.4285	500046	01.2633
450743	01.1239	470012	01.1595	490050	01.1466	490119	01.1527	500048	00.8712
450744	01.0244	470013	01.0612	490052	01.3433	490120	01.1897	500049	01.2898
450745	00.7457	470015	01.1573	490053	01.1956	490122	01.1100	500050	01.1577
460001	01.4797	470016	01.0429	490054	01.0816	490123	01.1051	500051	01.3718
460003	01.3695	470018	01.0886	490055	00.9146	490124	01.1487	500052	01.1647
460004	01.4548	470020	00.9799	490057	01.1709	490125	00.9641	500053	01.0959
460005	01.2192	470023	01.2370	490059	01.2585	490126	01.1046	500054	01.6860
460006	01.2000	470024	01.1160	490060	00.9273	490127	00.9375	500055	00.9806
460007	01.1914	490001	00.9416	490063	01.3965	490129	01.1030	500057	01.1951
460008	01.1319	490002	00.9523	490066	01.0482	490130	01.1543	500058	01.2593
460009	01.5388	490003	00.7818	490067	01.1025	490131	00.9014	500059	01.2824

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
500060	01.1026	500133	01.2009	510060	01.0473	520032	01.1620
500061	01.0193	500135	01.1348	510061	01.0236	520033	01.2164
500062	01.0517	500138	02.0732	510062	01.1898	520034	01.2319
500064	01.3244	500139	01.0987	510063	01.1977	520035	01.1733
500065	01.1854	500140	00.9980	510064	01.0156	520037	01.5444
500066	00.8212	500141	01.1827	510065	00.9961	520038	01.1650
500068	00.9855	500142	01.1827	510066	01.0807	520039	01.0351
500069	01.0208	500143	01.3577	510067	01.1590	520040	01.2216
500070	01.0813	500144	00.9841	510068	01.1101	520041	01.0601
500071	01.0748	500145	01.0043	510070	01.0653	520042	01.0859
500072	01.1507	500146	01.1915	510071	01.2280	520043	01.4570
500073	01.1159	500147	01.2843	510072	01.0743	520044	01.2865
500074	01.1549	500148	01.1595	510074	00.9884	520045	01.4314
500075	01.3255	500149	01.1046	510076	00.9715	520047	00.9660
500076	01.2703	500150	00.9277	510077	00.9968	520048	01.2763
500077	01.2078	500151	01.0623	510080	00.9542	520049	01.6885
500078	01.2307	500152	01.1213	510081	01.0119	520051	01.6543
500079	01.1421	500153	01.1936	510082	00.9534	520053	01.0359
500080	00.9362	500154	00.9921	510084	00.9696	520054	01.1017
500084	01.0209	500155	01.0171	510085	01.1437	520056	01.1251
500085	01.0628	500156	01.1305	510086	00.9981	520057	01.0957
500086	01.2152	500157	00.9045	520001	01.2524	520058	01.0904
500087	01.2485	500158	01.1148	520002	01.2524	520059	01.2328
500088	01.2559	500159	01.3941	520003	01.1030	520060	01.1450
500089	01.0786	500160	01.0237	520004	01.2460	520062	01.1946
500090	00.8773	500161	01.1636	520006	01.1108	520063	01.2049
500092	01.0533	500162	00.9515	520007	01.1201	520064	01.3728
500093	01.1093	500163	00.8939	520008	01.1763	520066	01.1863
500094	01.1490	500164	01.0508	520009	01.2862	520068	00.9641
500096	01.0947	500165	01.0759	520010	01.0717	520069	01.2269
500097	01.0549	500166	01.1299	520011	01.1056	520070	01.2341
500098	00.8813	500167	01.0862	520012	00.9894	520071	01.1385
500100	01.1003	500168	01.1655	520013	01.1958	520074	01.0901
500101	00.9934	500169	01.1904	520014	01.1782	520075	01.2558
500102	00.9842	500170	01.0049	520015	01.1511	520076	01.1831
500104	01.1098	500171	01.1857	520016	01.0547	520077	01.0780
500106	00.9140	500172	01.0630	520017	01.0897	520078	01.1997
500107	01.1462	500173	01.1495	520018	01.0951	520081	01.2237
500108	01.4898	500174	01.0219	520019	01.1872	520082	01.1926
500109	01.1254	500175	01.0280	520020	01.3459	520083	01.4154
500110	01.2178	500176	00.8931	520021	01.1660	520084	01.0766
500114	01.2745	500177	01.1877	520022	01.0742	520087	01.4120
500118	01.1810	500178	01.1839	520024	01.0031	520088	01.1873
500119	01.2399	500179	01.1029	520025	01.1256	520089	01.2451
500122	01.2384	500180	01.1518	520026	01.1430	520090	01.1162
500123	00.8577	500181	00.9988	520027	01.2069	520091	01.2918
500124	01.2365	500182	00.9127	520028	01.3051	520092	01.1290
500125	01.1076	500183	01.1861	520029	00.9873	520094	01.3597
500129	01.5177	500184	01.1682	520030	01.3483	520095	01.1980
500132	01.0111	500185	00.7758	520031	01.1682	520096	01.2181

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
520097	01.2036	520100	01.0989	520103	01.2553
520098	01.5392	520101	01.1259	520104	00.9559
520100	01.0989	520102	01.1309	520105	00.9355
520101	01.1259	520103	01.1650	520107	01.1857
520102	01.1309	520104	00.9559	520109	01.0933
520103	01.1650	520105	00.9355	520110	01.0959
520104	00.9559	520107	01.1857	520111	01.1103
520105	00.9355	520109	01.0933	520112	01.0653
520107	01.1857	520110	01.0959	520113	01.1922
520109	01.0933	520111	01.1103	520114	01.1177
520110	01.0959	520112	01.0653	520115	01.1475
520111	01.1103	520113	01.1922	520116	01.1127
520112	01.0653	520114	01.1177	520117	01.0411
520113	01.1922	520115	01.1475	520118	00.9319
520114	01.1177	520116	01.1127	520120	01.0818
520115	01.1475	520117	01.0411	520121	00.9836
520116	01.1127	520118	00.9319	520122	01.0875
520117	01.0411	520120	01.0818	520123	01.0750
520118	00.9319	520121	00.9836	520124	01.0603
520120	01.0818	520122	01.0875	520126	00.9392
520121	00.9836	520123	01.0750	520127	00.9204
520122	01.0875	520124	01.0603	520130	00.9712
520123	01.0750	520126	00.9392	520131	01.1044
520124	01.0603	520127	00.9204	520132	01.1749
520126	00.9392	520130	00.9712	520134	01.0605
520127	00.9204	520131	01.1044	520135	00.9664
520130	00.9712	520132	01.1749	520136	01.3721
520131	01.1044	520134	01.0605	520138	01.6780
520132	01.1749	520135	00.9664	520139	01.2344
520134	01.0605	520136	01.3721	520140	01.2974
520135	00.9664	520138	01.6780	520141	01.0550
520136	01.3721	520139	01.2344	520142	00.9885
520138	01.6780	520140	01.2974	520143	01.0378
520139	01.2344	520141	01.0550	520144	00.9899
520140	01.2974	520142	00.9885	520145	01.0608
520141	01.0550	520143	01.0378	520146	01.1416
520142	00.9885	520144	00.9899	520148	01.1428
520143	01.0378	520145	01.0608	520149	01.0604
520144	00.9899	520146	01.1416	520151	01.0557
520145	01.0608	520148	01.1428	520152	01.1377
520146	01.1416	520149	01.0604	520153	01.0409
520148	01.1428	520151	01.0557	520154	01.1266
520149	01.0604	520152	01.1377	520156	01.3597
520151	01.0557	520153	01.0409	520157	01.0677
520152	01.1377	520154	01.1266	520159	00.9465
520153	01.0409	520156	01.3597		
520154	01.1266	520157	01.0677		
520156	01.3597	520159	00.9465		
520157	01.0677				
520159	00.9465				

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1987

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PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX
520160 01.6560			
520161 01.0341			
520167 01.1715			
520170 01.1733			
520171 00.9442			
520173 01.1330			
520174 01.3669			
520175 00.7370			
520177 01.3275			
520178 01.1839			
520184 00.7272			
520185 00.9238			
530001 01.1147			
530002 01.1401			
530003 00.9118			
530004 00.9755			
530005 01.0481			
530006 01.0975			
530007 01.1946			
530008 01.0815			
530009 01.0371			
530010 01.0411			
530011 01.0954			
530012 01.3736			
530014 01.1096			
530015 01.0795			
530016 01.1471			
530017 00.8974			
530018 00.9517			
530019 00.8796			
530022 01.0049			
530023 00.9446			
530024 01.0081			
530025 01.1583			
530026 01.0980			
530027 00.9500			
530029 01.0855			
530031 00.8675			
530032 00.9926			

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 : CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1988.

BILLING CODE 4120-01-C

TABLE 4A.—WAGE INDEX FOR URBAN AREAS

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX	0.8629
Taylor, TX	
Aguadilla, PR	0.4596
Aguada, PR	
Aguadilla, PR	
Isabella, PR	
Moca, PR	
Akron, OH	0.9994
Portage, OH	
Summit, OH	
Albany, GA	0.7724
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	0.8675
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Albuquerque, NM	1.0158
Bernalillo, NM	
Alexandria, LA	0.8158
Rapides, LA	
Allentown-Bethlehem, PA-NJ	0.9828
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Altoona, PA	0.9446
Blair, PA	
Amarillo, TX	0.9297
Potter, TX	
Randall, TX	
*Anaheim-Santa Ana, CA	1.1994
Orange, CA	
Anchorage, AK	1.4575
Anchorage, AK	
Anderson, IN	0.9027
Henry, IN	
Madison, IN	
Anderson, SC	0.7815
Anderson, SC	
Ann Arbor, MI	1.1507
Lenawee	
Washtenaw, MI	
Anniston, AL	0.7824
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	0.9746
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Arecibo, PR	0.4375
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
Quebradillas, PR	
Asheville, NC	0.8474
Buncombe, NC	
Athens, GA	0.7686
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
*Atlanta, GA	0.9168

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
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	0.9868
Atlantic, NJ	
Cape May, NJ	
Augusta, GA-SC	0.8881
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	1.0093
Kane, IL	
Kendall, IL	
Austin, TX	1.0378
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.1081
Kern, CA	
*Baltimore, MD	1.0148
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	0.8879
Penobscot, ME	
Baton Rouge, LA	0.9375
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	0.9602
Barry, MI	
Calhoun, MI	
Beaumont-Port Arthur, TX	0.9366
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	0.9436
Columbiana, OH	
Beaver, PA	
Lawrence, PA	
Bellingham, WA	1.0790
Whatcom, WA	
Benton Harbor, MI	0.8382
Berrien, MI	
Cass, MI	
*Bergen-Passaic, NJ	1.0267
Bergen, NJ	
Passaic, NJ	
Billings, MT	0.9726
Yellowstone, MT	
Biloxi-Gulfport, MS	0.7987
Hancock, MS	
Harrison, MS	
Binghamton, NY	0.9079

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Broome, NY	
Tioga, NY	
Birmingham, AL	0.9198
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	0.9287
Burleigh, ND	
Morton, ND	
Bloomington, IN	0.9188
Monroe, IN	
Owen, IN	
Bloomington-Normal, IL	0.9434
McLean, IL	
Boise City, ID	1.0036
Ada, ID	
*Boston-Lawrence-Salem-Lowell-Brockton, MA	1.0792
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	1.0685
Boulder, CO	
Brandenton, FL	0.8768
Manatee, FL	
Brazoria, TX	0.8308
Brazoria, TX	
Bremerton, WA	0.9378
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1195
Fairfield, CT	
Brownsville-Harlingen, TX	0.8512
Cameron, TX	
Bryan-College Station, TX	0.9347
Brazos, TX	
Buffalo, NY	0.9697
Erie, NY	
Burlington, NC	0.7525
Alamance, NC	
Burlington, VT	0.9435
Chittenden, VT	
Grand Isle, VT	
Caguas, PR	0.3978
Caguas, PR	
Gurabo, PR	
San Lorenz, PR	
Agua Buenas, PR	
Cayey, PR	
Cidra, PR	
Canton, OH	0.9167
Carroll, OH	
Stark, OH	
Casper, WY	0.9814
Natrona, WY	
Cedar Rapids, IA	0.9215
Linn, IA	
Champaign-Urbana-Rantoul, IL	0.9114
Champaign, IL	
Charleston, SC	0.8441
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	0.9727
Kanawha, WV	
Lincoln, WV	
Putnam, WV	
*Charlotte-Gastonia-Rock Hill, NC-SC	0.8398

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	0.8795
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	0.9138
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	0.8932
Laramie, WY	
*Chicago, IL	1.1179
Cook, IL	
Du Page, IL	
McHenry, IL	
Chico, CA	1.1112
Butte, CA	
*Cincinnati, OH-KY-IN	1.0288
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	0.7463
Christian, KY	
Montgomery, TN	
*Cleveland, OH	1.0793
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.0016
El Paso, CO	
Columbia, MO	1.0346
Boone, MO	
Columbia, SC	0.8425
Lexington, SC	
Richland, SC	
Columbus, GA-AL	0.7383
Russell, AL	
Chattanooga, GA	
Muscogee, GA	
Columbus, OH	0.9267
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	0.8776
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	0.8771
Allegany, MD	
Mineral, WV	
*Dallas, TX	1.0075

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	0.7598
Caswell, NC	
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	0.9711
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.0077
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Preble, OH	
Daytona Beach, FL	0.8519
Volusia, FL	
Decatur, AL	0.7277
Lawrence, AL	
Limestone, AL	
Morgan, AL	
Decatur, IL	0.8939
Macon, IL	
*Denver, CO	1.1898
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	0.9794
Dallas, IA	
Polk, IA	
Warren, IA	
*Detroit, MI	1.0878
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	0.7903
Dale, AL	
Houston, AL	
Dubuque, IA	0.9683
Dubuque, IA	
Duluth, MN-WI	0.9447
St. Louis, MN	
Douglas, WI	
Eau Claire, WI	0.8877
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	0.8823
El Paso, TX	
Elkhart-Goshen, IN	0.9114
Elkhart, IN	
Elmira, NY	0.9125
Chemung, NY	
Enid, OK	0.9097
Garfield, OK	
Erie, PA	0.9459
Erie, PA	
Eugene-Springfield, OR	1.0322
Lane, OR	
Evansville, IN-KY	0.9932
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0000

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Clay, MN	
Cass, ND	
Fayetteville, NC	0.7872
Cumberland, NC	
Harnett, NC	
Fayetteville-Springdale, AR	0.7471
Washington, AR	
Flint, MI	1.1423
Genesee, MI	
Shiawassee, MI	
Florence, AL	0.7234
Colbert, AL	
Lauderdale, AL	
Florence, SC	0.7448
Florence, SC	
Fort Collins-Loveland, CO	1.0221
Larimer, CO	
*Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0393
Broward, FL	
Fort Myers-Cape Coral, FL	0.8962
Lee, FL	
Fort Pierce, FL	0.9520
Indian River, FL	
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	0.8700
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	0.8185
Okaloosa, FL	
Fort Wayne, IN	0.8981
Allen, IN	
De Kalb, IN	
Whitley, IN	
*Fort Worth-Arlington, TX	0.9446
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.0944
Fresno, CA	
Gadsden, AL	0.8368
Etowah, AL	
Gainesville, FL	0.8875
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.0749
Galveston, TX	
Gary-Hammond, IN	1.0383
Lake, IN	
Porter, IN	
Glens Falls, NY	0.8863
Warren, NY	
Washington, NY	
Grand Forks, ND	0.9433
Grand Forks, ND	
Grand Rapids, MI	1.0005
Allegan, MI	
Kent, MI	
Ottawa, MI	
Great Falls, MT	0.9936
Cascade, MT	
Greely, CO	1.0143
Weld, CO	
Green Bay, WI	0.9662
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	0.8684

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	0.8804
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	0.8842
Washington, MD	
Hamilton-Middletown, OH	0.9619
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	0.9875
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
*Hartford-Middletown-New Britain-Bristol, CT	1.0864
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	0.8310
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1308
Honolulu, HI	
Houma-Thibodaux, LA	0.8060
Lafourche, LA	
Terrebonne, LA	
*Houston, TX	0.9835
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	0.9038
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	0.7974
Madison, AL	
Marshall, AL	
*Indianapolis, IN	0.9911
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.1596
Johnson, IA	
Jackson, MI	0.9417
Jackson, MI	
Jackson, MS	0.8414
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	0.7484
Madison, TN	
Jacksonville, FL	0.8896

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	0.7336
Onslow, NC	
Janesville-Beloit, WI	0.8908
Rock, WI	
Jersey City, NJ	1.0566
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN-VA	0.8420
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	0.9032
Cambria, PA	
Somerset, PA	
Joliet, IL	1.0475
Grundy, IL	
Will, IL	
Joplin, MO	0.8623
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.1082
Kalamazoo, MI	
Van Buren, MI	
Kankakee, IL	0.8961
Kankakee, IL	
*Kansas City, KS-MO	1.0023
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	1.0352
Kenosha, WI	
Killeen-Temple, TX	0.9755
Bell, TX	
Coryell, TX	
Knoxville, TN	0.8310
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	0.9323
Howard, IN	
Tipton, IN	
LaCrosse, WI	0.9600
LaCrosse, WI	
Lafayette, LA	0.9233
St. Martin, LA	
Lafayette, IN	0.8641
Clinton, IN	
Tiptecanoe, IN	
Lake Charles, LA	0.9145
Calcasieu, LA	
Lake County, IL	1.0871
Lake, IL	
Lakeland-Winter Haven, FL	0.8236

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Polk, FL	
Lancaster, PA	0.9836
Lancaster, PA	
Lansing-East Lansing, MI	1.0160
Clinton, MI	
Eaton, MI	
Ingham, MI	
Ionia, MI	
Laredo, TX	0.7499
Webb, TX	
Las Cruces, NM	0.8336
Dona Ana, NM	
Las Vegas, NV	1.0839
Clark, NV	
Lawrence, KS	0.9718
Douglas, KS	
Lawton, OK	0.8554
Comanche, OK	
Lewiston-Auburn, ME	0.9006
Androscoggin, ME	
Lexington-Fayette, KY	0.9199
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	0.9133
Allen, OH	
Auglaize, OH	
Van Wert, OH	
Lincoln, NE	0.9258
Lancaster, NE	
Little Rock-North Little Rock, AR	0.9363
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	0.8012
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	0.9490
Lorain, OH	
*Los Angeles-Long Beach, CA	1.2426
Los Angeles, CA	
Louisville, KY-IN	0.9491
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	0.9539
Lubbock, TX	
Lynchburg, VA	0.8560
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robbins, GA	0.8264
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0137
Dane, WI	
Manchester-Nashua, NH	0.9174
Hillsborough, NH	
Merrimack, NH	
Mansfield, OH	0.8929
Morrow, OH	
Richland, OH	
Mayaguez, PR	0.4813

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
San German, PR	
McAllen-Edinburg-Mission, TX	0.7632
Hidalgo, TX	
Medford, OR	0.9671
Jackson, OR	
Melbourne-Titusville, FL	0.8835
Brevard, FL	
Memphis, TN-AR-MS	0.9616
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Merced, CA	1.0703
Merced, CA	
*Miami-Hialeah, FL	1.0120
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	0.9807
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.0544
Midland, TX	
*Milwaukee, WI	1.0360
Jefferson, WI	
Milwaukee, WI	
Ozaukee, WI	
Walworth, WI	
Washington, WI	
Waukesha, WI	
*Minneapolis-St. Paul, MN-WI	1.1181
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	0.8294
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.1012
Stanislaus, CA	
Monmouth-Ocean, NJ	0.9337
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	0.8446
Quachita, LA	
Montgomery, AL	0.8137
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	0.9536
Delaware, IN	
Muskegon, MI	0.9590
Muskegon, MI	
Naples, FL	0.9889
Collier, FL	
Nashville, TN	0.8851
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
*Nassau-Suffolk, NY	1.2322

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	0.9323
Bristol, MA	
New Haven-Waterbury-Meriden, CT	1.0660
New Haven, CT	
New London-Norwich, CT	1.0529
New London, CT	
*New Orleans, LA	0.9049
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
*New York, NY	1.3052
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
*Newark, NJ	1.0775
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	0.8466
Niagara, NY	
*Norfolk-Virginia Beach-Newport News, VA	0.9168
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, 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	1.3980
Alameda, CA	
Contra Costa, CA	
Ocala, FL	0.8158
Marion, FL	
Odessa, TX	0.8892
Ector, TX	
Oklahoma City, OK	1.0036
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia WA	1.0317
Thurston, WA	
Omaha, NE-IA	0.9793
Pottawatomie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	0.8801
Orange, NY	
Orlando, FL	0.9329

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	0.8333
Daviess, KY	
Oxnard-Ventura, CA	1.2965
Ventura, CA	
Panama City, FL	0.7858
Bay, FL	
Parkersburg-Marietta, WV-OH	0.8800
Washington, OH	
Wood, WV	
Pascagoula, MS	0.8902
Jackson, MS	
Pensacola, FL	0.08215
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	0.9807
Mason, IL	
Peoria, IL	
Tazewell, IL	
Woodford, IL	
*Philadelphia, PA-NJ	1.0900
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
*Phoenix, AZ	1.0061
Maricopa, AZ	
Pine Bluff, AR	0.7743
Jefferson, AR	
*Pittsburgh, PA	1.0206
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	0.9915
Berkshire, MA	
Ponce, PR	0.5480
Juana Diaz, PR	
Ponce, PR	
Portland, ME	0.9432
Cumberland, ME	
Sagadahoc, ME	
York, Me	
*Portland, OR	1.1258
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	0.9085
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	0.9567
Dutchess, NY	
*Providence-Pawtucket-Woonsocket, RI	0.9781
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
Provo-Orem, UT	0.9250
Utah, UT	
Pueblo, CO	0.9892
Pueblo, CO	
Racine, WI	0.9271
Racine, WI	
Raleigh-Durham, NC	0.9246

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	0.8677
Pennington, SD	
Reading, PA	0.9353
Berks, PA	
Redding, CA	1.0749
Shasta, CA	
Reno, NV	1.1168
Washoe, NV	
Richland-Kennewick, WA	0.9658
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	0.8907
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	1.1502
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	0.8291
Bedford, VA	
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0223
Olmsted, MN	
Rochester, NY	0.9416
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.0215
Boone, IL	
Winnebago, IL	
*Sacramento, CA	1.2104
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.0502
Bay, MI	
Midland, MI	
Saginaw, MI	
Tuscola, MI	
St. Cloud, MN	0.9632
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	0.8784
Buchanan, MO	
*St. Louis, MO-IL	1.0113

