FAA decisionmaker may affirm, modify, or reverse the initial decision, make any necessary findings, or may remand the case for any proceedings that the FAA decisionmaker determines may be necessary.

(1) The FAA decisionmaker may raise any issue, on the FAA decisionmaker's own initiative, that is required for proper disposition of the proceedings. The FAA decisionmaker will give the parties a reasonable opportunity to submit arguments on the new issues before making a decision on appeal. If an issue raised by the FAA decisionmaker requires the consideration of additional testimony or evidence, the FAA decisionmaker will remand the case to the administrative law judge for further proceedings and an initial decision related to that issue. If an issue raised by the FAA decisionmaker is solely an issue of law or the issue was addressed at the hearing but was not raised by a party in the briefs on appeal, a remand of the case to the administrative law judge for further proceedings is not required but may be provided in the discretion of the FAA decisionmaker.

(2) The FAA decisionmaker will issue the final decision and order of the Administrator on appeal in writing and will serve a copy of the decision and order on each party.

(3) A final decision and order of the Administrator after appeal is precedent in any other civil penalty action. Any issue, finding or conclusion, order, ruling, or initial decision of an administrative law judge that has not been appealed to the FAA decisionmaker is not precedent in any other civil penalty action.

§ 13.234 Petition to reconsider or modify a final decision and order of the FAA decisionmaker on appeal.

(a) *General.* Any party may petition the FAA decisionmaker to reconsider or modify a final decision and order issued by the FAA decisionmaker on appeal from an initial decision. A party shall file a petition to reconsider or modify with the FAA decisionmaker not later than 30 days after service of the FAA decisionmaker's final decision and order on appeal and shall serve a copy of the petition on each party. The FAA decisionmaker will not reconsider or modify an initial decision and order issued by an administrative law judge that has not been appealed by any party to the FAA decisionmaker.

(b) *Form and number of copies.* A party shall file a petition to reconsider or modify, in writing, with the FAA decisionmaker. The party shall file the original petition with the FAA decisionmaker and shall serve a copy of the petition on each party.

(c) *Contents.* A party shall state briefly and specifically the alleged errors in the final decision and order on appeal, the relief sought by the party, and the grounds that support the petition to reconsider or modify.

(1) If the petition is based, in whole or in part, on allegations regarding the consequences of the FAA decisionmaker's decision, the party shall describe these allegations and shall describe, and support, the basis for the allegations.

(2) If the petition is based, in whole or in part, on new material not previously raised in the proceedings, the party shall set forth the new material and include affidavits of prospective witnesses and authenticated documents that would be introduced in support of the new material. The party shall explain, in detail, why the new material was not discovered through due diligence prior to the hearing.

(d) *Repetitious and frivolous petitions.* The FAA decisionmaker will not consider repetitious or frivolous petitions. The FAA decisionmaker may summarily dismiss repetitious or frivolous petitions to reconsider or modify.

(e) *Reply petitions.* Any other party may reply to a petition to reconsider or modify, not later than 10 days after service of the petition on that party, by filing a reply with the FAA decisionmaker. A party shall serve a copy of the reply on each party.

(f) *Effect of filing petition.* Unless otherwise ordered by the FAA decisionmaker, filing of a petition pursuant to this section will not stay or delay the effective date of the FAA decisionmaker's final decision and order on appeal and shall not toll the time allowed for judicial review.

(g) *FAA decisionmaker's decision on petition.* The FAA decisionmaker has sole discretion to grant or deny a petition to reconsider or modify. The FAA decisionmaker will grant or deny a petition to reconsider modify within a reasonable time after receipt of the petition or receipt of the reply petition, if any. The FAA decisionmaker may affirm, modify, or reverse the final decision and order on appeal, or may remand the case for any proceedings that the FAA decisionmaker determines may be necessary.

§ 13.235 Judicial review of final decision and order.

A person may seek judicial review of a final decision and order of the Administrator as provided in section 1006 of the Federal Aviation Act of 1958, as amended. A party seeking judicial review of a final decision and order shall file a petition for review not later than 60 days after the final decision and order has been served on the party.

Issued in Washington, DC on April 17, 1990.

Gregory S. Walden,

Chief Counsel.

[FR Doc. 90-9173 Filed 4-17-90; 12:23 pm]

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Friday
April 20, 1990

Part V

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412 and 413

Medicare Program, Fiscal Year 1990; Mid-year Changes to the Inpatient Hospital Prospective Payment System; Final Rule With Request for Comments

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-672-FC]

RIN 0938-AE73

Medicare Program, Fiscal Year 1990; Mid-Year Changes to the Inpatient Hospital Prospective Payment System

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment implements several provisions of the Omnibus Budget Reconciliation Act of 1989 that affect Medicare payment for inpatient hospitals and that, in general, take effect on April 1, 1990. This final rule also responds to comments received concerning the changes we made in 1989 in implementing provisions of the Medicare Catastrophic Coverage Act of 1988 concerning adjustments applicable to prospective payment hospitals and to the target amounts of hospitals and units excluded from the prospective payment system due to the elimination of the day limitation on covered inpatient hospital days. We are making additional changes in these provisions to take into account the Medicare Catastrophic Coverage Repeal Act of 1989, and changes in the law made by the Family Support Act of 1988, which clarified the criteria for adjusting target amounts and changed the date for implementing that provision.

DATES: *Effective Date:* This final rule is effective on April 1, 1990. We refer the reader to section VI.A. of this preamble for a discussion of specific provisions that apply to specific periods.

Comment Date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 19, 1990.

ADDRESSES. Mail comments to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-672-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 Humphrey Building, 200 Independence Ave., SW, Washington, DC.

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

Due to staffing and resource limitations, we cannot accept facsimile (FAX) copies of comments. In commenting, please refer to file code BPD-672-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 Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Barbara Wynn, (301) 966-4529.

SUPPLEMENTARY INFORMATION:

I. Summary of the Omnibus Budget Reconciliation Act of 1989

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239) was enacted. The provisions of sections 6003 (c), (e), (f), and (h)(3), 6011, 6015(a), and 6205(a) of Public Law 101-239 made the following changes that affect Medicare payments to hospitals:

- For discharges occurring on or after April 1, 1990, hospitals located in rural areas with more than 100 beds, or those that are classified as sole community hospitals, can now qualify for a disproportionate share adjustment if the hospital has a disproportionate patient percentage of at least 30 percent. In addition, the disproportionate share payment adjustments for qualifying hospitals are increased.
- For cost reporting periods beginning on or after April 1, 1990, the payment methodology for sole community hospitals is revised. In addition, the change made in the September 1, 1989 prospective payment system final rule (54 FR 36480) that went into effect on October 1, 1989 to allow any rural hospital to qualify as a sole community hospital if it is more than 35 miles from another hospital is ratified.
- For cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993, a special payment method under the prospective payment system for Medicare-dependant small rural hospitals is established
- For discharges occurring on or after April 1, 1990, the wage index applicable to rural counties whose hospitals are deemed urban is revised.
- For discharges occurring on or after June 19, 1990 and before December 19, 1991, prospective payment hospitals receive an additional payment for the cost of administering blood clotting factors to hemophiliacs who are hospital inpatients.
- For cost reporting periods beginning on or after April 1, 1990, excluded hospitals and units may be assigned a new base period for purposes of the rate-of-increase limits if it would be more representative of the reasonable and necessary costs of inpatient services.
- For cost reporting periods beginning on or after December 19, 1989 and before the later of October 1, 1990 or the date the Secretary issues new regulations concerning payment for nursing and allied health education, the costs incurred by hospitals that meet certain criteria for training nursing students enrolled in a hospital-based nursing school are to be paid on the basis of reasonable cost.

Our implementation of these provisions are described below in section II. of this preamble. In section III.D. of this final rule, we respond to comments received on the September 30, 1988 prospective payment system final rule with comment (53 FR 38476) concerning the changes we made in implementing two provisions of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) concerning adjustments to the rates, weights, and outlier thresholds applicable to prospective payment hospitals and the target amounts applicable to hospitals and units excluded from the prospective payment system due to the elimination of the day limitation on covered inpatient hospital days.

In that section we also discuss changes in law made by the Family Support Act of 1988 (Pub. L. 100-485), which clarified the criteria for adjusting target amounts and changed the date for implementing that provision, as well as the termination of these catastrophic provisions effective January 1, 1990 because of the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101-234).

II. Provisions of the Final Rule Resulting From the Enactment of the Omnibus Budget Reconciliation Act of 1989

A. Wage Index

Under section 1886(d)(8)(B) of the Act, for discharges occurring on or after October 1, 1988, hospitals in certain rural counties adjacent to one or more Metropolitan Statistical Areas (MSAs) are considered to be located in one of the adjacent MSAs if certain standards are met. Under this provision, as a part of the September 30, 1988 prospective payment system final rule (53 FR 38476), we classified the wage data for those rural areas as if the hospitals in those areas were located in the adjacent MSAs and recomputed the wage index values for the affected MSAs and rural areas.

Because inclusion of the wage data from rural hospitals that are considered to be located in an adjacent MSA under section 1886(d)(8)(B) of the Act resulted in the reduction of the wage index values of several MSAs and rural areas, Congress enacted section 8403(a) of the Technical and Miscellaneous Revenue Act of 1988 (Pub. L. 100-647). Under that provision, which added a new section 1886(d)(8)(C) to the Act, if the inclusion of wage data from rural hospitals now considered to be located in an urban area results in a reduction of the wage value for the affected MSA or rural area, then the wage index values for those affected areas are determined as if section 1886(d)(8)(B) of the Act had not been enacted. The wage index value for those rural counties with hospitals that were deemed urban are determined on a county-specific basis as if the county were a separate urban area. This provision was implemented as part of the September 1, 1989 prospective payment system final rule (54 FR 36476).

For some hospitals in counties redesignated as urban under the provisions of section 1886(d)(8)(B) of the Act, the application of county-specific wage index values for Federal fiscal year (FY) 1990 resulted in lower total prospective payments than what those hospitals had received in FY 1989 because those hospitals were now subject to a lower wage index value. For some redesignated hospitals such as those that had a county-specific wage index value lower than the Statewide rural wage index, the decrease in payment was significant. In fact, the county-specific wage index value was sufficiently low in some cases that the hospitals redesignated as urban received lower payments than when they had been designated as rural.

In order to address the adverse impact on certain redesignated hospitals that resulted from the implementation of section 8403(a) of Public Law 100-647, Congress, in section 6003(h) of Pub. L. 101-239, revised the methodology for applying the wage index to hospitals affected by section 1886(d)(8)(B) of the Act.

Under section 6003(h)(3) of Public Law 101-239, section 1886(d)(8)(C) of the Act was revised with respect to discharges occurring on or after April 1, 1990. The provision revises the application of the wage index to redesignated hospitals based on the hypothetical impact the wage data from these hospitals would have on the wage index value of the MSA to which they have been redesignated.

- If including the wage data for the redesignated hospitals reduces the MSA wage index value by one percentage point or less, the MSA wage index value applies to the redesignated hospitals deemed to be part of that MSA. The MSA wage index value is determined exclusive of the wage data for the designated hospitals.
- If including the wage date for the redesignated hospitals reduces the MSA wage index value by more than one percentage point on an MSA's wage index, the wage index is applied separately to the MSA and to the hospitals deemed to be part of that MSA. In this case, the redesignated hospitals will continue to have their wage index determined on a county-specific basis, as if their county were a separate urban area. However, the wage index for such county will not be less than the Statewide rural wage index.
- Rural areas whose wage index values would be reduced by excluding the data for redesignated hospitals will continue to have their wage index calculated as if no redesignation had occurred. Those rural areas whose wage index values increased as a result of excluding the wage data for the redesignated hospitals will continue to have their wage index calculated exclusive of the redesignated hospitals.

The counties subject to the wage index of the MSA to which their hospitals were redesignated (that is, their impact on the MSA wage index would be one percentage point or less) are set forth in table 2a of the addendum to this document. The counties subject to a separate urban area wage index (that is, their impact on the MSA wage index would be greater than one percentage point) with a minimum wage index value equal to the Statewide rural wage index are set forth in tables 2b and 2c of the addendum to this document. A few counties are not included in the table even though they meet the criteria to permit hospitals to be redesignated. They are not included in the tables because there are no prospective payment hospitals in those counties.

B. Payments to Sole Community Hospitals (Section 412.92)

Under the prospective payment system, special payment protections are provided to sole community hospitals (SCHs). Prior to enactment of Public Law 101-239, section 1886(d)(5)(C)(ii) of the Act defined an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are at § 412.92(a). To be classified as an SCH, a hospital must either have been designated as an SCH prior to the beginning of the prospective payment system or it must be located in a rural area and meet one of the following requirements:

- It is located more than 35 miles from other like hospitals.
- It is located between 25 and 35 miles from other like hospitals, and it—
  - —Serves at least 75 percent of inpatients in its service area; or
  - —Has fewer than 50 beds and would qualify on the basis of serving 75 percent of its area's inpatients except that some patients seek specialized care unavailable at the hospital.
- It is located between 15 and 35 miles from other like hospitals and isolated by local topography or extreme weather for 30 days in each 2 out of 3 years.

SCHs are currently paid a blended rate based on 75 percent of the hospital-specific rate and 25 percent of the Federal regional rate. For cost reporting periods beginning before October 1, 1990, an SCH is eligible for a payment adjustment if, for reasons beyond its control, it experiences a decline in volume of greater than 5 percent compared to its preceding cost reporting period. (This adjustment is also available to a hospital that could qualify as an SCH but chooses not to be paid as an SCH.) In addition, an SCH is eligible for an adjustment to its payments if it adds new services or facilities. SCHs are also exempt from the percentage reductions in reasonable cost payments for capital-related costs, as provided in section 1886(g)(3) of the Act.

Sections 6003(e) (1) and (2) of Public Law 101-239, which amend section 1886(d)(5) of the Act, make changes in the qualifying criteria and payment methodology for SCHs. In this final rule, we are addressing only those changes that require immediate implementation (that is, by April 1, 1990).

We first wish to note that section 6003(e)(3) of Public Law 101-239 specifically states that any hospital classified as an SCH as of the date of enactment of Public Law 101-239 (December 19, 1989) will continue to be so classified regardless of whether it meets the revised criteria resulting from changes made in implementing section 6003(e)(1) of Public Law 101-239.

Section 1886(d)(5)(D)(iii)(I) of the Act incorporates the mileage standard that was established by regulation effective October 1, 1989. (See the September 1, 1989 prospective payment system final rule (54 FR 36480).) That is, section 1886(d)(5)(D)(iii)(I) of the Act states that

a hospital can qualify for SCH status if it is more than 35 road miles from another hospital. We believe that in adding this provision to the law, Congress intended to ratify our regulations and we are, therefore, not altering any of the policies or definitions regarding the mileage criterion that we have previously adopted. That is, we believe that the mileage should continue to be measured by the shortest route over improved roads maintained by any local, State, or Federal government entity for public use. Also, we see no evidence that Congress intended that we revise our current policy requiring that the distance between hospitals be measured to the nearest "like" hospital as defined in § 412.92(c)(2). We consider "like" hospitals to be those hospitals furnishing short-term acute care. That is, a hospital may not qualify for an SCH classification on the grounds that neighboring hospitals do not offer comparable specialty services. Rural hospitals that are located fewer than 35 road miles from the nearest like hospital can continue to qualify for SCH classification by meeting the criteria at § 412.92 (a)(2) or (a)(3). The application procedures to be followed, the documentary evidence that must be submitted, and the effective date for qualification remain the same as specified in existing regulations.

Section 1886(d)(5)(D) of the Act also requires that the Secretary publish standards to determine whether a hospital meets the criteria for classification as an SCH based on the time required for an individual to travel to the nearest alternative source of appropriate inpatient care. We plan to propose these standards in the proposed rule concerning FY 1991 changes to the inpatient hospital prospective payment system and FY 1991 rates.

Section 6003(e) of Public Law 101-239 also revised the payment methodology for hospitals classified as SCHs effective with hospital cost reporting periods beginning on or after April 1, 1990. As of that date, as provided in section 1886(d)(5)(D)(i) of the Act, SCHs will be paid based on whichever of the following rates yields the greatest aggregate payment for the cost reporting period: the Federal national rate applicable to the hospital, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge.

The SCH's fiscal intermediary will determine for each cost reporting period which of the payment options will yield the highest rate of payment. Payments will automatically be made at the highest rate using the best data available at the time of the intermediary's determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. This is because, in many instances, the hospital's FY 1987 cost report has not yet been audited and, in all instances, it is not possible to forecast the October 1, 1990 update factor for the Federal rates, outlier payments, the amount of the disproportionate share adjustment, or the indirect medical education adjustment, all of which are applicable only to payment based on the Federal rate. Therefore, the intermediary will make its determination based on what appears to yield the highest payment amount.

A final adjustment will be made at the close of the cost reporting period to determine precisely which of the three payment rates yielded the highest payment to the hospital. The settlement will take into account the adjustments described above. This is the same procedure currently in effect for both disproportionate share adjustments and indirect medical education adjustments.

We considered making the payment methodology decision completely prospective and paying SCHs on the highest of the three rates without taking into account changes in the Federal payment amounts during the hospital's cost reporting period. However, since we cannot prospectively determine with certainty which rate will yield the highest payment, the hospital may not be paid prospectively on the basis of the rate that would ultimately result in the greatest payment. To pay each hospital the correct amount, we will make a final adjustment at the end of the cost reporting period. We believe this is the only way to ensure that each hospital actually receives the highest payment available. We note that a new determination of which payment rate yields the highest total payment will be made at the start of each cost reporting period.

If a hospital disagrees with the intermediary's determination regarding the final amount of program payment to which it is entitled under this provision, it has the right to appeal the intermediary's decision in accordance with the criteria in subpart R of part 405 of the regulations, which concern provider payment determinations and appeals.

Section 1886(b)(3)(C) following (ii) of the Act provides that an SCH, for purposes of determining its payment rate based on the higher of the Federal rate or its hospital-specific rate, may substitute the hospital's cost reporting period, if any, beginning during FY 1987 for the FY 1982 base cost reporting period if that substitution results in an increase in the hospital's rate.

In calculating a hospital's hospital-specific rate based on its FY 1987 cost reporting period, we will, to the extent possible, use the same methodology as we did to calculate the hospital-specific rate based on a FY 1982 cost reporting period. That methodology is set forth in §§ 412.71 through 412.73 and was discussed in detail in several prospective payment system documents published in the **Federal Register** (September 1, 1983 (48 FR 3977); January 3, 1984 (49 FR 259); and June 1, 1984 (49 FR 23010)).

The FY 1987 cost reporting periods are those 12-month or longer cost reporting periods ending on or after September 30, 1987, and before September 30, 1988. If the hospital's last cost reporting period ending before September 30, 1988, is for a period that is less than 12 months, we will use the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

If a hospital has no cost reporting period beginning in FY 1987, it will not have a hospital-specific rate based on FY 1987. The hospital will not be allowed to substitute any other base period for the FY 1987 base period. This policy is based on the language of section 1886(b)(3)(C) following (ii) of the Act, which states that the hospital will be allowed to substitute its cost reporting period (if any) beginning in FY 1987. Therefore, if there is no FY 1987 cost reporting period, there will be no substitution of any other cost reporting period.

For each SCH, the intermediary will calculate a hospital-specific rate based on the hospital's FY 1987 cost report as follows:

- Determine the hospital's total allowable Medicare inpatient operating cost, as stated on the FY 1987 cost report.
- Divide the total Medicare operating cost by the number of Medicare discharges in the cost reporting period to determine the FY 1987 base period cost per case.
- In order to take into consideration the hospital's individual case-mix, the base year cost per case is divided by the hospital's case-mix index applicable to the FY 1987 cost reporting period. This step is necessary to standardize the hospital's base period cost for case mix. This is consistent with our treatment of FY 1982 base-period costs per case. A hospital's case mix is computed based

on its Medicare patient discharges subject to DRG-based payment. (The individual case-mix index values to be used in calculating the FY 1987 hospital-specific rate are set forth in Table 3d of this document.)

The fiscal intermediary will inform each SCH of its hospital-specific rate based on its FY 1987 cost reporting period within 180 days after the start of its cost reporting period beginning on or after April 1, 1990 (the first period to which the new payment methodology applies).

Our original policy on modification of FY 1982 base-period costs, as stated in § 412.72, provided that the intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base period through administrative action and judicial review, but only on a prospective basis. That is, any adjustment made to base-period costs would be effective with the first day of the hospital's cost reporting period beginning on or after the date of the decision to adjust the costs and would not be applied on a retroactive basis.

However, since we formulated our policy on modification to base-period costs, a decision of the U.S. Court of Appeals for the District of Columbia Circuit in *Georgetown University Hospital* v. *Bowen*, 862 F.2d 323, (D.C. Cir., 1988), has invalidated that policy. In that decision, the court rejected the principles and procedures established by Medicare regulations that authorize automatic prospective adjustments to the hospital-specific rate to reflect newly recognized base-period costs. On January 26, 1989, HCFA issued a ruling (HCFAR 89-1-1) that the hospital-specific rate based on FY 1982 will be revised retroactively to reflect additional base-period costs that are or will be recognized as the result of—

- A final, nonappealable court judgment; or
- The administrative actions defined in § 412.72(a)(3)(i), that is:

—A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889;

—A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1852 that resolved a matter at issue concerning the hospital's base-period notice of amount of program reimbursement;

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

—An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 that is final and no longer subject to review under applicable lower regulations by a higher reviewing authority and that resolved a matter of issue in the hospital's base-period notice of amount of program reimbursement.

We are adopting these policies regarding the FY 1982 base-period costs for the FY 1987 base-period costs. Any time the FY 1987 base-period costs are subject to modification for one of the reasons set forth above, the adjustment will be retroactive to the time of the intermediary's initial calculation of base-period costs. We are adding a new § 412.75 to describe calculations of a hospital-specific rate based on a FY 1987 base period.

In addition to the changes in qualifying criteria and payment methodology, the new section 1886(d)(5)(D) of the Act deleted the sunset date on the 5 percent volume decline adjustment, thus allowing SCHs to receive the adjustment indefinitely. (The sunset provision was in section 1886(d)(5)(C)(ii) of the Act. Section 6003(c)(1) of Public Law 101-239 amended that provision and redesignated it as section 1886(d)(5)(D) of the Act.) We are amending § 412.92 (e) and (f) to reflect this change.

C. Disproportionate Share Adjustment (Section 412.106)

Section 1886(d)(5)(F) of the Act provides for additional payments to prospective payment hospitals that serve a disproportionate share of low-income patients. Under section 1886(d)(5)(F)(v) of the Act, and under section § 412.106(b) of the regulation, a hospital qualifies for a disproportionate share adjustment if during the hospital's cost reporting period, the hospital has a disproportionate patient percentage that is at least equal to—

- 15 percent for an urban hospital with 100 or more beds or a rural hospital with 500 or more beds;
- 40 percent for an urban hospital with fewer than 100 beds;
- 45 percent for a rural hospital with fewer than 500 beds.

Additionally, a hospital can qualify for a disproportionate share adjustment as defined under § 412.106(c)(2) if 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.

Section 6003(c)(2) of Public Law 101-239 adds an additional qualifying methodology under section 1886(d)(F)(5)(v) of the Act for certain rural hospitals beginning with discharges occurring on or after April 1, 1990. That is, if a hospital located in a rural area has more than 100 beds, or is classified as a sole community hospital, and has a disproportionate patient percentage of a least 30 percent during its cost reporting period, the hospital will qualify for a disproportionate share adjustment.

Sections 1886(d)(5)(F) (iii) and (iv) of the Act define the allowable disproportionate share adjustments that are added to the Federal portion of Medicare prospective payments for those hospitals described in sections 1886(d)(5)(F) (i) and (v) of the Act that meet the disproportionate share qualifications. Currently those adjustments are—

- 2.5 percent plus one-half of the difference between the hospital's disproportionate patient percentage and 15 percent for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds;
- 5 percent for urban hospitals with fewer than 100 beds;
- 4 percent for rural hospitals with fewer than 500 beds; and
- 25 percent for urban hospitals with 100 or more beds receiving more than 30 percent of net inpatient revenues from State and local government sources for the care of indigent patients.

In addition, sections 6003(c) (2) and (3) of Public Law 101-239 amended section 1886(d)(5)(F) of the Act, which concerns the payment methodology for determining disproportionate share payment adjustments effective with discharges occurring on or after April 1, 1990. These changes provide for the following:

- The disproportionate share payment adjustment factor will be increased from 25 to 30 percent for a hospital that qualifies for a disproportionate share adjustment under § 412.106(c)(2), 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.
- A hospital located in an urban area and having 100 or more beds, or a hospital located in a rural area and having 500 or more beds, with a disproportionate patient percentage of greater than 20.2 percent will receive a disproportionate share adjustment that will increase the DRG revenue by 5.62

percent plus 65 percent of the difference between its disproportionate patient percentage and 20.2 percent. If the hospital's disproportionate patient percentage is less than 20.2 percent, the hospital's DRG revenue will be increased by 2.5 percent plus 60 percent of the difference between its disproportionate patient percentage and 15 percent.

- A hospital located in a rural area that is classified as both a rural referral center and an SCH will receive a disproportionate share adjustment that will increase the Federal portion of the hospital's DRG revenue by the greater of 10 percent, or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.
- A hospital located in a rural area and classified as a rural referral center will receive a disproportionate share adjustment that will increase the hospital's DRG revenue by 4 percent plus 60 percent of the difference between its disproportionate patient percentage and 30 percent.
- A hospital located in a rural area and classified as an SCH will receive a disproportionate share adjustment that will increase the Federal portion of the hospital's DRG revenue by 10 percent.

For a hospital with fewer than 100 beds located in an urban area, the disproportionate share adjustment will continue to be 5 percent. For a hospital with fewer than 500 beds located in a rural area, which is not classified as a rural referral center or sole community hospital, the disproportionate share adjustment will continue to be 4 percent.

D. Medicare-Dependent, Small Rural Hospitals (Section 412.108)

Section 6003(f) of Public Law 101–239, which added a new section 1886(d)(5)(G) of the Act, creates a new category of hospitals eligible for a special payment adjustment under the prospective payment system. The adjustment is limited to Medicare-dependent, small rural hospitals (MDHs) and is effective for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Section 1886(d)(5)(G)(iii) of the Act defines an MDH as any hospital that meets all of the following criteria:

- The hospital is located in a rural area.
- The hospital has 100 or fewer beds.
- The hospital is not classified as an SCH (as defined at § 412.92) at the same time that it is receiving payment under this provision.
- In the hospital's cost reporting period that began during FY 1987, not less than 60 percent of its inpatient days or discharges were attributable to patients covered by Medicare Part A benefits.

The term "rural area" will be defined as it is for all other prospective payment special adjustments, that is, any area outside an urban area as provided under § 412.63(b). Thus, a hospital in a rural county that is redesignated as urban under section 1886(d)(8)(C) of the Act would not be considered to be located in a rural area for the purposes of eligibility as an MDH.

Similarly, for purposes of determining a hospital's bed size, we will use the same definition that is currently used for determining number of beds to calculate the indirect medical education adjustment, the disproportionate share adjustment, and the rural referral center adjustments. This definition, which is set forth at § 412.118(b), states that the number of beds in a hospital is determined by counting the number of available bed days during the hospital's cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part units, and dividing that number by the number of days in the cost reporting period. Instructions for counting bed size for purposes of the indirect medical education adjustment as set forth in § 2405.3G of the Provider Reimbursement Manual (HCFA Pub. 15–1) will also be used for determining bed size for MDHs. (That is, beds used for purposes other than inpatient lodging, beds certified as long term, and temporary beds are not counted. However, beds in a temporarily closed wing or partially closed wing are counted if the wing can be immediately opened and the beds occupied.)

For determining whether at least 60 percent of the hospital's inpatient days or discharges were attributable to Medicare Part A beneficiaries, days and discharges will be counted from the hospital's 12-month or longer cost reporting period that ended on or after September 30, 1987 and before September 30, 1988. Only days and discharges from acute care inpatient hospital stays in the area of the hospital subject to the prospective payment system will be included.

If the hospital's last cost reporting period ending before September 30, 1988 is for a period that is less than 12 months, days and discharges will be counted for the hospital's most recent 12-month or longer cost reporting period ending before the short period report. We believe that, in calculating the Medicare utilization, we must use a complete 12-month cost reporting period in order to avoid the determination being made on a shorter period that covers fewer months that might not be reflective of a hospital's full-year utilization due to seasonal fluctuations in Medicare inpatient load. This will also result in our using the same cost reporting period for qualification as we are using to determine the hospital's FY 1987 hospital-specific rate. (See discussion on SCH payment methodology in section II.B., above and MDH payment methodology below.) Days and discharges from swing beds will be counted if the discharges were for acute care inpatient hospital stays. The Medicare count of days and discharges will include only those days and inpatient stays for which benefits were payable under part A.