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Clinton, IL	
Jersey, IL	
Macoupin, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Sullivan City, MO	
Salem, OR	1.0384
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2173
Monterey, CA	
*Salt Lake City-Ogden, UT	0.9480
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	0.8277
Tom Green, TX	
*San Antonio, TX	0.8351
Bexar, TX	
Comal, TX	
Guadalupe, TX	
*San Diego, CA	1.2313
San Diego, CA	
*San Francisco, CA	1.4902
Marin, CA	
San Francisco, CA	
San Mateo, CA	
*San Jose, CA	1.4279
Santa Clara, CA	
*San Juan, PR	0.5369
Barcelona, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Lugaillo, PR	
Manati, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Troje Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1392
Santa Barbara, CA	
Santa Cruz, CA	1.1980
Santa Cruz, CA	
Santa Fe, NM	0.9334
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.3232
Sonoma, CA	
Sarasota, FL	0.8975
Charlotte, FL	
Sarasota, FL	
Savannah, GA	0.8380

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	0.9290
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
*Seattle, WA	1.0868
King, WA	
Snohomish, WA	
Sharon, PA	0.9170
Mercer, PA	
Sheboygan, WI	0.9289
Sheboygan, WI	
Sherman-Denison, TX	0.8259
Grayson, TX	
Shreveport, LA	0.8967
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	0.9221
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	0.9523
Minnehaha, SD	
South Bend-Mishawaka, IN	0.9576
St. Joseph, IN	
Spokane, WA	1.0790
Spokane, WA	
Springfield, IL	0.9871
Christian, IL	
Menard, IL	
Sangamon, IL	
Springfield, MO	0.9047
Christian, MO	
Greene, MO	
Springfield, MA	0.9727
Hampden, MA	
Hampshire, MA	
State College, PA	1.0272
Centre, PA	
Steubenville-Weirton, OH-WV	0.9078
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1708
San Joaquin, CA	
Syracuse, NY	0.9700
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0294
Pierce, WA	
Tallahassee, FL	0.8506
Gadsden, FL	
Leon, FL	
*Tampa-St. Petersburg-Clearwater, FL	0.9098
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	0.8065
Clay, IN	
Virgo, IN	
Texarkana, TX-Texarkana, AR	0.8047
Miller, AR	
Bowie, TX	
Toledo, OH	1.1069
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KA	0.9759
Jefferson, KS	
Shawnee, KS	
Trenton, NJ	0.9982

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Mercer, NJ	
Tucson, AZ	0.9609
Pima, AZ	
Tulsa, OK	0.9319
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	0.9471
Tuscaloosa, AL	
Tyler, TX	0.9298
Smith, TX	
Utica-Rome, NY	0.8186
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.2408
Napa, CA	
Solano, CA	
Vancouver, WA	1.0740
Clark, WA	
Victoria, TX	0.7968
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	0.9550
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.1380
Tulare, CA	
Waco, TX	0.8559
McLennan, TX	
*Washington, DC-MD-VA	1.0922
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	
Fredericksburg City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Jefferson, WV	
Waterloo-Cedar Falls, IA	0.9403
Black Hawk, IA	
Bremer, IA	
Wausau, WI	0.9428

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

Areas That Qualify as Large Urban Areas Are Designated With an Asterisk

Urban area (constituent counties or county equivalents)	Wage index
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	0.9402
Palm Beach, FL	
Wheeling, WV-OH	0.8848
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.0438
Butler, KS	
Harvey, KS	
Sedgwick, KS	
Wichita Falls, TX	0.8264
Wichita, TX	
Williamsport, PA	0.8845
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0093
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	0.8577
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	0.9431
Worcester, MA	
Yakima, WA	0.9820
Yakima, WA	
York, PA	0.9312
Adams, PA	
York, PA	
Youngstown-Warren, OH	0.9912
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	0.9939
Sutter, CA	
Yuba, CA	

TABLE 4B.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.6926
Alaska	1.3880
Arizona	0.8753
Arkansas	0.7100
California	1.0397
Colorado	0.8640
Connecticut	0.9982
Delaware	0.8211
Florida	0.8007
Georgia	0.7363
Hawaii	0.9172

TABLE 4B.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Idaho	0.8302
Illinois	0.8171
Indiana	0.8073
Iowa	0.8046
Kansas	0.7922
Kentucky	0.7730
Louisiana	0.7818
Maine	0.8166
Maryland	0.8088
Massachusetts	1.0003
Michigan	0.8968
Minnesota	0.8578
Mississippi	0.7193
Missouri	0.7626
Montana	0.8532
Nebraska	0.7728
Nevada	0.9789
New Hampshire	0.8765
New Jersey ¹	
New Mexico	0.8335
New York	0.8129
North Carolina	0.7626
North Dakota	0.8437
Ohio	0.8570
Oklahoma	0.7914
Oregon	0.9999
Pennsylvania	0.8788
Puerto Rico	0.5377
Rhode Island ¹	
South Carolina	0.7260
South Dakota	0.7645
Tennessee	0.7140
Texas	0.7623
Utah	0.8756
Vermont	0.8362
Virginia	0.7747
Washington	0.9767
West Virginia	0.8387
Wisconsin	0.8395
Wyoming	0.9072

¹ All counties within the State are classified urban.

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TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
1	01	SURG				
2	01	SURG	3.4873	14.0	36	38
3	01	SURG	4.1406	13.0	35	37
4	01	SURG	2.9183	12.7	34	37
5	01	SURG	2.6837	12.2	34	36
6	01	SURG	1.5585	6.5	21	30
7	01	SURG	.4496	2.0	8	16
8	01	SURG	2.8433	11.8	34	36
9	01	SURG	.7432	3.3	20	27
10	01	MED	1.2857	7.0	29	31
11	01	MED	1.2443	7.8	30	32
12	01	MED	.7852	5.0	27	29
13	01	MED	.9296	6.9	29	31
14	01	MED	.9281	7.4	29	31
15	01	MED	1.2348	7.5	29	31
16	01	MED	.6333	4.2	17	28
17	01	MED	1.0512	6.6	29	31
18	01	MED	.6302	4.5	20	29
19	01	MED	.9585	6.3	28	30
20	01	MED	.6085	4.3	22	28
21	01	MED	1.7083	7.9	30	32
22	01	MED	1.3601	7.2	29	31
23	01	MED	.7025	4.5	18	29
24	01	MED	.9441	4.5	27	29
25	01	MED	.9528	5.3	25	29
26	01	MED	.5332	3.6	15	28
27	01	MED	.9116	2.9	20	27
28	01	MED	1.6526	4.7	27	29
29	01	MED	1.2170	6.0	28	30
30	01	MED	.5937	3.5	20	28
31	01	MED	.3539	2.0	8	17
32	01	MED	.6667	4.2	22	28
33	01	MED	.4083	2.8	13	27
34	01	MED	.2457	1.6	5	9
35	01	MED	1.2705	6.2	28	30
			.5770	3.9	19	28

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988. THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	*** (B)
36	02	SURG	RETINAL PROCEDURES	.6571	2.9	16
37	02	SURG	ORBITAL PROCEDURES	.7274	3.0	27
38	02	SURG	PRIMARY IRIS PROCEDURES	.3692	2.2	17
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.4722	1.7	7
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.4763	2.0	18
41	02	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3657	1.6	7
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6424	2.4	17
43	02	MED	HYPHEMA	.3699	3.7	28
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6346	5.8	30
45	02	MED	NEUROLOGICAL EYE DISORDERS	.5532	3.4	27
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/ CC	.6321	3.9	28
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.3652	2.6	27
48	02	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.4018	2.9	27
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	2.8418	11.2	35
50	03	SURG	SIALOADENECTOMY	.6448	2.6	17
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.5708	2.3	16
52	03	SURG	CLEFT LIP & PALATE REPAIR	.8499	3.0	27
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.6172	2.1	20
54	03	SURG	* SINUS & MASTOID PROCEDURES AGE 0-17	.6889	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.4613	1.7	12
56	03	SURG	RHINOPLASTY	.4684	1.8	13
57	03	SURG	T&A PROC. EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.9321	3.6	28
58	03	SURG	* T&A PROC. EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3097	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.3901	1.6	10
60	03	SURG	* TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2616	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	.7994	2.6	27
62	03	SURG	* MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3089	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1811	4.4	28
64	03	SURG	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.0883	4.9	29
65	03	MED	DYSEQUILIBRIUM	.4557	3.4	23
66	03	MED	EPISTAXIS	.4394	3.2	25
67	03	MED	EPIGLOTTITIS	1.0470	4.8	29
68	03	MED	OTITIS MEDIA & URI AGE >17 WITH CC	.7806	5.1	29
69	03	MED	* OTITIS MEDIA & URI AGE >17 W/O CC	.5349	3.9	27
70	03	MED	OTITIS MEDIA & URI AGE 0-17	.5853	3.4	27

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988.

THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
106	05	SURG				**
107	05	SURG	5.5493	14.3	36	38
108	05	SURG	4.2102	11.0	28	35
109	05	SURG	5.5817	11.4	33	35
110	05	SURG	3.7756	7.4	29	31
111	05	SURG	3.6677	12.7	35	37
112	05	SURG	2.1617	8.9	27	33
113	05	SURG	1.9042	5.7	28	30
114	05	SURG	2.4673	14.7	37	39
115	05	SURG	1.7145	10.2	32	34
116	05	SURG	3.9800	12.8	35	37
117	05	SURG	2.6632	6.5	25	30
118	05	SURG	1.2223	4.6	23	29
119	05	SURG	1.6529	2.8	13	27
120	05	SURG	.8264	4.0	23	28
121	05	MED	2.7403	11.3	33	35
122	05	MED	1.6545	9.1	31	33
123	05	MED	1.1455	6.8	26	31
124	05	MED	1.4232	3.0	25	27
125	05	MED	1.1854	4.5	24	28
126	05	MED	.6823	2.4	10	20
127	05	MED	3.0532	17.3	39	41
128	05	MED	1.0365	6.2	26	30
129	05	MED	.8359	8.0	22	32
130	05	MED	1.5132	2.8	25	27
131	05	MED	.8896	5.8	28	30
132	05	MED	.5886	4.2	24	28
133	05	MED	.7738	4.5	19	28
134	05	MED	.5624	3.4	14	27
135	05	MED	.6026	4.3	17	28
136	05	MED	.8927	5.2	24	29
137	05	MED	.5713	3.6	14	28
138	05	MED	.6315	3.3	21	27
139	05	MED	.8488	4.8	20	29
140	05	MED	.5742	3.5	14	27
			.6559	4.1	14	26

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988. THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
141	05	MED	.6882	4.5	18	28
142	05	MED	.5203	3.4	13	24
143	05	MED	.5397	3.0	11	20
144	05	MED	1.1483	5.8	28	30
145	05	MED	.6434	3.6	16	28
146	06	SURG	2.7773	14.3	36	38
147	06	SURG	1.8664	10.7	26	35
148	06	SURG	3.2745	14.6	37	39
149	06	SURG	1.7756	10.4	23	34
150	06	SURG	2.7173	12.6	35	37
151	06	SURG	1.4527	8.7	25	33
152	06	SURG	1.4807	8.1	30	32
153	06	SURG	1.0636	6.8	21	31
154	06	SURG	3.8125	13.3	35	37
155	06	SURG	1.7209	8.5	30	32
156	06	SURG	.8382	6.0	21	30
157	06	SURG	.9779	5.5	25	30
158	06	SURG	.5287	3.2	12	25
159	06	SURG	1.1103	5.7	23	30
160	06	SURG	.6585	3.7	13	25
161	06	SURG	.7331	3.7	16	28
162	06	SURG	.4714	2.4	8	15
163	06	SURG	.9388	4.6	23	29
164	06	SURG	2.4065	11.2	31	35
165	06	SURG	1.4236	7.9	18	27
166	06	SURG	1.4556	7.0	23	31
167	06	SURG	.8008	4.5	11	18
168	03	SURG	.9713	3.6	24	28
169	03	SURG	.5320	2.2	9	19
170	06	SURG	2.7677	11.4	33	35
171	06	SURG	1.3797	6.6	29	31
172	06	MED	1.2026	7.0	29	31
173	06	MED	.7004	4.2	25	28
174	06	MED	.9816	5.7	23	30
175	06	MED	.6376	4.3	14	26

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

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*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988.

THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
176	06	MED				
177	06	MED	.9927	6.1	25	30
178	06	MED	.7733	5.4	18	29
179	06	MED	.5684	4.2	13	23
180	06	MED	1.0929	7.3	29	31
			.9165	5.9	27	30
181	06	MED				
182	06	MED	.5340	4.1	15	28
183	06	MED	.7386	5.0	19	29
184	06	MED	.5284	3.7	14	27
185	03	MED	.6446	2.9	16	27
			.7488	4.3	23	28
186	03	MED				
187	03	MED	.4112	2.9	11	23
188	06	MED	.4579	2.1	8	16
189	06	MED	.9575	5.1	27	29
190	06	MED	.4872	3.0	15	27
			.7933	4.2	19	28
191	07	SURG				
192	07	SURG	5.3135	17.8	40	42
193	07	SURG	2.4801	11.7	34	36
194	07	SURG	3.0566	14.8	37	39
195	07	SURG	1.8809	10.7	33	35
			2.3363	12.1	32	36
196	07	SURG				
197	07	SURG	1.5628	9.3	21	31
198	07	SURG	1.7757	9.2	26	33
199	07	SURG	1.0456	6.5	15	22
200	07	SURG	2.2894	12.5	34	36
			2.6844	9.6	32	34
201	07	SURG				
202	07	MED	2.4875	9.0	31	33
203	07	MED	1.2400	7.4	29	31
204	07	MED	1.0904	6.6	29	31
205	07	MED	1.0266	6.1	24	30
			1.2386	6.8	29	31
206	07	MED				
207	07	MED	.6406	4.0	23	28
208	07	MED	.9574	5.7	24	30
209	08	SURG	.5798	3.7	15	28
210	08	SURG	2.3829	11.9	27	36
			2.1237	13.2	35	37

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988.

THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.5418	10.7	26	35
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4611	7.3	29	31
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7667	10.2	32	34
214	08	SURG	BACK & NECK PROCEDURES WITH CC	2.0618	12.0	34	36
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.3053	8.4	24	32
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.6331	8.5	30	32
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCULET & CONN TISS DIS	2.9985	13.9	36	38
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 WITH CC	1.5637	8.7	31	33
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	.9848	5.6	20	30
220	08	SURG	* LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	.9242	5.3	26	29
221	08	SURG	KNEE PROCEDURES WITH CC	1.5164	6.5	28	30
222	08	SURG	KNEE PROCEDURES W/O CC	.8259	3.5	20	27
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.0621	4.8	21	29
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	.6378	2.9	11	20
225	08	SURG	FOOT PROCEDURES	.6972	3.2	16	27
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3916	6.7	29	31
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6656	3.2	15	27
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	.8098	3.0	14	27
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5153	2.0	8	16
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.8502	4.3	25	28
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	.8773	3.6	23	28
232	08	SURG	ARTHROSCOPY	.9593	3.3	25	27
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC	1.6745	8.8	31	33
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	.8595	4.6	22	29
235	08	MED	FRACTURES OF FEMUR	1.1956	8.3	30	32
236	08	MED	FRACTURES OF HIP & PELVIS	.8869	7.1	29	31
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5724	4.7	21	29
238	08	MED	OSTEOMYELITIS	1.6503	10.8	33	35
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	.9787	7.6	30	32
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.1186	7.3	29	31
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6354	5.1	21	29
242	08	MED	SEPTIC ARTHRITIS	1.3247	8.5	31	33
243	08	MED	MEDICAL BACK PROBLEMS	.6560	5.1	26	29
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7181	5.5	26	30
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5214	4.2	18	28

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988.

NOTE: THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	*** (B)
246	08	MED				
247	08	MED	.5672	4.5	18	29
248	08	MED	.5365	3.8	18	28
249	08	MED	.6176	4.4	20	28
250	08	MED	.6678	4.4	26	28
251	08	MED	.6679	4.4	24	28
252	08	MED				
253	08	MED	.4203	2.5	11	24
254	08	MED	.3496	1.8	7	15
255	08	MED	.7831	6.0	28	30
256	08	MED	.4426	3.7	18	28
257	09	MED	.4638	2.9	16	27
258	09	MED				
259	09	MED	.6419	4.0	20	28
260	09	MED	.9893	6.0	17	29
261	09	MED	.7915	4.8	12	20
262	09	MED	.9873	5.0	27	29
263	09	MED	.6023	2.9	11	21
264	09	MED				
265	09	MED	.6377	2.6	9	17
266	09	MED	.4375	1.9	7	12
267	09	MED	2.7018	15.7	38	40
268	09	MED	1.5881	10.6	33	35
269	09	MED	1.4303	6.9	29	31
270	09	MED				
271	09	MED	.6895	3.3	19	27
272	09	MED	.6068	3.1	16	27
273	09	MED	.6173	2.5	13	27
274	09	MED	1.6854	8.1	30	32
275	09	MED	.6966	3.4	19	27
276	09	MED				
277	09	MED	1.2174	8.8	31	33
278	09	MED	1.0366	7.4	29	31
279	09	MED	.7079	5.9	26	30
280	09	MED	1.0508	6.4	28	30
281	09	MED	.5735	3.4	21	27
282	09	MED				
283	09	MED	.5320	3.1	17	27
284	09	MED	.9624	7.3	25	31
285	09	MED	.6829	5.8	18	30
286	09	MED	.7367	4.2	13	24
287	09	MED	.6403	4.6	23	29

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*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988.

THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

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TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
281	09	MED				***
282	09	MED	.4249	3.3	15	27
283	09	MED	.3424	2.2	9	19
284	09	MED	.7760	5.5	26	30
285	10	SURG	.4839	3.7	18	28
			3.0283	17.5	40	42
286	10	SURG				
287	10	SURG	2.5944	11.3	33	35
288	10	SURG	2.2201	13.7	36	38
289	10	SURG	2.0873	7.9	30	32
290	10	SURG	1.0952	5.1	20	29
			.8046	3.7	12	23
291	10	SURG				
292	10	SURG	.5103	2.2	7	14
293	10	SURG	2.7120	12.3	34	36
294	10	MED	1.1954	6.6	29	31
295	10	MED	.7587	6.1	22	30
			.7713	4.6	20	29
296	10	MED				
297	10	MED	.9396	6.1	28	30
298	10	MED	.5728	4.4	17	28
299	10	MED	.6434	3.3	15	27
300	10	MED	.8451	4.8	27	29
			1.1179	7.2	29	31
301	10	MED				
302	11	SURG	.6420	4.6	21	29
303	11	SURG	3.7012	15.8	38	40
304	11	SURG	2.7491	12.6	35	37
305	11	SURG	2.4603	10.9	33	35
			1.3334	6.2	28	30
306	11	SURG				
307	11	SURG	1.4321	8.1	30	32
308	11	SURG	.8634	5.2	17	29
309	11	SURG	1.5480	7.3	29	31
310	11	SURG	.8343	4.0	20	28
			.9112	4.6	22	29
311	11	SURG				
312	11	SURG	.5434	2.7	10	20
313	11	SURG	.8282	4.2	22	28
314	11	SURG	.5054	2.6	11	23
315	11	SURG	.4323	2.3	12	26
			2.4142	8.5	31	33

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*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988. THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
316	11	MED	1.2811	6.4	28	30
317	11	MED	.3494	2.0	9	19
318	11	MED	1.0683	6.2	28	30
319	11	MED	.5777	3.0	17	27
320	11	MED	1.0427	7.0	25	31
321	11	MED	.7247	5.5	18	29
322	11	MED	.7487	5.2	18	29
323	11	MED	.7915	3.1	15	27
324	11	MED	.4034	2.3	9	17
325	11	MED	.6933	4.6	21	29
326	11	MED	.4357	3.1	13	26
327	11	MED	.5511	3.1	15	27
328	11	MED	.6200	3.9	17	28
329	11	MED	.4227	2.5	10	21
330	11	MED	.2788	1.6	5	9
331	11	MED	.9143	5.4	27	29
332	11	MED	.5636	3.5	18	27
333	11	MED	.6645	3.5	21	27
334	12	SURG	1.8513	11.1	27	35
335	12	SURG	1.3617	8.9	18	26
336	12	SURG	1.0162	6.2	18	30
337	12	SURG	.6950	4.5	11	16
338	12	SURG	.7524	3.2	22	27
339	12	SURG	.5867	2.7	13	27
340	12	SURG	.4335	2.4	7	13
341	12	SURG	.9828	4.0	15	28
342	12	SURG	.4489	2.1	9	20
343	12	SURG	.3788	1.7	4	6
344	12	SURG	1.0815	5.5	23	30
345	12	SURG	.7907	4.1	21	28
346	12	MED	.9178	5.6	28	30
347	12	MED	.4833	2.6	13	27
348	12	MED	.6717	3.8	21	28
349	12	MED	.3870	2.1	9	17
350	12	MED	.6760	5.0	16	29

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THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	*** (B)
351	12	MED	* STERILIZATION, MALE	.3333	3	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5360	15	27
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	2.2704	35	37
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.4985	23	33
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.9453	12	17
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7596	13	20
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.2107	33	35
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.2466	19	30
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8525	11	15
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.7439	21	28
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.7185	16	27
362	13	SURG	ENDOSCOPIC TUBAL INTERRUPTION	.3701	5	10
363	13	SURG	D&C, COMIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6828	17	28
364	13	SURG	D&C, COMIZATION EXCEPT FOR MALIGNANCY	.4411	9	18
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9412	32	34
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.1233	28	30
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5110	16	27
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8683	23	30
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5058	17	27
370	14	SURG	CESAREAN SECTION W CC	.9456	19	30
371	14	SURG	CESAREAN SECTION W/O CC	.7099	10	14
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4442	11	20
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3099	6	9
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.5542	7	11
375	14	SURG	* VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6817	16	28
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3887	11	21
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	.6574	14	27
378	14	MED	ECTOPIC PREGNANCY	.7938	12	20
379	14	MED	THREATENED ABORTION	.2956	9	18
380	14	MED	ABORTION W/O D&C	.2531	6	11
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.3872	6	11
382	14	MED	FALSE LABOR	.1242	3	5
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.4416	18	28
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3200	12	26
385	15		* NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2232	15	26

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
386	15	* EXTREME IMMATURETY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.6480	17.9	39	42
387	15	* PREMATURETY W MAJOR PROBLEMS	1.8267	13.3	34	37
388	15	* PREMATURETY W/O MAJOR PROBLEMS	1.1571	8.6	30	33
389	15	* FULL TERM NEONATE W MAJOR PROBLEMS	1.7896	7.0	29	31
390	15	* NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1117	5.4	27	29
391	15	* NORMAL NEWBORN	.2218	3.1	7	11
392	16	* SPLENECTOMY AGE >17	3.6972	12.9	35	37
393	16	* SPLENECTOMY AGE 0-17	1.5206	9.1	30	33
394	16	* OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.4618	5.5	28	30
395	16	* RED BLOOD CELL DISORDERS AGE >17	.7427	4.5	23	29
396	16	* RED BLOOD CELL DISORDERS AGE 0-17	.4539	1.8	10	24
397	16	* COAGULATION DISORDERS	1.0425	5.6	28	30
398	16	* RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.2472	6.6	29	31
399	16	* RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6899	4.1	21	28
400	17	* LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.7513	11.1	33	35
401	17	* LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.1688	10.3	32	34
402	17	* LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	.9001	4.3	26	28
403	17	* LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.5824	8.2	30	32
404	17	* LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8024	4.8	27	29
405	17	* ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0407	4.9	26	29
406	17	* MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.7843	12.7	35	37
407	17	* MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	1.4537	7.0	29	31
408	17	* MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC	.9274	4.1	24	28
409	17	* RADIOTHERAPY	1.0473	6.9	29	31
410	17	* CHEMOTHERAPY	.4811	2.6	10	20
411	17	* HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4733	2.8	13	27
412	17	* HISTORY OF MALIGNANCY W ENDOSCOPY	.4334	2.2	10	21
413	17	* OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.2412	7.2	29	31
414	17	* OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.7876	4.9	27	29
415	18	* O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5992	15.0	37	39
416	18	* SEPTICEMIA AGE >17	1.5896	7.6	30	32
417	18	* SEPTICEMIA AGE 0-17	1.0354	5.9	27	30
418	18	* POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0188	6.9	29	31
419	18	* FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9854	5.9	24	30
420	18	* FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6760	4.6	17	29

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)
421	18	MED				
422	18	MED	.6529	4.4	17	28
423	18	MED	.7780	3.5	20	28
424	19	SURG	1.6059	8.2	30	32
425	19	MED	2.2865	12.8	35	37
			.6215	4.4	22	28
426	19	MED				
427	19	MED	.6286	5.8	28	30
428	19	MED	.5994	5.3	27	29
429	19	MED	.7351	6.1	28	30
430	19	MED	.8932	7.3	29	31
			.9089	8.8	31	33
431	19	MED				
432	19	MED	.7028	6.1	28	30
433	20		.7004	4.4	26	28
434	20		.4110	3.2	21	27
435	20		.8095	5.9	28	30
			.5738	5.0	27	29
436	20					
437	20		1.0164	11.2	33	35
438	20		1.2760	14.4	36	38
439	20		.0000	.0	0	0
440	21	SURG	1.7151	7.1	29	31
			2.4994	10.5	33	35
441	21	SURG				
442	21	SURG	.7038	2.5	14	26
443	21	SURG	1.9165	5.9	28	30
444	21	SURG	1.1903	4.2	26	28
445	21	MED	.7824	5.2	25	29
			.5207	3.8	17	28
446	21	MED				
447	21	MED	.4796	2.4	10	22
448	21	MED	.4734	2.6	12	24
449	21	MED	.3470	2.9	9	17
450	21	MED	.8077	4.5	22	28
			.4800	2.9	14	27
451	21	MED				
452	21	MED	.4819	2.9	18	27
453	21	MED	.9455	4.8	27	29
454	21	MED	.5064	3.2	16	27
455	21	MED	.8993	4.4	26	28
			.4405	2.7	13	27

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988.

THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD (A)	OUTLIER THRESHOLD (B)	***
456	22	MED	1.5827	4.7	27	29	26
457	22	SURG	2.6766	3.8	26	28	28
458	22	SURG	4.0349	17.1	39	41	34
459	22	SURG	2.0305	10.3	32	34	30
460	22	MED	1.0193	5.5	28		
461	23	SURG	.7333	2.4	17		
462	23	MED	1.8085	13.6	36		
463	23	MED	.7692	5.2	25		
464	23	MED	.4831	3.5	15		
465	23	MED	.3436	1.9	7		
466	23	MED	.5566	2.7	20		
467	23	MED	.4461	3.1	25		
468			3.3045	12.5	35		
469			.0000	.0	0		
470			.0000	.0	0		
471	08	SURG	4.1503	16.9	39		
472	22	SURG	12.2265	19.1	41		
473	17		2.9296	9.0	31		
474	04		12.3838	34.5	57		
475	04	MED	3.1437	8.9	31		
476			2.2225	14.9	37		
477			1.3763	6.3	28		

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

*** THE OUTLIER THRESHOLDS IN COLUMN (A) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER OCTOBER 1, 1988 AND BEFORE NOVEMBER 1, 1988. THE OUTLIER THRESHOLDS IN COLUMN (B) APPLY TO DISCHARGES THAT OCCUR ON OR AFTER NOVEMBER 1, 1988.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES. NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

BILLING CODE 4120-01-C

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	DRG
764.00.....	"Light-for-dates" without mention of fetal malnutrition, unspecified [weight].	390
764.01.....	"Light-for-dates" without mention of fetal malnutrition, less than 500 grams.	390
764.02.....	"Light-for-dates" without mention of fetal malnutrition, 500-749 grams.	390
764.03.....	"Light-for-dates" without mention of fetal malnutrition, 750-999 grams.	390
764.04.....	"Light-for-dates" without mention of fetal malnutrition, 1,000-1,249 grams.	390
764.05.....	"Light-for-dates" without mention of fetal malnutrition, 1,250-1,499 grams.	390
764.06.....	"Light-for-dates" without mention of fetal malnutrition, 1,500-1,749 grams.	390
764.07.....	"Light-for-dates" without mention of fetal malnutrition, 1,750-1,999 grams.	390
764.08.....	"Light-for-dates" without mention of fetal malnutrition, 2,000-2,499 grams.	390
764.09.....	"Light-for-dates" without mention of fetal malnutrition, 2,500+ grams.	391
764.10.....	"Light-for-dates" with signs of fetal malnutrition, unspecified [weight].	390
764.11.....	"Light-for-dates" with signs of fetal malnutrition, less than 500 grams.	389
764.12.....	"Light-for-dates" with signs of fetal malnutrition, 500-749 grams.	389
764.13.....	"Light-for-dates" with signs of fetal malnutrition, 750-999 grams.	389
764.14.....	"Light-for-dates" with signs of fetal malnutrition, 1,000-1,249 grams.	389
764.15.....	"Light-for-dates" with signs of fetal malnutrition, 1,250-1,499 grams.	389
764.16.....	"Light-for-dates" with signs of fetal malnutrition, 1,500-1,749 grams.	389
764.17.....	"Light-for-dates" with signs of fetal malnutrition, 1,750-1,999 grams.	389
764.18.....	"Light-for-dates" with signs of fetal malnutrition, 2,000-2,499 grams.	389
764.19.....	"Light-for-dates" with signs of fetal malnutrition, 2,500+ grams.	390
764.20.....	Fetal malnutrition without mention of "light-for-dates", unspecified [weight].	390
764.21.....	Fetal malnutrition without mention of "light-for-dates", less than 500 grams.	389
764.22.....	Fetal malnutrition without mention of "light-for-dates", 500-749 grams.	389
764.23.....	Fetal malnutrition without mention of "light-for-dates", 750-999 grams.	389
764.24.....	Fetal malnutrition without mention of "light-for-dates", 1,000-1,249 grams.	389

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	DRG
764.25.....	Fetal malnutrition without mention of "light-for-dates", 1,250-1,499 grams.	389
764.26.....	Fetal malnutrition without mention of "light-for-dates", 1,500-1,749 grams.	389
764.27.....	Fetal malnutrition without mention of "light-for-dates", 1,750-1,999 grams.	389
764.28.....	Fetal malnutrition without mention of "light-for-dates", 2,000-2,499 grams.	389
764.29.....	Fetal malnutrition without mention of "light-for-dates", 2,500+ grams.	390
764.90.....	Fetal growth retardation, unspecified, unspecified [weight].	390
764.91.....	Fetal growth retardation, unspecified, unless than 500 grams.	390
764.92.....	Fetal growth retardation, unspecified, 500-749 grams.	390
764.93.....	Fetal growth retardation, unspecified, 750-999 grams.	390
764.94.....	Fetal growth retardation, unspecified, 1,000-1,249 grams.	390
764.95.....	Fetal growth retardation, unspecified, 1,250-1,499 grams.	390
764.96.....	Fetal growth retardation, unspecified, 1,500-1,749 grams.	390
764.97.....	Fetal growth retardation, unspecified, 1,750-1,999 grams.	390
764.98.....	Fetal growth retardation, unspecified, 2,000-2,499 grams.	390
764.99.....	Fetal growth retardation, unspecified, 2,500+ grams.	391
765.00.....	Extreme immaturity, unspecified [weight].	387, 388
765.01.....	Extreme immaturity, less than 500 grams.	386
765.02.....	Extreme immaturity, 500-749 grams.	386
765.03.....	Extreme immaturity, 750-999 grams.	386
765.04.....	Extreme immaturity, 1,000-1,249 grams.	386
765.05.....	Extreme immaturity, 1,250-1,499 grams.	386
765.06.....	Extreme immaturity, 1,500-1,749 grams.	387, 388
765.07.....	Extreme immaturity, 1,750-1,999 grams.	387, 388
765.08.....	Extreme immaturity, 2,000-2,499 grams.	387, 388
765.09.....	Extreme immaturity, 2,500+ grams.	470
765.10.....	Other preterm infants, unspecified [weight].	387, 388
765.11.....	Other preterm infants, less than 500 grams.	387, 388
765.12.....	Other preterm infants, 500-749 grams.	387, 388
765.13.....	Other preterm infants, 750-999 grams.	387, 388
765.14.....	Other preterm infants, 1,000-1,249 grams.	387, 388
765.15.....	Other preterm infants, 1,250-1,499 grams.	387, 388
765.16.....	Other preterm infants, 1,500-1,749 grams.	387, 388

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	DRG
765.17.....	Other preterm infants, 1,750-1,999 grams.	387, 388
765.18.....	Other preterm infants, 2,000-2,499 grams.	387, 388
765.19.....	Other preterm infants, 2,500+ grams.	387, 388

TABLE 6B.—NEW OR REVISED PROCEDURE CODES

Procedure Code	Description	DRG
20.95.....	Implantation of electromagnetic hearing device.	55
22.11.....	Closed [endoscopic] [needle] biopsy of nasal sinus.	Non-OR
22.12.....	Open biopsy of nasal sinus.	53, 54
25.01.....	Closed [needle] biopsy of tongue.	Non-OR
25.02.....	Open biopsy of tongue Wedge biopsy.	168, 169
26.11.....	Closed [needle] biopsy of salivary gland or duct.	Non-OR
26.12.....	Open biopsy of salivary gland or duct.	51
31.43.....	Closed [endoscopic] biopsy of larynx.	Non-OR
31.44.....	Closed [endoscopic] biopsy of trachea.	Non-OR
31.45.....	Open biopsy of larynx or trachea.	55, 76, 77
35.84.....	Total correction of transposition of great vessels, not elsewhere classified.	108, 109
37.26.....	Cardiac electrophysiologic stimulation and recording studies.	Non-OR
37.27.....	Cardiac mapping.	Non-OR
37.33.....	Excision or destruction of other lesion or tissue of heart.	108, 109
37.34.....	Catheter ablation of lesion or tissues of heart.	108, 112
39.61.....	Extracorporeal circulation auxiliary to open heart surgery.	Non-OR
39.65.....	Extracorporeal membrane oxygenation [ECMO].	Non-OR
41.00.....	Bone marrow transplant, not otherwise specified.	394, 400, 406, 407
41.01.....	Autologous bone marrow transplant.	394, 400, 406, 407
41.02.....	Allogeneic bone marrow transplant with purging.	394, 400, 406, 407
41.03.....	Allogeneic bone marrow transplant without purging.	394, 400, 406, 407
42.24.....	Closed [endoscopic] biopsy of esophagus.	Non-OR
42.25.....	Open biopsy of esophagus.	63, 154, 155, 156, 400, 406, 407
45.16.....	Esophagogastroduodenoscopy [EGD] with closed biopsy.	Non-OR
45.23.....	Colonoscopy.	Non-OR
45.24.....	Flexible sigmoidoscopy.	Non-OR
45.42.....	Endoscopic polypectomy of large intestine.	Non-OR
48.23.....	Rigid proctosigmoidoscopy.	Non-OR

TABLE 6B.—NEW OR REVISED
PROCEDURE CODES—Continued

Procedure Code	Description	DRG
48.29.....	Other diagnostic procedures on rectum, rectosigmoid, and perirectal tissue.	Non-OR
86.22.....	Excisional debridement of wound, infection, or burn.	7, 8, 40, 41, 63, 76, 77, 120, 170, 171, 201, 217, 263, 264, 265, 266, 287, 315, 365, 394, 440, 459, 472
86.28.....	Nonexcisional debridement of wound, infection, or burn.	Non-OR
89.17.....	Polysomnogram.....	Non-OR
89.18.....	Other sleep disorder function tests.	Non-OR
89.59.....	Other nonoperative cardiac and vascular measurements.	Non-OR
93.90.....	Continuous positive airway pressure [CPAP].	¹ Non-OR
93.92.....	Other mechanical ventilation.	¹ Non-OR
99.71.....	Therapeutic plasmapheresis.	Non-OR
99.72.....	Therapeutic leukopheresis.	Non-OR
99.73.....	Therapeutic erythrocytapheresis.	Non-OR
99.74.....	Therapeutic plateletpheresis.	Non-OR
99.79.....	Other ²	Non-OR
99.88.....	Therapeutic photopheresis.	Non-OR

¹ If coded in addition with 96.04, Insertion of endotracheal tube, case may be assigned to DRG 475.

² Other therapeutic apheresis.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND
OTHER NONEXTENSIVE PROCEDURES
UNRELATED TO PRINCIPAL PROCEDURES
THAT GROUP TO DRG 477

Procedure code	Procedure
04.07.....	Other excision or avulsion of cranial and peripheral nerves.
04.43.....	Release of carpal tunnel.
08.11.....	Biopsy of eyelid.
08.20.....	Removal of lesion of eyelid, not otherwise specified (NOS).
08.21.....	Excision of chalazion.
08.22.....	Excision of other minor lesion of eyelid.
08.25.....	Destruction of lesion of eyelid.
08.33.....	Repair of blepharoptosis by resection or advancement of levator muscle or aponeurosis.
08.36.....	Repair of blepharoptosis by other techniques.
08.49.....	Other repair or entropion or ectropion.
08.52.....	Blepharorrhaphy.
08.59.....	Other adjustment of lid position.
08.70.....	Reconstruction of eyelid, NOS.
08.74.....	Other reconstruction of eyelid, full-thickness.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND
OTHER NONEXTENSIVE PROCEDURES
UNRELATED TO PRINCIPAL PROCEDURES
THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
08.81.....	Linear repair of laceration of eyelid or eyebrow.
08.82.....	Repair of laceration involving lid margin, partial-thickness.
08.83.....	Other repair of laceration of eyelid, partial-thickness.
08.84.....	Repair of laceration involving lid margin, full-thickness.
08.85.....	Other repair of laceration of eyelid, full-thickness.
08.86.....	Lower eyelid rhytidectomy.
08.87.....	Upper eyelid rhytidectomy.
08.89.....	Other eyelid repair.
08.91.....	Electrosurgical epilation of eyelid.
08.92.....	Cryosurgical epilation of eyelid.
08.93.....	Other epilation of eyelid.
08.99.....	Other operations on eyelids.
09.20.....	Excision of lacrimal gland, NOS.
09.21.....	Excision of lesion of lacrimal gland.
10.6.....	Repair of laceration of conjunctiva.
12.72.....	Cyclocryotherapy.
13.11.....	Intracapsular extraction of lens by temporal inferior route.
13.19.....	Other intracapsular extraction of lens.
13.2.....	Extracapsular extraction of lens by linear extraction technique.
13.3.....	Extracapsular extraction of lens by simple aspiration (and irrigation) technique.
13.41.....	Phacoemulsification and aspiration of cataract.
13.42.....	Mechanical phacofragmentation and aspiration of cataract by posterior route.
13.43.....	Mechanical phacofragmentation and other aspiration of cataract.
13.51.....	Extracapsular extraction of lens by temporal inferior route.
13.59.....	Other extracapsular extraction of lens.
13.61.....	Dissection of primary membranous cataract.
13.62.....	Excision of primary membranous cataract.
13.63.....	Mechanical fragmentation of primary membranous cataract.
13.64.....	Dissection of secondary membrane [after cataract].
13.65.....	Excision of secondary membrane [after cataract].

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND
OTHER NONEXTENSIVE PROCEDURES
UNRELATED TO PRINCIPAL PROCEDURES
THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
13.66.....	Mechanical fragmentation of secondary membrane [after cataract].
13.69.....	Other cataract extraction.
13.70.....	Insertion of pseudophakos, NOS.
13.71.....	Insertion of intraocular lens prosthesis at time of cataract extraction, one-stage.
13.8.....	Removal of implanted lens.
13.9.....	Other operations on lens.
14.71.....	Removal of vitreous, anterior approach.
14.72.....	Other removal of vitreous.
14.73.....	Mechanical vitrectomy by anterior approach.
14.74.....	Other mechanical vitrectomy.
14.75.....	Injection of vitreous substitute.
14.79.....	Other operations on vitreous.
15.13.....	Resection of one extraocular muscle.
20.01.....	Myringotomy with insertion of tube.
21.5.....	Submucous resection of nasal septum.
21.84.....	Revision rhinoplasty.
21.85.....	Augmentation rhinoplasty.
21.86.....	Limited rhinoplasty.
21.87.....	Other rhinoplasty.
21.88.....	Other septoplasty.
21.89.....	Other repair and plastic operations on nose.
21.99.....	Other operations on nose.
25.1.....	Excision or destruction of lesion or tissue of tongue.
26.21.....	Marsupialization of salivary gland cyst.
26.29.....	Other excision of salivary gland lesion.
26.30.....	Sialoadenectomy, NOS.
26.31.....	Partial sialoadenectomy.
26.32.....	Complete sialoadenectomy.
27.43.....	Other excision of lesion or tissue of lip.
28.11.....	Biopsy of tonsils and adenoids.
30.09.....	Other excision or destruction of lesion or tissue of larynx.
34.3.....	Excision or destruction of lesion or tissue of mediastinum.
34.4.....	Excision or destruction of lesion of chest wall.
38.00.....	Incision of vessel, unspecified site.
39.94.....	Replacement of vessel-to-vessel cannula.
40.0.....	Incision of lymphatic structures.
40.11.....	Biopsy of lymphatic structure.
40.19.....	Other diagnostic procedures on lymphatic structures.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND OTHER NONEXTENSIVE PROCEDURES UNRELATED TO PRINCIPAL PROCEDURES THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
40.21	Excision of deep cervical lymph node.
40.23	Excision of axillary lymph node.
40.24	Excision of inguinal lymph node.
40.29	Simple excision of other lymphatic structure.
43.42	Local excision of other lesion or tissue of stomach.
43.49	Other destruction of lesion or tissue of stomach.
45.31	Local excision of lesion of duodenum.
45.32	Other destruction of lesion of duodenum.
45.33	Local excision of lesion or tissue of small intestine, except duodenum.
54.34	Other destruction of lesion of small intestine, except duodenum.
45.41	Local excision of lesion or tissue of large intestine.
45.49	Other destruction of lesion of large intestine.
46.43	Other revision of stoma of large intestine.
48.35	Local excision of rectal lesion or tissue.
49.3	Local excision or destruction of other lesion or tissue of anus.
49.44	Destruction of hemorrhoids by cryotherapy.
49.45	Ligation of hemorrhoids.
49.46	Excision of hemorrhoids.
53.00	Unilateral repair of inguinal hernia, NOS.
53.01	Repair of direct inguinal hernia.
53.02	Repair of indirect inguinal hernia.
53.03	Repair of direct inguinal hernia with graft or prosthesis.
53.04	Repair of indirect inguinal hernia with graft or prosthesis.
53.05	Repair of inguinal hernia with graft or prosthesis, NOS.
53.10	Bilateral repair of inguinal hernia, NOS.
53.11	Bilateral repair of direct inguinal hernia.
53.12	Bilateral repair of indirect inguinal hernia.
53.13	Bilateral repair of inguinal hernia, one direct and one indirect.
53.14	Bilateral repair of direct inguinal hernia with graft or prosthesis.
53.15	Bilateral repair of indirect inguinal hernia with graft or prosthesis.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND OTHER NONEXTENSIVE PROCEDURES UNRELATED TO PRINCIPAL PROCEDURES THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
53.16	Bilateral repair of inguinal hernia, one direct and one indirect, with graft or prosthesis.
53.17	Bilateral inguinal hernia repair with graft or prosthesis, NOS.
53.21	Unilateral repair of femoral hernia with graft or prosthesis.
53.29	Other unilateral femoral herniorrhaphy.
53.31	Bilateral repair of femoral hernia with graft or prosthesis.
53.39	Other bilateral femoral herniorrhaphy.
54.21	Laparoscopy.
54.22	Biopsy of abdominal wall or umbilicus.
54.3	Excision or destruction of lesion or tissue of abdominal wall or umbilicus.
56.0	Transurethral removal of obstruction from ureter and renal pelvis.
56.1	Ureteral meatotomy.
56.2	Ureterotomy.
56.39	Other diagnostic procedures on ureter.
57.33	Closed [transurethral] biopsy of bladder.
57.39	Other diagnostic procedures on bladder.
57.49	Other transurethral excision or destruction of lesion or tissue of bladder.
57.59	Open excision or destruction of other lesion or tissue of bladder.
57.82	Closure of cystostomy.
58.0	Urethrotomy.
58.1	Urethral meatotomy.
61.2	Excision of hydrocele (of tunica vaginalis).
63.09	Other diagnostic procedures on spermatic cord, epididymis, and vas deferens.
63.1	Excision of varicocele and hydrocele of spermatic cord.
63.2	Excision of cyst of epididymis.
63.3	Excision of other lesion or tissue of spermatic cord and epididymis.
64.0	Circumcision.
64.11	Biopsy of penis.
64.2	Local excision or destruction of lesion of penis.
64.95	Insertion or replacement of non-inflatable internal prosthesis of penis.
64.96	Removal of internal prosthesis of penis.
64.97	Insertion or replacement of inflatable penile prosthesis.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND OTHER NONEXTENSIVE PROCEDURES UNRELATED TO PRINCIPAL PROCEDURES THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
66.21	Bilateral endoscopic ligation and crushing of fallopian tubes.
66.22	Bilateral endoscopic ligation and division of fallopian tubes.
66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes.
66.31	Other bilateral ligation and crushing of fallopian tubes.
66.32	Other bilateral ligation and division of fallopian tubes.
66.39	Other bilateral destruction or occlusion of fallopian tubes.
66.92	Unilateral destruction or occlusion of fallopian tube.
67.11	Endocervical biopsy.
67.12	Other cervical biopsy.
67.19	Other diagnostic procedures on cervix.
67.2	Conization of cervix.
67.31	Marsupialization of cervical cyst.
67.32	Destruction of lesion of cervix by cauterization.
67.33	Destruction of lesion of cervix by cryosurgery.
67.39	Other excision or destruction of lesion or tissue of cervix.
68.15	Closed biopsy of uterine ligaments.
68.16	Closed biopsy of uterus.
69.01	Dilation and curettage for termination of pregnancy.
69.09	Other dilation and curettage.
69.51	Aspiration curettage of uterus for termination of pregnancy.
69.52	Aspiration curettage following delivery or abortion.
69.95	Incision of cervix.
70.23	Biopsy of cul-de-sac.
70.24	Vaginal biopsy.
70.29	Other diagnostic procedures on vagina and cul-de-sac.
70.31	Hymenectomy.
70.32	Excision or destruction of lesion of cul-de-sac.
70.33	Excision or destruction of lesion of vagina.
70.76	Hymenorrhaphy.
71.11	Biopsy of vulva.
71.19	Other diagnostic procedures on vulva.
71.23	Marsupialization of Bartholin's gland (cyst).
71.3	Other local excision or destruction of vulva and perineum.
71.4	Operations on clitoris.
71.71	Suture of laceration of vulva or perineum.
71.79	Other repair of vulva and perineum.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND OTHER NONEXTENSIVE PROCEDURES UNRELATED TO PRINCIPAL PROCEDURES THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
76.2.....	Local excision or destruction of lesion of facial bone.
77.41.....	Biopsy of bone, scapula, clavicle, and thorax [ribs and sternum].
77.51.....	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal.
77.52.....	Bunionectomy with soft tissue correction and arthrodesis.
77.53.....	Other bunionectomy with soft tissue correction.
77.54.....	Excision of bunionette.
77.59.....	Other bunionectomy.
77.68.....	Local excision of lesion or tissue of bone, tarsals and metatarsals.
77.69.....	Local excision of lesion or tissue of bone, other.
80.26.....	Arthroscopy of knee.
80.6.....	Excision of semilunar cartilage of knee.
80.88.....	Other local excision or destruction of lesion of joint, foot, and toe.
80.98.....	Other excision of joint, foot, and toe.
81.18.....	Other fusion of toe.
82.11.....	Tenotomy of hand.
82.21.....	Excision of lesion of tendon sheath of hand.