In order to not disadvantage hospitals that receive payment from a health maintenance organization (HMO) or a competitive medical plan (CMP) for inpatient care provided to Medicare Part A beneficiaries enrolled with the HMO or CMP, the days and discharges for those stays will be counted. These days and discharges do not appear on the hospital's cost report as Medicare days and discharges. Thus, the hospital should notify its intermediary and provide documentary evidence to support the number of days and discharges attributable to Medicare HMO or CMP enrollees that should be included in the intermediary's determination of the hospital's Medicare utilization.

Days and discharges from distinct part units excluded from the prospective payment system and from newborn nursery units will not be counted. These definitions of days and discharges will apply to both the numerator (Medicare patient count) and the denominator (total patient count) in determining whether a hospital was at least 60 percent Medicare-dependent during FY 1987. A hospital that does not have an FY 1987 cost reporting period will not be able to qualify for this special payment adjustment. Section 1886(d)(5)(iii) of the Act clearly provides that the hospital must have been 60 percent Medicare-dependent in its cost reporting period beginning in FY 1987.

In determining whether the 60 percent utilization standard is met for days or discharges, there will be no rounding of the utilization percentage. That is, if a hospital had 59.4 percent or 59.7 percent for days or discharges, it will not meet the criterion. The language of section 1886(d)(5)(G)(iii) of the Act is clear in stating that "* * * *not less than* 60 percent of inpatient days or discharges during the cost reporting period beginning in fiscal year 1987 were attributable to inpatients entitled to

benefits under Part A." (Emphasis added.) We realize that some hospitals may fail to meet the standard by a narrow margin and thus may not qualify as MDHs. Whenever numeric standards are established, there will be those entities that narrowly miss meeting them as well as those that narrowly succeed in meeting them. Regardless of the standards selected, this will be true. If we did allow exceptions to these criteria, they would have to be limited to certain tolerances that, again, some hospitals would fail to meet by a small margin.

As set forth in section 1886(d)(5)(G)(i) of the Act, hospitals meeting the above criteria will be paid based on whichever of the following rates yields the greatest aggregate payment for the cost reporting period: the national Federal rate applicable to the hospital, the updated hospital-specific rate using FY 1982 cost per discharge, or the updated hospital-specific rate using FY 1987 cost per discharge. (See discussion above in section II.B. for a detailed description of the calculation of a hospital-specific rate based on an FY 1987 base period.)

Hospitals do not need to take any action to qualify for this adjustment. The fiscal intermediary will determine for each cost reporting period which hospitals meet the criteria to qualify as MDHs prior to the start of the hospital's first cost reporting period beginning on or after April 1, 1990. In addition, similar to our treatment of SCHs, the intermediary will determine for each cost reporting period which of the payment options will yield the highest rate of payment to a hospital that qualifies as an MDH. Payments will automatically be made at the highest rate using the best data available at the time of the intermediary determination. However, as with SCHs, since it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end, the intermediary will make its determination based on what appears to yield the highest rate. A final adjustment will be made at the close of the cost reporting period to determine precisely which of the three payment rates yielded the highest payment to the hospital.

At the time of the year-end settlement, an MDH's cost report will also be reviewed to ensure that it meets all the qualifying criteria, that is, that it is located in a rural area, that its bed count for the cost reporting period was 100 or fewer beds, and that it did not qualify as an SCH at the same time that it was receiving payments as an MDH.

For purposes of counting beds, the most recently submitted cost report will be used by the fiscal intermediary to determine whether a hospital meets this criterion provisionally. A final determination will be made each year based on its average number of beds during the cost reporting period. If a hospital's number of beds has changed since its most recent cost report was submitted and it believes it meets the criteria to qualify for this adjustment, the hospital must notify its intermediary and submit documentary evidence that its bed count is not above 100 beds.

As discussed above, the intermediary will use the hospital's FY 1987 cost report to determine if it meets the 60 percent Medicare dependency requirement on the basis of either days or discharges. If a hospital believes that the data in its cost report do not accurately reflect its Medicare utilization, it must notify its intermediary and submit verifiable documentation to prove that it meets the 60 percent Medicare-patient utilization requirement.

Whether the intermediary determines a hospital's classification as an MDH based on its own data or after a hospital's request, the classification will be effective with the start of the cost reporting period in which the hospital first meets all the qualifying criteria effective with the first cost reporting period that begins on or after April 1, 1990.

Each MDH will be informed of its FY 1987-based hospital-specific rate within 180 days after it qualifies as an MDH. That is, any hospital that the intermediary identifies as qualifying for MDH status will be notified of its hospital-specific rate within 180 days after the start of its cost reporting period beginning on or after April 1, 1990. However, any hospital that is identified as an MDH by the intermediary after the start of its cost reporting period will be notified of its hospital-specific rate within 180 days after the intermediary determines that it meets the qualifying criteria.

We note that there would be no advantage to a hospital currently approved as an SCH to give up that status to qualify for the MDH adjustment since the payment provisions for both are identical and MDHs are also entitled to the same volume adjustment protection (described below) that is afforded to SCHs. However, a hospital might wish to qualify for SCH status to take advantage of the higher rate for capital payments afforded to these hospitals. If a hospital that qualifies as an MDH also meets the criteria to qualify for SCH status, it can switch to SCH status by submitting a request to its fiscal intermediary and demonstrating that it meets the qualifying criteria for SCH status under § 412.92.

A hospital's status as an MDH will be terminated on the same date as its SCH status becomes effective. As provided in § 412.92(b)(2), that status is effective 30 days after the date of HCFA's written notification of approval. We note that § 412.92(b)(2) currently states that HCFA's notification of approval is given to the hospital. However, the notification actually is sent to the intermediary. Therefore, we are revising § 412.92(b)(2) by deleting the words "to the provider."

Section 1886(d)(5)(G)(ii) of the Act also provides that a hospital meeting the MDH criteria is entitled to an additional adjustment if, due to circumstances beyond its control, its total number of discharges in a cost reporting period has decreased by more than 5 percent compared to the number of discharges in its preceding cost reporting period. Since this adjustment for a 5 percent reduction in discharges is identical to the criteria and adjustment currently provided for SCHs, we are incorporating the same criteria and adjustments into the regulation for MDHs

Effective October 1, 1989, the responsibility for processing volume adjustments for SCHs was transferred from HCFA's central office to the Medicare fiscal intermediaries. Therefore, the review of and a determination on a request for this adjustment in payment for a Medicare-dependent, small rural hospital will be made by the hospital's intermediary.

The basic test for evaluating a hospital's request for special payment due to circumstances beyond its control (in this case, a decrease in volume) is whether the decrease in volume is the result of an unusual situation or occurrence that is both externally imposed on the hospital and beyond its control. These situations may include, but are not limited to, strikes, fires, floods, inability to recruit essential physician staff, unusual, prolonged, and severe weather conditions that affect the local economy, the closing of a major employer in the hospital's service area resulting in decreased population or loss of inpatient health insurance coverage for large numbers of people, and similar unusual occurrences with substantial cost effects.

In comparing discharges, the number of discharges in a cost reporting period is compared to the number of discharges in the immediately preceding cost

reporting period. This policy is based on the language in section 1886(d)(5)(G)(ii) of the Act which states that this additional payment is available in the case of an MDH "that experiences, in a cost reporting period compared to the *previous* cost reporting period, a decrease of more than five percent in its total number of inpatient cases due to circumstances beyond its control * * *." (Emphasis added.) Thus, if a hospital experiences an occurrence that results in a sustained decrease in cases, an adjustment would be made for the cost reporting period in which the change occurred (if it were at least a 5 percent decrease), but the adjustment would not be made during subsequent periods unless discharges decrease by at least another 5 percent. Section 1886(d)(5)(G) of the Act does not allow us to add together volume declines occurring in more than one year to meet the 5 percent volume decrease requirement. Therefore, a hospital that has volume declines of 2 percent in one year and 4 percent in the next year is not entitled to an adjustment for either year. Under section 1886(d)(5)(G)(ii) of the Act, the payment adjustment is made to compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services for the one year period in which the volume decline occurs.

Fixed costs are defined as those over which management has no control. Many truly fixed costs, for example, rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of patient volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization. However, in a hospital setting, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but which will also vary with volume. For purposes of this adjustment, many semifixed costs, such as personnel-related costs, may be considered as fixed costs on a case-by-case basis. An adjustment will not be made for truly variable costs, such as food and laundry services.

In evaluating semifixed costs, such as personnel, the intermediary will consider the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs would be considered fixed. As the period of decreased utilization continues, we would expect a cost-efficient hospital to take some action to reduce unnecessary expenses. Therefore, if a hospital does not reduce unnecessary expenses, we would not include such costs in determining the amount of the adjustment.

Section 1886(d)(5)(G)(ii) of the Act requires that the adjustment amount "fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." The intermediary will review the determination concerning core staff and services based on an individual hospital's needs and circumstances; for example, the intermediary will take into account the minimum staffing levels required by State agencies.

In addition, we believe that section 1886(d)(5)(G)(ii) makes it clear that a hospital that has continued to make a profit under the prospective payment system, even though there has been a decline of more than 5 percent in occupancy, is not entitled to receive a payment adjustment. A hospital that receives payments that are greater than the hospital's Medicare inpatient operating costs has been "fully compensated" for those costs by the prospective payment system. Consequently, we do not believe that any additional adjustment is warranted.

We recognize that some rural hospitals experiencing a volume decline may be having financial difficulties despite the fact that they have recovered their full Medicare inpatient operating costs under the prospective payment system. While it may be true that some hospitals are suffering financial hardship for any number of reasons, it is clearly inappropriate for Medicare to share in the costs attributable to non-Medicare beneficiaries. Therefore, we wish to clarify that any adjustment amounts granted to a Medicare-dependent, small rural hospital may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under the prospective payment system, including outlier payments, disproportionate share adjustment amounts and indirect medical education payment amounts.

An MDH that believes it qualifies for this adjustment must submit a written request to its Medicare fiscal intermediary. The requests must clearly document the circumstances causing the decrease in patient volume and the resulting effect on the hospital's costs. The request must show how the hospital reacted to the decline in volume, that is, what actions it took to control costs once it became evident that the circumstances beyond its control would cause a decline in volume of patient service. The hospital's request must be submitted within 180 days from the date of the notice of amount of program reimbursement (NPR) for the cost reporting period in question. The intermediary will make its determination and notify the hospital within 180 days from the date it receives the hospital's request and all of the required documentation.

E. Ceiling on Rate of Hospital Cost Increases (Section 413.40)

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) added section 1886 to the Act to establish a ceiling on the allowable rate of increase for hospital inpatient operating costs. This ceiling still applies to hospitals and units excluded from the prospective payment system. Excluded hospital and hospital units under section 1886(d)(1)(B) of the Act include psychiatric, rehabilitation, children's long-term hospitals, and psychiatric and rehabilitation distinct-part units of acute care hospitals. (Prior to FY 1988, alcohol/drug hospitals and distinct-part units were also excluded from the prospective payment system, but are now under the prospective payment system.)

These excluded hospitals and units receive payment for the inpatient hospital services they furnish on the basis of reasonable cost up to a ceiling. Under the rate of increase limits, an annual target amount (stated as inpatient operating cost per discharge) is set for each hospital, based on the hospital's own cost experience in its base year. 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) 5 percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period. The limit is based on an assumption that a provider's year-to-year inpatient operating costs should remain comparable to its base year,

except for inflation. Section 1886(b)(4)(A) of the Act gives the Secretary the authority to grant an exemption from, or an adjustment or exception to, the target rate of increase limit where events beyond the hospital's control or extraordinary circumstances create a distortion in the increase in costs.

Section 6015 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended the target rate adjustment authority contained in section 1886(b)(4)(A) of the Act to provide that a hospital or excluded unit may be assigned a new base year in lieu of adjustments to the existing target rate. Thus, the aassignment of a new base period is another mechanism HCFA may use, when appropriate, in determining the payment amount to an excluded hospital that has exceeded its ceiling in a cost reporting period. Section 6015 of Pub. L. 101–239 requires the Secretary to publish instructions by June 19, 1990 that set forth the application process under which hospitals may request target rate exemptions and adjustments.

1. Base Period

Section 1886(b)(3) of the Act provides for the use of a particular 12-month cost reporting period as the base period that serves as the basis for future periods' cost per case (that is, the target amount) after updating by the applicable percentage increase. The base period is the first cost reporting period of the excluded hospital or unit beginning before the period for which section 1886(b) of the Act applies. 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 excluded hospitals or hospital units that have a cost reporting period that is other than 12 months in duration. This policy is set forth in regulations at § 413.40(b).

A hospital's fiscal intermediary calculates the target amount by dividing the allowable inpatient operating costs as defined under section 1886(a)(4) by the number of Medicare discharges in the base year cost reporting period. A hospital could incur costs that exceed its ceiling due to extraordinary circumstances such as flood, fire, earthquake or similar unusual occurrences, or some other factor that has caused a distortion in the comparison of the base year and the applicable cost reporting period. Under section 1886(b)(4)(A) of the Act, the Secretary can provide for a exception or adjustment to the hospital's ceiling in such circumstances. Section 413.40(f) of the regulations implement section 1886(b)(4) of the Act regarding exemptions, adjustments and exceptions to the target rate of increase limit. The regulations provide that HCFA may adjust a hospital's operating costs considered in establishing cost per case, including both periods subject to the limit and the hospital's base periods, to take into account—

- Unusual costs due to extraordinary circumstances beyond the provider's control;
- Distortions in costs caused by a change in case mix as a result of the addition or discontinuation of services; or
- Factors such as a change in the inpatient hospital services that a hospital provides that could result in a significant distortion in the operating costs of inpatient hospital services. The adjustment may be made only if the hospital exceeds its limit for the cost reporting period and only to the extent the hospital's costs are reasonable, attributable to circumstances specified above, and verified by the intermediary.

The exceptions or adjustments we make to a hospital's target rate limit are most commonly for a particular problem in one cost reporting period, such as a hospital experiencing an increase in its Medicare average length of stay. This increase could cause a distortion in the comparison to its base year since the limit is calculated on a per discharge basis. If a hospital whose costs exceed the limit demonstrates that its increased costs are attributable to an average length of stay increase and that its costs are reasonable, we adjust the limit to recognize the increase in average length of stay over the base period.

In some situations, a permanent adjustment is made to a hospital's limit such as when a hospital adds a new and substantially different service. Such an addition would create the need for additional staff and also could result in treating a different kind of patient. However, only those costs associated with the addition of a new service would be included in the permanent adjustment made to the provider's rate-of-increase limit.

2. Assignment of a New Base Period

Section 6015(a) of Public Law 101–239 gives the Secretary authority to assign a new base period to a hospital if it is more representative of the reasonable and necessary costs of its inpatient services. We would authorize the assignment of a new base period only under limited circumstances and only when an adjustment cannot be accomplished through other provisions as discussed above. In order to justify the assignment of a new base period, a hospital must have a permanent, substantial, and significant change in the nature of services provided that results in costs exceeding its rate-of-increase. An example of such a change would be a psychiatric institution that previously had only provided limited care to its patient population and then had changed the entire focus of its work to providing a comprehensive range of psychiatric services to its patients.

However, should a hospital experience a significant change in patient care services and its costs exceed the target rate-of-increase limit, the remedy will not automatically be the assignment of a new base period. A general increase in costs beyond the limit is not grounds for rebasing. As discussed above, if a hospital adds a new service that results in increased costs, a permanent adjustment may be made to the hospital's limit to alleviate the distortion created by the new service and total rebasing would not be warranted.

Another situation that could occur is that the hospital may have significantly changed its patient care services but all the costs incurred above the ceiling may not be reasonable and necessary. One area we give particular attention to in this respect is indirect patient costs, (for example, administrative and general costs, and operation of plant.) The increase in indirect costs are often the result of factors unrelated to patient services and therefore, are not included in any adjustments and would not be included if the assignment of a new base period were approved. Rather, we expect cases of this nature to result in a rebasing of direct patient care costs only.

F. Payment for Hemophilia Inpatients

Hemophilia, a blood disorder characterized by prolonged coagulation time, is caused by an inherited deficiency of a factor in plasma necessary for blood to clot. The discovery in 1964 of a cryoprecipitate rich in antihemophilic factor activity facilitated management of acute bleeding episodes. For purposes of this final rule, hemophilia is considered to encompass the following conditions: Factor VIII deficiency (classical hemophilia); Factor IX deficiency (also termed plasma thromboplastin component (PTC) or Christmas factor deficiency); and Von Willebrand's disease. The most common factors required by hemophiliacs to increase coagulation are Factor VIII and Factor IX; a small number of hemophiliacs have developed inhibitors to these factors and require special treatment.

The basis for therapy of bleeding episodes is transfusion of material containing sufficient factor to temporarily correct the specific defect. Whole blood is not used for this purpose; its use is restricted to restoration of blood volume following severe loss. Plasma with a high content of factor may be used but factor concentrates are the preferred method of treatment since the content of factor is known and the load on the blood volume is less. The widespread use of clotting factor concentrates has been associated with more frequent emergence of abnormalities in liver function test results and the transmission of hepatitis viruses to some persons with hemophilia. Manufacturers of the clotting factors continually pursue development of methods for purification in an attempt to decrease the risks associated with their use. The emergence of acquired immunodeficiency syndrome (AIDS) has added impetus to the development of new and safer methods of producing clotting factors. Efforts to maintain a safe blood supply have resulted in increased efforts to improve purification of coagulation factors.

A variety of methods currently exist to reduce and inactivate viruses in coagulation concentrates, and multiple variations exist within each category. Dry heating, pasteurization, suspension heating, vapor heating, use of solvent detergent, and monoclonal antibody purification are among the methods currently being used for viral inactivation.

With the new developments in viral inactivation and the production of purified clotting factors, there has also been a dramatic increase in the costs. Several factors have contributed to this increase. The industry has committed significant resources in research and development to perfect the purification process and assure a safe supply of coagulation factor. Changes in production processes resulting from new technology have significantly reduced the yield of coagulation factors from the donor pool; thus, more plasma is required to produce one unit of coagulation factor. Periodic shortages have also contributed to price increases. Rapidly changing new technologies resulting in new products entering the market have functioned to enhance treatment efficacy at an increased cost.

The Prospective Payment Commission (ProPAC) recently completed a study entitled "The Adequacy of Prospective Payment for Medicare Beneficiaries with Hemophilia." ProPAC determined that hemophilia patients were distributed across several diagnostic-related groups (DRGs) and that patients with hemophilia had higher inpatient operating costs than other patients. However, while payments under the prospective payment system for these cases were slightly higher, the relative payment to cost ratios were lower. On October 2, 1989, ProPAC recommended to Congress implementation of a prospectively determined add-on payment for patients requiring the clotting factor, and that this payment should be determined on a per unit basis, based on a weighted average of the types of clotting factor available.

In response to ProPAC's recommendations and growing concern about increasing hospital costs for treating hemophiliacs, Congress enacted section 6011 of Public Law 101-239. That section amended section 1886(a)(4) of the Act to provide that prospective payment hospitals receive an additional payment for the costs of administering blood clotting factor to hemophiliacs who are hospital inpatients. The payment is to be based on a predetermined price per unit of the clotting factor multiplied by the number of units provided. Under section 6011 of Public Law 101-239, this add-on payment is effective for blood clotting factor furnished on or after June 19, 1990 and before December 19, 1991. In addition, section 6011 of Public Law 101-239, requires HCFA and ProPAC to develop and submit to Congress recommendations on how to pay for blood clotting factor. These recommendations are due not later than June 19, 1991.

We are establishing a price per unit of clotting factor based on the latest (1990) price listing available from the Drug Topics Red Book, the publication of pharmaceutical average wholesale prices. Although ProPAC recommended that we set an add-on payment amount for clotting factor based on a weighted average of the types of clotting factor available, we believe that it is more appropriate to set three separate add-on amounts, one for each of the three basic types of clotting factor. A comparison of the wholesale prices for the different types of clotting factor (that is, Factor VIII, Factor IX, and the other factors which are given to those patients with inhibiters to Factors VIII and IX (designated as Anti-inhibitors in this document)) reveals great variations among the three types. The Factor IX products are priced much lower than the Factor VIII products, and the special anti-inhibitor factors are priced higher than both of the other factors. Therefore, we believe that it would be more equitable to set an add-on payment amount for each type of blood clotting factor.

The add-on payment amount for each of the three types of factor is based on the median average wholesale price of the several products available in that category of factor. However, since we are aware that hospitals are generally able to negotiate direct selling prices with the various drug companies that are lower than the wholesale prices listed in the Drug Topics Red Book, we have discounted the average wholesale prices by 15 percent before calculating the median price. This 15 percent discount is based on the results of a study conducted by the Department's Office of Inspector General (OIG) entitled "Use of Average Wholesale Prices in Reimbursing Pharmacies Participating in Medicaid and the Medicare Prescription Drug Program" (Report No. A-06-89-00037, October 3, 1989). The OIG determined that the average wholesale price of a drug is heavily discounted in direct sales and that current data show that this discount averages 15.5 percent. In addition, the OIG report states that the average wholesale price is not a meaningful payment level, and it should not be used for making payment for drugs under Medicare.

The add-on payment amounts we have established for the three types of blood clotting factor are as follows:

Factor VIII—$.64 per unit
Factor IX—$.26 per unit
Other Hemophilia Clotting Factors (for example, Anti-inhibitors)—$1.00 per unit

Based on information from industry representatives, we believe that the clotting factors are generally available to hospitals or at below these prices.

We recognize that the products available, and their costs, are changing rapidly, with new products entering the market and existing products being discontinued. Since the market share of various products can shift dramatically within a short period of time, we believe the median price is preferable to a weighted average. We note, for example, several of the factor VIII products priced in ProPAC's report have been discontinued. In addition, we recognize that changes in the clotting factor market may require re-evaluation of the add on payment amount before the final rule setting forth the FY 1991 prospective payment rates is issued.

In setting the add-on payment amount, we considered whether other costs associated with the administration of hemophilia clotting factor should be

taken into account. Although section 1886(a)(4) of the Act refers to a payment for the costs of administering the clotting factor, there is nothing in the legislative history or the ProPAC recommendation to suggest that Congress intended that the payment cover more than the actual cost of the clotting factor. Other costs associated with the administration of the clotting factor, such as needles and intravenous (IV) tubing, are neither unique to the hemophilia inpatient nor unusually costly. Therefore, we have based the add-on payment amount on the cost of the clotting factor only.

To identify these factors, specific codes have been developed that will identify the three types and will be included in the bill submitted by the hospital.

Instructions will be issued to Medicare hospitals explaining the codes and how to use them. These codes will serve to identify the cases requiring payment for the clotting factor and will also permit the accumulation of data over time. The data will be evaluated in determining future payment alternatives.

Since we currently have no data concerning the administration of clotting factor under the prospective payment system, that is, in which DRGs clotting factor is most often provided to Medicare beneficiaries and in what volume, we are unable at this time to adjust the DRG weights to account for the payment of clotting factor as an add-on amount. In calculating DRG relative weights, it has been our policy to remove from the total charges of any case those charges that are paid for as an add-on amount, that is, paid for on a basis other than DRG payment. For example, since heart and kidney acquisition costs are paid on a reasonable cost basis, the acquisition charges are removed prior to computing the average charge for each DRG. Although we will consider a similar policy for the clotting factor add-on amount when we have accumulated the relevant data, we note that total payments will be relatively minor. ProPAC estimated that approximately 8 million units of clotting factor are administered to Medicare hospital inpatients annually.

G. Recognition of Nursing School Costs

1. Background

Medicare has historically paid a share of the net cost of approved medical education activities. Regulations concerning Medicare payment for nursing and allied health science educational costs are located at §§ 412.113(b) and 413.85. Section 413.85(b) defines approved educational activities as formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. Under § 413.85(e), approved medical education activities include training programs for nurses.

Section 413.85(a) specifies that the allowable cost of approved educational activities is the net cost, which is determined by deducting tuition revenues from total costs. The net costs incurred for classroom and clinical training in an approved nursing education program operated by the provider are included within the definition of allowable medical education costs. Under sections 1886 (a)(4) and (d)(1)(A) of the Act and § 412.113(b) of the regulations, the costs of approved medical education activities are excluded from the definition of operating costs and, in the case of approved nursing education programs operated by the provider, are paid on a reasonable cost basis.

Some hospitals support approved nursing education programs operated by another institution, such as a nearby college or university. When a program is operated by another institution, the classroom training generally takes place in the nonhospital setting and the majority of the costs of the program are borne by the other institution and not by the hospital. Although the hospital may incur some costs associated with its provision of clinical training to students enrolled in a nearby institution, the hospital also gains in return in the quality of patient care. Since we do not believe that this type of relationship was what Congress intended when it provided for the costs of approved medical education programs to be paid on a reasonable cost basis, § 413.85 excludes costs incurred for nonprovider-operated programs from the definition of the approved medical education activities. The costs incurred by a hospital to support a nonprovider-operated nursing education program, to the extent they are allowable, are considered normal operating costs and are included in the DRG payment for inpatient services and are paid on a reasonable cost basis for outpatient services.

The allowable costs of nonprovider-operated nursing education programs are defined in chapter 4 of the Provider Reimbursement Manual (HCFA Pub. 15-1). Under our current policy, costs incurred by the hospital for clinical training at the hospital that relate to care of the hospital's patients are allowable. In cases in which classroom training occurs at the hospital, costs incurred by the hospital are allowable if—

- The hospital's support does not constitute a redistribution of nonprovider costs to the hospital;
- The hospital is receiving a benefit for the support it furnishes; and
- The hospital's support is less than the cost the hospital would be expected to incur with a program of its own.

2. Section 6205 of Public Law 101-239.

Section 6205(a) of Public Law 101-239 created a new temporary category of "hospital-based nursing schools" in addition to those recognized under §§ 412.113(b) and 413.85. Costs incurred by hospitals for training nursing students enrolled in these schools are to be paid on the basis of reasonable cost as though the hospital met the criteria at § 413.85. As specified in section 6205(a)(1)(A) of Public Law 101-239, costs incurred by a "hospital-based nursing school" will qualify under this provision—

> * * * if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital.

To meet the first criterion, the hospital must incur at least 50 percent of the total costs, that is, the costs before deduction of tuition revenues, incurred for classroom and clinical training provided to students enrolled in an approved nursing education program at the hospital-based nursing school. This would include programs in both professional and practical nursing that are approved by the appropriate approving body under § 413.85(e). We note that approved allied health science education programs are not included in this provision. Moreover, a hospital will not be considered to be incurring costs through payments to an educational institution for training of students.

Neither section 6205 of Public Law 101-239 nor the Committee Report (H.R. Rep. No. 386, 101st Cong., 1st Sess. (1989)) that accompanied Public Law 101-239 elaborates on the second criterion, that the nursing school and the hospital share some common board members. We will consider this requirement to be met if at least 50 percent of the board with fewer members (either the hospital or the nursing school) are also members of the board of the other entity, regardless of the number of members of the larger board.

The third criterion, that all instruction be provided at, or on the immediate grounds of, the hospital is clarified in the Conference Committee Report (H.R. Rep. No. 386, 101st Cong., 1st Sess. 869 (1989)). The report states that a program complies with this requirement "* * * only if this instruction occurs on the hospital campus, *not on the campus of an institution with which the hospital is affiliated.*" (Emphasis added.) In instances where the hospital is contiguous to, or within, the campus of an educational institution, this criterion will be considered to be met only if the instruction is provided at the hospital.

Section 6205(b)(2)(A) of Public Law 101–239 requires that the Secretary issued proposed regulations before July 1, 1990 that specify—

- The relationship required between an approved nursing education or allied health education program and a hospital for the program's costs to be attributed to the hospital;
- The types of costs related to nursing or allied health education programs;
- The distinction between costs of approved educational activities paid on the basis of reasonable cost and educational costs treated as operating costs of inpatient hospital services; and
- The treatment of other funding sources for the program.

Section 6205(b)(2)(B) of Public Law 101–239 provides that the final rule will not be effective before October 1, 1990, or 30 days after publication of the final rule in the **Federal Register**, whichever is later.

In addition, section 6205(b)(2)(A) of Public Law 101–239 provides that during the period after December 18, 1989 and before October 1, 1990, there is to be no recoupment of overpayments attributable to nursing and allied health science costs that have been reported as allowable medical education costs payable on a reasonable cost basis and later have been determined to not meet the definition of these costs. We are issuing program instructions to our intermediaries to implement this provision.