TABLE 6C.—ELECTIVE, DIAGNOSTIC AND OTHER NONEXTENSIVE PROCEDURES UNRELATED TO PRINCIPAL PROCEDURES THAT GROUP TO DRG 477—Continued

Procedure code	Procedure
82.29.....	Excision of other lesion of soft tissue of hand.
82.41.....	Suture of tendon sheath of hand.
82.45.....	Other suture of other tendon of hand.
82.46.....	Suture of muscle or fascia of hand.
83.03.....	Bursotomy.
83.21.....	Biopsy of soft tissue.
83.39.....	Excision of lesion of other soft tissue.
83.61.....	Suture of tendon sheath.
85.12.....	Open biopsy of breast.
85.20.....	Excision or destruction of breast tissue, NOS.
85.21.....	Local excision of lesion of breast.
85.23.....	Subtotal mastectomy.
85.50.....	Augmentation mammoplasty, NOS.
85.53.....	Unilateral breast implant.
85.54.....	Bilateral breast implant.
86.21.....	Excision of pilonidal cyst or sinus.
86.25.....	Dermabrasion.
86.60.....	Free skin graft, NOS.
86.82.....	Facial rhytidectomy.
86.83.....	Size reduction plastic operation.
86.84.....	Relaxation of scar or web contracture of skin.
95.04.....	Eye examination under anesthesia.

Table 6d.—Additions to the CC Exclusions List

CCs that are added to the list are in Table 6d—Additions to the CC Exclusions List. (Previously, the indented diagnoses were recognized by the GROUPER as valid CCS for the asterisked principal diagnosis but will be excluded and thus ignored by the GROUPER for discharges occurring on or after October 1, 1988.)

Example:

*3488

3240

Diagnosis code 324.0 (Intracranial abscess) [Tuberculous pneumonia confirmed by other methods] was previously recognized by the GROUPER as a CC for principal diagnosis 348.8 (Brain conditions NEC). For discharges occurring on or after October 1, 1988, diagnosis code 3240 is no longer recognized as a CC for the principal diagnosis 348.8.

BILLING CODE 4120-01-M

*01166	1531	1920	01306	3979	*55001	5529	8088	76505
01166	1532	1921	01310	*3952	5528	*5513	8089	76506
*01481	1533	1922	01311	3979	5529	5528	82000	76507
01481	1534	1923	01312	*3959	*55002	5529	82001	76508
*0361	1535	1928	01313	3979	5528	*5518	82002	*76404
0361	1536	1960	01314	*3971	5529	5528	82003	76501
*0363	1537	1961	01315	3979	*55003	5529	82009	76502
0363	1538	1962	01316	*39890	5528	*5519	82010	76503
*03640	1539	1963	0360	3970	5529	5528	82011	76504
03640	1540	1965	0530	3971	*55010	5529	82012	76505
*03641	1541	1966	05472	3979	5528	*55200	82013	76506
03641	1542	1968	0721	3980	5529	5528	82019	76507
*03642	1543	1969	09042	39891	*55011	5529	82020	76508
03642	1548	1970	0942	*39891	5528	*55201	82021	*76405
*03643	1550	1971	11283	40201	5529	5528	82022	76501
03643	1551	1972	1142	40211	*55012	5529	82030	76502
*03681	1552	1973	11501	40291	5528	*55202	82031	76503
03681	1560	1974	11511	5184	5529	5528	82032	76504
*03682	1561	1975	11591	*4290	*55013	5529	8208	76505
03682	1562	1976	*3499	4290	5528	*55203	8209	76506
*0550	1568	1977	01300	*430	5529	5528	82100	76507
0550	1569	1978	01301	436	*55090	5529	82101	76508
*0551	1570	1980	01302	7800	5528	*5521	82110	*76406
0551	1571	1981	01303	*431	5529	5528	82111	76501
*0552	1572	1982	01304	436	*55091	5529	*76400	76502
0552	1573	1983	01305	7800	5528	*55220	76501	76503
*05571	1574	1984	01306	*4320	5529	5528	76502	76504
05571	1578	1985	01310	436	*55092	5529	76503	76505
*05671	1579	1986	01311	7800	5528	*55221	76504	76506
05671	1622	1987	01312	*4321	5529	5528	76505	76507
*1124	1623	19881	01313	436	*55093	5529	76506	76508
1124	1624	19882	01314	7800	5528	*55229	76507	*76407
*1125	1625	19889	01315	*4329	5529	5528	76508	76501
1125	1628	1990	01316	436	*55100	5529	*76401	76502
*11505	1629	*20281	0360	7800	5528	*5523	76501	76503
11515	1630	20241	0530	*4340	5529	5518	76502	76504
11595	1631	*2899	05472	436	*55101	5519	76503	76505
*11515	1638	2880	0721	*4341	5528	5528	76504	76506
11595	1639	2881	09042	436	5529	5529	76505	76507
*1958	1642	*3241	0942	*4349	*55102	*5531	76506	76508
1510	1643	3240	11283	436	5528	5528	76507	*76408
1511	1648	3249	1142	*436	5529	5529	76508	76501
1512	1649	325	11501	4340	*55103	*5920	*76402	76502
1513	1890	*3481	11511	4341	5528	5921	76501	76503
1514	1891	3481	11591	4349	5529	*70583	76502	76504
1515	1892	*3488	*3940	*5171	*5511	6820	76503	76505
1516	1910	3240	3979	5171	5528	*7331	76504	76506
1518	1911	*3489	*3941	*51881	5529	8080	76505	76507
1519	1912	3240	3979	51882	*55120	8082	76506	76508
1520	1913	*34989	*3942	7991	5528	8083	76507	*76409
1521	1914	01300	3979	*51882	5529	80843	76508	76501
1522	1915	01301	*3949	51881	*55121	80849	*76403	76502
1523	1916	01302	3979	7991	5528	80851	76501	76503
1528	1917	01303	*3950	*55000	5529	80852	76502	76504
1529	1918	01304	3979	5528	*55129	80853	76503	76505
1530	1919	01305	*3951	5529	5528	80859	76504	76506

76507	*76416	76502	76504	76506	76508	76501	76503	76505
76508	76501	76503	76505	76507	*76501	76502	76504	76506
*76410	76502	76504	76506	76508	76501	76503	76505	76507
76501	76503	76505	76507	*76495	76502	76504	76506	76508
76502	76504	76506	76508	76501	76503	76505	76507	*7678
76503	76505	76507	*76429	76502	76504	76506	76508	76501
76504	76506	76508	76501	76503	76505	76507	*76514	76502
76505	76507	*76423	76502	76504	76506	76508	76501	76503
76506	76508	76501	76503	76505	76507	*76508	76502	76504
76507	*76417	76502	76504	76506	76508	76501	76503	76505
76508	76501	76503	76505	76507	*76502	76502	76504	76506
*76411	76502	76504	76506	76508	76501	76503	76505	76507
76501	76503	76505	76507	*76496	76502	76504	76506	76508
76502	76504	76506	76508	76501	76503	76505	76507	*7679
76503	76505	76507	*76490	76502	76504	76506	76508	76501
76504	76506	76508	76501	76503	76505	76507	*76515	76502
76505	76507	*76424	76502	76504	76506	76508	76501	76503
76506	76508	76501	76503	76505	76507	*76509	76502	76504
76507	*76418	76502	76504	76506	76508	76501	76503	76505
76508	76501	76503	76505	76507	*76503	76502	76504	76506
*76412	76502	76504	76506	76508	76501	76503	76505	76507
76501	76503	76505	76507	*76497	76502	76504	76506	76508
76502	76504	76506	76508	76501	76503	76505	76507	*7798
76503	76505	76507	*76491	76502	76504	76506	76508	76501
76504	76506	76508	76501	76503	76505	76507	*76516	76502
76505	76507	*76425	76502	76504	76506	76508	76501	76503
76506	76508	76501	76503	76505	76507	*76510	76502	76504
76507	*76419	76502	76504	76506	76508	76501	76503	76505
76508	76501	76503	76505	76507	*76504	76502	76504	76506
*76413	76502	76504	76506	76508	76501	76503	76505	76507
76501	76503	76505	76507	*76498	76502	76504	76506	76508
76502	76504	76506	76508	76501	76503	76505	76507	*7800
76503	76505	76507	*76492	76502	76504	76506	76508	430
76504	76506	76508	76501	76503	76505	76507	*76517	431
76505	76507	*76426	76502	76504	76506	76508	76501	4320
76506	76508	76501	76503	76505	76507	*76511	76502	4321
76507	*76420	76502	76504	76506	76508	76501	76503	436
76508	76501	76503	76505	76507	*76505	76502	76504	*7854
*76414	76502	76504	76506	76508	76501	76503	76505	7854
76501	76503	76505	76507	*76499	76502	76504	76506	*7991
76502	76504	76506	76508	76501	76503	76505	76507	51881
76503	76505	76507	*76493	76502	76504	76506	76508	51882
76504	76506	76508	76501	76503	76505	76507	*76518	*80000
76505	76507	*76427	76502	76504	76506	76508	76501	430
76506	76508	76501	76503	76505	76507	*76512	76502	431
76507	*76421	76502	76504	76506	76508	76501	76503	4320
76508	76501	76503	76505	76507	*76506	76502	76504	4321
*76415	76502	76504	76506	76508	76501	76503	76505	436
76501	76503	76505	76507	*76500	76502	76504	76506	7800
76502	76504	76506	76508	76501	76503	76505	76507	*80001
76503	76505	76507	*76494	76502	76504	76506	76508	430
76504	76506	76508	76501	76503	76505	76507	*76519	431
76505	76507	*76428	76502	76504	76506	76508	76501	4320
76506	76508	76501	76503	76505	76507	*76513	76502	4321
76507	*76422	76502	76504	76506	76508	76501	76503	436
76508	76501	76503	76505	76507	*76507	76502	76504	7800

[illegible]

[illegible]

[illegible]

*80462	*80472	*80482	*80492	95209	*80507	95200	95201	9522
430	430	430	430	*80502	95200	95201	95202	9523
431	431	431	431	95200	95201	95202	95203	9524
4320	4320	4320	4320	95201	95202	95203	95204	9528
4321	4321	4321	4321	95202	95203	95204	95205	9529
436	436	436	436	95203	95204	95205	95206	*80600
7800	7800	7800	7800	95204	95205	95206	95207	95200
*80463	*80473	*80483	*80493	95205	95206	95207	95208	95201
430	430	430	430	95206	95207	95208	95209	95202
431	431	431	431	95207	95208	95209	*8058	95203
4320	4320	4320	4320	95208	95209	*80514	95200	95204
4321	4321	4321	4321	95209	*80508	95200	95201	95205
436	436	436	436	*80503	95200	95201	95202	95206
7800	7800	7800	7800	95200	95201	95202	95203	95207
*80464	*80474	*80484	*80494	95201	95202	95203	95204	95208
430	430	430	430	95202	95203	95204	95205	95209
431	431	431	431	95203	95204	95205	95206	*80601
4320	4320	4320	4320	95204	95205	95206	95207	95200
4321	4321	4321	4321	95205	95206	95207	95208	95201
436	436	436	436	95206	95207	95208	95209	95202
7800	7800	7800	7800	95207	95208	95209	95210	95203
*80465	*80475	*80485	*80495	95208	95209	*80515	95211	95204
430	430	430	430	95209	*80510	95200	95212	95205
431	431	431	431	*80504	95200	95201	95213	95206
4320	4320	4320	4320	95200	95201	95202	95214	95207
4321	4321	4321	4321	95201	95202	95203	95215	95208
436	436	436	436	95202	95203	95204	95216	95209
7800	7800	7800	7800	95203	95204	95205	95217	*80602
*80466	*80476	*80486	*80496	95204	95205	95206	95218	95200
430	430	430	430	95205	95206	95207	95219	95201
431	431	431	431	95206	95207	95208	9522	95202
4320	4320	4320	4320	95207	95208	95209	9523	95203
4321	4321	4321	4321	95208	95209	*80516	9524	95204
436	436	436	436	95209	*80511	95200	9528	95205
7800	7800	7800	7800	*80505	95200	95201	9529	95206
*80469	*80479	*80489	*80500	95200	95201	95202	*8059	95207
430	430	430	95200	95201	95202	95203	95200	95208
431	431	431	95201	95202	95203	95204	95201	95209
4320	4320	4320	95202	95203	95204	95205	95202	*80603
4321	4321	4321	95203	95204	95205	95206	95203	95200
436	436	436	95204	95205	95206	95207	95204	95201
7800	7800	7800	95205	95206	95207	95208	95205	95202
*80470	*80480	*80490	95206	95207	95208	95209	95206	95203
430	430	430	95207	95208	95209	*80517	95207	95204
431	431	431	95208	95209	*80512	95200	95208	95205
4320	4320	4320	95209	*80506	95200	95201	95209	95206
4321	4321	4321	*80501	95200	95201	95202	95210	95207
436	436	436	95200	95201	95202	95203	95211	95208
7800	7800	7800	95201	95202	95203	95204	95212	95209
*80471	*80481	*80491	95202	95203	95204	95205	95213	*80604
430	430	430	95203	95204	95205	95206	95214	95200
431	431	431	95204	95205	95206	95207	95215	95201
4320	4320	4320	95205	95206	95207	95208	95216	95202
4321	4321	4321	95206	95207	95208	95209	95217	95203
436	436	436	95207	95208	95209	*80518	95218	95204
7800	7800	7800	95208	95209	*80513	95200	95219	95205

95206	95207	95208	95209	95207	95200	95204	95208	95212
95207	95208	95209	*8068	95208	95201	95205	95209	95213
95208	95209	*80615	83900	95209	95202	95206	95210	95214
95209	*80610	95200	83901	*83940	95203	95207	95211	95215
*80605	95200	95201	83902	95200	95204	95208	95212	95216
95200	95201	95202	83903	95201	95205	95209	95213	95217
95201	95202	95203	83904	95202	95206	95210	95214	95218
95202	95203	95204	83905	95203	95207	95211	95215	95219
95203	95204	95205	83906	95204	95208	95212	95216	9522
95204	95205	95206	83907	95205	95209	95213	95217	9523
95205	95206	95207	83908	95206	95210	95214	95218	9524
95206	95207	95208	83910	95207	95211	95215	95219	9528
95207	95208	95209	83911	95208	95212	95216	9522	9529
95208	95209	*80616	83912	95209	95213	95217	9523	*8500
95209	*80611	95200	83913	95210	95214	95218	9524	430
*80606	95200	95201	83914	95211	95215	95219	9528	431
95200	95201	95202	83915	95212	95216	9522	9529	4320
95201	95202	95203	83916	95213	95217	9523	*8399	4321
95202	95203	95204	83917	95214	95218	9524	95200	436
95203	95204	95205	83918	95215	95219	9528	95201	7800
95204	95205	95206	95200	95216	9522	9529	95202	*8501
95205	95206	95207	95201	95217	9523	*83979	95203	430
95206	95207	95208	95202	95218	9524	95200	95204	431
95207	95208	95209	95203	95219	9528	95201	95205	4320
95208	95209	*80617	95204	9522	9529	95202	95206	4321
95209	*80612	95200	95205	9523	*83959	95203	95207	436
*80607	95200	95201	95206	9524	95200	95204	95208	7800
95200	95201	95202	95207	9528	95201	95205	95209	*8502
95201	95202	95203	95208	9529	95202	95206	95210	430
95202	95203	95204	95209	*83949	95203	95207	95211	431
95203	95204	95205	*8069	95200	95204	95208	95212	4320
95204	95205	95206	83900	95201	95205	95209	95213	4321
95205	95206	95207	83901	95202	95206	95210	95214	436
95206	95207	95208	83902	95203	95207	95211	95215	7800
95207	95208	95209	83903	95204	95208	95212	95216	*8503
95208	95209	*80618	83904	95205	95209	95213	95217	430
95209	*80613	95200	83905	95206	95210	95214	95218	431
*80608	95200	95201	83906	95207	95211	95215	95219	4320
95200	95201	95202	83907	95208	95212	95216	9522	4321
95201	95202	95203	83908	95209	95213	95217	9523	436
95202	95203	95204	83910	95210	95214	95218	9524	7800
95203	95204	95205	83911	95211	95215	95219	9528	*8504
95204	95205	95206	83912	95212	95216	9522	9529	430
95205	95206	95207	83913	95213	95217	9523	*8479	431
95206	95207	95208	83914	95214	95218	9524	95200	4320
95207	95208	95209	83915	95215	95219	9528	95201	4321
95208	95209	*80619	83916	95216	9522	9529	95202	436
95209	*80614	95200	83917	95217	9523	*8398	95203	7800
*80609	95200	95201	83918	95218	9524	95200	95204	*8505
95200	95201	95202	95200	95219	9528	95201	95205	430
95201	95202	95203	95201	9522	9529	95202	95206	431
95202	95203	95204	95202	9523	*83969	95203	95207	4320
95203	95204	95205	95203	9524	95200	95204	95208	4321
95204	95205	95206	95204	9528	95201	95205	95209	436
95205	95206	95207	95205	9529	95202	95206	95210	7800
95206	95207	95208	95206	*83950	95203	95207	95211	*8509

430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85100	*85110	*85120	*85130	*85140	*85150	*85160	*85170	*85180
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85101	*85111	*85121	*85131	*85141	*85151	*85161	*85171	*85181
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85102	*85112	*85122	*85132	*85142	*85152	*85162	*85172	*85182
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85103	*85113	*85123	*85133	*85143	*85153	*85163	*85173	*85183
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85104	*85114	*85124	*85134	*85144	*85154	*85164	*85174	*85184
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85105	*85115	*85125	*85135	*85145	*85155	*85165	*85175	*85185
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85106	*85116	*85126	*85136	*85146	*85156	*85166	*85176	*85186
430	430	430	430	430	430	430	430	430
431	431	431	431	431	431	431	431	431
4320	4320	4320	4320	4320	4320	4320	4320	4320
4321	4321	4321	4321	4321	4321	4321	4321	4321
436	436	436	436	436	436	436	436	436
7800	7800	7800	7800	7800	7800	7800	7800	7800
*85109	*85119	*85129	*85139	*85149	*85159	*85169	*85179	*85189

430	430	430	430	7800	7800	7800	7800	7800
431	431	431	431	*85230	*85240	*85250	*85300	*85310
4320	4320	4320	4320	430	430	430	430	430
4321	4321	4321	4321	431	431	431	431	431
436	436	436	436	4320	4320	4320	4320	4320
7800	7800	7800	7800	4321	4321	4321	4321	4321
*85190	*85200	*85210	*85220	436	436	436	436	436
430	430	430	85220	7800	7800	7800	7800	7800
431	431	431	*85221	*85231	*85241	*85251	*85301	*85311
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85191	*85201	*85211	436	436	436	436	436	436
430	430	430	7800	7800	7800	7800	7800	7800
431	431	431	*85222	*85232	*85242	*85252	*85302	*85312
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85192	*85202	*85212	436	436	436	436	436	436
430	430	430	7800	7800	7800	7800	7800	7800
431	431	431	*85223	*85233	*85243	*85253	*85303	*85313
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85193	*85203	*85213	436	436	436	436	436	436
430	430	430	7800	7800	7800	7800	7800	7800
431	431	431	*85224	*85234	*85244	*85254	*85304	*85314
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85194	*85204	*85214	436	436	436	436	436	436
430	430	430	7800	7800	7800	7800	7800	7800
431	431	431	*85225	*85235	*85245	*85255	*85305	*85315
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85195	*85205	*85215	436	436	436	436	436	436
430	430	430	7800	7800	7800	7800	7800	7800
431	431	431	*85226	*85236	*85246	*85256	*85306	*85316
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85196	*85206	*85216	436	436	436	436	436	436
430	430	430	7800	7800	7800	7800	7800	7800
431	431	431	*85229	*85239	*85249	*85259	*85309	*85319
4320	4320	4320	430	430	430	430	430	430
4321	4321	4321	431	431	431	431	431	431
436	436	436	4320	4320	4320	4320	4320	4320
7800	7800	7800	4321	4321	4321	4321	4321	4321
*85199	*85209	*85219	436	436	436	436	436	436

7800	7800	7800	8068	9524
*85400	*85410	*8739	8069	9528
430	430	8739	*95201	9529
431	431	*9051	8068	
4320	4320	95200	8069	
4321	4321	95201	*95202	
436	436	95202	8068	
7800	7800	95203	8069	
*85401	*85411	95204	*95203	
430	430	95205	8068	
431	431	95206	8069	
4320	4320	95207	*95204	
4321	4321	95208	8068	
436	436	95209	8069	
7800	7800	95210	*95205	
*85402	*85412	95211	8068	
430	430	95212	8069	
431	431	95213	*95206	
4320	4320	95214	8068	
4321	4321	95215	8069	
436	436	95216	*95207	
7800	7800	95217	8068	
*85403	*85413	95218	8069	
430	430	95219	*95208	
431	431	9522	8068	
4320	4320	9523	8069	
4321	4321	9524	*95209	
436	436	9528	8068	
7800	7800	9529	8069	
*85404	*85414	*92611	*9528	
430	430	95200	9529	
431	431	95201	*9529	
4320	4320	95202	9528	
4321	4321	95203	*9591	
436	436	95204	95200	
7800	7800	95205	95201	
*85405	*85415	95206	95202	
430	430	95207	95203	
431	431	95208	95204	
4320	4320	95209	95205	
4321	4321	95210	95206	
436	436	95211	95207	
7800	7800	95212	95208	
*85406	*85416	95213	95209	
430	430	95214	95210	
431	431	95215	95211	
4320	4320	95216	95212	
4321	4321	95217	95213	
436	436	95218	95214	
7800	7800	95219	95215	
*85409	*85419	9522	95216	
430	430	9523	95217	
431	431	9524	95218	
4320	4320	9528	95219	
4321	4321	9529	9522	
436	436	*95200	9523	

Table 6e—Deletions From the CC Exclusions List

CCs that are deleted from the list are in Table 6e—Deletions from the CC Exclusions List. (Previously, the indented diagnoses were not recognized by the GROUPER as valid CCs for the asterisked principal diagnosis but will be recognized as valid CCs for

discharges occurring on or after October 1, 1988.)