Section 6205(a)(2) Public Law 101–239 states that the new "hospital-based nursing school" provision applies to cost reporting periods beginning on and after enactment and "* * * on or before the date on which the Secretary issues regulations pursuant to subsection (b)(2)(A) [section 6205(b)(2)(A) of Pub. L. 101–239]." In citing section 6205(b)(2)(A), section 6205(a)(2) of Public Law 101–239 presents us with a logical inconsistency. Subparagraphs (A) and (B) of section 6205(b)(2), taken together, make it clear that the regulations referred to in section 6205(b)(2)(A) are proposed regulations, to be issued before July 1, 1990, and to be followed by a 60-day comment period. The final regulations (to which, it is assumed, the term "regulations" in section 6205(a)(2) of Public Law 101–239 refers) are to be effective no earlier than October 1, 1990. In light of the common understanding of the term "regulations", the temporary category of "hospital-based nursing schools" will expire with a hospital's first cost reporting period beginning on or after the date the final regulations required by section 6205(b)(2)(B)(iii) of Public Law 101–239 are issued.

Given the temporary and limited applicability of section 6205(a) of Public Law 101–239, we do not intend to amend the codified regulations to reflect the implementation of the policies explained above.

III. Temporary Elimination of the Day Limitation on Inpatient Hospital Services

A. Background

1. Medicare Catastrophic Coverage Act of 1988

After publication of a May 27, 1988 proposed rule concerning changes to the inpatient hospital prospective payment system and FY 1989 rates, on July 1, 1988, Public Law 100–360 was enacted. Under section 101(2) of Public Law 100–360, essentially unlimited inpatient hospital days were made available for Medicare beneficiaries (except for the inpatient psychiatric day limitation) effective for services furnished on or after January 1, 1989. Before enactment of Public Law 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. Under that system, 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 42 CFR 412.42(e)).

Hospitals and hospital associations expressed concern to Congress that they would be financially disadvantaged by not being permitted to bill beneficiaries on their third party insurers for inpatient hospital services that, before enactment of Public Law 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 Public Law 100–360 required the Secretary to take into consideration 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 of Public Law 100–360 when establishing the prospective payment rates, outlier thresholds, and diagnosis related group (DRG) weighting factors for FY 1989. In addition, section 104(c)(2) of Public Law 100–360 required the Secretary, when increasing the target amounts for hospitals excluded from the prospective payment system, to take into consideration on a hospital-specific basis, the same reduction in payments to excluded hospitals for cost reporting periods beginning on or after October 1, 1988.

2. The September 30, 1988 Final Rule

On September 30, 1988, we published the final rule (53 FR 38476) on changes to the inpatient hospital prospective payment system and FY 1989 rates. In that rule, we implemented two provisions of Public Law 100–360, which are discussed below, and we requested public comment on those changes.

3. The Family Support Act of 1988

Subsequent to the publication of the September 30 final rule, the Family Support Act of 1988 (Public Law 100–485) was enacted on October 13, 1988. Section 608(d) of Public Law 100–485 made several technical corrections to Public Law 100–360, including the following changes concerning provisions of Public Law 100–360 implemented in the September 30 final rule:

- Section 608(d)(3)(D) of Public Law 100–485 revised section 104(c)(2) of Public Law 100–360 to change the date for implementing the target rate adjustments from cost reporting periods that begin on or after October 1, 1988 to portions of cost reporting periods occurring on or after January 1, 1989.
- Section 608(d)(3)(E) of Public Law 100–485 revised section 104(c)(2) of Public Law 100–360 to specifically provide that an adjustment for any distortion due to higher costs caused by the expansion of inpatient hospital benefits is to be made whether or not a hospital or unit actually exceeded its target rate.

4. The Medicare Catastrophic Coverage Repeal Act of 1989

The Medicare Catastrophic Coverage Repeal Act (Public Law 101–234) was enacted on December 13, 1989. Under section 101(c) of Public Law 101–234,

any adjustment in payments to hospitals under the prospective payment system as provided for in section 104(c)(1) of Public Law 100–360 ended effective with discharges occurring on or after January 1, 1990. Under section 101(c)(2)(A)(i) of Public Law 101–234, the adjustment to the target rates for hospitals excluded from the prospective payment system, as provided for in section 104(c)(2) of Public Law 100–360, was eliminated effective with portions of cost reporting periods occurring on or after January 1, 1990. In addition, section 101(c)(2)(A)(ii) of Public Law 101–234 added clarification that in making any adjustment under section 104(c)(2) of Public Law 100–360, the adjustments to hospital target rates must be made disregarding whether a beneficiary had exhausted his or her Medicare benefits prior to January 1, 1989.

B. Hospitals Subject to the Prospective Payment System

Section 104(c)(1) of Public Law 100–360, as amended by section 101(c) of Public Law 101–234, requires the Secretary to take into consideration 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 of Public Law 100–360 in establishing the prospective payment rates, outlier thresholds, and DRG weighting factors for discharges occurring on or after October 1, 1988 and before January 1, 1990.

In the September 30, 1988 final rule, we stated that we had determined that the prospective payment system would automatically adjust to the expansion of inpatient hospital benefits under Public Law 100–360 (53 FR 38519). This is because increased payments would 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. Aggregate payments to hospitals would automatically reflect changes in the volume of Medicare discharges resulting from the elimination of the day limitation on inpatient hospital benefits. The additional discharges occurring as a result of the expansion of benefits would be covered and paid for automatically as are all other discharges under the prospective payment system. Hence, we determined that no adjustment to the standardized payment amounts was necessary to accommodate the additional discharges for Medicare beneficiaries who prior to Public Law 100–360 would have been financially liable for such care because they had exhausted their Medicare inpatient hospital benefits prior to admission.

On the other hand, we indicated there would be additional days of inpatient care (those occurring during the outlier portion of a hospital stay) for which benefits were exhausted and the hospital would previously have been permitted to bill beneficiaries. This care was not reflected in the data base used to establish the prospective payment rates. Because these inpatient days would, in general, be covered after January 1, 1989, we analyzed whether it was 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.

We analyzed FY 1987 data regarding noncovered days of hospital care furnished under the existing benefit structure. Most of these noncovered days would have been covered under Public Law 100–360, and in some cases would have constituted covered outlier days. We estimated that outlier payments for such days would be about one percent of total DRG payments. However, to reflect these additional payments by increasing the standardized amounts by one percent would have required that the outlier offsets to those rates or the outlier thresholds be increased to ensure that total outlier payments were between five and six percent of total DRG payments and did not exceed the outlier offset. Moreover, our September 1988 estimate was overstated to the extent that some proportion of hospital days continued to be noncovered even after implementation of Public Law 100–360 (for example, medically unnecessary days). Therefore, we determined that for October 1, 1988 it was inappropriate to incorporate an adjustment into the rates.

Instead, we estimated outlier payments and outlier offsets on the basis of days covered under the inpatient benefit structure as reflected in the FY 1987 MEDPAR data base, knowing that the proportion of days eligible for outlier payments would increase as expanded coverage began on January 1, 1989 and that a higher proportion of DRG payments would thus be attributable to outlier payments as a result of such expansion of benefits.

In light of the increases in the outlier thresholds that were already necessitated by the changes in outlier payment policy for FY 1989 described in detail in the September 30, 1988 final rule (53 FR 38502), we indicated in that rule that the latter approach was appropriate for FY 1989 and preferable to further possible increases in the outlier thresholds. Accordingly, while the outlier *offsets* to the standardized amounts averaged 5.1 percent for FY 1989, [1] we expected that outlier *payments* would comprise about 6.1 percent of total DRG payments during that same year. These larger than estimated outlier payments in effect constituted our FY 1989 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 of Public Law 100–360. We used the same methodology to adjust for the effects of catastrophic coverage in the FY 1990 payments (54 FR 36499).

The adjustments described above eliminated the need to increase the prospective payment rates to account for catastrophic coverage. 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 at 53 FR 38492 and 54 FR 36468 contained 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 was needed to take into account the elimination of the day limitation on inpatient hospital care resulting from implementation of Public Law 100–360.

C. Excluded Hospitals and Units

We provided in the September 30, 1988 final rule that hospitals and hospital units excluded from the prospective payment system may apply for increases to their target rates to correct any distortion due to higher costs caused by the expansion of inpatient hospital benefits due to the provisions of section 101 of Public Law 100–360. We provided for the adjustment under section 104(c)(2) of Public Law 100–360 to be available to any hospital that experiences a distortion due to increased costs caused by elimination of the inpatient coverage limitation, whether or not the hospital actually exceeds its target rate. This is because any distortion would be due to the effect

[1] Although we accurately stated at 53 FR 38505 that we are maintaining "the outlier pool at 5.1 percent", we inadvertently asserted at 53 FR 38520 that "the outlier offsets to the standardized amounts average 5.2 percent for FY 1989".

of section 101 of Public Law 100–360 and would be essentially unrelated to the actions of any individual hospital—it is a circumstance that could potentially affect all hospitals to some degree.

We provided that a hospital may request a target amount adjustment directly from its intermediary. The target amount would 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 would be based on the estimated incremental costs of care historically furnished to Medicare beneficiaries after they had exhausted benefits during an inpatient stay.

We provided that a hospital may request an adjustment from its intermediary after the effective date of the September 30 final rule (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, we provided that 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 stating whether the adjustment is to be based on its historical experience in its base period or its last cost reporting period beginning before October 1, 1988. (If this period is not of at least 12 months in 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 includes 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 would 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 hospital's data are derived; and
- Apply this ratio to the otherwise applicable target amount for cost reporting periods beginning on or after October 1, 1988.

We indicated that 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.

We provided the following example to illustrate 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

D. Discussion of Public Comments Concerning the September 30, 1988 Final Rule

Six letters were received timely containing comments on the provisions in Public Law 100–360 that were included in the September 30, 1988 final rule, that is, the only provisions of the final rule that were subject to comment. Although we received additional comments concerning various other aspects of the prospective payment system, we are not responding to those comments in this document.

All of the commenters raised issues concerning Medicare compensation to hospitals for losses that may be suffered due to the elimination of the Medicare day benefit limitation. Two of the commenters discussed the methodology for compensating prospective payment hospitals; five of the commenters raised issues concerning the target rate adjustments for excluded hospitals and units. In general, the commenters supported our methodology to adjust target rates; however, several commenters suggested modifications to our methodology.

1. Hospitals Subject to the Prospective Payment System

Comment: Two commenters expressed general concern that increases in outlier payments may not adequately compensate hospitals for losses that they may incur due to the elimination of the day limitation on hospital benefits. These commenters were concerned that HCFA did not address the issue of future adjustments to the system to provide additional funds for catastrophic coverage That is, these commenters wanted to know whether HCFA planned to collect data on the additional covered days in order to make an adjustment to the standardized amounts or whether permanent changes to the outlier policy would be adopted. Both commenters stated that HCFA should clearly specify now how additional funds will be incorporated into total payments under the prospective payment system in the future. One commenter suggested that HCFA collect the necessary data to develop an appropriate adjustment and publish the methodology for, and results of, the calculation of the effects of catastrophic coverage on prospective payment hospitals.

Response: We recognize that the funding of additional covered days through outlier payments was a temporary measure and had intended to develop a permanent adjustment once we had actual data on the impact of catastrophic coverage. However, because catastrophic coverage was repealed effective January 1, 1990, a permanent adjustment to finance the additional covered days of care that are currently funded through outlier payments is no longer necessary

Further, we note that since the funding of the additional covered days through outlier payments did not affect the outlier thresholds or the outlier offsets to the standardized amounts, no changes are required in the FY 1990 outlier payments and outlier offsets to account for the repeal of catastrophic coverage.

2. Hospitals and Units Excluded From the Prospective Payment System

Comment: Several commenters pointed out that although the elimination of the hospital day benefit limitation on Medicare inpatient hospital services under section 101 of Public Law 100–360 became effective January 1, 1989, under the September 30, 1988 final rule, target amounts would be adjusted for cost reporting periods beginning on or after October 1, 1988, which would be before the implementation date of section 101 of Public Law 100–360. The commenters suggested that our implementation date be revised. Similarly, some commenters asked that we apply the adjustments to portions of cost reporting periods occurring after January 1, 1989, even if the fiscal year for the hospital began before the effective date of the law, in order to ensure that costs for current inpatient beneficiaries who had exhausted their Medicare coverage would be recognized timely.

Response: Section 104(c)(2) of Public Law 100–360 specified that adjustments for excluded hospitals and units would begin for cost reporting periods starting on or after October 1, 1988. The policy set forth in our September 30, 1988 final rule conformed with this provision. However, subsequently, section 608(d)(3)(D) of Public Law 100–485 revised the date for implementing the target rate adjustments from cost reporting periods that begin on or after October 1, 1988 to portions of cost reporting periods occurring on or after January 1, 1989. Additionally, section 101(c) of Public Law 101–234 limited the adjustment provisions of section 104(c)(2) of Public Law 100–360 to portions of cost reporting periods occurring before January 1, 1990. In this document, we are revising § 413.40(i) to clarify that target rate adjustments will be made for any portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990.

Comment: One commenter requested that instead of the option of using the last cost reporting period beginning before October 1, 1988 as the basis for the target rate adjustment, a hospital be allowed to use an earlier cost reporting period so that any increases would be available closer to January 1, 1989. That is, rather than allowing a hospital the option of using its last cost reporting period beginning before October 1988 to determine any adjustment under § 413.40(i) as provided in the September 30, 1988 final rule, a hospital should be given the option of using the last cost reporting period ending before January 1, 1989 (the effective date of the elimination of the hospital day benefit limit).

Response: Based on section 608(d)(3)(D) of Public Law 100–485, which amended section 104(c)(2) of Public Law 100–360 to change the effective date for providing a target rate adjustment from cost reporting periods beginning on or after October 1, 1988 to any portion of a cost reporting period occurring on or after January 1, 1989, we are revising § 413.40(i)(2)(i) to provide that the alternative to using an excluded hospital's base year data in making this target rate adjustment is using the hospital's last cost reporting period ending before January 1, 1989. We had proposed to use the most recent cost reporting period data which began before October 1, 1988 for making the target rate adjustment as an option to using the hospital's base-year data to ensure that necessary data would be readily available. However, we agree that this slightly earlier cost reporting period should not present much more of a problem with respect to the ready availability of cost and day information needed by the intermediary.

Comment: One commenter expressed concern that only billed charges for ancillary services are to be used to determine ancillary costs for services furnished on the days after the beneficiary had exhausted inpatient hospital benefits in making the target amount adjustment. The commenter pointed out that in some cases hospitals will not have these data readily available and that in other cases billed ancillary charges will not even be obtainable, for example, in a no-charge, all-inclusive rate hospital or in a hospital that is paid on an average per diem rate under a State Medicaid program for care furnished to a Medicaid recipient. The commenter suggested that in addition to billed charges for ancillary services, actual cost data and average cost per diem be used in making the calculation for the target rate adjustment.

Response: We have revised § 413.40(i)(2)(iii) so that a hospital that is unable to document its actual ancillary charges, including a no-charge structure and an all-inclusive-rate hospital, may use an average cost per diem for ancillary services in lieu of estimating ancillary costs by applying departmental cost-to-charge ratios from the cost report to ancillary charges. We recognize that limiting the methodology to billed charges could be impossible in certain cases and could represent an unnecessary evidential burden in others. We believe intermediaries have adequate working relationships with the affected hospitals to ensure that reasonable determinations of ancillary costs will result.

Comment: Two commenters asked that we clarify the treatment of inpatient days for a Medicare beneficiary who was treated in the year used for the adjustment calculation and had exhausted his or her inpatient benefits before being admitted to an excluded hospital or unit.

Response: Section 101(c)(2)(A)(ii) of Public Law 101–234 amended section 104(c)(2) of Public Law 100–360 to require that target rate adjustments be made without regard to whether a beneficiary had exhausted Medicare coverage prior to January 1, 1989. Beneficiaries who exhausted their benefits before January 1, 1989, and became re-entitled to benefits under catastrophic coverage fall into two categories: those who exhausted their benefits after admission to the hospital and those who exhausted their benefits prior to admission. To account for these beneficiaries in the adjustment of the target rate for the impact of catastrophic coverage, it is necessary only to increase the target rate for hospital inpatient days for a beneficiary who exhausted benefits after admission, including any beneficiary who exhausted his or her inpatient benefits prior to the beginning of the selected cost reporting period.

If the beneficiary was discharged during the selected cost reporting period, this discharge must also be added to the total number of Medicare discharges because this discharge would not have been recorded as a Medicare discharge during the selected cost reporting period. (A discharge would have been counted during the cost reporting period in which the beneficiary exhausted his or her Medicare benefits and changed payment status.) No discharge would be added for a beneficiary who exhausted his or her benefits in either the prior or selected cost reporting period but was not discharged until a subsequent cost reporting period.

However, hospital inpatient days furnished to Medicare beneficiaries for which no payment was made during the selected cost reporting period because the beneficiary had exhausted his or her

inpatient hospital benefits prior to admission are not taken into account in calculating the costs to be used in the target rate adjustment determination. The target rate is determined on a cost per case basis. We believe that on average the cost for beneficiaries who had exhausted benefits during their stays (for which the exhausted day benefits are recognized in the adjustment) should approximate the average cost per discharge for the patients admitted after all benefits were exhausted. Therefore, an explicit adjustment to the target rate is unnecessary.

Comment: One commenter noted that although we stated in the preamble of the September 30, 1988, final rule (53 FR 38521) that intermediaries will make the target rate adjustment determinations, we provided in the regulations at § 413.30(i)(1) for HCFA to make these determinations. The commenter suggested that § 413.40(i)(1) be clarified to provide that intermediaries would determine target rate adjustments rather than HCFA although HCFA makes other exception, exemption, and adjustment determinations. Another commenter recommended that we make it clear that HCFA, rather than the intermediaries, should make the target rate adjustment determinations.

Response: We concur with the first commenter's suggestion and have revised § 413.40(i)(1) to indicate that the intermediaries will make these target rate determinations. This clarification will eliminate confusion concerning in which circumstances HCFA reserves its authority to make determinations.

Comment: One commenter suggested that we send notification and instructions to all excluded hospitals about the adjustment for higher costs caused by the expansion of inpatient hospital benefits, treat the applications expeditiously, provide for timely appeals, and advise hospitals that exceptions for case-mix changes are not precluded by this adjustment.

Response: We believe the changes at § 413.40(i) include adequate instructions and, further, will not confuse hospitals into thinking that this adjustment would prevent them from seeking any other applicable exception or adjustment, such as an exception for case-mix changes. This target rate adjustment procedure is clearly in addition to the other exceptions and adjustments provided in § 413.40 (g) and (h).

With respect to expeditious processing of applications for and appeals of these adjustments under § 413.40(i), we believe that the requirement in the preamble of the September 30, 1988 final rule (53 FR 38521) for the intermediary to make a determination on a request for a target rate adjustment and notify the hospital within 90 days of the date of receipt of the request assures timely processing. Further, we note that we issued a Program Memorandum (A–89–4) in July 1989 authorizing intermediaries to make an interim adjustment to a provider's target rate for purposes of adjusting interim payments. Finally, due to the relatively objective nature of the basis for this particular adjustment and an intermediary's extensive working relationship with most of the affected hospitals, we expect that appeals in those cases will be rare and that the standard appeals mechanisms provided by the regulations in subpart R of part 405 (§§ 405.1801 through 405.1889) are adequate to deal with these cases.

Comment: Several commenters suggested that the regulations added at § 413.40(i) because of Public Law 100–360 also provide HCFA with the authority to make target rate adjustments for changes in case mix, average length of stay, changing admission patterns, changes in professional review standards, inappropriate base-year factors, and a variety of other reasons that may be beyond the control of the hospital. Some commenters also suggested that these additional adjustments should be made automatically whether or not the hospital had exceeded its target rate.

Response: As we pointed out in the September 30, 1988 final rule (53 FR 38520), making a target rate adjustment to correct any distortion due to higher costs caused by the expansion of inpatient hospital benefits is an exception to our general rule that an excluded hospital or unit may not receive a target rate exception or adjustment unless the hospital or unit actually exceeded its target rate. Subsequently, section 608(d)(3)(E) of Public Law 100–485 revised section 104(c)(2) of Public Law 100–360 to specifically provide that an adjustment for any distortion due to higher costs caused by the expansion of inpatient hospital benefits is to be made whether or not a hospital or unit actually exceeded its target rate.

All other bases for exceptions and adjustments are subject to the provisions of the regulations at § 413.40(g) for exceptions and § 413.40(h) for adjustments. Under both paragraphs, HCFA may adjust a hospital's operating costs "only if a hospital's operating costs exceed the rate of increase ceiling imposed under this section."

Under the provisions currently in effect, hospitals have requested exceptions and adjustments and some have been granted. We have also provided intermediaries with the authority to make future exceptions and adjustments in those individual cases with the same recurring circumstances. However, the provisions of Public Law 100–360 do not provide authority to provide any exception or adjustment other than one for a distortion due to higher costs caused by the expansion of inpatient hospital benefits unless a hospital or unit actually exceeded its target rate. Thus, we are not revising the standards or procedures for any other type of exception or adjustment request.

Comment: Another commenter suggested that a long-term care hospital should be exempted from the rate-of-increase ceiling altogether because Medicare beneficiaries constitute a larger portion of its total patient utilization than the patient utilization of other types of hospitals. Thus, unlike other types of hospitals, long-term care hospitals are unable to balance lower payments from Medicare with higher payments from other payors.

Response: We have no statutory authority to exempt an excluded hospital or unit from the rate-of-increase ceiling rules. Moreover, we do not agree with the underlying premise of the comment. Medicare payments to long-term care hospitals, as well as to other hospitals excluded from the prospective payment system, are based on the reasonable cost of providing services to Medicare beneficiaries. The ceiling on the rate of increase in operating costs per case ensures that Medicare payments are reasonable and, in the case of efficient hospitals, should not necessitate balancing Medicare payments with higher payments from other payors.

For the convenience of the reader, we are presenting a revised example to illustrate the target amount adjustment. This example takes into account the provisions of section 104(c)(2) of Public Law 100–360 as amended by section 608(d) of Public Law 100–485 and by sections 101 (c) and (d) of Public Law 101–234, and changes made because of public comment:

Step 1. Medicare allowable inpatient operating costs for covered days of care in base cost year or last reporting period ending before January 1, 1989—$600,000

Step 2. Number of Medicare discharges for the cost reporting period used in Step 1—300

Step 3. Average cost per discharge (Step 1 divided by Step 2)—$2,000

Step 4. Estimated costs for ancillary services furnished to Medicare beneficiaries after exhaustion of Part A hospital benefits. (If actual ancillary

charges are available, ancillary costs are estimated by applying departmental cost-to-charge ratios from the cost report to the ancillary charges. If actual ancillary charges cannot be retrieved from the hospital's system, an ancillary cost per diem may be used in completing this step.)—$10,000

Step 5. Extimated routine costs of Medicare inpatient days furnished to beneficiaries after exhaustion of Part A hospital benefits equals 50 days of care multiplied by $400 for the Medicare allowable inpatient operating cost per diem (obtained from the Medicare cost report). (All-inclusive-rate hospitals and no-charge-structure hospitals use total inpatient operating costs per diem (which equals Step 1 divided by total Medicare inpatient days))—$20,000

Step 6. Total inpatient operating costs for Medicare beneficiaries notwithstanding exhaustion of Part A hospital benefits (Step 1 plus sum of Step 4 and Step 5)—$630,000

Step 7. Number of Medicare discharges for beneficiaries who had exhausted Part A hospital benefits in a prior cost reporting period—10

Step 8. Total Medicare discharages notwithstanding exhaustion of Part A hospital benefits (Step 2 plus Step 7)—310

Step 9. Average cost per discharge notwithstanding exhaustion of Part A hospital benefits (Step 6 divided by Step 8)—$2,032

Step 10. Ratio of average cost per discharge notwithstanding exhaustion of Part A hospital benefits to average cost per discharge (Step 9 divided by Step 3)—1.016

Step 11. Updated target rate applicable to latest cost reporting period beginning before January 1, 1989—$2,438

Step 12. Adjusted target rate applicable to any portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990 (Step 10 multiplied by Step 11)—$2,477

Step 13. Updated target rate eliminating Catastrophic coverage adjustment for portions of cost reporting period occurring after January 1, 1990 (Step 11 multiplied by FY 1990 update factor (1.055))—$2,572

IV. Technical Corrections From the September 30, 1988 Final Rule

Because several editorial errors were made in the regulations text of the September 30, 1988 final rule, we are amending §§ 405.310, 412.64, 412.92(f)(1), 412.96(b)(1)(ii), and 413.40 to correct these errors as follows:

- In the title of § 405.310(m), we are removing the period after the word "inpatients".
- We are correcting the section designation "§ 412.64" to read "§ 412.63".
- In the first sentence of § 412.84(h), we are removing the word "annually". In the September 30 final rule, in response to a public comment (53 FR 6507), we indicated that, as cost reports are settled by the intermediaries, we are instructing the intermediaries to update the hospital-specific cost-to-charge ratios effective with discharges 30 days after the date of the Notice of Amount of Program Reimbursement. This means that in any given year a hospital's cost-to-charge ratio may be updated more than once or not at all based on the number of cost reports settled. Although we had changed our proposed policy in response to the public comment, we failed to make a corresponding change in the regulations text.
- In the first sentence of § 412.92(f)(1), we are removing the word "hospital's" after the word "its".
- We are correcting the number "25" to read "275" in § 412.96(b)(1)(ii).
- In the title of § 413.40(h)(1), we are correcting the title "Capability of cost reporting periods." to read "Comparability of cost reporting periods."

V. Regulatory Impact Analysis

A. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. 12291 criteria for a "major rule;" that is, a rule that will be likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- A significant adverse effect 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 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 consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a 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 and hospitals located in certain New England counties, 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. Section 1886(d)(8)(B) of the Act specifies that hospitals located in certain rural counties adjacent to one or more urban areas are deemed to be located in the adjacent urban area. We have identified 52 rural hospitals, some of which may be considered small, that we have reclassified as urban hospitals. Also, section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent New England Metropolitan County. Thus, for purposes of the prospective payment system, we classified these hospitals as urban hospitals.

It is clear that the changes being implemented in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may 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 and the RFA.

B. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis is limited to presenting the projected effects of final policy and rate changes on current and projected payment rates. In the analysis that follows, we examined the effects of both statutory and final policy changes on hospital payments by projecting estimated payments under each set of policy changes onto the current payment amounts. That is, we projected the effects of each policy change on payments while holding all other payment variables constant. Thus, we are not attempting to predict behavioral responses to our policy changes, and we are not generally accounting for changes in such exogenous variables as admissions, lengths of stay, or case mix.

In view of the difficulty we have in quantifying impacts and attributing causality, we believe that the approach we are taking in the specific impact

discussions below is the most feasible one. Wherever possible, we have included quantitative representations of the changes being implemented in this final rule. As with previously published impact analyses, we are soliciting comments and information about the anticipated effects of these changes on the prospective payment system.

C. Hospitals Included In and Excluded From the Prospective Payment System

In general, hospitals began operating under the prospective payment system with the start of their cost reporting period beginning on or after October 1, 1983. Further, since September 1985, both Massachusetts and New York have terminated the waivers under which they were excluded from the Medicare prospective payment system, and hospitals in those States have entered the prospective payment system. (Massachusetts hospitals came under the Medicare prospective payment system in October 1985, while New York hospitals began receiving Medicare propsective payments in January 1986.) Effective January 1, 1989, the 94 short-term, acute care hospitals located in New Jersey came under the prospective payment system. The demonstration project being conducted in the Rochester region of New York State has ended and the 10 hospitals in that region are now under the prospective payment system.

With the enactment of section 9304 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), which added section 1886(d)(9) to the Act, the 58 acute care hospitals located in Puerto Rico began receiving payments under the prospective payment system effective with discharges occurring on or after October 1, 1987. Also, effective with cost reporting periods that began on or after October 1, 1987, alcohol/drug hospitals and units that had been excluded from the prospective payment system under § 412.22(c) of the regulations began receiving Medicare prospective payments. Thus, only 59 short-term, acute care hospitals remain excluded from the prospective payment system under section 1814(b)(3) of the Act (in Maryland) or demonstration projects (in the Finger Lakes regions of New York State). As of March 1, 1990, about 5,560 hospitals (85 percent of all Medicare-participating hospitals) were operating under the prospective payment system.

As of March 1, 1990, almost 940 Medicare hospitals were excluded from the prospective payment system and continue to be paid on the basis of their reasonable cost, subject to limits on the rate of their cost increases. These hospitals include psychiatric, rehabilitation, long-term care, and children's hospitals. Another 1,720 psychiatric and rehabilitation units in hospitals subject to the prospective payment system are excluded from the prospective payment system as of the same date. These units, too, are paid on the basis of reasonable cost subject to limits on the rate of their cost increases. Although hospitals extensively involved either in the treatment of cancer or cancer research have been paid on a reasonable cost basis, section 6003(a) of Public Law 101–239 specifically excluded these hospitals from the prospective payment system effective with cost reporting periods beginning on or after October 1, 1989. There are currently eight hospitals that HCFA has designated as cancer research or treatment hospitals.

Over 1,160 hospitals are now paid on various special bases under the prospective payment system, as required by statute. They include sole community hospitals; Medicare-dependent, small rural hospitals; and rural referral centers. In addition, there are some 1,580 hospitals that are now receiving additional payments on the basis of being classified as disproportionate share hospitals.

About 30 of these hospitals also receive special payments as rural referral centers. About 1,190 hospitals are receiving additional payments for the indirect cost of medical education. There are about 610 hospitals that qualify for additional payments under both the indirect medical education and disproportionate share payment provisions.

D. Impact of Repealing the Medicare Catastrophic Coverage Act of 1988

As a result of the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989 (Public Law 101–234), payment adjustments for hospitals and hospital units included and excluded from the prospective payment system that were authorized under sections 104 (c)(1) and (c)(2) of the Medicare Catastrophic Coverage Act of 1988 Public Law 100–360 have been repealed effective January 1, 1990.

The overall impact of section 101(a) of Public Law 100–360 was to permit beneficiaries to be treated for diseases or conditions requiring a covered level of hospital inpatient care without regard to the number of days of inpatient care. Thus, beneficiaries and other third party payers were relieved of the burden of paying for care once they had reached the former maximum number of hospital inpatient days allowed per spell of illness (90 days) or used up their lifetime reserve days (an additional 60 days).

Sections 104 (c)(1) and (c)(2) of Public Law 100–360 authorized the Secretary to adjust payments to both hospitals and hospital units included in and excluded from the prospective payment system. We implemented these provisions in the September 30, 1988 prospective payment system final rule (53 FR 38519). For hospitals and hospital units excluded from the prospective payment system, we revised § 413.40 to allow these hospitals and hospital units to receive an adjustment to their target rate based on the additional costs incurred in treating Medicare patients under the new catastrophic provisions. For hospitals paid under the prospective payment system, we maintained the outlier payment pool at the same percentage of total payments. This had the effect of using additional federal funds for day outliers to cover the costs of the additional days of hospital care allowed under the hospital catastrophic provisions.

The effect of repealing the inpatient hospital catastrohpic coverage provisions of Public Law 100–360 is to transfer back to beneficiaries or third party payers the obligation of paying for services once the 90 days allowed per spell of illness or the 60 lifetime reserve days are exhausted. The adjustment granted under § 413.40 is now withdrawn and excluded hospital and hospital unit target rates will be readjusted. Payments for day outliers to hospitals under the Medicare prospective payment system will automatically return to their previous levels. We are unable to assess the dollar impact of the repeal of the catastrophic provisions on excluded hospitals and hospital units because the requests for adjustments to the target rate were handled by each hospital's fiscal intermediary. The data to estimate the amount of the adjustments are for this reason not readily available. The repeal of the catastrophic provisions is estimated to reduce Medicare payments to prospective payment hospitals by approximately $1.3 billion in FY 1990. The hospitals will be able to charge the beneficiary or seek other third-party payment for the periods that will not be covered because of the reimposition of the benefit period limitations.

E. Impact on Excluded Hospitals and Units

As noted in the section C. of this impact analysis, almost 940 Medicare hospitals and 1,720 units in hospitals included in the prospective payment system currently are paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of

§ 413.40. Section 6015 of Public Law 101–239 amended the target rate adjustment authority contained in section 1886(b)(4) of the Act to provide that an excluded hospital or unit may, under certain conditions, be granted a new base year rather than an adjustment to the target rate already established. Thus, the assignment of a new base year period is another mechanism HCFA can now use, when appropriate, in determining the payment amount for an excluded hospital or unit that has exceeded its ceiling in a cost reporting period.

We expect that section 6015(a) of Public Law 101–239 that amended section 1886(b)(4) of the Act will have a minimal effect on hospitals and hospital units that are excluded from the prospective payment system. As described in section II.D.2. of this preamble, we anticipate the granting of a new hospital base year as a remedy for costs exceeding a hospital's target rate ceiling only under limited circumstances and only when other remedies provided for in our regulations will not suffice. We will grant the assignment of a new base year only when costs exceeding the hospital's ceiling were the result of permanent, substantial, and significant changes in patient services. Moreover, before we will assign a new base year, the hosptial will have to demonstrate the reasonableness of the costs associated with the change for which it was seeking a new base year.

Because we intend to assign a new base year only as a last resort, we anticipate that only a small proportion of the hospitals that apply for a new base year will be assigned one. Thus, while assignment of a new base year could represent a significant change in payments to those hospitals that are granted one, we expect the overall impact on payments to hospitals excluded from the prospective payment system to be very small.

F. Impact of Additional Payments for Hemophilia Clotting Factors

Based on a recommendation from the Prospective Payment Assessment Commission (ProPAC), section 6011(a) of Public Law 101–239 was enacted. That section amended section 1886(a)(4) of the Act to exclude the cost of hemophilia blood clotting factor from the definition of hospital inpatient operating cost. Section 6011(b) of Public Law 101–239 directs the Secretary to determine the amount of additional payments to be made to hospitals for blood clotting factor. As discussed in section II.F. of the preamble to this document, we have established prices for three clotting factors. They are as follows:

Factor VIII—$.64 per unit
Factor IX—$.26 per unit
All other Factors (Anti-inhibitors)—$1.00 per unit

In its report, ProPAC identified 2,239 Medicare hemophilia inpatient discharges in 1987 and 2,152 discharges in 1988. Applying the percentage of Medicare hemophilia inpatients to total hemophilia patients, ProPAC estimated that Medicare hemophilia inpatients utilized about 8 million units of clotting factor during the latest 12-month period for which data are available. Based on ProPAC's data, we expect the number of hemophilia discharges and the Medicare consumption of blood clotting factor to remain fairly constant over the next 2 years.

From discussions with industry representatives, we estimate that Factor VIII will account for 75 percent of the total blood clotting factor administered to Medicare hemophilia inpatients and that Factor IX and the Anti-inhibitors will constitute roughly equal shares of the other 25 percent. Based on these utilizations rates, we estimate the annual impact on the Medicare program will be additional payments of about $5.0 million.

While we are unable to determine the impact of the additional payments for the clotting factor on hospitals treating Medicare hemophilia inpatients, we believe they will adequately compensate hospitals for providing clotting factor to Medicare inpatients. Futhermore, the ProPAC report suggests that the overall impact will be minimal for most hospitals treating Medicare hemophilia patients. Of the almost 950 hospitals that treated Medicare hemophilia inpatients in 1987 and 1988, approximately 92 percent of these hospitals discharged between one and five Medicare hemophilia inpatients. Thus, for the majority of hospitals that treat Medicare hemophilia inpatients, the additional payments for hemophilia clotting factor should not make a significant difference in the total amount of payments these hospitals receive from Medicare.

G. Impact of New Provision Concerning Hospital-Based Nursing Schools

Section 6205(a)(2) of Public Law 101–239 establishes a new, temporary category of "hospital-based nursing schools." The criteria specified in the law for qualifying under this new category are—

- If before June 15, 1989, and for every year thereafter, the hospital incurred at least 50 percent of the costs of training nursing students at the school;
- The nursing school and hospital share some common board members; and
- All nursing instruction takes place at the hospital.

This category is to be effective for cost reporting periods beginning on or after the date of enactment of Public Law 101–239 (December 19, 1989) and expire with cost reporting periods beginning on or after the date the Secretary issues final regulations that specify—

- The relationship required between an approved nursing education or allied health education program and a hospital for the program's costs to be attributed to the hospital;
- The types of costs related to nursing or allied health education programs;
- The distinction between costs of approved educational activities paid on the basis of reasonable cost and educational costs treated as operating costs of inpatient hospital services; and
- The treatment of other funding sources for the program.

We cannot quantify the impact of these provisions. However, based on our experience in auditing hospital educational costs, we believe that only a very few hospitals will meet the criteria outlined in section 6205 of Public Law 101–239. Based on this perception of the number of hospitals affected by this provision, we expect the impact on the Medicare program to be minimal.

H. Quantitative Impact Analysis of the Final Policy Changes on Prospective Payment Hospitals

1. Basis and Methodology of Estimates

The data used in developing the following quantitative analysis of changes in payments, presented in Table I below, are taken from FY 1988 billing data and hospital-specific data for FY 1986 and FY 1987. As in previous analyses, we compared the effects of changes being implemented in this document to our estimate of the payment amounts under policies in effect on January 1, 1990.

In addition, we have treated all hospitals in our data base as if they have cost reporting periods that coincide with the Federal fiscal year. By establishing the same cost reporting period for all hospitals, we can show the effect of policy changes on payments for comparable 12-month periods. Treating all hospitals as though they had the same cost reporting period, however, will overstate the first year impact of those provisions applying to the

selection of payment rates for sole community hospitals and Medicare-dependent, small rural hospitals. Yet without assuming the same cost reporting period for all hospitals in our database, we could not display the full effects of these new payment provisions for sole community hospitals and Medicare-dependent, small rural hospitals. In actuality, these provisions will be phased in with cost reporting periods beginning on or after April 1, 1990, and, therefore, their full impact on hospital payments will not be felt until April 1, 1991.

Another element our analysis does not take into account is any behavioral changes hospitals may adopt in response to the policy changes being implemented in this final rule.

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 changes contained in this rule. Also, we could not categorize all the hospitals in our data base because in some cases the hospital-specific data necessary for constructing our impact model were missing. For some hospitals data on hospital bed size and type of ownership were missing. The missing data, however, did not prevent us from using the discharges from these hospitals to estimate the actual payments for FY 1990 and the projected payments under the new policies that serve as the bases of our simulation.

The following analysis examines, in column 1 of Table I, the effect of the provisions granting alternative payment rates for sole community hospitals and Medicare-dependent, small rural hospitals. In column 2 of Table I, we show the effects of the changes in the qualifying criteria for disproportionate share hospitals and the changes in formulas for determining additional payments to these hospitals. That is, in columns 1 and 2, all variables except those associated with the provision under examination were held constant so as to display the effects of each provision compared to the baseline (January 1, 1990) provisions. In the last column (column 3), we present the combined effect of all changes being implemented in this final rule. That is, column 3 displays the combined effects of the previous two columns as well as changes in the wage index reflecting the enactment of section 6003(h) of Public Law 101-234 that amended section 1886(d)(8)(B) of the Act. As such, this last column is the only one in which the effects of all the quantifiable payment policy changes on simulated FY 1990 payments are reflected.

Consistent with the display of the impact presented in Table I below, the following discussion of the impact simulation results is divided into three parts. The first and second parts describe the effects of two major changes being implemented in this document. These are as follows:

- Alternative payment rates for sole community hospitals and Medicare-dependent, small rural hospitals as provided for in sections 1886(d)(5)(D) and (d)(5)(G) of the Act; and
- The changes to the qualifying criteria and payment formula for disproportionate share hospitals under section 1886(d)(5)(F) of the Act.

The third part discusses the combined effect of all provisions being implemented in this rule.

TABLE I.—IMPACT OF THE CHANGES BEING IMPLEMENTED EFFECTIVE APRIL 1, 1990

	Number of hospitals [1]	Column 1, Medicare dependent/ sole community hospitals [2]	Column 2, disproportionate share payments [3]	Column 3, all changes [4]
All Hospitals	5,688	0.3	0.6	0.8
Urban by Region:				
New England	182	0.0	0.3	0.3
Middle Atlantic	482	0.0	0.7	0.7
South Atlantic	444	0.1	0.6	0.7
East North Central	540	0.0	0.4	0.4
East South Central	179	0.0	0.6	0.6
West North Central	200	0.0	0.2	0.2
West South Central	374	0.0	0.9	0.8
Mountain	119	0.1	0.3	0.3
Pacific	515	0.0	0.8	0.7
Puerto Rico	50	0.0	2.3	2.3
Rural by Region:				
New England	61	4.6	0.1	4.7
Middle Atlantic	91	1.6	0.0	1.6
South Atlantic	343	0.8	1.3	2.1
East North Central	332	1.0	0.0	1.0
East South Central	309	1.1	1.4	2.5
West North Central	578	2.5	0.1	2.6
West South Central	434	2.0	0.5	2.5
Mountain	251	4.6	0.0	4.6
Pacific	166	2.5	0.0	2.5
Puerto Rico	8	0.0	0.0	0.0
Large Urban Areas (populations over 1 million)	1,548	0.0	0.7	0.6
Other Urban Areas (populations of 1 million or fewer)	1,554	0.1	0.5	0.5
Urban Hospitals	3,102	0.0	0.6	0.6
0-99 Beds	701	0.2	0.0	0.4
100-199 Beds	797	0.0	0.6	0.7
200-299 Beds	604	0.0	0.5	0.5
300-499 Beds	644	0.1	0.6	0.5
400 + Beds	292	0.0	0.7	0.6
Rural Hospitals	2,586	1.8	0.5	2.3
0-49 Beds	1,061	4.4	0.1	4.5
50-99 Beds	832	2.9	0.0	2.9
100-149 Beds	367	1.1	0.5	1.6

TABLE I.—IMPACT OF THE CHANGES BEING IMPLEMENTED EFFECTIVE APRIL 1, 1990—Continued

	Number of hospitals [1]	Column 1, Medicare dependent/ sole community hospitals [2]	Column 2, disproportionate share payments [3]	Column 3, all changes [4]
150–200 Beds	150	1.1	0.9	1.9
200+ Beds	149	0.7	1.0	1.7
Teaching Status:				
Non-Teaching	4,496	0.6	0.4	1.0
Resident/Bed Ratio Less than 0.25	963	0.0	0.5	0.5
Resident/Bed Ratio 0.25 or Greater	227	0.0	1.3	1.2
Disproportionate Share Hospitals (DSH):				
Non-DSH	4,110	0.5	0.0	0.5
Urban DSH:				
100 Beds or More	1,167	0.0	1.2	1.1
Fewer Than 100 Beds	81	0.0	0.0	0.0
Rural DSH				
100 Beds or More—not Rural Referral Centers or Sole Community Hospitals	83	0.0	2.8	2.7
Fewer than 100 beds—not Rural Referral Centers or Sole Community Hospitals	174	0.3	0.0	0.3
Sole Community Hospitals	41	8.2	5.2	14.0
Rural Referral Centers and Sole Community Hospitals or Rural Referral Centers	32	1.0	5.9	6.8
Urban Teaching and DSH:				
Both Teaching and DSH	609	0.0	1.3	1.2
Teaching and No DSH	498	0.0	0.0	0.0
No Teaching and DSH	639	0.0	1.1	1.0
No Teaching and No DSH	1,356	0.1	0.0	0.2
Other Special Status (Rural):				
Sole Community Hospitals	308	9.4	0.6	10.1
Rural Referral Centers	195	0.0	1.0	1.0
Sole Community & Rural Referral	23	8.3	0.3	8.5
Medicare-Dependent	608	6.8	0.0	6.9
Type of Ownership:				
Voluntary	3,116	0.2	0.4	0.7
Proprietary	918	0.3	0.5	0.7
Government	1,555	0.6	1.2	1.7
Medicare Utilization as Percent of Inpatient Days:				
0–25	400	0.1	2.4	2.3
25–50	2,983	0.2	0.6	0.7
50–65	1,737	0.5	0.2	0.7
Over 65	408	1.6	0.0	1.6

[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] Data for the analysis of the payment alternatives granted under section 1886(d)(5)(D)(i) of the Act as amended by sections 6003 (e) and (f) of Public Law 101-239 come from FY 1986 and 1987 hospital cost reports. We determined for the approximately 970 Medicare-dependent, small rural hospitals and sole community hospitals in our database which payment alternative would provide the highest payment amount. Our payment determinations and those which each hospital's intermediary will make may differ because the intermediary will have the most recent hospital cost reports.

[3] Payment simulation of disproportionate share hospitals is based on 1988 discharge data and hospital cost report data for FY 1986 and FY 1987. The baseline for those sole community hospitals and Medicare-dependent, small rural hospitals that qualify for disproportionate share payments is the new payment methodology as provided for in sections 6003 (e) and (f) of Public Law 101-239 (analyzed in Column I).

[4] Column 3 includes combined payment alternatives for Medicare-dependent, small rural hospitals and sole community hospitals; new payment provisions for disproportionate share hospitals; and changes to the hospital wage index required by section 1886(d)(8)(C) of the Act as amended by section 6003(h) of Pub. L. 101-239.

2. Impact Simulation Results

a. *Impact on Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals.* Section 6003(e) of Public Law 101–239 revised the payment methodology for hospitals classified as SCHs effective with hospital cost reporting periods beginning on or after April 1, 1990. As of that date, as provided in section 1886(d)(5)(D)(i) of the Act, SCHs will be paid based on whichever of the following rates yields the highest aggregate payment for the cost reporting period.

- The Federal rate applicable to the hospital.
- The updated hospital-specific rate based on FY 1982 cost per discharge.
- The updated hospital-specific rate based on FY 1987 cost per discharge.

In a similar provision, section 6003(f) of Public Law 101–239, which added a new section 1886(d)(5)(G) of the Act, creates a new category of hospitals under the prospective payment system eligible for a special payment adjustment. The adjustment is limited to Medicare-dependent, small rural hospitals and is effective for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Section 6003(f) of Public Law 101–239 provides Medicare-dependent, small rural hospitals the same payment options afforded to sole community hospitals under section 6003(e) of Public Law 101–239. In section II.D. of this preamble, we discuss, in detail, the criteria for being classified as a Medicare-dependent, small rural hospital.

In our analysis of these provisions, we compared payments under our regulations in effect before April 1, 1990 with projected payments under the regulations that were effective on April 1, 1990 for sole community hospitals and hospitals we identified as meeting the criteria for a Medicare-dependent, small rural hospital based on the FY 1986, FY 1987 and FY 1988 cost reports that were available to us.

As part of our simulation we had to determine which of the three payment alternatives provided for in the law would produce the highest payment for each of the sole community hospitals and Medicare-dependent, small rural hospitals for which we had cost report data. Based on the available cost report data for each hospital, we compared payments based on the hospital-specific

payment amount using FY 1982 and FY 1987 base period costs to the total payment amount the hospital would receive based on the Federal standardized payment amount. That is, we examined the effects of changing only the payments for sole community hospitals and Medicare-dependent, small rural hospitals while holding all other variables at their pre-April 1, 1990 levels.

The following summarizes our determinations with respect to the method of payment used in simulating payments to Medicare-dependent, small rural hospitals:

- 25 percent of the identifiable Medicare-dependent, small rural hospitals will be paid a hospital-specific rate based on their FY 1982 cost reporting period.
- 22.2 percent of the hospitals will be paid a hospital-specific rate based on their FY 1987 cost reporting period.
- 52.8 percent of the hospitals will be paid the Federal national payment rate.

We made similar determinations for all sole community hospitals (including sole community hospitals that are also rural referral centers) concerning which method of payment would result in the highest payment for each hospital. Using the available cost report data, we determined that—

- 44.7 percent of all sole community hospitals will be paid a hospital-specific rate based on their FY 1982 cost reporting period;
- 28.8 percent of all sole community hospitals will be paid a hospital-specific rate based on their FY 1987 cost reporting period; and
- 26.5 percent will be paid the Federal payment rate.

Overall, the provisions of sections 6003 (e) and (f) of Public Law 101–239 will raise the national average payment to hospitals by 0.3 percent. The impact of these changes, however, will be concentrated on the approximately 970 hospitals we have identified as being either a sole community or a Medicare-dependent small rural hospital.

We anticipate that payments to hospitals that qualify as Medicare-dependent, small rural hospitals will increase by about 6.8 percent. Payments to sole community hospitals and sole community hospitals that are also rural referral centers are expected to increase by 9.4 percent and 8.3 percent, respectively. Payment to sole community hospitals that also qualify as disproportionate share hospitals will increase by 8.2 percent. However, sole community hospitals that are also rural referral centers and disproportionate share hospitals can expect only a 1.0 percent increase in payments.

Since sections 6003 (e) and (f) of Public Law 101–239 are intended primarily to benefit rural hospitals, rural hospitals in all bed-size groupings are projected to receive increases, with hospitals having fewer than 50 beds receiving the largest percentage increases of 4.4 percent.

Our geographic analysis shows the largest percentage increase in payments concentrated in the rural portions of the Mountain and New England census divisions. We are projecting both areas to receive a payment increase of about 4.6 percent. However, because we have identified 14 sole community hospitals located in urban areas, average payments to urban hospitals in the south Atlantic and Mountain census division are projected to increase 0.1 percent.

b. *Impact on Disproportionate Share Hospitals.* Section 6003(c)(2) of Public Law 101–239 amended section 1886(d)(5)(F)(v) of the Act by adding an additional criterion for qualifying as a disproportionate share hospital. A hospital will qualify for disproportionate share payments if it is located in a rural area, is classified as a sole community hospital or has more than 100 beds, and its disproportionate share patient percentage during the current cost reporting year is 30 percent.

Sections 6003(c) (2) and (3) of Public Law 101–239 amended section 1886(d)(5)(F) of the Act by providing increased payments to hospitals for their disproportionate share patients. Section II.C. of this preamble describes in detail the changes in the payment formulas.

In this analysis, except for those sole community hospitals (and sole community hospitals that are also rural referral centers) that now qualify for disproportionate share payments, we compared only the changes in disproportionate share payments that are effective on April 1, 1990 with disproportionate share payments based on policies in effect before April 1, 1990. For sole community hospitals and Medicare-dependent, small rural hospitals that qualify for disproportionate share payments, we compared projected April 1, 1990 disproportionate share payment amounts to payments based on the standardized Federal payment amount as the baseline payment level rather than the payment blend of 75 percent hospital-specific amount and 25 percent standardized Federal payment amount that was in effect before April 1, 1990. We adopted this approach for sole community hospitals because section 1886(d)(5)(F)(ii) of the Act requires that only those hospitals that receive payment based on the Federal payment amount can receive additional payments for treating disproportionate share patients. As discussed in the previous section of this impact analysis and in section II.D. of the preamble to this rule, sections 6003 (e) and (f) of Public Law 101–239 allow sole community hospitals and Medicare-dependent, small rural hospitals to be paid the higher of the Federal standardized rate or a hospital-specific rate. We believe that an impact analysis of the increase in disproportionate share payments for qualifying sole community hospitals and Medicare-dependent, small rural hospitals is more fairly presented by comparing the increase in disproportionate share payments to a baseline reflecting the payment alternatives contained in sections 6003 (e) and (f) of Public Law 101–239 (that is, the Federal standardized amount) rather than to the pre-April 1, 1990 baseline.

This analysis shows that 41 sole community hospitals paid on the basis of the Federal rate will also be eligible for the increased payments for rural disproportionate share hospitals. We project that these sole community hospitals will receive a 5.2 percent increase in payments as a result of the changes in the disproportionate share payment policies.

The largest percentage increase in disproportionate share payments is expected to go to hospitals that are classified as rural referral centers or as both rural referral centers and sole community hospitals. We expect these hospitals to receive an average payment increase of about 5.9 percent.

In terms of hospital bed size, hospitals in all but two bed size categories are expected to receive payment increases. The two categories that will not receive payment increases are urban hospitals with fewer than 100 beds, and rural hospitals with between 50 and 99 beds.

Geographically, the payment increase will be distributed widely among hospitals located in urban areas. The projected average percentage increase in payments for all hospitals in urban areas is 0.6 percent, with increases in 7 of the 10 geographic regions displayed in Table I expected to equal or exceed 0.6 percent. Urban hospitals in the other three geographical regions are expected to receive increases of between 0.2 and 0.4 percent. The largest percentage increase of 2.3 percent is projected for urban hospitals in Puerto Rico.

The average payment increase for all rural hospitals is expected to be 0.5 percent. In contrast to the broad increases for urban hospitals, increases for rural hospitals will be concentrated in the East South Central and South

Atlantic census divisions. These areas are expected to receive increases averaging 1.4 percent and 1.3 percent, respectively.

c. *Combined Impact of All Changes.* Column 3 of table I presents the combined effects of all changes being implemented in this final rule. That is, column 3 combines the changes in payments for Medicare-dependent, small rural hospitals and sole community hospitals, and the changes in qualifying criteria and payment formulas for disproportionate share hospitals. In addition, column 3 includes the effects of revising the wage index values for hospitals located in certain rural counties adjacent to urban areas as required by section 1886(d)(8)(C) of the Act, as amended by section 6003(h) of Public Law 101-239 and changes in the outlier offset for urban hospitals.

At the national level, the effect of all provisions being implemented in this final rule is to increase the average payment to hospitals by 0.8 percent. As expected, the largest payment increases go to sole community hospitals that also qualify as disproportionate share hospitals. We estimate that they will receive an average payment increase of 14.0 percent. Overall, sole community hospitals are expected to receive a 10.1 percent increase in payments. Hospitals identified in our database as Medicare-dependent, small rural hospitals can expect an increase of 6.9 percent. As a result of the changes being implemented in this final rule, average payments to all rural hospitals are projected to rise 2.3 percent, with rural hospitals with fewer than 50 beds expected to receive a 4.5 percent increase. Average payments to urban hospitals will increase by 0.6 percent, with urban hospitals with between 100 and 199 beds receiving a 0.7 percent increase in payments.

Our impact analysis of the census divisions shows that rural hospitals in the New England census division will receive the largest payment increase of 4.7 percent. Urban hospitals in the Puerto Rico will receive the largest increase among urban hospitals. We expect these hospitals to receive an average increase of about 2.3 percent.

As a final point, there are interactions that result from the combining of the various separate provisions analyzed in the previous columns that we are unable to isolate. Thus, the values appearing in column 3 do not represent merely the additive effects of the previous columns, but include certain interactive effects that we are not able to isolate.

Table II presents the projected average payments per case that are effective April 1, 1990 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 that were effective January 1, 1990. 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 January 1, 1990 to April 1, 1990 equals the percentage changes shown in the last column of table I.

TABLE II—COMPARISON OF PAYMENT PER CASE (JANUARY 1, 1990 COMPARED TO APRIL 1, 1990)

	Number of hospitals	Column 1 average payment per case Jan. 1, 1990	Column 2 average payment per case Apr. 1, 1990	Column 3 all changes [1]
All hospitals	5,688	$4,788	$4,828	0.8
Urban by Region:				
New England	182	5,427	5,441	0.3
Middle Atlantic	482	5,669	5,707	0.7
South Atlantic	444	4,798	4,832	0.7
East North Central	540	5,158	5,180	0.4
East South Central	179	4,449	4,475	0.6
West North Central	200	5,314	5,327	0.2
West South Central	374	4,829	4,868	0.8
Mountain	119	5,197	5,213	0.3
Pacific	515	6,022	6,066	0.7
Puerto Rico	50	2,072	2,120	2.3
Rural by Region:				
New England	61	3,738	3,914	4.7
Middle Atlantic	91	3,509	3,564	1.6
South Atlantic	343	3,182	3,249	2.1
East North Central	332	3,207	3,239	1.0
East South Central	309	2,752	2,821	2.5
West North Central	578	2,982	3,060	2.6
West South Central	434	2,890	2,963	2.5
Mountain	251	3,300	3,451	4.6
Pacific	166	3,876	3,972	2.5
Puerto Rico	8	1,558	1,558	0.0
Large urban areas (population over 1 million)	1,548	5,704	5,740	0.6
Other urban areas (population of 1 million or fewer)	1,554	4,754	4,779	0.5
Urban hospitals	3,102	5,239	5,270	0.6
0-99 beds	701	3,950	3,966	0.4
100-199 beds	797	4,475	4,506	0.7
200-299 beds	604	4,872	4,897	0.5
300-499 beds	644	5,316	5,346	0.5
Over 400 beds	292	6,274	6,314	0.6
Rural hospitals	2,586	3,128	3,201	2.3
0-49 beds	1,061	2,686	2,807	4.5
50-99 beds	832	2,872	2,956	2.9
100-149 beds	367	3,096	3,146	1.6
150-200 beds	150	3,295	3,359	1.9
Over 200 beds	149	3,653	3,714	1.7
Teaching Status:				
Non-teaching resident/bed ratio	4,496	4,004	4,045	1.0
Less than 0.25 resident/bed ratio	963	5,277	5,301	0.5
0.25 or greater	227	7,860	7,953	1.2

TABLE II—COMPARISON OF PAYMENT PER CASE (JANUARY 1, 1990 COMPARED TO APRIL 1, 1990)—Continued

	Number of hospitals	Column 1 average payment per case Jan. 1, 1990	Column 2 average payment per case Apr. 1, 1990	Column 3 all changes [1]
Disproportionate Share Hospitals (DSH):				
Non-DSH	4,110	4,373	4,394	0.5
Urban DSH:				
100 beds or more	1,167	5,754	5,819	1.1
Fewer than 100 beds	81	3,637	3,637	0.0
Rural DSH:				
100 beds or more—not rural referral centers or sole community hospitals	83	2,843	2,921	2.7
Fewer than 100 beds—not rural referral centers or sole community hospitals	174	2,563	2,572	0.3
Sole community hospitals	41	2,840	3,237	14.0
Sole community & rural referral center or rural referral centers	32	3,721	3,973	6.8
Urban Teaching and DSH:				
Both teaching and DSH	609	6,351	6,426	1.2
Teaching and no DSH	498	5,449	5,449	0.0
No teaching and DSH	639	4,681	4,730	1.1
No teaching and no DSH	1,356	4,410	4,418	0.2
Other Special Status (rural):				
Sole community hospital	308	3,157	3,476	10.1
Rural referral center (RRC)	195	3,732	3,770	1.0
Sole community and rural referral center	23	3,723	4,041	8.5
Medicare-dependent	608	2,703	2,688	6.9
Type of Ownership:				
Voluntary	3,116	4,959	4,992	0.7
Proprietary	918	4,280	4,312	0.7
Government	1,555	4,367	4,443	1.7
Medicare Utilization As Percent of Inpatient Days:				
0-25	400	6,320	6,468	2.3
25-50	2,983	5,005	5,040	0.7
50-65	1,737	4,227	4,258	0.7
Over 65	408	4,038	4,104	1.6

[1] Percentage changes shown in this column are taken from Table 1, column 3. Because the dollar amounts shown in this table are rounded to the nearest dollar, percentage changes computed on the basis of the amounts in columns 1 and 2 of this table will differ slightly from those displayed in this column.