Example:

*01100

494

496

Diagnosis codes 494 (Bronchiectasis) and 496 (Chronic Obstructive Pulmonary Disease) were previously not recognized

by the GROUPER as CCs for principal diagnosis 011.00 (Tuberculosis of lung, infiltrative, unspecified documentation). For discharges occurring on or after October 1, 1988, diagnosis codes 494 and 496 will be recognized as CCs for the principal diagnosis 011.00.

BILLING CODE 4120-01-M

*01100	496	494	*01180	496	4958	496	494	*4870
494	*01125	496	494	*01205	4959	*0391	496	494
496	494	*01153	496	494	496	494	*4809	496
*01101	496	494	*01181	496	500	496	494	*490
494	*01126	496	494	*01206	501	*11505	496	4911
496	494	*01154	496	494	502	494	*481	4912
*01102	496	494	*01182	496	503	496	494	4918
494	*01130	496	494	*01210	504	*11515	496	4919
496	494	*01155	496	494	505	494	*4820	*4910
*01103	496	494	*01183	496	5060	496	494	4911
494	*01131	496	494	*01211	5061	*11595	496	4912
496	494	*01156	496	494	5070	494	*4821	4918
*01104	496	494	*01184	496	5071	496	494	4919
494	*01132	496	494	*01212	5078	*1221	496	*4950
496	494	*01160	496	494	5080	494	*4822	494
*01105	496	494	*01185	496	5081	496	494	496
494	*01133	496	494	*01213	5111	*1304	496	74861
496	494	*01161	496	494	5118	494	*4823	*4951
*01106	496	494	*01186	496	5119	496	494	494
494	*01134	496	494	*01214	5130	*1363	496	496
496	494	*01162	496	494	515	494	*4824	74861
*01110	496	494	*01190	496	5160	496	494	*4952
494	*01135	496	494	*01215	5161	*1922	496	494
496	494	*01163	496	494	5162	1910	*4828	496
*01111	496	494	*01191	496	5163	1911	494	74861
494	*01136	496	494	*01216	5168	1912	496	*4953
496	494	*01164	496	494	5169	1913	*4829	494
*01112	496	494	*01192	496	5171	1914	494	496
494	*01140	496	494	*01236	5172	1915	496	74861
496	494	*01165	496	481	5178	1916	*483	*4954
*01113	496	494	*01193	4820	*01280	1917	494	494
494	*01141	496	494	4821	494	1918	496	496
496	494	*01166	496	4822	496	1919	*4841	74861
*01114	496	494	*01194	4823	*01281	*1923	494	*4955
494	*01142	496	494	4824	494	1910	496	494
496	494	*01170	496	4828	496	1911	*4843	496
*01115	496	494	*01195	4829	*01282	1912	494	74861
494	*01143	496	494	483	494	1913	496	*4956
496	494	*01171	496	4841	496	1914	*4845	494
*01116	496	494	*01196	4843	*01283	1915	494	496
494	*01144	496	494	4845	494	1916	496	74861
496	494	*01172	496	4846	496	1917	*4846	*4957
*01120	496	494	*01200	4847	*01284	1918	494	494
494	*01145	496	494	4848	494	1919	496	496
496	494	*01173	496	485	496	*20281	*4847	74861
*01121	496	494	*01201	486	*01285	20242	494	*4958
494	*01146	496	494	4870	494	*4800	496	494
496	494	*01174	496	494	496	494	*4848	496
*01122	496	494	*01202	4950	*01286	496	494	74861
494	*01150	496	494	4951	494	*4801	496	*4959
496	494	*01175	496	4952	496	494	*485	494
*01123	496	494	*01203	4953	*0212	496	494	496
494	*01151	496	494	4954	494	*4802	496	74861
496	494	*01176	496	4955	496	494	*486	*500
*01124	496	494	*01204	4956	*0310	496	494	494
494	*01152	496	494	4957	494	*4808	496	496

74861	74861	5846	5809	74191	*80506	83913	83914	83913
*501	*5089	5847	5810	74192	86399	83914	83915	83914
494	494	5848	5811	74193	*80507	83915	83916	83915
496	496	5849	5812	*7479	86399	83916	83917	83916
74861	74861	585	5813	74100	*80508	83917	83918	83917
*502	*5171	59010	58181	74101	86399	83918	*83949	83918
494	496	59011	58189	74102	*80510	*80600	83900	*83969
496	*5178	5902	5819	74103	86399	86399	83901	83900
74861	4911	5903	5834	74190	*80511	*80601	83902	83901
*503	4912	59080	5845	74191	86399	86399	83903	83902
494	4918	59081	5846	74192	*80512	*80602	83904	83903
496	4919	5909	5847	74193	86399	86399	83905	83904
74861	4928	591	5848	*7484	*80513	*80603	83906	83905
*504	496	5990	5849	74861	86399	86399	83907	83906
494	*5182	*5921	585	*7485	*80514	*80604	83908	83907
496	4928	5800	59010	74861	86399	86399	83910	83908
74861	*5183	5804	59011	*74860	*80515	*80605	83911	83910
*505	4928	58081	5902	74861	86399	86399	83912	83911
494	*51889	58089	5903	*74869	*80516	*80606	83913	83912
496	4911	5809	59080	74861	86399	86399	83914	83913
74861	4912	5810	59081	*7488	*80517	*80607	83915	83914
*5060	4918	5811	5909	74861	86399	86399	83916	83915
494	4919	5812	591	*7489	*80518	*80608	83917	83916
496	4928	5813	5935	74861	86399	86399	83918	83917
74861	496	58181	5950	*7598	*8058	*80609	*83950	83918
*5062	*5198	58189	5951	7882	83900	86399	83900	*83979
494	4911	5819	5952	*7640	83901	*80610	83901	83900
496	4912	5834	5954	7650	83902	86399	83902	83901
74861	4918	5845	59581	*7641	83903	*80611	83903	83902
*5063	4919	5846	59582	7650	83904	86399	83904	83903
494	4928	5847	59589	*7642	83905	*80612	83905	83904
496	494	5848	5959	7650	83906	86399	83906	83905
74861	496	5849	*74689	*7649	83907	*80613	83907	83906
*5070	*5199	585	74100	7650	83908	86399	83908	83907
494	4911	59010	74101	*7650	83910	*80614	83910	83908
496	4912	59011	74102	7650	83911	86399	83911	83910
74861	4918	5902	74103	*7651	83912	*80615	83912	83911
*5071	4919	5903	74190	7650	83913	86399	83913	83912
494	4928	59080	74191	*7678	83914	*80616	83914	83913
496	494	59081	74192	7650	83915	86399	83915	83914
74861	496	5909	74193	*7679	83916	*80617	83916	83915
*5078	*5920	591	*7469	7650	83917	86399	83917	83916
494	5800	5935	74100	*7798	83918	*83940	83918	83917
496	5804	5950	74101	7650	*8059	83900	*83959	83918
74861	58081	5951	74102	*80500	83900	83901	83900	*8398
*5080	58089	5952	74103	86399	83901	83902	83901	83900
494	5809	5954	74190	*80501	83902	83903	83902	83901
496	5810	59581	74191	86399	83903	83904	83903	83902
74861	5811	59582	74192	*80502	83904	83905	83904	83903
*5081	5812	59589	74193	86399	83905	83906	83905	83904
494	5813	5959	*74789	*80503	83906	83907	83906	83905
496	58181	*5929	74100	86399	83907	83908	83907	83906
74861	58189	5800	74101	*80504	83908	83910	83908	83907
*5088	5819	5804	74102	86399	83910	83911	83910	83908
494	5834	58081	74103	*80505	83911	83912	83911	83910
496	5845	58089	74190	86399	83912	83913	83912	83911

83912	*9051	*95206
83913	83900	8072
83914	83901	8073
83915	83902	*95207
83916	83903	8072
83917	83904	8073
83918	83905	*95208
*8399	83906	8072
83900	83907	8073
83901	83908	*95209
83902	83910	8072
83903	83911	8073
83904	83912	*9591
83905	83913	83900
83906	83914	83901
83907	83915	83902
83908	83916	83903
83910	83917	83904
83911	83918	83905
83912	*92611	83906
83913	83900	83907
83914	83901	83908
83915	83902	83910
83916	83903	83911
83917	83904	83912
83918	83905	83913
*8479	83906	83914
83900	83907	83915
83901	83908	83916
83902	83910	83917
83903	83911	83918
83904	83912	
83905	83913	
83906	83914	
83907	83915	
83908	83916	
83910	83917	
83911	83918	
83912	*95200	
83913	8072	
83914	8073	
83915	*95201	
83916	8072	
83917	8073	
83918	*95202	
*86385	8072	
86390	8073	
86391	*95203	
86392	8072	
86393	8073	
86394	*95204	
*8739	8072	
86122	8073	
86130	*95205	
86131	8072	
86132	8073	

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	25329	19.2277	6	9	14	23	38
002	5247	19.5948	4	8	13	24	41
003	7	19.1429	1	7	16	23	24
004	4625	17.1762	1	7	13	21	35
005	49433	8.2420	3	4	6	10	15
006	2403	2.8577	1	1	2	3	5
007	5345	23.4047	1	1	12	25	52
008	4704	5.4917	2	2	3	6	11
009	2133	11.6606	1	2	8	13	22
010	17721	11.7036	2	4	8	15	24
011	5454	7.5994	2	3	5	9	16
012	27345	10.6930	1	4	7	12	19
013	5597	10.0668	2	4	8	13	21
014	321584	10.8247	3	5	8	13	20
015	156828	5.6459	2	5	8	11	17
016	14434	9.3384	2	3	4	7	11
017	7006	6.5074	2	4	7	11	18
018	12355	9.4988	2	4	7	11	18
019	12480	6.1090	2	5	5	10	12
020	5978	11.7556	1	4	9	13	24
021	812	9.9741	2	5	7	11	19
022	13465	5.8789	2	4	5	10	11
023	4440	6.9410	2	3	5	8	14
024	45544	7.6544	1	2	5	9	15
025	30010	4.8032	1	2	4	6	9
026	46	4.8696	1	1	3	5	11
027	2522	9.6122	1	2	3	5	12
028	6332	9.6270	1	2	5	12	20
029	4958	5.2691	1	2	6	12	12
030	1	1.0000	1	1	4	1	1
031	4485	6.5115	1	2	4	8	12
032	5376	3.9038	1	2	4	5	19
034	11567	9.5162	1	2	6	11	11
035	5912	5.5940	1	2	4	4	6
036	20865	3.4337	1	2	3	4	9
037	3207	4.6289	1	2	3	5	5
038	1576	2.8756	1	1	2	3	3
039	36756	2.0577	1	1	2	2	3
040	6042	2.8929	1	1	2	2	3
041	1	1.0000	1	1	1	1	1
042	23928	3.1286	1	1	2	4	6
043	326	5.6319	1	1	2	4	8
044	2424	7.0120	1	1	2	4	5
045	3687	4.4337	3	2	6	9	13
046	3667	6.1246	1	2	3	6	12
047	3695	3.6111	1	2	4	8	12
049	5958	16.0493	1	1	2	5	30
050	5586	3.2642	4	8	13	19	6
051	828	3.0785	1	1	2	4	6
052	137	4.2847	1	1	2	3	6
053	9584	3.3463	1	1	2	3	7

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
054	3	5.6667	4	4	5	8	8
055	8979	2.6191	1	1	1	2	5
056	1740	2.4184	1	1	2	3	5
057	782	6.4182	1	2	2	7	14
058	1	2.0000	2	2	2	2	2
059	366	2.0902	1	1	1	2	4
060	1	3.0000	3	3	3	3	3
061	370	5.7162	1	1	2	6	14
062	3	6.3333	1	1	2	15	15
063	4412	8.0249	1	2	5	9	17
064	6509	8.8536	1	2	5	11	20
065	31957	4.2223	2	2	3	5	8
066	10551	4.1719	1	2	3	5	7
067	459	6.4619	2	3	5	8	12
068	12434	6.4945	2	3	5	8	12
069	5978	4.8337	2	3	4	6	9
070	29	4.2414	1	2	3	6	7
071	119	6.4034	2	2	4	7	10
072	816	5.0956	1	2	3	6	9
073	9335	5.9875	1	2	4	7	12
074	1	1.0000	1	1	1	1	1
075	29757	15.3040	6	8	12	18	28
076	11002	13.3815	2	5	10	17	27
077	2605	6.4952	1	4	10	19	14
078	28984	10.8142	4	7	10	13	18
079	85845	13.0629	4	6	10	16	24
080	20377	9.7503	3	5	8	12	17
081	5	6.6000	1	1	5	7	16
082	91280	9.6726	2	4	7	12	20
083	6849	8.8258	2	4	7	11	17
084	2941	5.5172	2	3	7	11	10
085	15165	9.3068	2	4	7	12	18
086	3190	6.3749	2	3	5	8	12
087	47137	8.3414	1	4	6	10	16
088	124868	8.1612	3	4	6	10	15
089	263402	9.5163	3	4	6	10	15
090	96970	7.1951	3	5	8	12	17
091	47	5.1702	2	3	4	9	12
092	10028	9.2849	2	3	4	7	10
093	3317	6.8869	2	3	5	9	13
094	8330	10.0190	3	5	8	12	19
095	1925	6.3709	2	3	5	8	12
096	186394	7.5181	3	4	6	9	13
097	53522	5.7106	2	3	5	7	10
098	17	4.5294	1	2	4	6	7
099	23844	5.4333	2	2	4	6	10
100	13026	3.5125	1	2	3	4	6
101	18474	7.4485	2	2	3	4	9
102	8061	5.4672	1	2	3	7	10
103	47	43.4681	13	19	30	44	122
104	9459	22.0792	10	13	18	26	39

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
105	10151	16.8540	8	10	13	19	30
106	53944	16.8970	9	11	14	19	27
107	39401	13.1811	7	9	10	14	21
108	1746	16.7709	2	8	13	21	33
109	9987	12.2587	1	4	9	16	26
110	61599	16.7861	6	4	13	20	31
111	20953	10.2816	5	7	6	12	16
112	82473	7.9777	2	3	14	10	36
113	33075	19.3258	6	9	11	23	28
114	8750	14.1126	3	6	13	18	15
115	7069	15.3607	6	9	10	19	13
116	56434	8.2242	3	4	8	4	8
117	4019	6.6163	2	3	4	7	14
118	8230	3.9887	1	2	4	4	36
119	4420	6.4597	1	2	10	22	18
120	19636	17.6634	3	6	12	13	13
121	132941	11.0133	4	7	10	17	14
122	130066	8.1824	2	5	8	10	13
123	68963	5.5977	1	1	3	7	14
124	73831	6.3658	1	1	5	8	13
125	102216	3.2186	1	2	2	4	7
126	3443	22.5321	5	11	20	31	43
127	510324	8.2170	3	6	6	10	15
128	35137	9.2010	4	6	8	11	14
129	8353	5.8719	1	1	2	7	14
130	56711	8.1413	2	3	5	10	15
131	34209	5.8984	1	2	5	8	11
132	20940	6.0324	1	2	4	7	11
133	9230	4.5930	2	3	4	5	10
134	40176	5.7260	1	2	4	7	10
135	7356	7.1767	2	3	5	7	14
136	2424	4.9922	1	2	4	6	12
138	157843	6.3931	1	2	4	6	12
139	85064	4.4553	1	2	4	6	12
140	373528	5.0035	1	2	4	6	12
141	64694	5.9560	2	3	4	6	12
142	42100	4.3111	1	2	4	6	12
143	88303	3.7171	1	2	4	6	12
144	44617	8.0890	2	4	6	12	12
145	9516	4.8851	1	2	4	6	12
146	17754	18.5319	1	9	15	21	16
147	5752	12.3381	7	11	11	21	32
148	104184	17.6789	8	10	14	20	31
149	31973	11.2711	7	9	10	17	27
150	15454	15.4338	6	9	12	18	16
151	7553	9.9155	5	7	9	12	19
152	6679	10.3201	3	6	8	10	12
153	4503	17.8277	3	5	8	10	12
154	43806	17.7071	4	6	13	21	34
155	11126	10.2766	4	6	9	12	18
156	4	4.5000	1	1	1	8	8

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
157	23374	7.5480	2	3	6	9	14
158	24655	4.0349	1	2	3	5	8
159	12096	7.4747	2	4	6	9	14
160	16867	4.4600	2	2	4	6	8
161	31425	5.1492	1	2	4	6	10
162	55766	2.9848	1	2	3	4	5
163	16	6.1250	1	3	5	7	8
164	3863	13.2827	6	8	11	15	22
165	3084	8.6877	5	6	8	10	13
166	2276	8.8352	3	5	7	10	15
167	2973	5.0750	3	3	5	6	8
168	4249	9.5700	1	2	5	12	22
169	5100	3.8037	1	1	2	4	8
170	11626	16.3211	3	7	12	20	32
171	3022	9.1181	2	4	7	11	17
172	31197	10.5325	2	4	7	13	22
173	7080	6.3517	2	4	6	8	13
174	122648	7.3642	1	4	6	9	13
175	41742	5.1376	2	3	4	6	9
176	11725	8.0206	2	4	6	10	15
177	17848	6.6538	3	4	5	8	12
178	10678	4.9852	3	3	4	6	8
179	7341	9.6762	2	4	7	12	19
180	50932	7.9655	3	5	7	10	15
181	29543	5.1367	2	3	4	6	9
182	220655	6.4852	2	3	4	6	12
183	107799	4.6684	2	2	4	6	8
184	58	4.5172	1	2	2	5	8
185	5090	6.7277	1	2	2	8	14
186	3	9.3333	4	4	5	15	15
187	2335	3.0540	1	1	2	3	6
188	33036	7.4828	2	3	5	9	15
189	14245	4.2717	1	2	3	5	9
190	188	6.3511	2	3	4	7	11
191	5809	21.4355	8	11	17	26	40
192	2744	22.7336	6	10	15	27	47
193	8749	18.1870	8	11	15	22	32
194	2714	12.5733	5	8	11	16	21
195	23660	14.2826	7	9	12	16	23
196	5076	10.3869	6	7	9	12	16
197	55785	11.2320	5	7	9	13	19
198	44404	7.1995	4	5	6	8	11
199	3505	15.5512	5	8	13	20	29
200	2173	13.9742	2	6	11	18	29
201	4376	13.1412	2	5	10	17	27
202	15097	10.2601	2	5	8	13	20
203	30900	9.6514	2	4	7	12	20
204	33091	8.0349	3	4	6	10	15
205	18568	9.6658	2	4	7	12	19
206	4549	5.7265	1	2	4	7	12
207	34559	7.5178	2	4	6	9	14

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPEE V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
208	19449	4.7088	1	2	4	6	9
209	185439	13.3208	8	9	12	15	20
210	79658	16.0924	7	10	13	18	27
211	52574	12.0293	6	8	11	14	18
212	12	10.1667	1	6	8	9	12
213	5133	14.0746	4	6	10	17	28
214	21375	14.8495	6	8	12	18	27
215	32382	9.7039	4	6	12	18	27
216	4801	13.6045	2	4	8	12	17
217	12745	22.3197	3	7	10	18	30
218	10391	11.6841	4	7	15	29	48
219	17313	6.9251	3	6	9	14	21
220	1	3.0000	3	4	6	8	12
221	3295	10.1560	3	3	3	3	3
222	9048	5.0868	2	3	7	13	21
223	12478	6.5162	1	2	4	7	11
224	8727	3.6809	1	2	5	8	12
225	16849	4.8740	1	2	3	4	7
226	3740	10.6374	2	4	7	10	10
227	8618	4.4233	1	2	3	5	23
228	5393	4.4840	1	2	3	5	9
229	5126	2.7876	1	1	3	5	9
230	3545	7.2217	1	2	2	3	5
231	7996	6.2996	1	2	4	8	14
232	868	6.2903	1	2	3	7	14
233	553	12.5913	3	5	9	15	25
234	6552	6.2793	2	3	5	8	12
235	6385	14.0799	2	4	8	15	25
236	39479	10.1272	2	5	9	15	25
237	2031	6.2713	2	3	5	8	12
238	5448	14.7417	4	7	11	18	30
239	61195	10.2798	3	5	9	15	25
240	10812	9.9791	3	5	9	15	25
241	7293	6.6432	2	3	5	8	12
242	2469	11.5233	2	3	5	8	12
243	141904	6.9902	2	3	5	8	12
244	11837	7.6225	2	3	5	8	12
245	9529	5.6149	2	3	5	8	12
246	2414	5.9925	2	3	5	8	12
247	10606	5.1742	1	2	4	7	10
248	7178	6.0561	2	3	5	8	12
249	5393	6.8581	1	2	4	7	10
250	3562	6.9402	1	2	4	7	10
251	6030	3.5391	1	1	2	4	7
252	14865	8.8736	2	4	7	10	17
253	19699	5.3260	1	2	4	7	10
254	9770	5.6950	1	2	4	7	10
255	22465	7.1536	3	4	6	8	12
256	28105	5.3778	3	4	6	8	12
257	3728	7.4268	2	4	6	8	12
258	5006	3.6247	1	2	3	5	9
260							

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
261	4535	3.3032	1	2	3	4	6
262	4456	2.8324	1	1	2	3	5
263	25373	22.1475	6	9	15	27	45
264	7920	14.6138	4	7	11	18	29
265	5217	11.5277	2	4	7	14	24
266	6886	5.0293	1	2	3	7	11
267	622	4.6833	1	2	3	6	10
268	2179	3.9523	1	1	2	4	8
269	8671	12.1872	2	4	8	15	25
270	8086	5.1534	1	2	3	6	11
271	17661	12.2979	3	6	9	14	22
272	6728	9.7952	3	5	7	12	19
273	3898	7.7719	2	4	6	9	18
274	4565	9.9553	2	3	7	12	22
275	1205	6.1566	1	2	4	6	12
276	990	4.6083	1	2	3	6	10
277	50701	9.1369	3	5	7	11	16
278	29751	6.9421	3	4	6	8	12
279	4	3.7500	2	2	4	6	13
280	12745	6.7524	2	3	5	8	9
281	11437	4.6129	1	2	3	6	6
282	2	6.0000	6	6	6	9	15
283	6000	7.7022	2	3	6	9	10
284	4152	5.1626	1	2	3	6	45
285	3174	24.1150	1	1	18	29	28
286	1418	14.9513	6	8	10	17	40
287	6718	20.0085	5	5	14	23	23
288	552	12.3370	3	5	7	12	15
289	3753	7.2601	2	3	5	7	9
290	8873	4.9948	2	3	4	5	5
291	215	3.0093	1	1	2	3	34
292	3992	17.8151	4	8	13	21	19
293	1051	10.2940	2	4	6	12	14
294	103723	7.7577	3	4	6	9	12
295	3005	6.2536	2	3	5	8	16
296	165280	8.6290	2	3	4	7	10
297	63289	5.7995	2	3	4	5	9
298	63	4.4762	1	2	3	5	15
299	999	7.4895	1	3	5	9	19
300	10678	9.8400	3	5	7	12	12
301	3616	6.2801	2	3	5	8	33
302	6233	18.6725	8	11	15	23	27
303	15162	15.3758	7	9	12	18	28
304	12938	14.7880	4	7	11	18	15
305	8599	8.4501	4	5	7	11	20
306	10595	10.6865	4	5	8	13	11
307	7551	6.2670	3	4	5	8	12
308	7613	10.8043	2	4	8	13	21
309	5302	5.6226	1	2	4	8	12
310	29569	6.5484	2	3	5	8	13
311	32363	3.5070	1	2	3	4	7