VI. Other Required Information

A. Effective Dates

The effective date of this final rule (including the addendum) is April 1, 1990. Changes made by section 101(c) of Public Law 101-234 (eliminating the outlier payments attributable to catastrophic coverage) are applicable to discharges occurring on or after January 1, 1990 and changes required by section 101(d) of Public Law 101-234 to target rates for hospitals excluded from the prospective payment system are applicable for cost reporting periods beginning on or after January 1, 1990. Changes made by the following sections are applicable for discharges occurring on or after April 1, 1990: section 6003(c)(2) of Public Law 101-239 (disproportionate share adjustments) and section 6003(h) of Public Law 101-239 (wage index revisions for rural counties whose hospitals are deemed urban). Changes made by the following sections of Public Law 101-239 are applicable for cost reporting periods beginning on or after April 1, 1900: section 6015 (ceiling on rate of hospital cost increases); section 6003(f) (Medicare-dependent, small rural hospitals); and, section 6003(e) (sole community hospitals). Changes made by section 6011 of Public Law 101-239 (administering blood clotting factors to hemophiliacs, who are inpatients) are applicable for discharges occurring on or after June 19, 1990. Changes made by section 6205(a) of Public Law 101-239 (recognition of hospital-based nursing school costs) are effective for cost reporting periods beginning on or after December 19, 1989.

B. Waiver of Notice of Proposed Rulemaking and 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking for a regulation to provide a period for public comment. However we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest. In addition, section 1871(b)(2)(B) of the Act provides that the notice of proposed rulemaking is not required if a statute establishes a specific deadline for implementation that is less than 150 days from enactment. Because several provisions of Public Law 101-239, enacted December 19, 1989, and several provisions of Public Law 101-234, enacted December 14, 1989, contained in this final rule require implementation within 150 days, we are implementing this final rule without first issuing a notice of proposed rulemaking. However, we are providing a 60-day comment period for public comment, as indicated at the beginning of this final rule.

In addition, we normally provide a delay of 30 days in the effective date for documents such as this. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date. Under the clear direction contained in Public Law 101-239, the effective date for the majority of the provisions included in this final rule is April 1, 1990, just as several provisions of Public Law 102-234 went into effect on January 1, 1990. In general, the provisions of Public Law 101-239 implemented in this final rule are beneficial to most hospitals. If we were to provide for a 30-day delay in the effective date for these changes, most hospitals would be deprived of the full benefits of these provisions. Thus, a 30-day delay in the effective date would be contrary to the public interest. Therefore, we find good cause to waive the usual 30-day delay.

C. 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 through 3511).

D. Public Comments

Because of the large number of items of correspondence we normally receive concerning regulations, we cannot acknowledge or respond to the comments individually. However, if we decide that changes are necessary as a result of our consideration of all comments received by the date and time specified in the "DATES" section of this preamble, we will respond to the comments and issue any appropriate changes in the final rule that implements changes to the inpatient hospital prospective payment system and sets forth the FY 1991 rates, which will be published on approximately September 1, 1990.

List of Subjects

42 CFR Part 412

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as set forth below:

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

Subchapter B—Medicare Program

I. 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, the introductory text in paragraph (e) is revised and a new paragraph (e)(7) 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 receive payments for the following:

* * * * *

(7) For discharges on or after June 19, 1990 and before December 19, 1991, a payment amount per unit for blood clotting factor provided to Medicare inpatients who are hemophiliacs.

C. In subpart D, § 412.63, paragraph (h) is revised; paragraphs (i), (j), and (k) are redesignated as paragraphs (j), (k), and (l), respectively; and a new paragraph (i) is added, to read as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

§ 412.63 Federal rates for fiscal years after Federal fiscal year 1984.

* * * * *

(h) *Applicable percentage change for fiscal year 1990.* (1) The applicable percentage change for fiscal year 1990 is—

(i) For discharges occurring on or after October 1, 1989 and before January 1, 1990, 5.5 percent; and

(ii) For discharges occurring on or after January 1, 1990 and before October 1, 1990—

(A) 9.72 percent for hospitals located in rural areas;

(B) 5.62 percent for hospitals located in large urban areas; and

(C) 4.97 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1990, the applicable percentage change for fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (h)(1)(ii) of this section.

(i) *Applicable percentage change for fiscal year 1991 and following.* The applicable percentage change for fiscal year 1991 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)).

* * * * *

D. Subpart E is amended as follows:

Subpart E—Determination of Transition Period Payment Rates

1. In § 412.73, the title is revised to read "Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period."; paragraph (c)(6) is revised; and new paragraphs (c)(7) and (c)(8) are added to read as follows:

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

* * * * *

(c) *Updating base-year costs.* * * *

(6) *For Federal fiscal year 1989.* For cost reporting periods beginning in Federal fiscal year 1989, the update factor is determined using the methodology set forth in § 412.63(g).

(7) *For Federal fiscal year 1990.* (i) For cost reporting periods beginning in Federal fiscal year 1990, the base-period cost per discharge is updated as follows:

(A) For cost reporting periods beginning on or after October 1, 1989 and before January 1, 1990, by 5.5 percent for discharges occurring before January 1, 1990 and by the factors set forth in paragraph (c)(7)(i)(B) of this section for discharges occurring on or after January 1, 1990.

(B) For cost reporting periods beginning on or after January 1, 1990 and before October 1, 1990, by—

(*1*) 9.72 percent for hospitals located in rural areas;

(*2*) 5.62 percent for hospitals located in large urban areas; and

(*3*) 4.97 percent for hospitals located in other urban areas.

(ii) For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1991 (that is, beginning on or after October 1, 1990 and before October 1, 1991), the update factor for the cost reporting period beginning during Federal fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (c)(7)(i)(B) of this section.

(8) *For Federal fiscal years 1991 and following.* For Federal fiscal years 1991 and following, the update factor is determined using the methodology set forth in § 412.63(i).

* * * * *

2. A new § 412.75 is added to read as follows:

§ 412.75 Determination of the hospital-specific rate based on a Federal fiscal year 1987 base period.

(a) *Base period costs.* (1) For each hospital, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(2) If the hospital's last cost reporting period ending before September 30, 1988 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(b) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the

hospital's case-mix index for the base period.

(d) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1988, the update factor is determined using the methodology set forth in § 412.73 (c)(5) through (c)(8) of § 412.63.

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge will be multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Modification of base-period costs.* (1) The intermediary may modify base-period costs to take into account additional costs recognized as allowable costs for the hospital's base-period as the result of any of the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

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

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

(iv) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(2) The intermediary recalculates the hospital's base-period costs to reflect the modification determined appropriate under paragraph (f)(1) of this section and the adjustments are effective retroactively to the time of the intermediary's initial determination of base-period costs.

Subpart F—Payment for Outlier Cases

§ 412.84 [Amended]

E. In subpart F, in the first sentence of § 412.84(h), the word "annually" is removed.

F. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

1. In § 412.90, a new paragraph (i) is added to read as follows:

§ 412.90 General rules.

* * * * *

(i) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990, and ending before April 1, 1993, HCFA adjusts the prospective payment rates determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital. Criteria for identifying these hospitals are set forth in § 412.108.

2. In § 412.92, the introductory text of paragraph (a) and paragraphs (b)(2)(i) and (d)(1) are revised; the first sentence in paragraph (e) is revised by deleting the words "and before October 1, 1990"; the existing introductory text of paragraph (e)(3)(i) is redesignated as paragraph (e)(3)(i)(A); the existing paragraph (e)(3)(i)(A) is redesignated as the introductory text of paragraph (e)(3)(i); and the first sentence in paragraph (f) is amended by removing the words "and before October 1, 1990".

§ 412.92 Special treatment: Sole community hospitals.

(a) *Criteria or 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 § 412.63(b)) and meets one of the following conditions.

* * * * *

(b) *Classification procedures.* * * *

(2) *Effective dates of classification.* (i) Sole community hospital status is effective 30 days after the date of HCFA's written notification of approval.

* * * * *

(d) *Determining prospective payment rates for sole community hospitals.*—(1) *General rule.* For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(i) The Federal payment rate applicable to the hospitals as determined under § 412.63, subject to the regional floor defined in § 412.70(c)(6).

(ii) The hospital-specific rate as determined under § 412.73.

(iii) The hospital-specific rate as determined under § 412.75.

* * * * *

§ 412.96 [Amended]

3. In § 412.96(b)(1)(ii), the number "25" is changed to "275".

4. In § 412.106, the introductory texts of paragraphs (c) and (c)(1) are republished; paragraphs (c)(1) (ii) and (iii) are redesignated as paragraphs (c)(1) (iii) and (iv); a new paragraph (c)(1)(ii) is added; newly redesignated paragraph (c)(1)(iv) is revised; paragraph (d)(1) is revised; paragraph (d)(2) is removed; and paragraph (d)(3) is redesignated as paragraph (d)(2) and revised to read as follows:

§ 412.106 Special treatment: Hospitals that service a disproportionate share of low-income patients.

* * * * *

(c) *Criteria for classification.* A hospital is classified as a "disproportionate share" hospital under any of the following circumstances:

(1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following: * * *

(ii) 30 percent, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under § 412.92 of this subpart.

* * * * *

(iv) 45 percent, if the hospital is located in a rural area and has 100 or fewer beds.

* * * * *

(d) *Payment adjustment*—(1) *Method of adjustment.* If a hospital serves a disproportionate number of low-income patients, its total DRG revenues are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

(2) *Payment adjustment factors.* (i) If the hospital meets the criteria of paragraph (c)(1)(i) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the payment adjustment factor is 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital's disproportionate patient percentage is less than 20.2 percent, the payment adjustment factor is 2.5 percent plus 60 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(B) If the hospital is classified as a sole community hospital, the payment adjustment factor is 10 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(D) If the hospital is not classified as either a sole community hospital or a rural referral center, the payment adjustment factor is 4 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section, the payment adjustment factor is equal to 5 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section, the payment adjustment factor is 4 percent.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is 30 percent.

5. A new § 412.108 is added to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital*— (1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in § 412.63(b)) and meets all the following conditions:

(i) The hospital has 100 or fewer beds as defined in § 412.118(b) during the cost reporting period.

(ii) The hospital is not also classified as a sole community hospital under § 412.92.

(iii) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's 12-month or longer cost reporting period ending on or after September 30, 1987 and before September 30, 1988. If the hospital's last cost reporting period ending before September 30, 1988 is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period ending before the short period is used.

(2) *Counting days and discharges.* In counting inpatient days and discharges for purposes of meeting the criteria in paragraph (a)(1)(iii) of this section, only days and discharges from acute care inpatient stays are counted, including days and discharges from swing beds, but not including days and discharges from distinct part units excluded from the prospective payment system under §§ 412.25 through 412.32 or from newborn nursery units.

(b) *Classification procedures.* The fiscal intermediary determines whether a hospital meets the criteria in paragraph (a) of this section. If a hospital disagrees with an intermediary's decision, it should notify its intermediary and submit documentable evidence that it meets the criteria.

(c) *Payment methodology.* A hospital that meets the criteria in paragraph (a) of this section is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(1) The Federal payment rate applicable to the hospital as determined under § 412.63, subject to the regional floor defined in § 412.70(c)(6).

(2) The hospital-specific rate as determined under § 412.73.

(3) The hospital-specific rate as determined under § 412.75.

(d) *Additional payments to hospitals experiencing a significant volume decrease.* (1) HCFA provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges 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 Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and it must—

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) The intermediary 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, the intermediary considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs reimbursed on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(i) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(ii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.

G. In subpart H, § 412.115, a new paragraph (c) is added to read as follows:

Subpart H—Payments to Hospitals Under the Prospective Payment System

§ 412.115 Additional payments.

* * * * *

(c) *Administration of blood clotting factor.* For discharges on or after June 19, 1990, and before December 19, 1991, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is hemophiliac.

II. 42 CFR part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST OF REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for part 413 is revised to read as follows:

Authority: Sec. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, and 1395ww) and sec. 104(c) of Pub. L. 100-360 as amended by sec. 608(d)(3) of Pub. L. 100-485

(42 U.S.C. 1395ww (note)) and sec. 101(c) of Pub. L. 101-234.

B. In § 413.40, paragraph (i) is revised; and a new paragraph (j) is added to read as follows:

§ 413.40 Ceiling on rate of hospital cost increases.

* * * * *

(i) *Target amount revisions for the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360)*—(1) *General rule.* For cost reporting periods or any portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990, the intermediary 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 the affected cost reporting period. A request for adjustment must include the following:

(i) A statement from the hospital specifying that the adjustment is to be based on its historical experience in—

(A) Its base period; or

(B) Its last cost reporting period ending before January 1, 1989. (If this period is less than 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 part A hospital benefits during an inpatient hospital stay. (Excluded from the count are days for stays that were not covered in their entirety because, prior to admission, the beneficiary had exhausted both part A hospital benefits and days in excess of the lifetime limitation on inpatient psychiatric hospital services.)

(B) The number of discharges applicable to Medicare beneficiaries for which no payment was made because the beneficiary had exhausted part A hospital benefits during the hospital stay but in a prior cost reporting period.

(C) The actual charges for ancillary services furnished on the days counted in paragraph (i)(2)(iii)(A) of this section. (A hospital that is unable to document its ancillary charges may substitute average cost per diem for actual charges for ancillary services.)

(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. The adjustment is calculated as follows:

(i) *Step 1*—Determine the average cost per Medicare discharge by dividing the Medicare allowable inpatient operating costs for covered days of care in the base year or the last cost reporting period ending before January 1, 1989 by the number of Medicare discharges in that cost reporting period.

(ii) *Step 2*—Determine the estimated costs for ancillary services furnished to beneficiaries after exhaustion of part A hospital benefits. (If actual ancillary charges are available, ancillary costs are estimated by applying departmental cost-to-charge ratios from the cost report to the ancillary charges. If actual ancillary charges cannot be retrieved from the hospital's system, an ancillary per diem amount may be used in completing this step.)

(iii) *Step 3*—Determine the estimated routine costs of Medicare inpatient days furnished to beneficiaries after exhaustion of part A hospital benefits (days of care multiplied by the Medicare allowable inpatient operating cost per diem (obtained from the cost report). (No-charge-structure and all-inclusive-rate hospitals use total inpatient operating costs per diem (which equals the Medicare allowable inpatient operating costs in the cost reporting period divided by total Medicare inpatient days).

(iv) *Step 4*—Determine the total inpatient operating costs for beneficiaries notwithstanding exhaustion of part A hospital benefits (by adding the Medicare allowable inpatient operating costs in the cost reporting period plus the sum of the numbers computed in paragraphs (i)(3)(ii) and (i)(3)(iii) of this section).

(v) *Step 5*—Determine the total number of Medicare discharges notwithstanding exhaustion of part A hospital benefits by adding the number of Medicare discharges for the cost reporting period and the number of discharges for beneficiaries who had exhausted part A hospital benefits in the prior cost reporting period and were discharged during the subsequent period.

(vi) *Step 6*—Determine the average cost per discharge notwithstanding exhaustion of part A hospital benefits by dividing the number computed in paragraph (i)(3)(iv) of this section by the number computed in paragraph (i)(3)(v) of this section.

(vii) *Step 7*—Determine the ratio of average cost per discharge notwithstanding exhaustion of part A hospital benefits to average cost per discharge (by dividing the number computed in paragraph (i)(3)(vi) of this section by the number computed in paragraph (i)(3)(iii) of this section).

(viii) *Step 8*—Determine the adjusted target rate applicable to the discharges in any cost reporting period or portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990 by multiplying the updated target rate applicable to the cost reporting period or portion of the cost reporting period occurring on or after January 1, 1989 by the number computed in paragraph (i)(3)(vii) of this section

(ix) *Step 9*—Determine the appropriate target rate for portions of any cost reporting period occurring on and after January 1, 1990 by updating the hospitals' target rate prior to adjustment pursuant to paragraphs (i)(3)(i) through (i)(3)(viii).

(4) *Time period for determination and notification.* The intermediary notifies the hospital of the adjustment to the target rate for cost reporting periods or any portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990 no later than 90 days after receipt of all data needed to make the determination. An interim adjustment is made if the notice of amount of program reimbursement has not been issued for the period selected under paragraph (i)(2)(i) of this section. If an interim adjustment is made, the intermediary notifies the hospital of the final adjustment to the target rate no later than 30 days after the notice of amount of program reimbursement is issued for the period selected under paragraph (i)(2)(i) of this section.

(j) *Assignment of a new base period*—(1) *General rule.* (i) Effective with cost reporting periods beginning on or after April 1, 1990, HCFA may assign a new base period to establish a revised ceiling if the new base period is more representative of the reasonable and necessary cost of furnishing impatient services and all the following conditions apply:

(A) The actual allowable inpatient costs of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the target amount

established under paragraph (c) of this section.

(B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period.

(C) The exceptions and adjustments described in paragraphs (g) and (h) of this section would not result in recognition of the reasonable and necessary costs of providing inpatient services.

(ii) The revised ceiling will be based on the necessary and proper costs incurred during the new base period. Increases in overhead costs (for example, administrative and general costs and housekeeping costs) will not be taken into consideration unless the hospital documents that these increases result from substantial and permanent changes in furnishing patient care services.

(2) *New base period.* The new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change.

(3) *New applicable rate of increase percentages.* The revised ceiling resulting from the assignment of a new base period is increased by the applicable rate of increase percentages described in paragraph (c)(3) of this section.

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

Dated: March 23, 1990.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: April 11, 1990.

Louis W. Sullivan,

Secretary.

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

Addendum—Schedule of Standardized Amounts Effective With Discharges on or After April 1, 1990

I. 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 established 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 provision 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.

Since all adjustments for variation in hospital operating costs or target amounts except those for the disproportionate share hospitals have already been accounted for consistent with the construction of the standardized amounts, no revision was made at the hospital level for those factors. Therefore, the discussion below is limited to the impact of the disproportionate share payment provisions in section 6003(c) of Public Law 101–239 on the standardized amounts.

A. Costs for Hospitals That Serve a Disproportionate Share of Low-Income Patients

Before enactment of Public Law 101–239, 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, 1995, 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.

The original standardization for the disproportionate share adjustment was discussed in the **Federal Register** in the September 3, 1986 final rule (51 FR 31498). A subsequent restandardization for the disproportionate share adjustment was discussed in the **Federal Register** in the September 30, 1988 final rule (53 FR 38536). Thus, we have consistently interpreted amendments to the disproportionate share hospital provisions to require us to restandardize the base year PPS amounts.

Section 6003(c) of Public Law 101–239 amended section 1886(d) of the Act to provide revised criteria used in classifying a hospital as a "disproportionate share" hospital as well as increases in the applicable payment adjustments effective with discharges occurring on or after April 1, 1990. These changes, which were discussed earlier in this document, will result in higher adjustment factors than were taken into account in standardizing the costs used to establish the standardized amounts. In addition, more hospitals will receive disproportionate share payments under the revised qualifying criteria established by section 6003(c) of Public Law 101–239.

The legislative language in Public Law 101–239 is silent with respect to standardization for the increased payments associated with this provision, and makes no modification to the standardization requirement under sections 1886(d)(2)(C)(iv) and 1886(d)(9)(B)(ii)(IV) of the Act. Restandardization to remove the additional disproportionate share payments would reduce the standardized amounts by approximately 0.6 percent. However, it was Congress' intent in enacting section 6003(c) of Public Law 101–239 that the increased payments to disproportionate share hospitals be funded through additional program expenditures and not from a redistribution of payments to all hospitals. Therefore, in this unique case, the Secretary is using his general exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to implement section 6003(c) without restandardization of the base year prospective payment system amounts. Therefore, no adjustment to the standardized amounts has been made to account for the disproportionate share changes.

B. Other Adjustments to the Average Standardized Amounts

As a result of the changes in the disproportionate share payment provisions and the wage index values applicable to redesignated rural hospitals, it was necessary to recalculate the budget neutrality factors that are required by section 1886(d)(8)(D) of the Act for certain rural

hospitals that are deemed urban under section 1886(d)(8)(B) of the Act. Section 1886(d)(8)(D) of the Act specifies that, in recalculating the budget neutrality factors, two payment conditions must be met. First, the FY 1990 standardized amounts are to be adjusted so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8) (B) and (C) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. That is, the additional payments to those rural hospitals that have been deemed urban must be financed through a reduction in the urban standardized payment amounts. Second, the rural standardized amounts are to be adjusted so that aggregate payments to those rural hospitals that have not been deemed urban are not changed as a result of these provisions.

The following are the budget neutrality factors that were used to establish the standardized amounts effective for discharges occurring on or after January 1, 1990:

Urban: .999516

Rural: .999244

The budget neutrality factors for the standardized amounts effective for discharges occurring on or after April 1, 1990 are as follows:

Urban: .999133

Rural: .999147

Section 1886(b)(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 discharges involving 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 or estimated total DRG payments attributable to outlier payments for hospitals located in urban areas and those located in rural areas.

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 discharges involving 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 outlier payments for hospitals located in urban areas and those located in rural areas. Because of the revised payment rules set forth in this document, the outlier adjustment factor for urban hospitals must be revised. The outlier adjustment factor applied to the urban standardized amounts in the December 29, 1989 notice effective for discharges occurring on or after January 1, 1990 was .943622. The outlier adjustment factor applied to the urban standardized amounts to establish the payment rates effective for discharges occurring on or after April 1, 1990 is .943759. The outlier adjustment factor applied to the rural standardized amounts remains at .978500. There is no change in the outlier thresholds. The revised standardized amounts effective for discharges occurring on or after April 1, 1990 are shown in Tables 1a, 1b, and 1c.

II. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. The tables are as follows:

Table 1a—National Adjusted Standardized Amounts, Labor/Nonlabor

Table 1b—Regional Adjusted Standardized Amounts, Labor/Nonlabor

Table 1c—Adjusted Standardize Amounts for Puerto Rico, Labor/Nonlabor

Table 2a—Wage Index for Rural Counties Whose Hospitals Are Deemed Urban—Using Urban Area Wage Index

Table 2b—Wage Index for Rural Counties Whose Hospitals Are Deemed Urban—Computed as Separate Urban Areas

Table 2c—Wage Index for Rural Counties Whose Hospitals are Deemed Urban—Using Statewide Rural Wage Index

Table 3d—Hospital Case Mix Indexes for Cost Reporting Periods Beginning in FY 1987

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
2507.57	888.18	2467.88	874.11	2433.05	673.86

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)	2633.24	927.12	2591.55	912.44	2696.96	799.40
2. Middle Atlantic (PA, NJ, NY)	2365.74	879.79	2328.28	865.86	2562.89	755.72
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2525.31	810.62	2485.32	797.78	2469.05	655.31
4. East North Central (IL, IN, MI, OH, WI)	2663.61	959.08	2621.44	943.90	2500.26	728.33
5. East South Central (AL, KY, MS, TN)	2423.64	733.99	2385.26	722.37	2447.07	611.08
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2526.01	873.90	2486.02	860.06	2378.46	652.85
7. West South Central (AR, LA, OK, TX)	2511.46	805.12	2471.70	792.37	2281.04	600.39
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2421.90	863.14	2383.55	849.48	2319.01	695.06
9. Pacific (AK, CA, HI, OR, WA)	2356.62	965.11	2319.31	969.50	2243.50	777.93

TABLE 1c—ADJUSTED STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban		Other urban		Rural	
	Labor-related	Non-labor-related	Labor-related	Non-labor-related	Labor-related	Non-labor-related
Puerto Rico	2,227.36	398.48	2,192.12	392.16	1,626.27	301.04
National	2,474.28	828.84				

TABLE 2a—FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—USING URBAN AREA WAGE INDEX

County	Urban area	Wage index
Macoupin, IL	St. Louis, MO–IL	1.0126
Mason, IL	Peoria, IL	0.9794
Clinton, IN	Lafayette, IN	0.8843
Allegan, MI	Grand Rapids, MI.	1.0076
Ionia, MI	Lansing-East Lansing, MI.	1.0360
Shiawassee, MI	Flint, MI	1.1653
Tuscola, MI	Saginaw-Bay City-Midland, MI.	1.0769
Clinton, MO	Kansas City, KS–MO.	1.0093
Van Wert, OH	Lima, OH	0.9178
Cherokee, SC	Greenville-Spartanburg, SC.	0.9322
Bedford, VA	Roanoke, VA	0.8224
Fredericksburg City, VA.	Washington, DC–MD–VA.	1.0827
Jefferson, WI	Milwaukee, WI	1.0132
Walworth, WI	Milwaukee, WI	1.0132

TABLE 2a—FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—USING URBAN AREA WAGE INDEX—Continued

County	Urban area	Wage index
Jefferson, WV	Washington, DC–MD–VA.	1.0827

TABLE 2b—WAGE INDEX FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—COMPUTED AS SEPARATE URBAN AREAS

County	Urban area	Wage index
Limestone, AL	Huntsville, AL	0.7455
Marshall, AL	Huntsville, AL	0.7207
Charlotte, FL	Sarasota, FL	0.8311
Indian River, FL	Fort Pierce, FL	0.8613
Lenawee, MI	Ann Arbor, MI	1.1580
Henry, IN	Anderson, IN	0.8411
Columbiana, OH	Beaver County, PA.	0.9089

TABLE 2c—WAGE INDEX FOR RURAL COUNTIES WHOSE HOSPITALS ARE DEEMED URBAN—USING STATEWIDE RURAL WAGE INDEX

County	Urban area	Wage index
Christian, IL	Springfield, IL	0.7994
Jefferson, KS	Topeka, KS	0.7908
Barry, MI	Battle Creek, MI	0.9110
Cass, MI	Benton Harbor, MI.	0.9110
Van Buren, MI	Kalamazoo, MI	0.9110
Harnett, NC	Fayetteville, NC	0.7639
Genesee, NY	Rochester, NY	0.8069
Morrow, OH	Mansfield, OH	0.8568
Lawrence, PA	Beaver County, PA.	0.8760