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
312	4172	6.1407	1	2	4	8	13
313	4144	3.5784	1	2	3	4	7
314	3	5.6667	4	4	5	8	8
315	25298	14.0137	2	4	9	18	30
316	40046	9.4619	2	4	7	12	19
317	1997	3.0145	1	4	2	8	6
318	7967	9.3906	1	1	2	12	20
319	1996	4.4469	2	3	6	6	10
320	130960	8.9066	3	5	7	11	15
321	47404	6.6566	3	4	6	8	11
322	58	6.5690	2	4	5	8	10
323	23385	4.3036	1	2	3	5	9
324	20345	3.1416	1	2	2	4	6
325	11530	6.3063	2	3	5	8	12
326	7327	4.1015	1	2	3	5	8
327	7	4.1429	1	1	3	5	6
328	2279	5.2677	1	2	4	7	10
329	963	3.3178	1	1	2	4	6
330	2	2.0000	2	2	2	2	2
331	23594	7.7729	2	3	6	9	15
332	10836	4.9563	1	2	3	6	10
333	92	6.0326	1	2	3	6	10
334	8299	12.5632	7	8	11	15	14
335	8324	9.5288	6	7	9	11	14
336	89759	7.4941	3	4	6	9	13
337	119247	5.0367	3	4	5	7	8
338	10781	5.4994	1	1	3	5	13
339	6591	4.0681	1	1	3	5	9
340	4	11.0000	1	1	2	6	25
341	16730	5.1451	2	3	4	6	9
342	1077	3.1746	1	1	2	3	7
344	3611	7.3099	2	4	6	8	14
345	2524	6.0396	1	2	4	7	12
346	10799	8.3611	2	3	6	10	17
347	3674	3.8677	1	1	2	5	8
348	6241	5.5869	1	2	4	7	11
349	5767	2.8663	1	1	2	3	6
350	9608	6.0276	2	4	5	7	10
351	3	1.0000	1	1	1	1	1
352	1313	4.4547	1	2	3	5	9
353	1786	15.3365	7	8	12	18	27
354	6405	10.3533	5	6	8	12	17
355	7636	6.7048	4	5	6	8	9
356	27724	5.9256	3	4	5	7	9
357	6365	13.6624	6	6	11	16	25
358	12970	8.9091	5	6	7	10	15
359	28018	6.1932	4	5	6	7	9
360	5252	5.8740	1	2	4	7	12
361	537	4.6145	1	2	2	5	10
362	32	1.9688	1	1	1	3	3
363	4395	5.4325	1	2	3	5	11

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
364	5578	3.1682	1	1	2	3	7
365	3468	12.7696	4	6	9	16	25
366	5778	10.0748	2	3	7	13	22
367	2021	4.6051	1	2	3	5	10
368	1483	7.6522	3	4	6	9	14
369	3575	5.0719	1	2	3	6	10
370	435	7.7494	4	5	6	8	13
371	622	5.2926	3	4	5	6	7
372	256	3.8828	1	2	3	4	4
373	1616	2.7587	1	2	3	4	5
374	288	3.5372	2	3	4	4	4
375	2	3.5000	3	3	3	4	4
376	108	3.9630	1	2	3	4	4
377	38	4.7105	1	2	3	4	4
378	109	5.0734	3	4	5	6	7
379	216	3.0185	1	1	2	2	6
380	56	2.0714	1	1	1	2	5
381	298	2.4329	1	1	1	2	5
382	116	1.5259	1	1	1	2	3
383	658	5.3526	1	2	3	6	10
384	86	3.6163	1	1	2	4	8
385	7	10.0000	1	1	2	4	9
386	1	9.0000	9	9	9	9	18
389	48	13.8542	2	3	5	8	31
390	47	18.7447	2	3	7	12	18
392	2265	17.1475	1	3	6	10	34
393	1	6.0000	6	6	12	16	6
394	2043	8.2863	1	2	5	10	18
395	76455	6.4224	1	3	5	8	12
396	42	3.6190	1	3	5	10	17
397	10100	7.7628	2	4	7	10	15
398	10879	9.1697	2	4	7	11	17
399	3147	5.7830	2	4	7	11	12
400	7900	15.7396	1	3	6	11	32
401	5805	15.3115	4	7	11	19	31
402	4215	6.4996	3	6	9	15	14
403	24571	12.1003	1	2	5	15	25
404	8971	7.0128	2	3	5	9	15
405	2	2.5000	2	3	3	3	3
406	3746	17.1743	5	8	13	22	33
407	2120	9.2212	2	5	8	11	18
408	10169	6.7689	2	4	6	11	16
409	8100	10.6063	2	4	6	15	23
410	127070	3.4165	1	2	3	4	6
411	698	4.2120	1	2	3	4	8
412	611	3.2079	1	2	3	4	7
413	10158	10.7714	2	4	6	14	23
414	4907	7.5017	1	3	5	9	16
415	22439	21.0602	1	4	8	26	42
416	9337	10.6946	5	9	16	13	20
417	31	7.4194	2	4	7	9	13

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V5.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
472	188	33.7660	1	10	28	48	73
473	7909	15.8780	2	4	9	23	39
474	8780	45.4845	13	22	35	56	85
475	17989	13.2293	2	5	11	17	26

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPEE V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	25329	19.2277	6	9	14	23	38
002	5247	19.5948	4	8	13	24	41
003	5247	19.1429	1	7	16	23	24
004	4625	17.1762	4	7	13	21	35
005	49433	8.2420	3	4	6	10	15
006	2403	2.8577	1	1	2	3	5
007	5341	23.4155	2	6	12	25	52
008	4708	5.4947	1	2	3	6	11
009	2133	11.6606	2	4	8	13	22
010	17721	11.7036	2	4	8	15	22
011	5454	7.5994	1	3	5	9	16
012	27345	10.6930	2	4	7	12	19
013	5597	10.0688	3	5	8	12	18
014	321583	10.8246	3	5	8	13	21
015	156828	5.6459	2	3	4	7	10
016	14432	9.3395	2	3	4	7	17
017	7008	6.5060	2	3	4	7	11
018	12355	9.4988	2	4	5	11	18
019	12480	6.1090	1	2	3	8	12
020	5978	11.7556	2	5	9	15	24
021	812	9.9741	3	4	7	13	19
022	13465	5.8789	2	3	5	7	11
023	4440	6.9410	1	2	3	8	14
024	45544	7.6544	2	3	5	9	15
025	30010	4.8032	1	2	3	6	9
026	46	4.8686	1	1	2	5	11
027	2522	9.6122	1	2	3	12	23
028	6274	9.6302	1	3	5	12	20
029	5016	5.3154	1	2	4	17	12
030	1	1.0000	1	1	1	1	1
031	4455	6.5181	1	2	4	8	12
032	5406	3.9129	1	2	3	5	8
033	11567	9.5162	2	4	6	11	19
034	5912	5.5940	1	2	3	7	11
035	20865	3.4337	1	2	3	4	6
036	3207	4.6289	1	2	3	5	9
037	1576	2.8756	1	1	2	3	5
038	36756	2.0577	1	1	2	3	6
039	6076	2.9668	1	1	2	3	6
040	1	1.0000	1	1	1	1	1
041	23928	3.1296	1	1	2	4	6
042	326	5.6319	1	2	4	5	8
043	2424	7.0120	3	4	6	9	13
044	3687	4.4337	1	2	3	6	8
045	3467	6.1246	1	2	4	8	12
046	3695	3.6111	1	1	2	5	8
047	7489	15.7227	3	7	12	19	30
049	5548	3.2495	1	2	3	4	6
050	832	3.0913	1	1	2	3	6
051	236	4.8305	1	1	2	3	6
052	9447	3.3779	1	1	2	3	6
053							10

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
054	3	5.6667	4	4	5	8	8
055	8955	2.6385	1	1	1	2	5
056	1734	2.4781	1	1	2	3	5
057	850	6.3306	1	2	3	7	14
058	1	2.0000	1	2	2	2	4
059	368	2.1712	1	1	1	2	4
060	1	3.0000	1	3	3	3	3
061	569	5.1880	1	1	3	5	13
062	3	5.3333	1	1	2	5	15
063	6514	7.5111	1	1	4	18	15
064	7322	8.8815	1	2	5	11	16
065	31957	4.2223	1	2	3	5	20
066	10551	4.1719	2	2	3	8	8
067	459	6.4619	2	3	5	8	12
068	12434	6.4345	2	3	5	8	12
069	5978	4.8337	2	3	4	6	9
070	29	4.2144	1	2	4	6	7
071	119	6.4034	1	2	4	7	10
072	816	5.0956	1	2	4	7	9
073	9327	5.8918	1	2	4	7	12
074	1	1.0000	1	2	4	7	12
075	29757	15.3040	16	18	12	18	28
076	13871	16.1283	3	6	11	20	32
077	207	6.8360	1	6	11	13	15
078	28984	10.8142	4	7	10	16	18
079	91377	12.8809	4	7	10	17	24
080	14845	9.6362	3	6	10	17	24
081	5	6.6000	1	5	8	16	27
082	91280	9.6726	2	4	5	12	20
083	6849	8.8258	2	4	7	12	20
084	2941	5.5172	2	4	7	11	18
085	15165	9.3068	2	4	7	12	20
086	3190	6.3749	2	4	5	10	16
087	41137	8.3414	2	4	6	11	15
088	124868	8.1612	1	3	6	10	15
089	293506	9.3206	3	4	6	11	17
090	66865	7.0091	3	4	6	11	15
091	47	5.1702	2	4	6	9	12
092	10182	9.2520	3	4	7	12	18
093	3163	6.8761	3	4	6	11	15
094	8330	10.0190	3	4	7	12	18
095	1925	5.3709	3	4	6	11	15
096	186419	7.5179	3	4	6	11	15
097	53497	5.7106	3	4	6	11	15
098	17	4.5294	2	3	5	7	10
099	23844	5.4333	1	3	4	6	10
100	13026	3.5125	1	2	4	6	10
101	20196	7.4020	1	2	3	4	6
102	6339	5.0771	1	2	3	4	6
103	47	43.4681	13	19	30	44	122
104	9459	22.0792	10	13	18	26	39

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
105	10161	16.8540	8	10	13	19	30
106	53944	16.8970	9	11	14	19	27
107	36200	13.0297	8	9	10	14	20
108	4947	15.5559	5	9	12	18	28
109	9987	12.2587	1	4	9	16	26
110	61599	16.7861	6	9	13	20	31
111	20953	10.2816	5	7	9	12	16
112	82473	7.9777	2	3	6	10	16
113	33075	19.3258	6	9	14	23	36
114	8750	14.1126	3	6	11	18	27
115	7069	15.3607	6	9	13	19	27
116	56434	8.2242	3	4	7	10	15
117	4019	6.6163	2	3	4	8	13
118	8230	3.9887	1	2	3	4	8
119	4420	6.4597	1	2	3	4	8
120	20862	17.6798	3	6	12	22	36
121	132941	11.0133	4	7	10	13	18
122	130066	8.1824	2	5	8	10	13
123	68863	5.5977	1	1	3	7	14
124	73831	6.3658	1	1	2	8	13
125	102216	3.2186	1	2	2	4	7
126	3443	22.5321	5	11	20	31	43
127	510324	8.2170	3	6	6	10	15
128	35137	9.2010	4	6	8	11	14
129	8953	5.8719	1	1	2	7	14
130	56711	8.1413	2	3	5	10	15
131	34209	5.8984	1	2	5	8	11
132	20940	6.0324	2	3	5	7	11
133	9230	4.5930	1	2	4	5	8
134	40176	5.7260	2	3	4	7	10
135	7356	7.1767	2	3	5	7	10
136	2424	4.9922	1	2	4	6	8
138	137843	6.3931	2	3	4	6	8
139	85064	4.4553	1	2	4	6	9
140	373528	5.0035	2	3	4	6	9
141	64694	5.9560	2	3	4	6	9
142	42100	4.3111	1	2	3	5	8
143	88303	3.7171	1	2	3	5	8
144	44617	8.0890	2	4	6	10	16
145	9516	4.8851	1	2	3	6	9
146	6392	16.6023	8	11	14	19	27
147	3131	11.7480	7	9	11	14	18
148	115528	17.8689	8	10	14	21	31
149	34599	11.4052	7	8	10	13	17
150	15444	15.4325	6	9	12	18	27
151	7557	9.9194	5	7	9	12	16
152	6677	10.3211	3	6	8	12	19
153	4505	7.8260	3	5	8	10	12
154	43730	17.7039	5	9	13	21	34
155	10.2820	10.2820	4	6	9	13	18
156	14.5000	14.5000	1	1	1	8	8

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
157	23376	7.5483	2	3	6	9	14
158	24664	4.0348	1	2	3	5	8
159	12088	7.4795	2	4	6	9	14
160	16887	4.4595	2	2	4	6	8
161	31433	5.1493	1	2	4	6	10
162	55821	2.9852	1	2	3	4	5
163	16	6.1250	1	2	3	4	8
164	3863	13.2827	6	8	11	15	22
165	3084	8.8877	5	8	8	10	13
166	2276	8.8352	5	6	7	10	13
167	2973	5.0743	3	5	5	6	8
168	2458	6.2681	3	3	3	7	15
169	3286	3.1074	1	2	2	3	6
170	11743	16.4425	4	7	12	21	32
171	2856	9.4807	4	4	7	12	18
172	31197	10.5325	2	4	7	13	22
173	7080	6.3517	1	4	8	13	13
174	122848	7.3642	2	4	6	9	13
175	41742	5.1376	2	3	6	10	15
176	11725	8.0206	3	4	6	8	12
177	17848	6.6538	3	4	5	6	9
178	10678	4.9852	2	3	4	6	12
179	7341	9.6762	3	5	7	10	15
180	50932	7.9655	2	4	6	8	12
181	29543	5.1367	2	3	4	6	9
182	22654	6.4852	2	3	5	8	12
183	107800	4.6684	2	2	4	6	8
184	58	4.5172	1	2	2	5	8
185	4323	6.2970	1	2	4	8	12
186	3	9.3333	4	4	9	15	15
187	2313	2.9464	1	1	2	3	6
188	33029	7.4834	2	3	5	9	15
189	14236	4.2730	1	2	3	5	9
190	188	6.3511	2	3	4	7	11
191	7106	23.4249	8	11	18	29	45
192	1447	14.1279	6	8	12	17	25
193	13137	17.7056	7	10	15	21	31
194	3490	12.4086	5	8	11	15	20
195	21461	14.0877	7	9	12	16	23
196	4756	10.2984	6	7	9	12	16
197	53596	10.9838	5	7	9	13	18
198	43948	7.1505	4	5	6	8	11
199	3505	15.5512	5	8	13	20	29
200	2173	13.9742	2	6	11	18	28
201	4531	13.6171	2	5	10	17	28
202	15097	10.2601	2	5	8	13	20
203	30900	9.6514	2	4	7	12	20
204	33091	8.0349	3	4	6	10	15
205	18568	9.6658	2	4	7	12	19
206	4549	5.7265	1	4	6	7	12
207	34559	7.5178	2	4	6	9	14

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
208	19449	4.7088	1	2	4	6	9
209	185439	13.3208	8	9	12	15	20
210	79642	16.0895	7	10	13	18	27
211	52590	12.0349	6	8	11	14	18
212	12	10.1667	1	6	8	17	28
213	5133	14.0746	4	6	10	18	27
214	21374	14.8496	6	8	12	17	28
215	32383	9.7040	4	6	10	18	27
216	4801	13.6045	4	6	10	18	30
217	12745	22.3197	2	4	15	29	48
218	10391	11.6841	4	7	15	29	48
219	17313	5.9251	3	6	6	8	12
220	1	3.0000	3	4	6	8	12
221	3295	10.1560	2	3	3	3	3
222	9048	5.0868	1	2	4	7	21
223	12478	6.2162	1	2	4	7	11
224	8727	3.6909	1	2	3	4	12
225	16899	4.8740	1	2	3	4	7
226	4010	10.6928	2	4	7	10	10
227	9344	4.4386	1	2	3	5	23
228	5393	4.4840	1	2	3	5	9
229	5126	2.7876	1	1	2	3	5
230	3375	7.1615	1	1	2	3	5
231	7170	6.3257	1	1	2	3	5
232	868	6.2903	1	1	2	3	5
233	5153	12.5913	3	5	9	14	14
234	6552	6.2793	2	3	5	7	14
235	6385	14.0799	2	4	8	15	25
236	3979	10.1272	2	5	8	15	25
237	2031	6.2713	2	3	5	8	12
238	5448	14.7417	4	7	11	18	30
239	61195	10.2798	3	5	8	13	20
240	10812	9.5791	3	5	8	12	19
241	7393	6.6432	3	5	8	12	19
242	2469	11.5233	3	5	8	14	23
243	141904	6.9902	2	3	6	9	13
244	11837	7.6225	2	3	6	9	14
245	5529	5.5149	2	3	6	9	14
246	2414	5.5925	2	3	6	9	14
247	10606	5.1742	2	3	6	9	14
248	7178	6.0561	1	2	4	7	10
249	5393	6.8581	1	2	4	7	10
250	3562	6.9402	1	2	4	7	10
251	6030	3.5391	1	1	2	4	7
252	14865	8.8736	1	1	2	4	7
253	19699	5.3260	1	1	2	4	7
254	9770	7.1526	1	1	2	4	7
255	2465	5.3778	3	4	6	8	11
256	28105	7.4268	3	4	6	8	11
257	3728	3.6247	2	3	5	7	9
258	506		1	2	3	5	6

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
261	4535	3.3032	1	2	3	4	6
262	4426	2.6324	1	1	2	3	5
263	25373	22.1475	6	9	15	27	45
264	7920	14.6138	4	7	11	18	29
265	5217	11.5277	2	4	7	14	24
266	6886	5.0293	1	2	3	6	11
267	622	4.6833	1	2	3	6	10
268	2179	3.9523	1	1	2	4	8
269	9028	12.5176	2	4	9	16	26
270	8155	5.2473	1	2	3	6	11
271	17661	12.2979	3	6	9	14	22
272	6728	9.7952	3	5	7	12	19
273	3898	7.7719	2	4	6	9	16
274	4565	9.9553	2	3	7	12	22
275	990	6.1566	1	3	4	6	10
276	1205	4.6083	1	2	3	6	12
277	50701	9.1369	3	5	7	11	16
278	29751	6.9421	3	4	6	11	12
279	4	3.7500	2	2	4	4	5
280	12745	6.7524	2	2	3	6	13
281	11437	4.6129	1	3	5	8	9
282	2	6.0000	6	6	6	6	6
283	6000	7.7022	2	3	6	9	15
284	4152	5.1626	1	2	4	6	10
285	3174	24.1150	7	11	18	29	45
286	1418	14.9513	6	8	10	17	28
287	6718	20.0085	5	8	14	23	40
288	552	12.3370	3	5	7	12	23
289	3753	7.2601	2	3	5	7	15
290	8873	4.9948	2	3	4	5	9
291	215	3.0093	1	1	2	3	5
292	4003	17.8294	1	8	13	21	34
293	1051	10.2940	4	4	7	12	19
294	103723	7.7577	3	4	6	9	14
295	3005	6.2536	2	3	5	8	12
296	165280	8.6290	2	4	6	10	16
297	63299	5.7995	2	3	4	7	10
298	63	4.4762	1	2	3	5	9
299	999	7.4895	1	3	5	9	15
300	10678	9.8400	3	5	7	12	19
301	3616	6.2801	3	3	5	8	12
302	6233	18.6725	8	11	15	23	33
303	15162	15.3758	7	9	12	18	27
304	13767	14.5245	4	7	11	18	28
305	7770	8.2407	4	5	7	10	15
306	10612	10.6823	4	5	8	13	20
307	7533	6.2634	3	4	5	8	11
308	7811	10.6799	2	4	8	13	21
309	5649	5.5335	1	2	4	7	11
310	29986	6.5380	2	3	5	8	13
311	31940	3.4759	1	2	3	4	6

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 05/88 GROUPEL V6.0

DRO	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
312	3987	6.1680	1	2	4	8	13
313	3791	3.5083	1	2	3	4	7
314	3	5.6667	4	4	5	8	8
315	25476	13.9985	2	4	9	18	30
316	40046	9.4619	2	4	7	12	19
317	1997	3.0145	1	1	2	3	6
318	7967	9.3906	1	3	6	12	20
319	1996	4.4469	2	1	3	6	10
320	130960	8.9066	1	5	11	16	15
321	47404	6.6566	3	4	8	11	11
322	58	6.5690	3	5	10	16	10
323	24914	4.3382	2	3	5	8	9
324	18816	3.0013	1	2	3	4	6
325	11530	6.3063	1	3	5	9	12
326	7327	4.1015	2	2	3	5	8
327	7	4.1429	1	1	3	5	6
328	2279	5.2677	1	2	4	7	10
329	963	3.3178	1	1	2	4	6
330	2	2.0000	1	2	2	4	6
331	23594	7.7729	2	3	6	9	15
332	10836	4.9563	2	2	5	9	10
333	92	6.0326	1	3	3	6	14
334	8299	12.5632	7	8	11	15	20
335	8324	9.5288	6	7	9	11	14
336	89758	7.4941	3	4	6	9	13
337	119247	5.0367	3	4	5	6	8
338	10781	5.4994	1	1	3	7	13
339	6591	4.0681	1	1	3	5	9
340	4	11.0000	1	1	2	16	25
341	16730	5.1451	2	3	4	6	9
342	1077	3.1746	1	1	2	3	7
343	3599	7.3184	1	4	4	8	14
344	2520	6.0321	2	2	6	7	12
345	10799	8.3611	1	3	4	10	17
346	3674	3.8677	2	1	2	5	8
347	6241	5.5869	1	2	4	7	11
348	5767	2.8663	1	1	2	3	6
349	9608	6.0276	2	4	5	10	16
350	3	1.0000	1	1	1	1	10
351	1313	4.4547	1	2	1	1	9
352	1786	15.3365	1	8	12	18	27
353	6405	10.3533	7	6	12	17	17
354	7636	6.7048	5	5	8	12	19
355	27724	5.9256	4	4	5	8	9
356	6365	18.6624	3	8	11	16	25
357	12970	8.9091	5	6	7	10	15
358	28017	6.1982	4	5	6	7	9
359	5251	5.8739	1	2	4	7	12
360	537	4.6145	1	2	2	5	10
361	32	1.9688	1	1	1	2	3
362	4395	5.4325	1	2	3	5	11

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
364	5378	3.1682	1	1	2	3	7
365	3515	13.0785	4	6	9	16	26
366	5778	10.0748	2	3	7	13	22
367	2021	4.6051	1	2	3	5	10
368	1483	7.6622	3	4	6	9	14
369	3575	5.0719	1	2	3	6	10
370	435	7.7494	1	2	3	6	13
371	622	5.2926	3	4	5	8	7
372	256	3.8828	1	2	3	6	4
373	1616	2.7587	1	2	3	4	4
374	289	3.5917	2	2	3	4	5
375	2	3.5000	3	3	4	4	4
376	108	3.9630	1	2	3	4	8
377	38	4.7105	1	2	3	4	7
378	109	5.0734	1	2	3	4	7
379	216	3.0185	1	1	2	6	6
380	56	2.0714	1	1	1	4	5
381	298	2.4329	1	1	1	2	4
382	116	1.5259	1	1	1	2	5
383	658	5.3526	1	1	1	2	5
384	86	3.6163	1	2	3	6	3
385	7	10.0000	1	1	2	4	10
389	48	13.8542	1	2	5	8	8
390	47	8.7447	1	3	7	12	18
392	2265	17.1475	1	3	6	10	31
393	1	6.0000	6	8	12	21	18
394	2317	10.2624	1	6	12	6	34
395	76455	6.4224	1	2	6	12	23
396	42	3.6190	1	3	5	8	12
397	10100	7.7628	1	3	5	2	7
398	10861	9.1734	2	3	1	10	15
399	3165	5.7896	2	4	6	11	17
400	7900	15.7395	1	2	7	17	12
401	5805	15.3115	4	6	11	19	32
402	4215	6.4996	3	6	11	19	31
403	24571	12.1003	1	2	4	8	14
404	8971	7.0128	2	5	9	15	25
405	2	2.5000	1	3	5	9	15
406	3744	17.1741	5	8	13	22	33
407	2122	9.2290	2	5	8	11	33
408	10169	6.7589	2	5	8	11	18
409	8100	10.6063	2	4	6	7	16
410	127070	3.4165	2	2	3	15	23
411	598	4.2120	1	2	3	4	6
412	611	3.2079	1	2	3	5	8
413	10156	10.7726	1	4	8	14	23
414	4909	7.5005	2	3	5	9	16
415	22439	21.0602	1	3	8	14	42
416	99337	10.6946	5	9	16	26	20
417	31	7.4194	2	5	9	13	13
418	11479	8.9634	3	4	7	11	17

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
419	14208	7.8528	2	4	6	9	15
420	4971	5.8970	2	8	5	7	11
421	11821	5.7451	2	8	4	7	11
422	97	5.3402	1	3	4	7	10
423	6524	11.9093	3	5	8	14	24
424	8384	22.2624	3	7	15	26	44
425	15259	6.3229	2	3	4	8	12
426	11183	8.1590	2	3	6	10	16
427	2059	7.8120	2	3	5	9	16
428	1285	10.4856	1	3	6	13	22
429	31527	11.7737	3	4	7	13	21
430	62101	12.8448	3	5	9	16	27
431	427	9.2108	2	3	6	11	19
432	651	7.1321	1	2	4	8	15
433	5063	5.0660	1	3	4	6	12
434	16037	8.7405	2	3	6	10	20
435	14937	7.7344	2	3	6	8	21
436	4875	15.4888	2	3	5	24	29
437	7934	18.0883	4	6	15	27	30
438	1150	13.0365	1	3	8	17	30
439	7136	17.4113	1	3	12	22	33
440	1134	4.3201	1	1	2	4	9
441	40417	10.2225	1	3	6	13	23
442	17555	6.7155	1	2	4	9	15
443	3523	7.1367	1	3	5	9	14
444	3117	5.1830	1	2	4	6	10
445	1	2.0000	1	2	2	2	7
446	2890	3.7339	1	1	3	5	4
447	1	4.0000	1	4	5	4	4
448	30826	6.5831	2	3	8	12	18
449	13196	4.1022	1	3	5	9	15
450	14	4.8571	1	2	3	4	9
451	25623	7.1609	1	3	5	6	14
452	12296	4.5614	1	2	4	8	15
453	4086	7.2312	1	2	3	6	14
454	1780	4.0365	1	2	3	5	8
455	239	10.0711	1	2	3	5	10
456	140	8.6143	1	2	3	5	12
457	1743	24.7177	5	10	19	32	51
458	947	15.5956	3	6	11	19	33
459	2453	9.5944	2	4	7	12	19
460	9522	4.8649	1	1	2	5	11
461	5360	18.4851	1	3	15	25	36
462	9758	7.2406	2	3	5	9	14
463	4205	4.5942	1	2	3	6	9
464	1082	2.8373	1	1	3	3	5
465	4529	5.3939	1	1	2	6	11
466	7299	8.5845	1	1	3	6	14
467	68717	19.0396	3	8	14	23	38
468	3710	19.0081	10	12	16	23	31
471	188	38.7660	1	10	28	48	73
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TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY87 MEDPAR UPDATE 06/88 GROUPER V6.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
473	7909	15.8780	2	4	9	23	39
474	8780	45.4845	13	22	35	56	85
475	17989	13.2293	2	5	11	17	26
476	11271	18.0169	8	11	15	21	30
477	38485	10.6069	1	3	7	13	21

Table 8 --
 Statewide Average Cost-to-Charge Ratios
 For Urban and Rural Hospitals
 (Case Weighted)

State	Urban	Rural
Alabama	0.5194	0.5815
Alaska	0.6731	0.8809
Arizona	0.6117	0.6523
Arkansas	0.6076	0.5922
California	0.6095	0.6023
Colorado	0.6747	0.7349
Connecticut	0.7262	0.8198
Delaware	0.6008	0.6079
District of Columbia	0.6429	--
Florida	0.5455	0.5496
Georgia	0.6174	0.5996
Hawaii	0.6498	0.7848
Idaho	0.7100	0.7257
Illinois	0.6055	0.6643
Indiana	0.7174	0.7392
Iowa	0.7118	0.7290
Kansas	0.6590	0.7555
Kentucky	0.6030	0.5904
Louisiana	0.6001	0.6339
Maine	0.6815	0.6640
Maryland	0.7315	0.7333
Massachusetts	0.6993	0.7797
Michigan	0.6214	0.7019
Minnesota	0.7073	0.7762
Mississippi	0.6301	0.6376
Missouri	0.5989	0.6416
Montana	0.6694	0.7304
Nebraska	0.6232	0.7383
Nevada	0.5141	0.6392
New Hampshire	0.7298	0.7469
New Jersey	0.6823	--
New Mexico	0.5939	0.6106
New York	0.6270	0.7102
North Carolina	0.6560	0.5987
North Dakota	0.7175	0.7089
Ohio	0.7129	0.7016
Oklahoma	0.6111	0.6355
Oregon	0.6747	0.6872
Pennsylvania	0.5684	0.6402
Puerto Rico	0.5959	0.7761
Rhode Island	0.7797	--
South Carolina	0.5975	0.5795
South Dakota	0.6142	0.6991
Tennessee	0.5642	0.5681
Texas	0.6134	0.7097
Utah	0.6636	0.6854
Vermont	0.7698	0.7129
Virginia	0.6019	0.6018
Washington	0.6933	0.7362
West Virginia	0.6474	0.6071
Wisconsin	0.7769	0.7733
Wyoming	0.7400	0.7458

Appendix A—Regulatory Impact Analysis

I. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish a final regulatory impact analysis for any final rule that meets one of the E.O. criteria for a "major rule"; that is, that will be likely to result in: an annual effect on the economy of \$100 million or more; a major increase in cost or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or 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.

In addition, we generally prepare a final regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all hospitals as small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a final regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside of a Metropolitan Statistical Area or New England County Metropolitan Area, as modified for purposes of the prospective payment system in accordance with the provisions of 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21). Section 1886(d)(8)(B) of the Act, as added by section 4005(a) of the Pub. L. 100-203, specifies that hospitals located in certain rural counties adjacent to urban areas are deemed to be located in an adjacent urban area. We have identified more than 50 hospitals, some of which may be considered small, which we are classifying as urban hospitals.

It is clear that changes presented in this document will affect both a substantial number of small rural hospitals as well other classes of hospitals, and the effects on some will be significant. Therefore, the discussion

below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in accordance with E.O. 12291, section 1102 and the Act, and the RFA.

II. Impact on Excluded Hospitals and Units

As of July 1, 1988, there were 847 Medicare hospitals and 1,563 units in hospitals excluded from the prospective payment system and therefore, paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of § 413.40. For cost reporting periods beginning in FY 1989, these hospitals will have their individual target amounts increased by the hospital market basket percentage increase. We are projecting an increase in the hospital market basket of 5.4 percent.

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, and the relative gains in productivity (efficiency) the hospital or unit is able to achieve. For hospitals and units that incur per discharge costs lower than their target amounts, the primary impact will be to affect the level of incentive payments made under § 413.40(d). A hospital may receive incentive payments of incurring costs that are less than its target amount, but may not receive payments for costs that exceed that target amount. Even with the full market basket increase, we expect that the increased ceiling on payments will maintain existing incentives for economy and efficiency experienced by excluded hospitals and units.

III. Analysis of the Quantifiable Impact of Changes in Policy Affecting Rates and Payment Amounts

A. Basis and Methodology of Estimates

In the initial impact analysis, the data used in developing the quantitative estimates of changes in payments in Table I, below, were derived from FY 1987 billing data and hospital-specific data for FY 1985 and FY 1986. As in previous analyses, we compared the effects of changes being made for FY 1989 to our estimate of the payment amounts in effect for FY 1988.

Although many of the FY 1988 payment parameters have been in effect only since April 1, 1988, for purposes of initial impact analysis, we assumed that all payment parameters had been in effect since October 1, 1987. Moreover, section 4002(g)(1)(B) of Pub. L. 100-203 specifies that the update factors applicable to rates for discharges occurring on or after April 1, 1988 are

deemed to have been in effect since October 1, 1987 for purposes of determining updated payment rates for discharges occurring in FY 1989. Thus, by assuming that all of the April 1, 1988 parameters have been in effect for the entire 12-month period of FY 1988, we constructed a base year set of parameters that were internally consistent and conformed to the requirement in section 4002(g)(1)(B) of Pub. L. 100-203.

In addition, we treated all hospitals in our data base as if they had the same cost reporting period; that is a cost reporting period coinciding with the Federal fiscal year. Also, our model did not take into account any prospective behavioral changes in response to these proposals.

For this final impact analysis, we are adopting the same method of analysis and the same base year parameters as we did for the initial impact analysis.

As in the initial impact analysis, the tables and the discussion that follow reflect our best effort to identify and quantify the effects of the changes being implemented in this document. It should be noted, however, that as a result of gaps in our data, we are unable to quantify some of the effects of the final rule. Also, we could not include data from all the hospitals in the recalibration data set for modeling the impact analysis because in some cases the hospital-specific data necessary for constructing our impact model were missing. Data on hospital bed size and type of ownership were the data elements most frequently missing. The absent data prevented us from properly classifying and displaying these hospitals in the impact analysis. The missing data, however, did not prevent us from using the discharges from these hospitals in recalibrating the DRG weights or calculating the FY 1989 outlier payments.

The analysis that follows examines separately each of the major changes being made for FY 1989. That is, all variables except those associated with the provisions under examination were held constant so as to display the effects of each provision compared to baseline provisions. In columns 1 and 2 of Table I, we are comparing estimated FY 1988 payments under current policy with the FY 1988 payments that would have resulted if only the specified changes were made. To isolate the impact of the changes in the outlier policy displayed in column 3 of Table I, we compared FY 1989 payment amounts that we estimate will be paid under the final outlier policy (as described in section V.E. of the preamble to this final rule) against

FY 1989 estimated payments under current outlier policy with updated outlier thresholds. Because we are not adopting the wage index based solely on 1984 data but rather are continuing to use the blended wage index to determine payment amounts we have omitted any discussion of the wage index in this impact analysis.

Column 4 of Table I presents the combined effect of all changes set forth in this rule. That is, column 4 displays the combined effects of the previous three columns as well as the FY 1989 update factor (which, given a weighted average of 3.3 percent increase, generally has the largest effect), and the provision to consider the hospitals

located in certain rural counties adjacent to MSAs or NECMAs to be located in an adjacent urban area. As such, column 4 is the only one in which the combined effects of the payment policy changes on simulated FY 1989 payments are reflected.

Consistent with the display of the impact presented in Table I, the following discussion is divided into three parts. The first part (columns 1 and 2) describes the effects of two major changes mandated by the statute: (1) annual changes to the DRG classification system and recalibration of the DRG weights required under section 1886(d)(4)(C) of the Act; and (2) changes to payments for

disproportionate share hospitals required under section 1886(d)(5)(F) of the Act, changes to payments for the indirect medical education costs of teaching hospitals required under 1886(d)(5)(B) of the Act, and adjustments to the rates in accordance with section 1886(d)(3)(C)(ii) of the Act, all of which were amended by section 4003 of Pub. L. 100-203. The second part of the discussion (column 3) deals with the effects of changes to the outlier payment policy, while the final section (column 4) discusses the combined effect of all the provisions of this final rule.

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TABLE I--ESTIMATED IMPACT OF THE CHANGES IN THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals 1/ (1)	Reclassification and Recalibration 2/ (1)	Statutory Teaching and DSH Changes 3/ (2)	Outlier Payment Changes 4/ (3)	Combined Effect of All Changes 5/ (4)
All Hospitals	5698	0.0	-0.5	0.0	1.9
Urban by Region					
New England	187	0.0	-0.9	-0.3	0.6
Middle Atlantic	373	0.0	-0.4	-1.5	-0.5
South Atlantic	434	0.1	-0.6	0.0	1.6
East North Central	517	0.1	-0.7	0.3	1.8
East South Central	176	0.1	-0.7	-0.1	1.0
West North Central	204	0.1	-0.7	0.9	2.5
West South Central	384	0.2	-0.3	0.8	3.5
Mountain	126	0.1	-0.5	0.7	3.0
Pacific	526	0.1	-0.3	0.6	2.8
Puerto Rico	52	-0.1	0.7	-0.6	1.8
Rural by Region					
New England	61	-0.3	-0.7	0.5	2.9
Middle Atlantic	102	-0.2	-0.5	-0.5	2.9
South Atlantic	357	-0.1	-0.3	-0.3	2.9
East North Central	368	-0.3	-0.3	0.0	4.4
East South Central	318	0.0	-0.2	-0.2	2.9
West North Central	599	-0.4	-0.2	-0.1	3.1
West South Central	459	-0.1	-0.2	-0.2	3.0
Mountain	274	-0.2	-0.2	0.3	3.1
Pacific	173	-0.3	-0.3	0.0	3.0
Puerto Rico	8	-0.5	0.2	-0.3	1.4
Large Urban Areas (populations over 1 million)	1511	0.1	-0.3	-0.2	1.6
Other Urban Areas (populations with 1 million or smaller)	1468	0.0	-0.8	0.3	1.7
Urban Hospitals	2979	0.1	-0.5	0.0	1.6
0-99 Beds	698	-0.1	-0.5	0.1	2.0
100-199 Beds	766	-0.1	-0.2	-0.3	1.6
200-299 Beds	577	0.0	-0.4	0.0	1.8
300-399 Beds	610	0.1	-0.6	0.0	1.6
400 + Beds	271	0.3	-0.7	0.2	1.6
Rural Hospitals	2719	-0.2	-0.3	-0.1	3.2
0-49 Beds	1103	-0.2	0.0	-0.1	3.9
50-99. Beds	863	-0.2	0.0	-0.2	4.0
100-149 Beds	383	-0.3	-0.2	-0.1	3.7
150-199 Beds	154	-0.3	-0.5	0.1	2.8
200 + Beds	158	-0.1	-0.7	-0.2	1.9

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Table I - continued

	Number of Hospitals ^{1/}	Reclassification and Recalibration ^{2/}	Statutory Teaching and DSH Changes ^{3/}	Outlier Payment Changes ^{4/}	Combined Effect of All Changes ^{5/}
<u>Teaching Status</u>					
Non-Teaching	4602	-0.1	-0.3	0.0	2.3
Resident/Bed Ratio					
Less than 0.25	896	0.1	-0.7	0.1	1.5
Resident/Bed Ratio					
0.25 or Greater	200	0.5	-0.6	-0.3	1.2
<u>Disproportionate Share</u>					
Hospitals (DSH)					
Non-DSH	4431	-0.1	-0.6	0.2	2.1
Urban DSH 100					
Beds or More	920	0.3	-0.3	-0.4	1.4
Urban DSH fewer than 100					
Beds	96	0.2	-0.5	-0.4	0.9
Rural DSH	251	0.1	-0.1	-0.4	3.2
Urban Teaching and DSH					
Both Teaching and DSH	499	0.4	-0.4	-0.4	1.2
Teaching only	520	0.0	-0.9	0.4	1.7
DSH only	517	0.0	0.0	-0.3	1.9
Non-teaching and Non-DSH	1443	-0.1	-0.5	0.2	1.9
<u>Other Special Status (rural)</u>					
Sole Community Hospitals					
(SCHs)	302	-0.2	-0.4	0.1	3.7
Rural Referral Centers					
(RRCs)	199	-0.2	-0.9	0.0	1.7
Both SCH & RRC	21	-0.4	-1.5	0.2	3.0
<u>Type of Ownership</u>					
Voluntary	3058	0.0	-0.6	0.1	1.7
Proprietary	952	0.0	-0.3	-0.6	1.6
Government	1565	0.2	-0.1	0.2	2.7

^{1/} Because data necessary to classify some hospitals by category were missing, some hospitals were omitted from the analysis. Therefore, the total number of hospitals in each category may not equal the national total.

^{2/} Recalibration of the DRG weights and classification changes are based on FY 1987 billing data and charges and are performed annually in accordance with section 1886(d)(4)(c) of the Act.

^{3/} This column reflects the combined effects of adjustments to the indirect medical education cost factor required under section 1886(d)(5)(B)(ii) of the Act, and changes to payments for disproportionate share hospitals required under section 1886(d)(5)(F) of the Act, and adjustments to the rates in accordance with section 1886(d)(3)(C)(ii) of the Act, all of which were amended by section 4003 of Pub. L. 100-203.

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4/ Outlier payments under the new outlier policy were compared to payments under the FY 1988 outlier payment policies. In both cases, FY 1987 data and updated thresholds were used.

5/ This column shows the combined effects of all the previous columns as well as the effects of the update factors mandated under section 1886(b)(3)(B)(1) of the Act, and the effects of section 1886(d)(8) of the Act, which requires that the hospitals located in certain rural counties adjacent to MSAs or NECHAs be considered to be located in an adjacent urban area. Also FY 1988 baseline payments reflect an estimate of outlier payments at 5.9 percent in contrast to the 5.1 percent set for the outlier pool. Because our total FY 1989 estimated payments do not perpetuate this 0.8 percent excess of outlier payments relative to the outlier pool, this column reflects the 0.8 percent reduction in total prospective payments necessary to ensure equality between projected outlier payments and the outlier offsets. In addition, this column captures certain interactive effects that we are not able to quantify.

B. Statutory Changes

Columns 1 and 2 of Table I display the estimated percentage change in payments that will result from each of the statutory changes that become effective on October 1, 1988 as mandated by Pub. L. 100-203; that is, changes in the amount paid to hospitals qualifying as disproportionate share hospitals and in the factor used to calculate the amount paid to hospitals for the indirect cost of graduate medical education. We also include among the statutory changes the required annual reclassification and recalibration of DRG weights.

In column 1, we present the combined effects of revising the current DRG definitions and recalibrating the weights to reflect changes in practice patterns, modes of treatment, and new technologies as required each year by section 1886(d)(4)(C) of the Act. These changes are described in section III of the preamble to this final rule. That is, we compared estimated FY 1988 payments to hospitals using an estimate of each hospital's case-mix index based on the FY 1988 DRG classifications and weighting factors with simulated FY 1988 payments using an estimate of each hospital's case-mix index based on the DRG classifications and recalibrated weighting factors being implemented in this document.

In general, there is little difference in the impact between this final analysis and the one we published in the proposed rule. Overall, the effect of reclassification and recalibration on estimated FY 1988 payments will be negligible. Analyzing the effects geographically, however, column 1 shows that urban hospitals will benefit by about 0.1 percent and rural hospitals will experience payment reductions of about 0.2 percent. Urban hospitals in the West South Central census division will benefit the most from the recalibration of the DRG weights while rural hospitals in Puerto Rico and the West North Central census division will be the most adversely affected as a result of recalibration. Teaching hospitals with large teaching programs will receive about a 0.5 percent increase while rural hospitals with 100-199 beds will experience a 0.3 percent decrease as a result of these changes.

Column 2 displays the combined effects of the changes mandated under section 4003 (a) and (c) of Pub. L. 100-203. Section 4003(a) of Pub. L. 100-203 (which revised section 1886(d)(5)(B)(ii) of the Act) reduces the education adjustment factor used to determine the indirect medical education payment from approximately 8.1 percent to

approximately 7.7 percent of discharges occurring on or after October 1, 1988 and before October 1, 1990.

Section 4003(c) of Pub. L. 100-203 amended section 1886(d) of the Act to provide the following changes to the disproportionate share adjustment:

- The adjustment is extended to discharges occurring before October 1, 1990.
- For hospitals that qualify for a disproportionate share adjustment because they receive more than 30 percent of net patient revenues from State and local governmental sources for the care of indigent patients, the payment adjustment factor is increased from 15 percent to 25 percent.
- For hospitals that have 100 or more beds and are located in an urban area and for hospitals that have 500 or more beds and are located in a rural area, the 15 percent cap on the amount of the payment adjustment is eliminated.

The values in column 2 also reflect the effects of restandardization of the rates for the revised indirect medical education factor and, using the latest available data, estimated payments to hospitals serving a disproportionate share of low income patients in accordance with the revised payment formula. Also, we had to adjust the rates in order to generate program savings consistent with the reduction in the indirect medical education factor mandated by section 1886(d)(3)(C)(ii) of the Act (see section II.A.4.c. of the addendum to this final rule).

The overall effect of changing the indirect teaching adjustment factor and payments to disproportionate share hospitals is to reduce payments, nationally, by about 0.5 percent. By far, the greatest burden of the payment reductions will fall on urban hospitals. On average, these hospitals may expect a 0.5 percent reduction while rural hospitals may experience only a 0.3 percent payment reduction. Urban and rural hospitals in the New England region will receive the largest reductions in payments of about 0.9 percent and 0.7 percent, respectively, while rural hospitals in several regions will experience reductions averaging around 0.2 percent. Among the various types of hospitals, both rural referral centers that do not also qualify as sole community hospitals and urban hospitals that qualify for indirect medical education payments will sustain a 0.9 percent reduction in payments. Urban hospitals with 400 beds or more and rural hospitals with 200 or more beds are projected to receive a 0.7 percent reduction in payments.