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TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 1 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.2303	010059	00.9728	010122	00.9859	030012	01.1173	030091	00.8891
010004	00.9804	010060	00.9780	010123	01.2290	030013	01.1313	040001	01.0745
010005	01.1483	010061	00.9705	010124	01.2337	030014	01.3012	040002	01.0376
010006	01.1902	010062	00.9521	010125	00.9995	030016	01.1248	040003	00.9615
010007	00.9555	010064	01.4703	010126	01.0113	030017	01.2760	040004	01.2781
010008	00.9980	010065	01.0600	010127	01.3143	030018	01.3697	040005	01.0513
010009	01.1159	010066	00.8766	010128	00.9728	030019	01.1441	040006	01.0050
010010	00.9988	010067	00.9141	010129	01.0580	030020	01.3221	040007	01.4125
010011	01.3136	010068	01.1427	010130	01.0711	030022	01.2805	040008	01.0603
010012	01.2834	010069	01.0807	010131	01.2697	030023	01.2200	040009	00.9670
010015	01.1685	010072	01.1015	010133	00.9524	030024	01.4378	040010	01.1450
010016	01.1967	010073	00.9370	010134	00.9251	030025	01.1606	040011	00.9131
010018	00.9431	010074	00.9355	010136	00.9590	030027	01.0507	040013	01.0284
010019	01.1208	010075	01.0463	010137	01.2073	030030	01.5190	040014	01.1532
010020	00.9880	010078	01.2155	010138	00.9859	030033	01.2513	040015	01.1700
010021	01.0576	010079	01.0404	010139	01.4737	030034	01.1397	040016	01.3322
010022	00.9933	010080	00.9825	010142	00.9081	030035	01.1499	040017	01.1625
010023	01.2091	010081	01.5230	010143	01.0883	030036	01.1471	040018	01.1341
010024	01.2683	010083	01.0427	010144	01.1554	030037	01.6508	040019	01.2155
010025	01.1879	010084	01.3104	010145	01.1882	030038	01.4318	040020	01.3809
010026	00.9560	010085	01.2715	010146	01.0004	030040	01.0377	040021	00.9835
010027	01.0802	010086	01.0295	010148	01.0215	030041	00.9448	040022	01.4739
010028	01.0019	010087	01.2701	010149	01.3243	030043	01.0507	040024	00.9635
010029	01.2071	010089	01.0315	010150	01.0222	030044	01.0837	040025	00.9396
010030	00.9384	010090	01.3211	010152	01.1775	030046	00.9806	040026	01.2716
010031	01.2162	010091	01.0421	020001	01.3987	030047	01.0106	040027	01.1752
010032	00.9144	010092	01.2911	020002	01.0684	030049	01.0338	040028	01.0765
010033	01.7402	010094	01.1690	020004	01.0592	030051	01.1402	040029	01.0829
010034	01.0878	010095	01.0129	020005	00.9437	030054	00.9508	040030	00.9355
010035	01.0620	010096	00.9109	020006	01.0897	030055	01.1076	040031	00.9786
010036	01.0634	010097	01.0149	020007	00.8905	030057	01.2368	040032	00.9913
010038	01.0752	010098	01.0921	020008	01.0416	030059	01.3926	040033	00.8291
010039	01.5440	010099	01.0141	020009	00.8357	030060	01.2147	040035	00.9430
010040	01.1549	010100	01.1863	020010	00.8207	030061	01.3363	040036	01.1709
010041	00.8123	010101	01.0750	020011	00.9515	030062	01.1943	040037	01.0494
010043	00.9736	010102	00.9074	020012	01.3105	030063	01.1885	040039	00.9627
010044	00.9272	010103	01.4942	020013	00.9551	030064	01.3923	040040	00.9542
010045	01.0055	010104	01.5097	020014	01.0397	030065	01.3897	040041	01.1634
010046	01.2041	010108	01.1128	020017	01.2549	030067	00.9668	040042	01.2096
010047	00.9784	010109	01.0678	020024	01.0375	030068	01.0592	040043	00.9501
010049	01.0568	010110	00.9166	020025	00.9126	030069	01.2270	040044	00.9349
010050	00.9876	010112	01.0374	030001	01.1696	030080	01.4060	040045	00.9433
010051	00.8947	010113	01.3614	030002	01.4721	030081	00.9616	040047	01.0036
010052	01.0084	010114	01.2269	030003	01.2665	030082	00.6432	040048	01.1016
010053	01.0077	010115	00.9933	030006	01.3662	030083	01.2121	040050	01.0417
010054	01.1362	010117	00.9478	030007	01.2062	030085	01.0859	040051	00.9092
010055	01.2562	010118	01.1535	030008	01.5802	030086	01.1665	040053	01.0082
010056	01.1895	010119	01.1528	030009	01.2713	030087	01.1565	040054	01.0835
010057	01.1121	010120	00.9522	030010	01.3510	030088	01.2178	040055	01.2635
010058	01.0629	010121	01.0880	030011	01.2725	030089	01.1598	040058	00.9258

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040060	01.0163	050011	01.1673	050074	00.9600	050133	01.1756	050197	01.7187
040062	01.1563	050013	01.9811	050075	01.2224	050134	01.2552	050199	01.2038
040063	01.2898	050014	01.1132	050076	01.4461	050135	01.4892	050201	01.0241
040064	00.9858	050015	01.2735	050077	01.4275	050136	01.2275	050202	01.1739
040066	00.9559	050016	01.1241	050078	01.1903	050137	01.1655	050204	01.4023
040067	01.0313	050017	01.6257	050079	01.3338	050138	01.4055	050205	01.1207
040069	01.0259	050018	01.1795	050080	01.1350	050139	01.2175	050207	01.1929
040070	00.9564	050019	00.9577	050081	01.5174	050140	01.2074	050208	01.1757
040071	01.2071	050021	01.2268	050082	01.3053	050141	01.2111	050211	01.2740
040072	01.0278	050022	01.3428	050084	01.3818	050143	01.2164	050212	01.0717
040074	01.0931	050024	01.1669	050086	01.1688	050144	01.3063	050213	01.2331
040075	01.1316	050025	01.4895	050087	01.2994	050145	01.2382	050214	01.3504
040076	00.9417	050026	01.4886	050088	01.0669	050146	01.2326	050215	01.3200
040077	00.9220	050028	01.2325	050089	01.2746	050147	00.9713	050217	01.1495
040078	01.2105	050029	01.2454	050090	01.2524	050148	01.1263	050219	01.3946
040080	01.0070	050030	01.1584	050091	01.1411	050149	01.1649	050220	01.1526
040081	00.8798	050032	01.1422	050092	01.0904	050150	01.2194	050221	01.3692
040082	01.1146	050033	01.3103	050093	01.4597	050151	01.2441	050222	01.2007
040084	01.0380	050034	01.1922	050096	01.1596	050152	01.2968	050224	01.3825
040085	01.0353	050036	01.4272	050097	01.2711	050153	01.5227	050225	01.1841
040087	00.9734	050038	01.2448	050098	00.9771	050154	01.2297	050226	01.4205
040088	01.1097	050039	01.4653	050099	01.3463	050155	01.1628	050228	01.2552
040090	00.9236	050040	01.1257	050100	01.6869	050159	01.1951	050229	01.2479
040091	01.1029	050041	01.1488	050101	01.2559	050161	01.3398	050230	01.2442
040093	01.0071	050042	01.2037	050102	01.2742	050164	01.3376	050231	01.3867
040095	00.9284	050043	01.5298	050103	01.3903	050166	01.2234	050232	01.6133
040098	01.1442	050045	01.1461	050104	01.3137	050167	01.2914	050233	01.1458
040100	01.0659	050046	01.2087	050107	01.2487	050168	01.4548	050234	01.1818
040105	01.0046	050047	01.5321	050108	01.3207	050169	01.3660	050235	01.3162
040106	01.0402	050049	01.2544	050109	01.6870	050170	01.3642	050236	01.2111
040107	01.0593	050051	01.1397	050110	01.1018	050172	01.1806	050238	01.2311
040108	00.9089	050052	01.1311	050111	01.2166	050173	01.3701	050239	01.2896
040109	01.1994	050053	01.2275	050112	01.3171	050174	01.4917	050240	01.2935
040114	01.6259	050054	01.1915	050113	01.1782	050175	01.2216	050241	01.1726
040115	01.0099	050055	01.1732	050114	01.3706	050177	01.3134	050242	01.3192
040116	01.2129	050056	01.2043	050115	01.3702	050179	01.1820	050243	01.2612
040118	01.0561	050057	01.2634	050116	01.3744	050180	01.3497	050245	01.5119
040119	01.1365	050058	01.2937	050117	01.1897	050181	01.2812	050248	01.1282
040122	01.0235	050060	01.3303	050118	01.1655	050183	01.2017	050251	01.0442
040123	00.9088	050061	01.2054	050119	00.8513	050186	01.3342	050253	01.2018
040124	00.9968	050063	01.3387	050121	01.1095	050187	01.0120	050254	01.1496
040126	00.9544	050065	01.3251	050122	01.4064	050188	01.3395	050256	01.5480
040128	00.8931	050066	01.1875	050124	01.2625	050189	00.9871	050257	01.3812
040130	01.0329	050067	01.1975	050125	01.1733	050190	01.1292	050258	01.3379
050002	01.1814	050068	01.1105	050126	01.2690	050191	01.3721	050260	00.9152
050004	01.1625	050069	01.4305	050127	01.2521	050192	01.0290	050261	01.1385
050006	01.2505	050070	01.1619	050128	01.4059	050193	01.3248	050262	01.5063
050007	01.3759	050071	01.1589	050129	01.5073	050194	01.2460	050263	01.2427
050008	01.3086	050072	01.2380	050131	01.1911	050195	01.2863	050264	01.3235
050009	01.3812	050073	01.1614	050132	01.2108	050196	01.1507	050267	01.4286

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 3 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050268	01.1973	050342	01.2607	050418	01.1140	050489	01.0857	050575	01.1144
050269	01.1730	050343	01.1341	050419	01.1196	050491	01.3280	050576	01.1348
050270	01.2255	050345	01.2760	050420	01.2259	050492	01.2216	050577	01.2482
050272	01.2424	050348	01.3109	050421	01.2400	050494	01.1126	050578	01.1958
050274	00.9832	050349	01.0065	050423	01.0839	050496	01.5751	050579	01.3391
050276	01.0771	050350	01.3110	050424	01.5724	050497	00.9871	050580	01.1025
050277	01.2672	050351	01.3838	050425	01.2051	050498	01.2042	050581	01.2864
050278	01.3214	050352	01.1153	050426	01.2389	050502	01.6642	050583	01.7187
050279	01.1484	050353	01.6283	050427	00.9808	050503	01.2911	050584	01.2881
050280	01.2157	050355	00.9325	050430	00.9041	050506	01.2815	050585	01.2558
050281	01.2698	050357	01.4549	050431	01.1346	050510	01.1431	050586	01.1042
050282	01.2229	050359	01.0685	050432	01.3782	050512	01.1339	050587	01.2356
050283	01.2775	050360	01.2303	050433	01.0084	050515	01.2823	050588	01.1920
050286	01.0184	050361	00.9285	050434	01.0676	050516	01.3117	050589	01.3208
050289	01.6257	050362	00.9364	050435	01.1229	050517	01.1422	050590	01.2274
050290	01.3782	050363	01.2532	050436	01.0841	050522	01.2945	050591	01.2051
050291	01.1496	050366	01.1626	050438	01.3712	050523	01.1246	050592	01.2751
050292	01.1506	050367	01.2053	050440	01.1282	050526	01.2170	050593	01.1219
050293	00.8705	050369	01.2019	050441	01.6062	050527	01.3084	050594	01.9893
050295	01.3247	050371	01.1529	050442	01.1539	050528	01.1911	050597	01.1467
050296	01.1340	050372	01.0812	050443	00.9242	050530	01.2092	050598	01.1989
050298	01.0888	050373	01.1041	050444	01.1995	050531	01.2114	050599	01.3661
050299	01.2954	050376	01.3069	050446	00.9065	050534	01.2730	050601	01.1837
050300	01.2426	050377	01.0307	050447	01.3330	050535	01.2931	050603	01.3987
050301	01.2073	050378	01.1290	050448	00.9896	050537	01.2109	050604	01.2306
050302	01.2644	050379	01.0173	050449	01.2475	050539	01.2548	050605	01.0531
050305	01.3314	050380	01.5528	050450	00.9696	050541	01.3889	050607	01.1690
050307	01.3517	050381	00.9604	050451	01.0616	050542	01.1122	050608	01.1081
050308	01.4919	050382	01.2920	050454	01.6541	050543	01.1712	050609	01.2501
050309	01.2355	050383	01.0783	050455	01.4949	050544	01.1853	050613	01.0652
050310	01.0868	050385	01.2194	050456	01.3140	050545	00.7699	050615	01.1724
050312	01.5490	050387	00.9738	050457	01.4664	050546	01.0702	050616	01.1226
050313	01.1031	050388	00.8907	050458	00.6621	050547	00.8858	050618	01.0205
050315	01.3363	050390	01.2510	050459	01.2505	050549	01.4092	050619	01.2578
050317	01.2076	050391	01.1606	050464	01.8514	050550	01.2937	050622	01.1743
050318	00.9539	050392	00.9591	050467	01.1716	050551	01.3040	050623	01.3144
050319	01.2402	050393	01.3599	050468	01.3147	050552	01.1402	050624	01.2040
050320	01.1810	050394	01.3549	050469	00.9653	050557	01.2169	050625	01.3861
050324	01.5811	050395	01.1511	050470	01.0734	050559	01.3443	050630	01.0370
050325	01.2368	050396	01.3887	050471	01.6207	050560	01.1477	050633	01.2073
050326	01.2467	050397	01.0401	050473	01.2315	050561	01.0897	050635	01.2346
050327	01.5174	050401	01.2446	050476	01.2875	050564	01.1882	050636	01.2364
050328	01.2536	050404	01.0917	050477	01.2107	050565	01.1613	050637	01.2004
050329	01.2081	050406	00.9874	050478	01.1228	050566	00.9891	050638	00.9612
050331	01.2880	050407	01.1961	050481	01.3617	050567	01.2986	050641	01.0461
050333	01.0829	050410	01.0504	050482	01.0037	050568	01.2619	050644	01.1368
050334	01.2894	050411	01.2182	050483	01.2186	050569	01.2171	050649	01.2249
050335	01.1085	050413	01.2905	050485	01.4148	050570	01.4718	050650	01.2548
050336	01.2418	050414	01.1535	050486	01.3124	050571	01.2528	050651	01.2089
050337	01.1282	050417	01.1451	050488	01.2218	050573	01.3912	050657	01.0945

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050660	00.9051	060038	01.1324	070005	01.3086	100002	01.2902	100056	01.1014
050661	01.0188	060039	01.0956	070006	01.1879	100004	01.1065	100057	01.2080
050662	00.7996	060041	00.9220	070007	01.2315	100005	01.0523	100059	01.4736
050663	01.1083	060042	00.9792	070008	01.1554	100006	01.3937	100060	01.4297
050666	00.9511	060043	01.0489	070009	01.1745	100007	01.6641	100061	01.3040
050667	01.1880	060044	01.1931	070010	01.4008	100008	01.3887	100062	01.2058
050668	01.2804	060045	01.0161	070011	01.2679	100009	01.3550	100063	01.1993
050669	00.8036	060046	01.0878	070012	01.1571	100010	01.2392	100065	01.1064
050671	00.9507	060047	01.1740	070013	01.1884	100011	00.9923	100067	01.3165
050672	00.6649	060049	01.1022	070014	01.1782	100012	01.2607	100068	01.1631
050674	01.2236	060050	01.2085	070015	01.1983	100013	00.9392	100069	01.2344
050675	01.2198	060051	01.2924	070016	01.2355	100014	01.1584	100070	01.3140
050676	00.9623	060052	00.8945	070017	01.2683	100015	01.2542	100071	01.2646
050677	01.2153	060053	00.8779	070018	01.2024	100016	01.0397	100072	01.1639
050678	01.1723	060054	01.2284	070019	01.1743	100017	01.2621	100073	01.5656
050679	01.1212	060056	00.9593	070020	01.2555	100018	01.2586	100074	01.1481
060001	01.4113	060057	01.2828	070021	01.2112	100019	01.2660	100075	01.5470
060003	01.1920	060058	00.9625	070022	01.5722	100020	01.2132	100076	01.1224
060004	01.0702	060060	01.1077	070023	01.1991	100021	01.2112	100077	01.2298
060005	01.4955	060062	00.9996	070024	01.1979	100022	01.4082	100078	01.0838
060006	01.2115	060063	01.0829	070025	01.5119	100023	01.1866	100079	01.2043
060007	01.1742	060064	01.2450	070026	01.1350	100024	01.1828	100080	01.2355
060008	01.1945	060065	01.2229	070027	01 2396	100025	01.4299	100081	01.0334
060009	01.2266	060066	01.0598	070028	01.3376	100026	01.3468	100082	01.2815
060010	01.4881	060067	00.9947	070029	01.2103	100027	00.9987	100083	01.1208
060011	01.2049	060068	01.2037	070030	01.1439	100028	01.1528	100084	01.3139
060012	01.3790	060070	01.1662	070031	01.2634	100029	01.2452	100085	01.1766
060013	01.2452	060071	01.2618	070033	01 1911	100030	01.0680	100086	01.2272
060014	01.4873	060072	00.9541	070034	01.2294	100032	01.2914	100087	01.5396
060015	01.3366	060073	00.9038	070035	01.2924	100033	01.3007	100088	01.3083
060016	01.2218	060074	01.0998	070036	01.2718	100034	01.3630	100089	01.1677
060017	01.2335	060075	01.1552	080001	01.3971	100035	01.2069	100090	01.1305
060018	01.1574	060076	01.2487	080002	01.1551	100036	01.2456	100092	01.1492
060019	01.2302	060077	00.9978	080003	01.2382	100038	01.4269	100093	01.2637
060020	01.3392	060083	00.9694	080004	01.2357	100039	01.3381	100098	00.9940
060022	01.5079	060085	00.9096	080005	01.1121	100040	01.3606	100099	01.1602
060023	01.3198	060087	01.2401	080006	01.1324	100042	01.1514	100100	01.1808
060024	01.4020	060088	01.0908	080007	01.1781	100043	01.2506	100102	01.0276
060026	01.3689	060090	01.0086	090001	01.3532	100044	01.2312	100103	00.9594
060027	01.2459	060092	00.9596	090002	01.1139	100045	01.2419	100105	01.1795
060028	01.3601	060093	01.0792	090003	01 3762	100046	01.1694	100106	01.0923
060029	00.9697	060096	01.1732	090004	01.4421	100047	01.1811	100107	01.1429
060030	01.2074	060097	01 0195	090005	01 2457	100048	00.9719	100108	01.0115
060031	01.3787	060098	01 1919	090006	01.2166	100049	01.1628	100109	01.1721
060032	01.3431	060099	00 8867	090007	01.0917	100050	01.0991	100110	01.3585
060033	01.2087	060101	01 7209	090008	01.1657	100051	01.0810	100112	00.9422
060034	01.2245	070001	01.6643	090009	01 2080	100052	01.2662	100113	01.6225
060035	01 1540	070002	01 5316	090010	01.0311	100053	01.1505	100114	01.2458
060036	01.1418	070003	01 2228	090011	01.5708	100054	01.3158	100115	01.1403
060037	00.9882	070004	01 1497	100001	01 2676	100055	01.1837	100117	01.1953

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 5 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100118	01.1457	100181	01.0954	100246	01.1981	110032	01.1343	110092	01.0448
100120	01.1857	100183	01.1659	100248	01.4588	110033	01.2277	110093	01.0239
100121	01.0869	100185	01.0599	100249	01.2113	110034	01.2733	110094	00.9829
100122	01.1333	100186	01.3218	100252	01.1784	110035	01.1700	110095	01.2200
100124	01.1573	100187	01.1883	100253	01.2395	110036	01.4767	110096	01.0168
100125	01.1749	100189	01.2005	100254	01.2393	110037	01.0861	110097	01.0186
100126	01.2873	100191	01.2395	100255	01.2257	110038	01.2015	110098	00.9192
100127	01.3277	100194	01.2265	100256	01.2770	110039	01.1582	110099	00.9000
100128	02.0691	100195	01.1535	100258	01.3928	110040	00.9417	110100	01.0617
100129	01.2022	100196	01.2297	100259	01.1088	110041	01.1648	110101	00.9883
100130	01.1706	100199	01.2868	100260	01.1862	110042	01.0128	110103	00.9040
100131	01.2361	100200	01.2824	100262	01.2252	110044	01.1216	110104	01.0694
100132	01.2327	100203	01.2201	100263	01.1519	110045	01.0361	110105	01.1456
100134	00.9263	100204	01.4072	100264	01.2823	110046	01.1534	110107	01.4233
100135	01.4296	100206	01.1634	100265	01.1614	110047	00.9275	110108	00.9253
100137	01.1571	100207	01.2588	100266	01.1219	110048	01.0795	110109	00.9714
100139	01.1429	100208	01.2736	100267	01.1999	110049	00.9246	110111	01.0056
100140	01.0638	100209	01.3032	100268	01.2240	110050	01.0026	110112	00.9524
100142	01.0616	100210	01.4842	100269	01.1919	110051	00.9389	110113	00.9592
100143	01.0323	100211	01.2754	100271	01.4270	110052	00.8999	110114	01.0842
100144	01.0469	100212	01.3342	100273	01.0626	110054	01.1805	110115	01.3453
100145	01.2219	100213	01.3365	100275	01.1592	110055	00.9394	110117	00.9338
100146	01.0329	100214	01.2881	100276	01.2628	110056	00.9197	110118	00.9396
100147	01.0232	100217	01.1305	100277	01.0870	110059	01.0530	110120	00.9518
100149	01.1775	100218	01.1309	110001	01.0980	110061	00.8640	110121	00.9486
100150	01.2251	100219	01.2389	110002	01.2026	110062	00.9565	110122	01.1641
100151	01.5323	100220	01.5442	110003	01.1656	110063	01.0082	110123	00.9696
100152	01.1704	100221	01.6707	110004	01.2332	110064	01.1948	110124	01.0397
100154	01.3440	100222	01.1433	110005	01.1774	110065	01.0754	110125	01.1040
100156	01.0630	100223	01.3247	110006	01.1724	110066	01.2334	110127	00.9783
100157	01.3461	100224	01.1842	110007	01.3844	110069	01.0705	110128	01.1587
100159	01 0176	100225	01.2257	110008	01.0547	110070	00.9412	110129	01.3445
100160	01 1208	100226	01.1952	110009	01.0308	110071	00.9645	110130	00.9550
100161	01.3038	100227	01.0190	110010	01.8212	110072	00.9367	110131	00.9877
100162	01.2292	100228	01.1903	110011	01.1360	110073	01.0459	110132	01.0735
100164	00.9971	100229	01.3813	110013	01.0010	110074	01.1972	110133	00.9475
100165	00.9713	100230	01.1690	110014	01.1406	110075	01.0785	110134	00.8712
100166	01.2743	100231	01.4848	110015	01.0698	110076	01.2580	110135	01.0284
100167	01.1714	100232	01.0618	110017	00.9313	110077	00.9645	110136	01.1340
100168	01.2940	100234	01.2788	110018	01.1052	110078	01.4444	110140	00.9145
100169	01.5028	100235	01.2883	110020	01.1665	110079	01.0886	110141	00.9183
100170	01.2027	100236	01.2802	110023	01.1266	110080	01.0432	110142	01.1130
100172	01.2413	100237	01.7054	110024	01.2114	110081	00.9936	110143	01.1818
100173	01.1983	100238	01.3480	110025	01.1622	110083	01.1899	110144	01.1434
100174	01.4030	100239	01.3643	110026	01.0732	110085	01.1514	110149	01.0456
100175	01.0779	100240	00.7533	110027	01.0180	110086	01.1371	110150	01.0877
100176	01.6684	100241	01.0497	110028	01.3738	110087	01.1871	110151	00.9891
100177	01.1725	100242	01.1910	110029	01.1424	110088	00.8301	110152	00.9264
100179	01.4299	100243	01.2758	110030	01.1342	110089	01.1108	110153	01.0044
100180	01.3872	100244	01.2370	110031	01.1261	110091	01.1804	110154	00.9801

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
110155	00.9654	120010	01.4207	130048	00.9966	140053	01.5240	140113	01.4268
110156	00.9153	120011	01.2831	130049	01.2339	140054	01.3135	140114	01.1229
110157	01.1048	120012	01.0282	130050	00.8292	140055	01.0019	140115	01.1216
110158	01.0427	120014	01.1472	130051	01.0504	140058	01.0668	140116	01.2376
110161	01.2204	120015	00.7754	130054	00.9275	140059	01.0530	140117	01.1879
110162	00.8765	120016	01.0456	130056	00.9525	140061	01.1255	140118	01.3527
110163	01.2249	120018	00.8238	140001	01.2411	140062	01.1829	140119	01.4659
110164	01.2574	120019	01.0428	140002	01.2232	140063	01.2280	140120	01.1205
110165	01.1376	120021	00.8272	140003	00.9912	140064	01.1662	140121	01.0149
110166	01.2080	120022	01.4610	140004	01.0438	140065	01.2024	140122	01.2330
110168	01.3112	120024	00.9841	140005	00.9001	140066	01.0949	140123	01.1222
110169	00.6938	130001	01.0237	140007	01.1677	140067	01.4681	140125	01.1084
110170	00.8820	130002	01.2581	140008	01.2511	140068	01.1666	140126	01.4368
110171	01.1668	130003	01.2378	140010	01.2887	140069	01.0488	140127	01.1379
110172	01.0926	130005	01.2643	140011	01.0430	140070	01.2551	140128	01.0026
110174	00.9689	130006	01.5218	140012	01.2234	140072	01.1500	140129	01.0287
110175	00.9364	130007	01.3767	140013	01.2269	140074	01.0865	140130	01.1413
110176	01.0872	130008	00.8736	140014	01.0547	140075	01.2848	140131	01.1256
110177	01.3482	130009	00.9129	140015	01.1327	140077	01.0052	140132	01.2864
110178	01.0393	130010	00.9777	140016	00.9870	140079	01.1816	140133	01.2180
110179	01.1062	130011	01.2602	140017	01.2581	140080	01.5770	140134	01.2479
110181	01.0430	130012	00.9313	140018	01.2919	140081	01.0730	140135	01.1307
110183	01.1226	130013	01.1897	140019	00.9311	140082	01.1928	140136	01.0116
110184	01.0802	130014	01.2111	140023	01.1567	140083	01.1690	140137	01.0783
110185	01.0675	130015	00.9976	140024	00.9681	140084	01.1715	140138	01.1731
110186	01.0541	130016	00.9088	140025	01.0770	140085	01.1633	140139	01.0780
110187	01.0389	130017	00.9841	140026	01.1203	140086	01.0839	140140	01.0466
110188	01.2110	130018	01.2031	140027	01.1248	140087	01.2153	140141	00.9957
110189	00.9833	130019	01.1315	140029	01.2438	140088	01.5052	140142	01.1074
110190	01.0834	130021	00.9368	140030	01.3452	140089	01.1385	140143	01.0848
110191	01.2173	130022	01.1564	140031	01.0619	140090	01.2492	140144	01.0911
110192	01.2927	130024	01.1772	140032	01.1360	140091	01.3241	140145	01.1598
110193	01.0301	130025	01.0105	140033	01.1315	140093	01.1335	140146	00.9817
110194	00.9787	130026	01.0605	140034	01.0886	140094	01.1239	140147	01.0549
110195	00.9655	130027	00.9176	140035	01.0820	140095	01.3362	140148	01.3619
110196	01.3017	130028	01.1873	140036	01.0716	140097	01.0842	140150	01.2936
110198	01.1812	130029	01.1054	140037	01.0620	140098	01.1685	140151	01.0561
110200	01.4294	130030	00.9395	140038	01.0952	140099	01.1103	140152	01.0503
110201	01.2029	130031	01.1108	140039	00.9529	140100	01.3607	140154	01.1204
110202	00.9754	130032	00.9666	140040	01.1931	140101	01.0887	140155	01.0909
110203	00.9353	130034	00.8969	140041	01.0735	140102	01.0357	140156	01.1966
120001	01.4915	130035	01.0602	140042	00.9886	140103	01.1231	140157	01.0244
120002	01.0614	130036	01.1554	140043	01.1338	140104	01.1078	140158	01.2230
120003	01.0372	130037	01.0669	140045	01.0241	140105	01.1932	140159	01.1870
120004	01.2340	130038	00.8879	140046	01.1395	140107	00.9386	140160	01.2639
120005	01.1116	130039	01.1208	140047	01.0601	140108	01.1546	140161	01.0196
120006	01.1475	130040	00.9849	140048	01.1191	140109	00.9779	140162	01.1787
120007	01.5138	130043	01.0255	140049	01.2605	140110	01.1593	140164	01.1815
120008	01.0513	130044	00.9566	140051	01.1902	140111	01.0058	140165	01.0331
120009	00.9469	130045	00.9727	140052	01.2274	140112	01.1206	140166	01.1494

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 7 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140167	01.0702	140232	00.9934	150012	01.3614	150067	01.0081	150129	01.1703
140168	01.0554	140233	01.4465	150013	01.0483	150069	01.1423	150130	01.1551
140170	01.0092	140234	01.2042	150014	01.2242	150070	01.0392	150132	01.3112
140171	00.9598	140235	00.9868	150015	01.1254	150071	01.1487	150133	01.1691
140172	01.3782	140236	00.9697	150017	01.4774	150072	01.2501	150134	01.2970
140173	00.9693	140239	01.3720	150018	01.1586	150073	01.0681	150136	01.0901
140174	01.2550	140240	01.1729	150019	01.2083	150074	01.3812	160001	01.1484
140176	01.1212	140241	00.8966	150020	01.0488	150075	01.1684	160002	01.3172
140177	01.1295	140242	01.2914	150021	01.3946	150076	01.0087	160003	01.0248
140179	01.2378	140243	01.1016	150022	01.0696	150077	01.1274	160004	01.1475
140180	01.2826	140245	01.0055	150023	01.2635	150078	01.0436	160005	01.1556
140181	01.1426	140246	01.0563	150024	01.1237	150079	01.0457	160007	01.1055
140182	01.2568	140247	00.9911	150025	01.3614	150081	01.0184	160008	01.1519
140184	01.1014	140248	01.1118	150026	01.1812	150082	01.3254	160009	01.1063
140185	01.1861	140249	00.8427	150027	01.0504	150083	00.7980	160012	01.0730
140186	01.1058	140250	01.2152	150029	01.1537	150084	01.5492	160013	01.2090
140187	01.3028	140251	01.2348	150030	01.1319	150085	00.9362	160014	01.0236
140188	01.0060	140252	01.2092	150031	01.0050	150086	01.1204	160016	01.2157
140189	01.1215	140253	01.1574	150032	01.6010	150088	01.1491	160018	00.9835
140190	01.0197	140258	01.2640	150033	01.3729	150089	01.1780	160020	01.0597
140191	01.1593	140261	01.1360	150034	01.0951	150090	01.2816	160021	01.0152
140193	00.9731	140271	00.9998	150035	01.1535	150091	01.0715	160023	01.1150
140197	01.2627	140273	01.0922	150036	01.0408	150092	01.0785	160024	01.1701
140199	01.0755	140275	01.0938	150037	01.1741	150094	00.9770	160025	01.5256
140200	01.3528	140276	01.8067	150038	01.1323	150095	01.0639	160026	01.1347
140202	01.1783	140280	01.1405	150039	01.0176	150096	01.0142	160027	01.1097
140203	01.0743	140281	01.3876	150042	01.1548	150097	01.0558	160028	01.1239
140204	01.2221	140285	01.0858	150043	01.1076	150098	01.0551	160029	01.2414
140205	01.0373	140286	01.1591	150044	01.1524	150099	01.2293	160030	01.2464
140206	01.0755	140288	01.4058	150045	01.1345	150100	01.4091	160031	01.0639
140207	01.2015	140289	01.2448	150046	01.2989	150101	01.0211	160032	01.0459
140208	01.3273	140290	01.2333	150047	01.3292	150102	01.0526	160033	01.2436
140209	01.2780	140291	01.1928	150048	01.1600	150103	00.9834	160034	01.0014
140210	00.9988	140292	01.1455	150049	01.0131	150104	01.0924	160035	01.0147
140211	01.1241	140293	00.9685	150050	01.1539	150105	01.0921	160036	01.1877
140212	01.0647	140294	01.0653	150051	01.1968	150106	01.0035	160037	01.0602
140213	01.1608	140295	01.2165	150052	01.0271	150109	01.2255	160038	01.2063
140215	01.1360	140297	01.3156	150053	00.9704	150110	00.9156	160039	01.0041
140216	00.9240	140299	01.0352	150054	01.0411	150111	01.0840	160040	01.2148
140217	01.2721	150001	01.1238	150056	01.4916	150112	01.1433	160041	01.0671
140218	01.0377	150002	01.1427	150057	02.0467	150113	01.0887	160043	00.9978
140219	01.1854	150003	01.3345	150058	01.4064	150114	01.0323	160044	01.2385
140220	01.0952	150004	01.2032	150059	01.0815	150115	01.1933	160045	01.4446
140223	01.3536	150005	01.1351	150060	01.0884	150122	01.0919	160046	01.0303
140224	01.2973	150006	01.1942	150061	01.1111	150123	00.9755	160047	01.2345
140226	00.9572	150007	01.1007	150062	01.0008	150124	01.1354	160048	01.0734
140228	01.4979	150008	01.1921	150063	01.0996	150125	01.2708	160049	00.9223
140229	01.0715	150009	01.1917	150064	01.0582	150126	01.6186	160050	01.0389
140230	00.9651	150010	01.0655	150065	01.1423	150127	01.0862	160051	01.1232
140231	01.2551	150011	01.2057	150066	01.0743	150128	01.1195	160052	01.0874

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160053	01.1194	160109	01.0218	170017	01.1110	170075	00.8871	170138	01.1514
160054	01.0145	160110	01.3767	170018	01.0559	170076	01.0932	170139	01.0922
160055	01.0021	160111	01.1736	170019	01.2320	170077	00.9406	170140	01.0147
160056	01.0278	160112	01.2072	170020	01.1648	170079	00.9001	170142	01.2121
160057	01.2112	160113	01.0837	170021	01.0253	170080	00.9875	170143	01.1399
160058	01.5236	160114	01.0118	170022	01.1684	170081	01.0371	170144	01.3158
160059	01.2011	160115	01.0843	170023	01.2884	170082	00.9109	170145	01.1098
160060	01.0341	160116	01.0618	170024	00.9986	170084	00.9333	170146	01.2417
160061	01.0779	160117	01.2799	170025	01.1616	170085	01.0235	170147	01.1886
160062	01.0742	160118	01.0829	170026	01.0422	170086	01.4154	170148	01.1994
160063	01.1467	160119	00.9285	170027	01.1653	170087	01.2747	170150	01.0639
160064	01.2377	160120	01.0106	170030	00.9862	170088	01.0015	170151	01.0135
160065	01.0808	160122	01.0794	170031	00.9853	170089	00.8886	170152	00.9415
160066	01.1050	160123	01.1342	170032	01.0427	170090	00.9804	170159	00.9357
160067	01.1781	160124	01.1797	170033	01.1607	170092	01.0157	170160	00.9199
160068	00.9680	160126	01.1353	170034	00.9592	170093	01.0159	170164	01.2130
160069	01.2516	160129	01.0816	170035	00.9494	170094	00.9991	170166	00.9984
160070	00.9806	160130	01.1513	170036	00.9579	170095	01.0692	170168	01.0141
160071	01.2392	160131	01.1442	170037	01.1594	170097	00.9800	170170	01.1448
160072	01.0786	160132	01.1814	170038	01.0192	170098	01.0497	170171	01.1499
160073	00.9302	160133	01.1631	170039	01.0433	170099	01.0681	170172	00.9116
160074	01.1480	160134	00.9778	170040	01.3836	170100	00.8326	170173	01.0012
160075	01.0446	160135	00.8930	170041	01.0058	170101	01.0558	170174	00.9434
160076	00.9331	160138	01.0833	170043	01.0547	170102	00.9820	170175	01.1650
160077	00.9826	160140	01.0679	170044	01.2462	170103	01.2030	170176	01.3471
160079	01.2395	160141	00.9681	170045	01.0567	170104	01.2832	180001	01.1315
160080	01.0502	160142	01.0889	170046	00.9582	170105	01.0534	180002	01.0142
160081	01.0982	160143	00.9960	170049	01.1794	170106	01.0659	180004	01.1004
160082	01.5026	160145	01.0325	170050	01.0328	170108	00.9956	180005	01.0318
160083	01.3920	160146	01.2756	170051	01.0570	170109	01.0572	180006	00.8716
160085	01.1370	160147	01.2826	170052	01.0856	170110	00.9273	180007	01.3058
160086	00.9802	160151	01.0926	170053	00.9818	170112	00.9607	180009	01.0921
160088	01.0575	160152	01.0163	170054	01.1122	170113	01.1084	180010	01.5791
160089	01.1510	160153	01.4763	170055	01.0139	170114	01.1108	180011	00.9873
160090	01.0379	170001	01.1351	170056	00.9852	170115	01.0594	180012	01.1438
160091	01.1580	170002	01.2191	170057	01.0408	170116	01.1397	180013	01.2153
160092	01.0141	170003	01.0991	170058	01.0536	170117	01.0008	180014	01.4561
160093	00.9667	170004	01.0573	170060	00.9964	170119	00.9572	180015	01.0721
160094	01.0974	170005	00.9551	170061	01.0470	170120	01.1571	180016	01.1908
160095	01.1181	170006	01.1756	170062	00.9330	170121	00.8278	180017	01.1843
160097	01.2704	170007	01.1075	170063	00.9324	170122	01.5981	180018	01.1669
160098	01.1139	170008	00.9901	170064	01.0220	170123	01.3707	180019	01.1009
160099	01.0486	170009	01.1239	170066	00.9405	170124	01.0302	180020	01.0346
160101	01.1342	170010	01.0969	170067	01.0305	170125	00.9067	180021	00.9426
160102	01.2998	170011	01.2057	170068	01.1879	170126	00.9448	180023	00.8520
160103	00.9083	170012	01.3577	170069	01.0117	170128	01.0429	180024	00.9728
160104	01.0710	170013	01.2566	170070	00.9585	170131	01.1402	180025	01.1586
160106	01.1541	170014	01.0854	170072	00.9496	170133	01.1845	180026	01.0541
160107	01.0489	170015	01.0811	170073	01.1116	170134	01.0534	180027	01.0540
160108	01.1705	170016	01.4897	170074	01.1139	170137	01.1433	180028	00.9416

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 9 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180029	01.1586	180099	00.9614	190023	00.9428	190112	01.2548	190178	00.9494
180030	01.0066	180100	01.1427	190025	01.1152	190113	01.1459	190179	00.9595
180031	01.0222	180101	01.1431	190026	01.2457	190114	00.9694	190180	01.0348
180032	00.9019	180102	01.1990	190027	01.2970	190115	01.2351	190182	01.0364
180033	01.0769	180103	01.4593	190029	01.0964	190116	01.1282	190183	01.0540
180034	01.0263	180104	01.2956	190033	00.9220	190117	01.0271	190184	00.8960
180035	01.2253	180105	00.8795	190034	01.1662	190118	00.9937	190185	01.1802
180036	01.0391	180106	00.8799	190035	01.2919	190119	00.9871	190186	00.9249
180037	01.2129	180108	00.9034	190036	01.4173	190120	00.9719	190187	00.9177
180038	01.1458	180114	00.8942	190037	01.0235	190122	01.1560	190188	00.9909
180040	01.6100	180115	00.9919	190039	01.3691	190124	01.3373	190189	01.1295
180041	01.0107	180116	01.2323	190040	01.3046	190125	01.1820	190190	01.1181
180042	00.9810	180117	00.9893	190041	01.3338	190127	01.0950	190191	01.1371
180043	01.0038	180118	00.9516	190043	01.0396	190128	01.0381	190193	01.1605
180044	01.0056	180120	00.9347	190044	01.0174	190130	00.9370	190194	01.0700
180045	01.1176	180121	01.0156	190045	01.1960	190131	01.1308	190195	01.0331
180046	00.9958	180122	00.9014	190046	01.3159	190132	01.1007	190196	00.9954
180047	00.9792	180123	01.2243	190047	01.1558	190133	01.0263	190197	01.2074
180048	01.1093	180124	01.2287	190048	01.0497	190134	00.8518	190198	01.1043
180049	01.1599	180125	00.9573	190049	01.0581	190135	01.3462	190199	01.3461
180050	01.2292	180126	01.0856	190050	00.9930	190136	00.9694	190200	01.3006
180051	01.2231	180127	01.0875	190053	01.1811	190137	00.9747	190201	01.0277
180053	00.9172	180128	01.1193	190054	01.2859	190138	00.7599	190202	01.1560
180054	01.0628	180129	00.9816	190058	00.9863	190140	00.9805	190203	01.3474
180055	01.0113	180130	01.2852	190059	01.0106	190142	00.9732	190204	01.2926
180056	01.1023	180132	01.2163	190060	01.1729	190144	01.1202	190205	01.1457
180058	00.8773	180133	01.1805	190064	01.3068	190145	00.9363	190206	01.4665
180059	00.9374	180134	01.0958	190065	01.3673	190146	01.3378	190207	01.1207
180060	00.9150	180136	01.2265	190071	01.0157	190147	00.8941	200001	01.2242
180062	00.9135	180137	01.4236	190075	01.2014	190148	00.8697	200002	01.0769
180063	00.9426	180138	01.1401	190077	00.9721	190149	01.0587	200003	00.9571
180064	01.0531	190001	01.0359	190078	01.0750	190151	01.1291	200005	00.8615
180065	00.9399	190002	01.3822	190079	01.1156	190152	01.2309	200006	01.1295
180066	01.0132	190003	01.1238	190081	00.9512	190155	00.9867	200007	01.0226
180067	01.4668	190004	01.1594	190083	00.9144	190156	00.8741	200008	01.2088
180069	01.0248	190005	01.2160	190086	01.1764	190157	00.9168	200009	01.5634
180070	01.0866	190006	01.0889	190088	01.1276	190158	01.1362	200012	01.0847
180072	01.1104	190007	01.0078	190089	01.1196	190160	01.0548	200013	01.1417
180075	00.9306	190008	01.3997	190090	01.1492	190161	01.0368	200015	01.2101
180078	00.9350	190009	01.0861	190092	01.1704	190162	01.2695	200016	01.1048
180079	00.9647	190010	01.0948	190095	00.9299	190164	01.0885	200017	01.2214
180080	01.1368	190011	01.0376	190098	01.2906	190165	00.9877	200018	01.1312
180081	01.2500	190012	01.0593	190099	01.1347	190166	00.8922	200019	01.2601
180085	01.2207	190013	01.1460	190101	00.9311	190167	01.3031	200020	01.1128
180087	01.0013	190014	00.9808	190102	01.2560	190169	00.9879	200021	01.1305
180088	01.3921	190015	01.2091	190103	00.9305	190170	01.0059	200023	00.9741
180092	01.0272	190017	01.1762	190106	01.1519	190173	01.2411	200024	01.1641
180093	01.2462	190018	01.2147	190109	01.0378	190175	01.1593	200025	01.2239
180094	00.9741	190019	01.3477	190110	00.9871	190176	01.4233	200026	01.0017
180095	01.0770	190020	01.0968	190111	01.3291	190177	01.0976	200027	01.0817

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
200028	01.0413	210031	01.5240	220030	01.1000	220094	01.1194	230020	01.2265
200031	01.1661	210032	01.0714	220031	01.5806	220095	01.1094	230021	01.2174
200032	01.2587	210033	01.1003	220033	01.1741	220097	01.1029	230022	01.2184
200033	01.5911	210034	01.1347	220034	01.0773	220098	01.1712	230024	01.4306
200034	01.1953	210035	01.1166	220035	01.0895	220099	01.0936	230027	01.1200
200037	01.1553	210036	01.1164	220036	01.3655	220100	01.2378	230029	01.3116
200038	01.0468	210037	01.1564	220038	01.1272	220101	01.2079	230030	01.2586
200039	01.2610	210038	01.1655	220040	01.2016	220102	00.9454	230031	01.3382
200040	01.0836	210039	01.1111	220041	01.1084	220104	01.1112	230032	01.6930
200041	01.1115	210040	01.2790	220042	01.1030	220105	01.1101	230034	01.0459
200043	00.8092	210043	01.1575	220045	01.1765	220106	01.1178	230035	01.1260
200044	01.1446	210044	01.1601	220046	01.2803	220107	01.0500	230036	01.2543
200047	01.1501	210045	01.0469	220048	01.1214	220108	01.0790	230037	01.0063
200049	00.9632	210046	01.0510	220049	01.1515	220110	01.7746	230038	01.5276
200050	01.1707	210047	01.1714	220050	01.0408	220111	01.1335	230039	01.2921
200051	00.9897	210048	01.1114	220051	01.2077	220114	01.0731	230040	01.1892
200052	01.0626	210049	01.1904	220052	01.1842	220115	01.2915	230041	01.0900
200055	01.0413	210050	00 6864	220053	01.1584	220116	01.7056	230042	01.1157
200058	00.7707	210051	01 1974	220055	01.1650	220117	01.0382	230043	00.8224
200062	01.0623	210052	01.0923	220057	01.1605	220118	01 7723	230046	01.5655
200063	01.2145	210054	01.1493	220058	01 0557	220119	01.2189	230047	01.1365
200066	01 1324	210055	01 1359	220060	01.1215	220120	01.0502	230051	00.9817
210001	01.2344	210056	01 3282	220061	01.2091	220121	01.0464	230053	01.3381
210002	01 5384	210057	01 1467	220062	00 8922	220123	01.0069	230054	01.3812
210003	01 1715	210058	01 7118	220063	01.1057	220126	01.1732	230055	01.0537
210004	01 1782	210059	01 1693	220064	01 1839	220128	01.0822	230056	00.9669
210005	01 2376	220001	01 1826	220065	01.1220	220129	01.1597	230057	01.0083
210006	01 0369	220002	01 3061	220066	01 2285	220131	01.0904	230058	01.0908
210007	01 3958	220003	00 9989	220067	01 2002	220133	00.7624	230059	01.3867
210008	01 1409	220004	01.1511	220068	00 8217	220135	01.1121	230060	01.1135
210009	01 3188	220005	01 1326	220070	01 1432	220153	01 0354	230062	01.0868
210010	01 1331	220006	01 1919	220071	01 6108	220154	00.9250	230063	01.1693
210011	01 2107	220008	01 1777	220072	01 1003	220156	01.1411	230065	01.2263
210012	01 1939	220009	01.1582	220073	01.1578	220162	01 0610	230066	01.1730
210013	01 2529	220010	01 1393	220074	01 0842	220163	01.7642	230067	00.9226
210015	01 1864	220011	01 2007	220075	00 7557	220171	01.3423	230068	01.3015
210016	01 4431	220012	01 2152	220076	01 1624	230001	01 1611	230069	01.1021
210017	01 1146	220015	01 1718	220077	01 4503	230002	01.1419	230070	01.2998
210018	01.1898	220016	01 1514	220079	01 1432	230003	01.1356	230071	00.6860
210019	01 2653	220017	01 1935	220080	01 1438	230004	01.5059	230072	01.1280
210021	01 1635	220019	01 1044	220081	01 0283	230005	01.1524	230075	01.2598
210022	01 1612	220020	01 1386	220082	01 1530	230006	01.0497	230076	01.1764
210023	01 1391	220021	01 1461	220083	01 1802	230007	01.0507	230077	01.7057
210024	01 1883	220022	01 0571	220084	01 1345	230011	01.0940	230078	01.0588
210025	01 1124	220023	01 1731	220086	01 5091	230012	01.0868	230080	01.1634
210026	01 1738	220024	01 1519	220087	00 9251	230013	01.1979	230081	01.1035
210027	01 1955	220025	01 1071	220088	01 3943	230014	01.1010	230082	01.1783
210028	01 0559	220026	01 2203	220089	01 2020	230015	01.1088	230084	01.0553
210029	01 3224	220028	01 2156	220090	01 1118	230017	01 3613	230085	01.1281
210030	01 0478	220029	01 1242	220092	01 1746	230019	01.2612	230086	01.0331

NOTE CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 11 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230087	01.0791	230149	01.0920	230223	01.2086	240026	01.3128	240087	01.1497
230089	01.2140	230150	01.4965	230224	01.0714	240027	01.0548	240088	01.3980
230090	01.4388	230151	01.2997	230225	01.1401	240028	01.1127	240089	00.9942
230092	01.2571	230153	01.1762	230227	01.1802	240029	01.0869	240090	01.0581
230093	01.1210	230154	01.1120	230228	01.1702	240030	01.3095	240091	01.0452
230095	01.0993	230155	01.0095	230230	01.2863	240031	00.9538	240093	01.2924
230096	01.0877	230156	01.5042	230231	00.9732	240033	00.9676	240094	01.0671
230097	01.2317	230157	01.2483	230232	01.0739	240036	01.2723	240096	01.0524
230098	01.1478	230158	00.9482	230235	00.9736	240037	01.0255	240097	01.0442
230099	01.1145	230159	01.1940	230236	01.2324	240038	01.3651	240098	01.0071
230100	01.1149	230161	00.8807	230237	01.1500	240040	01.1014	240099	01.1460
230101	01.0848	230162	00.9848	230239	01.0733	240041	01.1650	240100	01.2056
230102	01.2025	230163	00.9111	230241	01.0991	240043	01.1785	240101	01.0744
230103	01.0711	230165	01.5596	230244	01.1718	240044	01.0781	240102	00.9428
230104	01.3573	230167	01.1937	230253	01.0813	240045	01.0647	240103	01.0506
230105	01.3748	230169	01.1659	230254	01.1780	240046	01.2716	240104	01.1933
230106	01.0901	230171	01.1674	230256	01.0891	240047	01.2669	240105	00.9691
230107	00.9918	230172	01.1207	230257	00.9820	240048	01.2443	240106	01.2408
230108	01.1303	230173	01.1468	230259	01.0784	240049	01.5971	240107	01.0629
230110	01.1912	230174	01.1711	230264	01.3228	240050	01.1137	240108	01.0190
230111	00.9732	230175	00.9071	230265	01.0565	240051	00.9542	240109	01.0052
230113	00.9482	230176	01.1337	230266	01.1158	240052	01.1960	240110	01.0776
230114	00.8872	230178	01.0894	230269	01.1505	240053	01.3716	240111	01.0248
230115	00.9558	230179	00.9313	230270	01.1908	240056	01.3257	240112	01.0743
230116	00.9107	230180	01.0786	230273	01.2843	240057	01.5934	240114	01.0047
230117	01.7438	230181	01.0807	230276	00.8097	240058	00.9848	240115	01.2480
230118	01.1982	230184	01.1212	230277	01.1197	240059	01.0460	240116	00.9559
230119	01.0291	230186	01.0785	240001	01.3606	240061	01.4090	240117	01.1252
230120	01.0564	230188	01.0668	240002	01.5005	240062	01.1555	240118	00.9854
230121	01.1596	230189	00.9580	240003	01.1525	240063	01.3179	240119	00.9005
230122	01.2099	230190	01.0402	240004	01.3368	240064	01.1884	240121	00.9589
230124	01.0818	230191	00.9033	240005	00.9426	240065	00.9563	240122	01.0973
230125	01.2936	230193	01.1751	240006	01.1794	240066	01.2423	240123	01.0657
230128	01.3004	230194	01.1366	240007	01.0843	240069	01.0612	240124	01.0458
230129	01.6825	230195	01.2569	240008	01.0491	240071	01.1043	240125	01.0589
230130	01.3299	230197	01.0968	240009	01.1521	240072	01.0185	240127	01.0307
230132	01.2617	230198	01.1679	240010	01.8533	240073	00.9891	240128	01.0572
230133	01.1705	230201	01.0440	240011	01.0230	240074	01.0562	240129	00.9366
230134	01.0835	230204	01.2327	240013	01.2600	240075	01.1514	240130	01.0429
230135	01.1814	230205	01.1591	240014	01.0831	240076	01.1800	240131	01.2833
230137	01.0588	230207	01.1411	240016	01.2776	240077	01.0135	240132	01.2384
230138	00.8890	230208	01.3302	240017	01.1816	240078	01.3235	240133	01.1181
230140	01.0945	230211	00.9362	240018	01.2016	240079	01.0926	240134	01.0501
230141	01.3518	230212	01.0950	240019	01.4049	240080	01.2293	240136	01.0058
230142	01.1449	230213	01.0257	240020	01.1465	240081	01.2955	240137	01.0851
230143	01.2824	230216	01.2639	240021	01.0254	240082	01.3120	240138	00.9734
230144	01.1429	230217	01.1521	240022	01.1078	240083	01.2575	240139	01.0662
230145	01.1410	230219	00.9067	240023	01.0484	240084	01.2570	240140	00.8723
230146	01.1319	230221	01.2010	240024	01.1208	240085	00.9004	240141	01.0238
230147	01.2447	230222	01.1831	240025	01.1713	240086	01.0921	240142	01.2206

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
240143	00.9912	250012	00.9273	250073	00.9423	250137	00.8628	260052	01.1551
240144	01.0081	250014	01.0045	250075	00.9433	250138	01.0284	260053	01.0870
240145	01.0019	250015	01.0159	250076	00.9045	250139	00.9145	260054	01.2222
240146	00.9930	250016	00.8628	250077	00.9051	250140	00.8755	260055	01.0630
240148	00.9501	250017	00.9005	250078	01.2181	260001	01.4340	260056	01.1122
240150	00.9869	250018	01.0146	250079	00.8556	260002	01.3375	260057	01.0542
240152	01.0220	250019	01.1509	250081	01.1209	260003	01.0349	260058	01.1941
240153	01.0368	250020	00.9693	250082	01.1043	260004	01.0497	260059	00.9919
240154	00.9686	250021	00.9090	250083	00.8746	260005	01.1939	260061	01.1092
240155	00.9858	250023	00.8992	250084	01.1070	260006	01.2691	260062	01.1395
240156	00.9618	250024	00.9321	250085	00.9771	260007	01.1687	260063	01.1545
240157	01.1274	250025	00.9833	250086	01.0194	260008	01.2411	260064	01.2272
240158	01.1935	250026	00.8558	250088	01.0448	260009	01.1738	260065	01.4152
240160	01.0044	250027	00.9438	250089	01.0016	260010	01.1677	260066	01.0312
240161	01.0317	250029	00.8852	250091	00.9088	260011	01.2576	260067	01.0490
240162	01.1279	250030	00.9071	250093	01.1221	260012	00.9328	260068	01.7320
240163	01.0240	250031	01.1171	250094	01.1322	260013	01.1247	260070	01.0309
240165	00.9607	250032	01.1692	250095	01.0299	260014	01.4240	260073	01.0118
240166	01.1417	250033	00.9084	250096	01.1049	260015	01.0474	260074	01.1148
240167	00.9017	250034	01.3188	250097	01.0780	260016	01.1003	260077	01.2563
240169	00.9443	250035	00.9125	250098	00.8920	260017	01.2288	260078	01.0583
240170	01.0958	250036	00.9572	250099	01.0801	260018	00.9995	260079	01.0233
240171	01.0809	250037	00.9479	250100	01.1586	260019	00.9974	260080	01.1676
240172	01.0532	250038	00.9158	250101	00.8895	260020	01.4032	260081	01.4210
240173	01.0078	250039	00.9318	250102	01.3658	260021	01.2517	260082	01.1620
240175	00.8993	250040	01.0673	250104	01.1697	260022	01.3765	260085	01.3544
240176	00.8596	250042	01.0452	250105	00.8789	260023	01.2244	260086	01.0274
240177	01.0684	250043	00.8623	250107	00.9231	260024	01.0583	260088	01.1599
240179	01.0464	250044	01.0092	250109	00.8959	260025	01.1855	260089	01.0848
240180	01.0218	250045	01.0533	250110	00.9324	260026	01.0422	260090	01.2996
240183	01.1786	250046	00.9721	250111	00.8397	260027	01.3377	260091	01.4352
240184	01.0042	250047	00.8864	250112	00.9273	260029	01.1340	260092	01.0096
240187	01.1608	250048	01.2611	250113	00.9354	260030	01.1440	260093	01.0597
240192	00.9418	250049	00.9202	250114	00.8516	260031	01.3602	260094	01.1039
240193	00.9429	250050	01.1600	250117	00.9623	260032	01.4510	260095	01.2957
240196	01.3765	250051	00.8500	250118	01.0504	260033	01.2928	260096	01.3333
240200	00.9361	250057	01.0358	250119	00.9296	260034	01.0639	260097	01.1522
240201	01.0210	250058	01.0773	250120	01.0615	260035	00.9834	260100	01.1008
240207	01.1862	250059	01.0004	250121	00.9602	260036	01.0613	260102	01.0554
240210	01.2955	250060	00.8165	250122	01.1993	260037	01.2415	260103	01.2042
250001	01.3791	250061	00.9927	250123	01.1109	260039	01.2658	260104	01.4094
250002	00.8609	250062	01.0416	250124	00.8891	260040	01.3348	260105	01.7396
250003	00.8786	250063	00.9072	250125	01.0524	260041	01.0590	260107	01.2457
250004	01.2593	250065	01.0152	250126	00.9770	260042	01.1540	260108	01.5593
250005	00.9911	250066	00.9068	250128	01.0579	260044	01.1035	260109	00.9835
250006	00.9529	250067	01.0799	250129	01.0424	260047	01.1818	260110	01.4035
250007	01.0321	250068	00.8624	250131	01.0021	260048	01.1554	260111	01.0736
250008	00.8651	250069	01.1203	250132	00.9932	260049	00.9341	260112	01.3148
250009	01.0931	250071	01.0072	250133	00.8569	260050	01.0212	260113	01.1223
250010	01.0148	250072	01.1222	250134	01.0132	260051	01.0778	260115	01.0767