Small rural hospitals will experience virtually no change in payments as a result of these changes in the statute.

C. Other Changes

Column 3 of Table I shows the estimated effects of changes to the outlier payment policy that we are implementing in this final rule. As a result of the changes to outlier payments that we have made in §§ 412.80, 412.82, 412.84, and the new § 412.86 of the regulations, many day outlier cases whose adjusted charges exceed the cost outlier threshold will be paid using the cost outlier methodology because that methodology generates the higher payment. Also, because we are increasing the marginal cost factor from 60 percent to 75 percent for cost outlier cases (with the exception of cases falling into the six burn-related DRGs described in section V.E.6. of the preamble to this final rule), hospitals will generally receive higher payments for these types of cases. For discharges of both day and cost burn outlier cases that occur on or after April 1, 1988 and before October 1, 1989, section 4008(d)(1)(A) of Pub. L. 100-203 specifies the use of a 90 percent marginal cost factor in computing payment. Because we are required, under section 1886(d)(5)(A)(iii) of the Act, to ensure that outlier payments are between five and six percent of total payments, the necessary corollary of improving payment for outlier cases is that the total number of cases for which we may make outlier payments will have to be decreased.

As discussed in section V.E. of the preamble to this rule, we have adopted several changes in the methodology to be used to identify and pay for outlier cases in FY 1989—an increase to 75 percent in the marginal cost factor for cost outliers; the application of the greater of the day or cost outlier payment amounts to determine payment for the most expensive day outliers (that is, those day outliers whose charges adjusted to cost exceed the cost outlier threshold); and the use of hospital-specific cost-to-charge ratios to adjust charges to cost for discharges from each hospital.

Also, as explained in section V.E. of the preamble, the more complete MEDPAR data now available indicated that we either had to revise the thresholds for day and cost outliers upward in order to preserve the pool of outlier payments at the targeted 5.0 percent that we proposed, revise the marginal cost factors, maintain the proposed thresholds at the proposed levels and increase the size of the outlier

pool, or implement a combination of all three. As discussed in section V.E. of the preamble, we selected a combination of all three changes.

Table II displays some of the major alternative day and cost outlier thresholds we considered adopting along with alternative marginal cost factors used in determining cost outlier payments, and the average of the outlier payment offsets (that is, the size of the outlier pool) required to finance each set of alternatives. As can be seen from Table II, the option we chose represents a compromise between maintaining the outlier pool at the level we proposed but raising the thresholds, and enlarging the outlier pool at the expense of payments for nonoutlier cases in order to keep the thresholds the same as we proposed. It should be noted that, even current outlier payment policies, based on the more complete MEDPAR data available to us, would have resulted in higher outlier thresholds than those in effect for FY 1988. Specifically, making no change in outlier policy (as we have done for discharges occurring on or after October 1, 1988 and before November 1, 1988) and maintaining the outlier pool at the level of 5.1 percent necessitates increasing the day outlier thresholds for FY 1989 from the mean length of stay for each DRG plus the lesser of 18 days or 2.0 standard deviations to the mean length of stay plus the lesser of 22 days

or 2.0 standard deviations. Cost outlier thresholds increase similarly from the FY 1988 level of \$14,000 or 2.0 times the Federal DRG payment to \$23,750 or 2.0 times the Federal DRG payment.

TABLE II.—COMPARISON OF DAY AND COST OUTLIER THRESHOLDS, MARGINAL COST FACTOR FOR PAYMENT OF COST OUTLIERS AND RESULTING OUTLIER POOLS BASED ON A GREATER OF DAY OR COST PAYMENT POLICY

Thresholds	Marginal cost factor	Outlier payment pool
(1) 24 Days or 3 SDs ¹ \$27,000 or 2x ²	0.80	* 5.4
(2) 24 Days or 3 SDs \$28,000 or 2x ³	* 0.75	* 5.1
(3) 24 Days or 3 SDs \$27,000 or 2x ⁴	* 0.70	* 5.0
(4) 24 Days or 3 SDs \$27,000 or 2x ⁵	0.75	5.2
(5) 25 Days or 3 SDs \$29,000 or 2x ⁶	0.80	5.0

¹ SD = Standard deviation above the mean of the log distribution of lengths of stay for each DRG.

² 2x means 2 times the adjusted Federal rate for the DRG.

³ Outlier thresholds that were proposed in the May 27, 1988 Federal Register.

⁴ The outlier pool that would have resulted from adoption of the outlier thresholds and marginal cost factor as proposed in the May 27, 1988 Federal Register.

⁵ The outlier thresholds being implemented in this final rule.

⁶ The marginal cost factor being adopted in this final rule.

⁷ The outlier pool that was implemented in the April 5, 1988 notice and that we are maintaining for FY 1989 in this final rule.

⁸ The marginal cost factor that would have to be implemented were we to adopt the outlier thresholds and outlier pool as proposed in the May 27, 1988 Federal Register.

⁹ The outlier pool we proposed in the May 27, 1988 Federal Register.

¹⁰ The outlier thresholds we would have to adopt were we to implement the marginal cost factor and outlier pool as proposed in the May 27, 1988 Federal Register.

As discussed in detail in section V.E. of the preamble to this final rule, the changes being made to the outlier policy will focus outlier payments much more precisely on the most expensive cases than does the outlier policy that was in effect for the first five years of the prospective payment system. Table III compares the percent of cases identified as either day or cost outlier, the percent of payments made to each type of outlier, and the average outlier payment per case for each type under both the FY 1988 and FY 1989 policies, both with thresholds updated for FY 1989. (The part of this table describing the distribution of day and cost outlier cases and payments to each under the outlier payment policy adopted in this final rule can also be found in section V.E. of the preamble. It is duplicated here to facilitate comparison of the distribution of day and cost outlier cases and payments under the FY 1988 and FY 1989 outlier policies.)

TABLE III.—COMPARISON OF THE PERCENT OF DAY AND COST OUTLIER CASES, PERCENT OF PAYMENTS FOR EACH TYPE OF OUTLIER CASE, AND THE AVERAGE PAYMENT PER CASE UNDER THE FY 1988 AND FY 1989 OUTLIER POLICIES

Type of outlier case	Percentage of outlier cases	Percentage of outlier payments	Average outlier payment per outlier case
FY 1988 Policy¹			
Meets day threshold only	55.6	31.9	\$3,286
Meets day and cost thresholds, paid using day methodology	24.7	47.0	10,870
Meets day and cost thresholds, paid using cost methodology			
Subtotal—All cases meeting day threshold	80.3	78.9	
Meets cost threshold only	19.7	21.1	6,109
Total	100.0	100.0	5,717
FY 1989 Policy²			
Meets day threshold only	57.0	27.4	\$4,591
Meets day and cost thresholds, paid using day methodology	10.6	18.4	16,550
Meets day and cost thresholds, paid using cost methodology	15.0	39.6	25,132
Subtotal—All cases meeting day threshold	82.6	85.4	
Meets cost threshold only	17.4	14.6	8,039
Total	100.0	100.0	9,547

¹ Day outlier threshold = mean length of stay + the lesser of 22 days or 2.0 standard deviations for each DRG. Cost outlier threshold = the greater of \$23,750 or 2.0 times the Federal DRG payment for each DRG. Marginal cost factor = .60 for both day and cost outliers. The outlier pool size = 5.1 percent of all DRG payments. National average cost-to-charge ratio = .66. We note that this policy will be in effect for discharges occurring on or after October 1, 1988 and before November 1, 1988.

² Day outlier threshold = mean length of stay + the lesser of 24 days or 3.0 standard deviations for each DRG. Cost outlier threshold = the greater of \$28,000 or 2.0 times the Federal DRG payment for each DRG. Marginal cost factor = .60 for day outlier methodology; marginal cost factor = .75 for cost outlier methodology. Outlier pool size = 5.1 percent of all DRG payments. Hospital-specific cost-to-charge ratios will be used.

Table III shows that we have increased the average outlier payment per case for both day and cost outlier cases. Payments for cases that qualify for outlier payments solely on the basis of length of stay will decrease as percentage of total outlier payments from 31.9 percent to 27.4 percent while the percentage of cases will increase from 55.6 percent to 57.0 percent. The average payment for these cases will also increase from \$3,286 per case to \$4,591 per case.

The major effects of the change in the outlier policy, however, will be felt among those hospitals with extremely costly day outliers; that is, cases that exceed both the day and the cost outlier thresholds. The proportion of such cases is expected to remain relatively stable, increasing from 24.7 percent to 25.6 percent of outlier cases. Under the policy of paying the greater of day or cost outlier payments, the number of such cases paid on the basis of the day outlier methodology will decrease from 24.7 percent to 10.6 percent, and the proportion of total payments for these cases will also drop from 47.0 percent to 18.4 percent. Conversely, the number of cases paid on the basis of the cost outlier methodology will increase from zero to 15.0 percent, and the proportion of payments for such cases will increase from zero under the FY 1988 policy to 39.6 percent under the FY 1989 outlier policy. Outlier payments for all "dual" outlier cases, with regard to the methodology under which they are paid, will increase from an average of \$10,870 per outlier case under FY 1988 policy to \$21,579 per case (which is a weighted average of payments for dual outliers paid under either methodology).

Finally, the number of cost outlier cases—that is, those qualifying solely on the basis of high costs—are projected to decline slightly, from 19.7 percent to 17.4 percent. The average outlier payment for cost outlier cases will also increase significantly, from \$6,109 to \$8,039.

The increase in the average outlier payment per outlier case is a result of a much more specifically targeted policy aimed at reducing the financial risk associated with extraordinarily high cost cases. Although we expect this change in policy to benefit many hospitals that treat outlier cases, some hospitals will experience reductions in outlier payments because of the overall reduction in the number of cases that will qualify as outliers.

Column 3 of Table I presents the impact these changes will have on estimated FY 1989 payments. Because total payments systemwide under any outlier policy are constrained to the level of total payments systemwide if

there were no outlier policy (hence, no outlier offsets to the rates), there is no aggregate national effect resulting from the changes in outlier payment policies. The distributive effects of these changes, however, are significant.

Payments to urban hospitals in the Middle Atlantic region are projected to decline by 1.5 percent while payments to urban hospitals in the West North Central region are projected to increase by about 0.9 percent over levels that would occur if there were no change in outlier policy. The outlier policy change is expected to produce about a 0.1 percent reduction in prospective payments to rural hospitals overall, with a projected decrease in payments of 0.5 percent for rural hospitals in the Middle Atlantic region and a projected increase of 0.5 percent for rural hospitals in the New England region.

Those urban hospitals that have graduate medical education programs and serve a disproportionate share of low-income patients will experience a reduction in payments of about 0.4 percent, while those urban teaching hospitals that do not serve a disproportionate share of low-income patients can expect to gain about 0.4 percent in payments.

D. Combined Effects

Column 4 of Table I reflects the change in payments based on FY 1989 rates that incorporate the combined effects of all changes. In addition to the changes described in columns 1 through 3, column 4 also reflects the update factors mandated under section 4002(a) of Pub. L. 100-203, which amended section 1886(b)(3)(B)(i) of the Act. Based on a projected 5.4 percent increase in the hospital market basket, the update factor is—

- 3.9 percent for hospitals located in rural areas;
- 3.4 percent for hospitals located in large urban areas; and
- 2.9 percent for hospitals located in other urban areas.

This column also shows the effects of the provision in section 4005(a) of Pub. L. 100-203, which added section 1886(d)(8)(B) to the Act. This provision requires that hospitals in certain rural counties adjacent to urban areas be deemed to be located in an adjacent urban area if the rural county meets criteria specified in the statute.

Based on the most recent discharge data available, we anticipate that total outlier payments for FY 1988 will equal 5.9 percent of total prospective payments, instead of the 5.1 percent accounted for by the offsets to the FY 1988 rates. Therefore, column 4 also reflects a reduction of 0.8 percent in

payments compared to FY 1988 payments because the FY 1988 baseline payments are overstated by 0.8 percent, the amount that reflects outlier payments in excess of the outlier offsets reflected in the FY 1988 standardized amounts.

Nationally, all changes we are implementing are expected to result in a 1.9 percent payment increase. As one might expect, generally, hospitals located in rural areas will benefit more than hospitals located in urban areas because of the comparatively larger update factor granted these hospitals and the smaller effect of the indirect medical education and disproportionate share changes on hospitals located in rural areas. Rural hospitals will receive an average payment increase of 3.2 percent per case. Hospitals located in large urban areas will receive the smallest increase, largely because of the negative effects of the reduction in the indirect medical education factor mandated by statute, and reductions in outlier payments as a result of the revised policy for outliers. Their increase will be 1.6 percent compared to the 1.7 percent increase projected for hospitals located in other urban areas.

Among hospitals grouped by category, rural hospitals that are disproportionate share hospitals and rural hospitals that are sole community hospitals but not rural referral centers are projected to receive the largest increases in payments, of about 3.2 percent and 3.7 percent, respectively. Small urban disproportionate share hospitals (fewer than 100 beds) will receive the smallest increase of 0.9 percent. Small rural hospitals can expect to receive an average increase in their per case payments of nearly 4.0 percent.

We must point out that there are interactions that result from combining the various separate provisions analyzed in columns 1, 2, and 3 of Table I that we are unable to isolate. Thus, the values appearing in column 4 of Table I do not represent merely the additive effects of the previous columns plus the update factors.

Table IV presents the projected FY 1989 average payments per case for urban and rural hospitals and for the different categories of hospitals shown in Table I, and compares them with the average estimated per case payments for FY 1988. As such, this table presents in terms of the average dollar amounts paid per discharge the combined effects of the changes presented in Table I; that is, the percentage change in average payments from FY 1988 to FY 1989 equals the percentage changes shown in the last column of Table I.

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TABLE IV

Comparison of Payment Per Case
(FY 1989 Compared to FY 1988)

	Number of Hospitals	Average FY 1988 Payment Per Case	Average FY 1989 Payment Per Case	Percentage Change ^{1/}
<u>All Hospitals</u>	5698	\$4300	\$4381	1.9
<u>Urban by Region</u>				
New England	187	4922	4950	0.6
Middle Atlantic	373	5404	5379	-0.5
South Atlantic	434	4303	4370	1.6
East North Central	517	4767	4851	1.8
East South Central	176	4101	4144	1.0
West North Central	204	4716	4835	2.5
West South Central	384	4298	4449	3.5
Mountain	126	4627	4766	3.0
Pacific	526	5348	5496	2.8
Puerto Rico	52	1824	1858	1.8
<u>Rural by Region</u>				
New England	61	3394	3492	2.9
Middle Atlantic	102	3127	3216	2.9
South Atlantic	357	2855	2937	2.9
East North Central	368	2888	3014	4.4
East South Central	318	2445	2516	2.9
West North Central	599	2669	2752	3.1
West South Central	459	2558	2635	3.0
Mountain	274	2956	3049	3.1
Pacific	173	3466	3569	3.0
Puerto Rico	8	1287	1305	1.4
<u>Large Urban Areas</u> (populations over 1 million)	1511	5175	5258	1.6
<u>Other Urban Areas</u> (populations with 1 million or smaller)	1468	4317	4388	1.7
<u>Urban Hospitals</u>	2979	4758	4836	1.6
0-99 Beds	698	3694	3769	2.0
100-199 Beds	766	4113	4177	1.6
200-299 Beds	577	4441	4519	1.8
300-399 Beds	610	4816	4893	1.6
400 + Beds	271	5648	5737	1.6

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Table IV - Continued

	Number of Hospitals	Average FY 1988 Payment Per Case	Average FY 1989 Payment Per Case	Percentage Change ^{1/}
<u>Rural Hospitals</u>	2719	\$2798	\$2888	3.2
0-49 Beds	1103	2372	2464	3.9
50-99 Beds	863	2541	2643	4.0
100-149 Beds	383	2748	2850	3.7
150-199 Beds	154	3001	3085	2.8
200 + Beds	158	3303	3367	1.9
<u>Teaching Status</u>				
Non-Teaching	4602	3611	3694	2.3
Resident/Bed Ratio Less than 0.25	896	4844	4918	1.5
Resident/Bed Ratio 0.25 or Greater	200	7197	7286	1.2
<u>Disproportionate Share Hospitals (DSH)</u>				
Non-DSH	4431	3945	4029	2.1
Urban DSH 100 Beds or More	920	5317	5392	1.4
Urban DSH Fewer than 100 Beds	96	4400	4440	0.9
Rural DSH	251	2473	2550	3.2
<u>Urban Teaching and DSH</u>				
Both Teaching and DSH	499	5893	5963	1.2
Teaching only	520	4951	5035	1.7
DSH only	517	4292	4371	1.9
Nonteaching and Non-DSH	1443	4053	4129	1.9
<u>Other Special Status (rural)</u>				
Sole Community Hospitals	302	2790	2893	3.7
Rural Referral Centers (RRCs)	199	3430	3487	1.7
Both SCH & RRC	21	3502	3608	3.0
<u>Type of Ownership</u>				
Voluntary	3058	4468	4545	1.7
Proprietary	952	3842	3902	1.6
Government	1565	3879	3985	2.7

^{1/} Percentage changes shown in this column are taken from Table I, column 4. The dollar amounts shown in this table are rounded to the nearest dollar. Therefore, percentage changes computed on the basis of these amounts will differ slightly from those displayed in this column as a result of rounding.

Comment: One commenter stated that hospitals with high Medicare utilization may be more severely affected by the "averaging concept" inherent in the prospective payment system and, with no adjustment for severity of illness, the policy changes being implemented in this rule may disadvantage these

hospitals. The commenter asked us to include in our impact analysis a discussion of the effects of policy changes in this final rule on hospitals with high Medicare utilization.

Response: We have analyzed the effects of our policies in this final rule on hospitals that report Medicare

utilization (that is, Medicare inpatient days divided by total inpatient days) of greater than 50 percent and compared the results to the effects on hospitals reporting less than 50 percent Medicare patient utilization. We present the results of this analysis in the following table.

TABLE V.—IMPACT OF PROSPECTIVE PAYMENT POLICY CHANGES ON HOSPITALS BY MEDICARE UTILIZATION

	Reclassification and recalibration	Teaching and DSH	Outlier changes	Combined changes
Less than 50 percent.....	0.1	-0.5	0.1	1.9
More than 50 percent.....	-0.1	-0.5	-0.2	1.8

Based on the above analysis, we do not observe any significantly different effects on hospitals whose Medicare utilization is greater than 50 percent of the total patient days than on those hospitals with less than 50 percent Medicare utilization.

Since analyzing the effects of policy changes on the basis of Medicare utilization does not appear to reveal any significantly new information, we have not incorporated this analysis into our standard impact analysis tables. We believe that the hospital groupings currently included in our analysis are sufficiently comprehensive to make inclusion of a high Medicare utilization variable unnecessary at the time. However, we will continue to monitor the effect of the prospective payment system on hospitals with high Medicare utilization.

Appendix B—Final Recommendation of Update Factors for Rates of Payment for Inpatient Hospital Services

I. Background

Section 1886(e)(4) of the Act, as amended by section 4002(f) of Pub. L. 100-203, required that the Secretary, taking into consideration the recommendations of ProPAC, recommend an update factor for FY 1989 that takes into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Section 1886(e)(4) of the Act also applies to the target rate-of-increase limits for hospitals and units excluded from the prospective payment system.

As required by section 1886(e)(5) of the Act, we published the initial recommended FY 1989 update factors that are provided for under section 1886(e)(4) of the Act as Appendix C of

the May 27, 1988 proposed rule (at 53 FR 19628).

We recommended that we use the update factors determined by Congress and set forth in section 1886(b)(3)(B)(i) of the Act. (The target rate-of-increase update factor is set forth in section 1886(b)(3)(B)(ii) of the Act.) That is, we recommended update factors of 3.3 percent for prospective payment hospitals in rural areas, 2.8 percent for prospective payment hospitals in large urban areas, 2.3 percent for prospective payment hospitals in other urban areas, and 4.8 percent for hospitals excluded from the prospective payment system. In recommending these increases, we took into account the requirement in section 1886(e)(4) of the Act that the amounts be high enough to ensure the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we addressed ProPAC's Recommendations 1 through 5, which concerned updating the standardized amounts and the rate-of-increase limits. Also, we requested public comment on our recommendations.

Under section 1886(e)(5) of the Act, we are also required to provide a final recommendation of appropriate update factors after consideration of public comments. Accordingly, the purpose of this Appendix is to do so.

We note that although we recommended appropriate update factors, requested and received public comments on these recommendations, and are providing final recommendations, Congress actually prescribed the update factors to be used in FY 1989 in section 1886(b)(3)(B)(i) of the Act, as amended by section 4002(a) of Pub. L. 100-203. That is, as explained

in the addendum to this final rule, the update factors for FY 1988 for inpatient hospital services for hospitals under the prospective payment system equal the market basket rate of increase forecasted for FY 1989 minus—

- 1.5 percentage points for hospitals located in rural areas;
- 2.0 percentage points for hospitals located in large urban areas; and
- 2.5 percentage points for hospitals located in other urban areas.

The most recent forecasted hospital market basket increase for FY 1989 is 5.4 percent. Therefore, the applicable percentage increases are—

- 3.9 for hospitals located in rural areas;
- 3.4 for hospitals located in large areas; and
- 2.9 for hospitals located in other urban areas.

For cost reporting periods beginning on or after October 1, 1988, section 1886(b)(3)(ii) of the Act, as amended by section 4002(e) of Pub. L. 100-203, provides that the applicable percentage increase for hospitals and units excluded from the prospective payment system equals the market basket rate of increase. Because the most recent forecasted hospital market basket increase for FY 1989 is 5.4 percent, the increase in the hospital's target amount is also 5.4 percent.

We received one item of correspondence during the public comment period concerning our recommendations and our responses to ProPAC recommendations 1 through 5. After consideration of all the arguments presented, we have decided not to change our proposals. Therefore, we recommend update factors of 3.9 percent for prospective payment hospitals in rural areas, 3.4 percent for prospective

payment hospitals in large urban areas, 2.9 percent for prospective payment hospitals in other urban areas, and 5.4 percent for hospitals and units excluded from the prospective payment system.

Comment: One commenter expressed concern that the update factor recommended by the Secretary did not include a discussion or presentation of the data used to form the basis of our recommendation. The commenter noted that ProPAC consistently bases its update recommendations on an analysis of changes in the hospital market basket, productivity, scientific and

technological advancement, and case mix. The commenter also noted that the Secretary merely indicated acceptance of the recommendation of the Bipartisan Budget Summit.

Response: As the commenter stated, the Secretary is recommending an update consistent with Bipartisan Budget Summit. We believe this update is reasonable and takes into account the recent decline in Medicare operating margins experienced by the hospital industry. We believe an increase that is somewhat lower than the hospital market basket is appropriate, in order to

encourage the hospital industry to control costs and to allow the Medicare program to share in cost savings. We also believe that an approach that gradually takes into account the excessive payments made to the hospital industry during the first two years of operation of the prospective payment system is appropriate and requires that the update factor be less than the increase in the hospital market basket.

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