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
. CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 13 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
260116	01.1430	270004	01.6625	270073	01.0244	280055	00.9958	280122	00.5067
260118	01.2451	270006	00.8845	270079	00.9506	280056	01.1050	290001	01.3778
260119	01.2422	270007	00.9627	270080	01.1401	280057	01.0551	290002	00.9762
260120	01.1454	270008	00.9363	270081	00.9518	280058	01.1387	290003	01.5105
260122	01.0553	270009	00.9995	270082	00.8982	280060	01.3170	290005	01.2205
260123	01.0007	270011	01.0975	270083	01.0722	280061	01.2777	290006	01.0306
260127	01.0295	270012	01.3620	280001	01.1084	280062	01.1250	290007	01.4606
260128	01.0648	270013	01.1548	280003	01.6649	280064	01.0915	290008	01.2197
260129	01.0793	270014	01.4380	280004	01.1393	280065	01.2414	290009	01.2920
260131	01.2475	270016	00.8973	280005	01.3801	280066	01.1335	290010	01.0822
260134	01.1056	270017	01.2475	280009	01.3143	280068	00.9104	290011	01.0415
260137	01.1734	270018	01.0156	280010	01.1475	280070	01.0210	290012	01.2065
260138	01.5596	270019	00.9260	280011	01.0272	280071	00.9497	290013	00.9549
260141	01.7046	270021	01.1128	280012	01.2409	280073	00.9954	290014	00.9711
260142	01.1765	270023	01.3066	280013	01.4791	280074	01.1065	290015	00.9165
260143	01.3462	270024	00.9325	280014	01.1328	280075	01.0871	290016	01.0507
260146	01.0092	270026	00.9341	280015	01.0289	280076	01.0047	290018	00.8192
260147	01.0156	270027	01.0717	280017	01.2278	280077	01.3137	290019	01.1323
260148	00.9096	270028	01.0253	280018	01.0186	280078	01.0647	290020	00.9161
260158	01.1813	270029	00.9887	280020	01.3601	280079	00.9240	290021	01.4112
260159	01.0140	270030	00.9383	280021	01.3793	280080	01.0296	290022	01.4946
260160	01.1576	270031	00.8965	280022	01.0764	280081	01.3291	290027	01.0346
260162	01.2053	270032	01.1098	280023	01.2702	280082	00.9169	290031	01.0115
260163	01.1448	270033	00.8677	280024	00.8928	280083	01.0219	290032	01.2212
260164	01.0677	270035	01.0164	280025	01.0498	280084	00.9911	290033	01.0437
260165	00.9847	270036	00.9629	280026	01.0304	280085	01.2450	300001	01.2352
260166	01.1787	270039	01.0723	280028	00.9248	280088	01.4897	300002	01.0816
260172	01.1124	270040	01.0800	280029	01.0137	280089	00.9986	300003	01.5878
260173	01.1686	270041	00.9687	280030	01.5165	280090	01.0121	300005	01.2267
260175	01.1589	270042	01.1630	280031	01.0382	280091	01.0674	300006	01.0530
260176	01.3369	270043	00.8183	280032	01.2002	280092	00.9139	300007	01.0457
260177	01.2982	270044	01.0497	280033	00.9992	280093	00.9158	300008	01.1262
260178	01.2752	270046	00.9439	280034	01.2722	280094	01.0376	300009	01.1950
260179	01.3668	270047	00.8434	280035	01.0035	280097	00.8741	300010	01.2180
260180	01.3547	270048	01.0087	280037	01.0851	280098	01.0021	300011	01.1918
260182	01.0545	270049	01.2801	280038	01.1854	280101	01.0655	300012	01.1945
260183	01.2727	270050	00.9665	280039	01.0150	280102	01.0543	300013	01.0625
260186	01.1102	270051	01.0767	280040	01.4682	280103	00.8920	300014	01.2168
260188	01.1698	270052	00.9028	280041	01.0981	280104	01.0076	300015	01.0737
260189	00.9924	270053	00.7952	280042	01.1273	280105	01.1736	300016	01.1676
260190	01.1317	270055	00.8111	280043	01.0398	280106	01.1097	300017	01.1881
260191	01.1798	270057	01.1639	280045	01.0674	280107	01.0661	300018	01.1999
260192	00.7967	270058	00.9615	280046	01.1560	280108	01.0454	300019	01.1450
260193	01.1808	270059	00.9644	280047	01.1384	280109	00.9380	300020	01.1050
260195	01.0480	270060	00.8575	280048	01.0302	280110	01.0913	300021	01.0893
260197	01.1440	270063	00.9200	280049	01.0891	280111	01.1890	300022	01.1218
260200	01.1025	270067	00.9362	280050	01.0080	280114	00.9572	300023	01.1678
270001	00.9084	270068	00.8914	280051	01.0656	280115	01.0861	300024	01.1553
270002	01.0460	270071	00.9122	280052	01.1090	280117	01.1919	300028	01.1186
270003	01.0885	270072	00.9470	280054	01.1529	280118	01.1628	300029	01.2416

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
300033	01.0041	310058	01.0549	320010	01.2212	330022	01.0086	330092	01.0171
300034	01.4557	310059	00.8795	320011	01.0436	330023	01.2056	330094	01.2128
310001	01.4248	310060	01.1843	320012	00.9911	330024	01.4789	330095	01.1482
310002	01.6940	310061	01.1234	320013	01.0016	330025	01.0338	330096	01.0324
310003	01.1234	310062	01.0568	320014	00.8993	330027	01.2269	330097	01.0855
310005	01.1586	310063	01.2395	320016	01.0515	330028	01.1811	330100	00.6224
310006	01.1528	310064	01.1957	320017	01.1823	330029	01.2245	330101	01.4885
310008	01.2239	310067	01.1463	320018	01.1893	330030	00.9796	330102	01.1848
310009	01.1318	310068	01.1807	320019	01.2438	330033	01.2644	330103	01.1583
310010	01.2015	310069	01.1107	320021	01.5681	330034	01.1423	330104	01.1941
310011	01.1826	310070	01.1995	320022	01.2463	330035	01.0567	330106	01.4784
310012	01.2631	310071	01.1644	320023	01.0641	330037	01.1100	330107	01.1516
310013	01.2232	310072	01.1671	320030	01.0203	330038	01.0979	330108	01.2179
310014	01.4201	310073	01.1790	320031	00.9155	330039	01.0271	330110	00.9785
310015	01.2591	310074	01.2318	320032	00.9684	330041	01.2350	330111	01.0827
310016	01.1472	310076	01.2434	320033	01.1338	330043	01.1384	330114	00.9990
310017	01.2575	310077	01.4991	320035	00.9550	330044	01.2083	330115	01.1234
310018	01.0780	310078	01.1875	320037	01.2026	330045	01.1895	330116	00.9831
310019	01.4535	310081	01.1429	320038	01.1550	330046	01.2850	330118	01.3471
310020	01.1505	310083	01.1227	320046	01.0297	330047	01.1474	330119	01.2138
310021	01.1910	310084	01.1677	320048	01.0639	330048	01.1731	330121	01.0084
310022	01.1814	310085	01.2039	320051	00.9949	330049	01.2496	330122	01.1184
310024	01.1997	310086	01.1747	320053	01.0221	330050	01.0717	330125	01.4887
310025	01.0928	310087	01.1570	320063	01.2510	330052	01.1768	330126	01.0879
310026	01.1452	310088	01.1445	320065	01.1249	330053	01.0456	330132	01.0782
310027	01.1814	310090	01.2154	320068	00.9936	330055	01.2461	330133	01.1863
310028	01.1071	310091	01.1652	320069	01.0987	330056	01.2238	330135	01.1110
310029	01.6091	310092	01.1907	320071	00.9227	330057	01.3084	330136	01.2473
310031	02.1063	310093	01.0932	320072	02.4145	330058	01.1295	330140	01.4891
310032	01.1304	310094	01.0973	320074	01.0751	330059	01.3454	330141	01.1753
310033	01.1577	310096	01.3424	320076	01.1303	330061	01.2031	330142	01.1745
310034	01.1554	310105	01.1010	320077	00.9003	330062	01.0073	330144	01.0111
310036	01.1503	310108	01.1737	330001	01.1586	330064	01.1935	330148	01.0386
310038	01.3908	310110	01.1399	330002	01.2178	330065	01.1801	330151	01.0808
310039	01.1789	310111	01.1763	330003	01.2487	330066	01.1387	330152	01.2167
310040	01.0752	310112	01.1261	330004	01.1793	330067	01.2302	330153	01.2545
310041	01.2112	310113	01.2071	330005	01.4311	330072	01.2157	330154	01.3056
310042	01.0883	310115	01.1733	330006	01.2440	330073	01.1134	330155	01.1674
310043	01.1692	310116	01.2072	330007	01.1838	330074	01.1089	330157	01.1812
310044	01.1923	310118	01.1616	330008	01.1208	330075	01.0236	330158	01.2006
310045	01.1462	310119	01.2760	330009	01.0338	330076	01.1269	330159	01.2806
310047	01.2722	310120	01.0781	330010	01.1335	330078	01.2415	330160	01.1912
310048	01.1972	310121	01.0467	330011	01.1285	330079	01.1772	330161	01.0381
310049	01.1755	320001	01.3382	330012	01.3668	330082	01.1335	330162	01.2580
310050	01.1293	320002	01.2178	330013	01.7798	330084	00.9818	330163	01.1155
310051	01.2526	320003	01.2205	330014	01.1691	330085	01.3105	330164	01.3086
310052	01.1897	320004	01.1158	330015	01.2404	330086	01.1439	330165	01.0774
310054	01.2589	320005	01.1816	330016	01.0472	330088	01.1842	330166	01.0413
310056	01.1396	320006	01.1443	330019	01.0911	330090	01.5243	330167	01.3680
310057	01.2319	320009	01.2327	330020	01.0007	330091	01.1728	330168	01.0565

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 15 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330169	01.1737	330241	01.6410	330338	01.1043	340030	01.6746	340099	01.1506
330171	01.2239	330242	01.1976	330339	00.9634	340031	01.1313	340100	01.1842
330174	00.9773	330244	01.0351	330340	01.0658	340032	01.3390	340104	01.0185
330175	01.0585	330245	01.2214	330345	00.8202	340034	01.3018	340105	01.2493
330176	00.9089	330246	01.2058	330350	01.6303	340035	01.0973	340106	01.0354
330177	01.0828	330247	00.6170	330351	01.0762	340036	01.0495	340107	01.2542
330179	00.9729	330249	01.1816	330353	01.1230	340037	01.2133	340109	01.2197
330180	01.2112	330250	01.1446	330354	00.9969	340038	01.2049	340111	01.2191
330181	01.1827	330252	00.8898	330357	01.2088	340039	01.1473	340112	00.9957
330182	02.0469	330254	00.9643	330359	00.9834	340040	01.5338	340113	01.7528
330183	01.2743	330256	00.9298	330372	01.1283	340041	01.1853	340114	01.2376
330184	01.1874	330257	01.0251	330381	01.1012	340042	01.1359	340115	01.3028
330185	01.1132	330258	01.1678	330386	01.1184	340044	00.9984	340116	01.4395
330186	01.1131	330259	01.1874	330387	00.8924	340045	01.0724	340119	01.1598
330188	01.1248	330261	01.1834	330389	01.7418	340047	01.6001	340120	01.0955
330189	00.7565	330263	00.9654	330390	01.0985	340049	00.6621	340121	01.0049
330191	01.1798	330264	01.0845	330391	01.5366	340050	01.1246	340122	01.0463
330193	01.2799	330265	01.2293	330393	01.4851	340051	01.2668	340123	01.1531
330194	01.3844	330267	01.1564	330394	01.1918	340052	00.9703	340124	01.0276
330195	01.4346	330268	01.1667	330395	01.2249	340053	01.4101	340125	01.3775
330197	01.0624	330270	01.7985	330397	01.2579	340054	00.9761	340126	01.2078
330198	01.1926	330272	00.9990	330398	01.1170	340055	01.2410	340127	01.1724
330201	01.2818	330273	01.1289	330399	01.1922	340060	01.0911	340129	01.1178
330203	01.2513	330275	01.1430	340001	01.2074	340061	01.5442	340130	01.1998
330205	01.0961	330276	01.1809	340002	01.5423	340063	01.0984	340131	01.2655
330208	01.1540	330277	01.0692	340003	01.1642	340064	01.0576	340132	01.2293
330209	01.1684	330279	01.1746	340004	01.3083	340065	01.1268	340133	01.1348
330210	01.0997	330281	00.8137	340005	01.1466	340067	00.9981	340135	00.9964
330211	01.1244	330285	01.3226	340006	01.0516	340068	01.1766	340136	00.8738
330212	01.0830	330286	01.1566	340007	01.1651	340069	01.6091	340137	01.0884
330213	01.0316	330288	01.0077	340008	01.0713	340070	01.2475	340138	01.1463
330214	01.5619	330290	01.4490	340010	01.3101	340071	01.0491	340141	01.2672
330215	01.1548	330291	01.0793	340011	01.0290	340072	01.0956	340142	01.1732
330217	01.0601	330293	01.0856	340012	01.1050	340073	01.2255	340143	01.3221
330218	01.1617	330297	01.0904	340013	01.1770	340075	01.1378	340144	01.1495
330219	01.2934	330304	01.1693	340014	01.4227	340076	01.0900	340145	01.1289
330221	01.1604	330306	01.2156	340015	01.2298	340079	00.9262	340146	00.9848
330222	01.1379	330307	01.0954	340016	01.1370	340080	01.0275	340147	01.2283
330223	01.0691	330308	01.1250	340017	01.1663	340084	01.0784	340148	01.2565
330224	01.1455	330309	01.1391	340018	01.3011	340085	01.2408	340151	01.0414
330225	01.1715	330314	01.1928	340019	01.1591	340087	01.0500	340153	01.9130
330226	01.1755	330315	01.0919	340020	01.1982	340088	01.1253	340154	00.8298
330229	01.1517	330316	01.2117	340021	01.2396	340089	00.9801	340155	01.3427
330230	01.2671	330320	01.1119	340022	01.1237	340090	01.1230	340157	01.2151
330232	01.1658	330327	00.9499	340023	01.1851	340091	01.4821	340158	01.0870
330233	01.2021	330331	01.0870	340024	01.1513	340093	01.0672	340159	01.1053
330235	01.1504	330332	01.0974	340025	01.1202	340094	01.2387	340160	01.0540
330236	01.2550	330333	01.1314	340026	00.9916	340096	01.1086	340162	01.1583
330238	01.0712	330335	01.1075	340027	01.1426	340097	01.0059	340164	01.2359
330239	01.1178	330336	01.0993	340028	01.2462	340098	01.5437	340166	01.2237

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
340167	00.7341	350061	01.0185	360053	01.1718	360107	01.1074	360165	01.0721
350001	01.0143	350065	00.9453	360054	01.2158	360108	01.0957	360166	00.9805
350002	01.4223	350067	00.8445	360055	01.1906	360109	01.0351	360167	00.8700
350003	01.1784	360001	01.1466	360056	01.1369	360110	00.7045	360168	00.9495
350004	01.5753	360002	01.1609	360057	01.0055	360112	01.3625	360169	00.9813
350005	01.1872	360003	01.2966	360058	01.1187	360113	01.1744	360170	01.0994
350006	01.1772	360006	01.5374	360059	01.2360	360114	01.0165	360171	01.1111
350007	00.9455	360007	01.0203	360061	00.8351	360115	01.1302	360172	01.2103
350008	00.9182	360008	01.1633	360062	01.4306	360116	01.0288	360174	01.1025
350009	01.1580	360009	01.1828	360063	01.0233	360118	01.2239	360175	01.1157
350010	01.1052	360010	01.1029	360064	01.3204	360119	01.0736	360176	01.1416
350011	01.5033	360011	01.2706	360065	01.1994	360121	01.0745	360177	01.0688
350012	00.9595	360012	01.2519	360066	01.1250	360122	01.1573	360178	01.1858
350013	00.9725	360013	01.1033	360067	01.1307	360123	01.1310	360179	01.1612
350014	00.9805	360014	01.1891	360068	01.2941	360124	01.2528	360180	01.8687
350015	01.5076	360015	01.3556	360069	01.0211	360125	01.0943	360184	01.0612
350016	01.0944	360016	01.2595	360070	01.2123	360126	01.1948	360185	01.2029
350017	01.2157	360017	01.4070	360071	01.1904	360127	00.9821	360186	00.9509
350018	00.9300	360018	01.2812	360072	01.1491	360128	01.1093	360187	01.1956
350019	01.3133	360019	01.1631	360074	01.2068	360129	01.0062	360188	01.0823
350020	01.2224	360020	01.1570	360075	01.3060	360130	01.0795	360189	01.1292
350021	01.0836	360021	01.1822	360076	01.1695	360131	01.1377	360192	01.2282
350023	00.9263	360022	01.1537	360077	01.2801	360132	01.1267	360193	01.1847
350024	00.9675	360024	01.1130	360078	01.1784	360133	01.2760	360194	01.0983
350025	01.0137	360025	01.1127	360079	01.5094	360134	01.3252	360195	01.1742
350027	01.0048	360026	01.0928	360080	01.1676	360135	01.0806	360197	01.0837
350029	00.8877	360027	01.3704	360081	01.1971	360136	00.9974	360200	01.1097
350030	01.0642	360028	01.1760	360082	01.2077	360137	01.4077	360203	01.0927
350031	01.0348	360029	01.0927	360083	01.0993	360139	01.1249	360204	01.0819
350032	01.1959	360030	01.0700	360084	01.3003	360140	01.0259	360210	01.1288
350033	00.9059	360031	01.1348	360085	01.4953	360141	01.2733	360211	01.0924
350034	00.9666	360032	01.1522	360086	01.1444	360142	01.0562	360212	01.2796
350035	00.8309	360034	01.1103	360087	01.1904	360143	01.1498	360213	01.1037
350036	00.9445	360035	01.3692	360088	01.0306	360144	01.2051	360218	01.2271
350038	00.9413	360036	01.1391	360089	01.0911	360145	01.2830	360230	01.2265
350039	00.9025	360037	01.5444	360090	01.2094	360147	01.1599	360231	01.1112
350041	00.9684	360038	01.2511	360091	01.2254	360148	01.1316	360232	01.1059
350042	01.0059	360039	01.1472	360092	01.1304	360149	01.0496	360234	01.1758
350043	01.1419	360040	01.1459	360093	01.0761	360150	01.1640	360236	01.1056
350044	00.8968	360041	01.1600	360094	01.0943	360151	01.1964	360238	01.0093
350047	00.9978	360042	01.0909	360095	01.2167	360152	01.2798	360239	01.1733
350048	00.9661	360044	01.1516	360096	01.0847	360153	01.0912	360240	01.9546
350049	01.0206	360045	01.3337	360098	01.2319	360154	01.0891	370001	01.5093
350050	00.9451	360046	01.0328	360099	01.0909	360155	01.1160	370002	01.0356
350051	00.8560	360047	01.0478	360100	01.1913	360156	01.0977	370004	01.0887
350053	00.9424	360048	01.3987	360101	01.3283	360159	01.1298	370005	00.9543
350055	00.8648	360049	01.1317	360102	01.1987	360161	01.2265	370006	01.1591
350056	00.9321	360050	01.1008	360103	01.2351	360162	01.0967	370007	01.1558
350058	00.9717	360051	01.3457	360104	01.0093	360163	01.4442	370008	01.1872
350060	00.9304	360052	01.4114	360106	01.0975	360164	01.1544	370011	00.9344

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 17 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370012	00.9415	370079	00.9362	370159	01.1757	380043	00.9815	390014	00.9855
370013	01.3430	370080	01.0308	370161	01.0365	380044	01.0528	390015	01.1294
370015	01.1228	370082	00.9469	370163	00.8992	380045	01.1510	390016	01.1085
370016	01.2224	370083	01.0252	370165	01.0479	380047	01.3747	390017	01.0659
370017	00.9583	370084	00.9332	370166	01.0031	380048	00.9349	390018	01.1858
370018	01.2137	370085	00.9421	370168	00.8790	380050	01.2065	390019	01.0637
370019	01.0539	370086	01.0468	370169	01.0451	380051	01.2564	390020	01.1541
370020	01.1482	370089	01.2203	370176	01.1231	380052	01.1990	390021	01.0572
370021	01.0051	370091	01.4219	370177	00.9453	380055	01.1722	390022	01.1230
370022	01.1761	370092	00.9650	370178	00.9919	380056	00.9833	390023	01.1985
370023	01.1468	370093	01.4365	370179	00.9713	380059	01.0025	390024	00.7180
370025	01.2234	370094	01.1738	370182	00.9462	380060	01.2595	390025	00.8565
370026	01.2644	370095	01.0093	370183	01.0589	380061	01.4031	390026	01.2064
370028	01.4528	370096	00.9989	370184	01.2499	380062	00.8565	390027	01.5285
370029	01.2204	370097	01.2445	380001	01.3786	380063	01.1160	390028	01.5788
370030	01.1780	370099	00.9762	380002	01.1629	380064	01.2567	390029	01.4828
370032	01.2201	370100	01.0226	380003	01.1437	380065	01.0734	390030	01.1207
370033	01.0536	370103	01.0593	380004	01.6233	380066	01.1715	390031	01.1604
370034	01.1111	370105	01.8384	380005	01.1306	380068	01.0939	390032	01.1706
370035	01.3676	370106	01.2500	380006	01.1631	380069	01.0662	390034	01.0873
370036	01.0747	370107	01.0027	380007	01.4470	380070	01.0148	390035	01.2899
370037	01.5240	370108	01.0498	380008	01.1110	380071	01.2243	390036	01.2435
370038	00.9384	370109	00.8910	380009	01.5651	380072	00.8680	390037	01.2026
370039	01.1237	370110	00.9755	380010	01.1736	380075	01.2214	390039	01.1032
370040	01.0747	370112	00.9691	380011	01.0343	380077	00.9557	390040	01.0491
370041	01.0117	370113	01.1474	380013	01.0515	380078	01.1079	390041	01.1351
370042	00.8814	370114	01.4130	380014	01.1487	380079	01.1806	390042	01.1916
370043	00.9473	370117	01.0631	380016	00.9259	380081	00.9713	390043	01.0505
370045	01.0766	370121	01.1255	380017	01.5552	380082	01.2104	390044	01.4219
370046	01.0585	370122	00.9166	380018	01.4891	380083	01.1262	390045	01.2382
370047	01.1087	370123	01.1277	380019	01.2593	380084	01.3678	390046	01.3563
370048	01.0037	370125	00.9769	380020	01.2627	380087	01.0079	390047	01.3886
370049	01.1410	370126	01.0063	380021	01.1925	380088	01.1439	390048	01.1428
370050	00.9523	370130	01.0025	380022	01.1803	380089	01.2385	390049	01.3331
370051	01.0003	370131	00.9207	380023	01.2380	380090	01.3123	390050	01.7141
370054	01.0963	370133	00.9952	380024	01.2303	380091	01.2305	390051	01.9470
370056	01.2253	370136	00.9975	380025	01.3004	380094	01.1538	390052	01.0758
370057	01.1423	370138	01.0317	380026	01.1667	390001	01.1983	390054	01.1688
370059	01.1549	370139	01.0429	380027	01.2689	390002	01.2264	390055	01.4846
370060	01.0011	370140	01.0155	380029	01.0369	390003	01.0960	390056	01.1064
370061	00.9175	370141	01.3346	380030	00.9756	390004	01.2407	390057	01.2373
370063	01.1100	370144	01.2033	380031	00.9681	390005	01.0528	390058	01 2628
370064	00.9962	370146	00.9797	380033	01.5034	390006	01.4772	390059	01.3544
370065	01.1517	370148	01.2202	380035	01.2671	390007	01.1398	390060	01.1708
370069	01.0429	370149	01.2093	380036	01.0818	390008	01.1727	390061	01.2204
370071	00.9030	370153	01.0890	380037	01.1662	390009	01.3396	390062	01.0947
370072	01.0005	370154	00.9799	380038	01.2102	390010	01.1006	390063	01.4640
370076	01.0944	370156	01.0044	380039	01.2151	390011	01.1834	390064	01.2997
370077	01.1490	370157	00.9893	380040	01.1152	390012	01.2048	390065	01.1665
370078	01.3671	370158	01.0441	380042	01.0503	390013	01.1793	390066	01.2153

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390067	01.4670	390127	01.1297	390186	01.0910	390260	01.2380	400112	01.1933
390068	01.2593	390128	01.1201	390187	01.1366	390261	01.6842	400113	01.0460
390069	01.1721	390130	01.0114	390188	01.0788	390262	01.3830	400114	01.0291
390070	01.1342	390131	01.2098	390189	01.0637	390263	01.3927	400115	01.0058
390071	01.1071	390132	01.0500	390191	01.1077	390265	01.2558	400116	01.1609
390072	01.0002	390133	01.3365	390192	01.0532	390266	01.1475	400117	01.1185
390073	01.1726	390135	01.2430	390193	01.1638	390267	01.1476	400118	01.0272
390074	01.1868	390136	01.1765	390194	01.0484	390268	01.1249	400119	01.1342
390075	01.2468	390137	01.1017	390195	01.3639	390270	01.1942	410001	01.1522
390076	01.1900	390138	01.2483	390196	01.1388	390272	01.1090	410002	01.0749
390077	01.2941	390139	01.4303	390197	01.2413	390275	00.6165	410004	01.2074
390078	01.0749	390143	00.9148	390198	01.1989	390276	00.8717	410005	01.2686
390079	01.6120	390145	01.1769	390199	01.2228	400001	01.1251	410006	01.2013
390080	01.1759	390146	01.1472	390200	01.0256	400002	01.2155	410007	01.3663
390081	01.1838	390147	01.1417	390201	01.3212	400003	01.1122	410008	01.0749
390083	01.1757	390148	01.0684	390203	01.2632	400004	01.1134	410009	01.1879
390084	01.1189	390149	01.1996	390204	01.1795	400005	01.0127	410010	00.9767
390086	01.1317	390150	01.1230	390205	01.1437	400006	01.1553	410011	01.1290
390088	01.2968	390151	01.2054	390206	01.2294	400007	01.0611	410012	01.3444
390090	01.5475	390152	01.0908	390209	01.0167	400008	01.0262	410013	01.1153
390091	01.1124	390153	01.1701	390211	01.1242	400009	00.9502	410014	01.1188
390092	01.1274	390154	01.1190	390213	00.9916	400010	00.8847	410016	01.0227
390093	01.1269	390155	01.2693	390215	01.1715	400011	01.0151	420002	01.2710
390095	01.2592	390156	01.2386	390217	01.0683	400012	00.9830	420003	01.1156
390096	01.2036	390157	01.1341	390219	01.1972	400013	00.9202	420004	01.7233
390097	01.3270	390158	01.2341	390220	01.1982	400014	01.2242	420005	01.0612
390098	01.5411	390159	01.1596	390222	01.2192	400016	01.1895	420006	01.2459
390100	01.5770	390160	01.1434	390223	01.5627	400017	01.0034	420007	01.4408
390101	01.2043	390161	01.0894	390224	00.9088	400018	01.0062	420009	01.1988
390102	01.2268	390162	01.1809	390225	01.2610	400019	01.0886	420010	01.0227
390103	01.0624	390163	01.1540	390226	01.4705	400021	01.3263	420011	01.0696
390104	01.1706	390164	01.4899	390228	01.2003	400022	01.1878	420014	01.0676
390106	01.0322	390165	01.0958	390229	01.2989	400023	00.5717	420015	01.1120
390107	01.1652	390166	01.1338	390231	01.2635	400024	01.0406	420016	01.0382
390108	01.2343	390167	01.1625	390232	01.1195	400025	00.9553	420017	01.0197
390109	01.2248	390168	01.1605	390233	01.2259	400026	00.9779	420018	01.5038
390110	01.1609	390169	01.1803	390234	01.3150	400027	01.0611	420019	01.1161
390111	01.5825	390170	01.5741	390235	01.6145	400028	01.0163	420020	01.1388
390112	01.1226	390171	01.0824	390236	01.0793	400029	01.1009	420022	01.2095
390113	01.1794	390172	01.1199	390237	01.4128	400032	01.0553	420023	01.1711
390114	01.0187	390173	01.0969	390238	00.8670	400087	01.1487	420026	01.6344
390116	01.1987	390174	01.4855	390242	01.1704	400088	00.7892	420027	01.1307
390117	01.0625	390176	01.1048	390244	00.9201	400089	00.9742	420028	00.9941
390118	01.0858	390178	01.3202	390245	01.2571	400090	01.0400	420029	01.4351
390119	01.2124	390179	01.1934	390246	01.1156	400094	01.0042	420030	01.0843
390121	01.1933	390180	01.2559	390247	01.0616	400098	01.0027	420031	00.9273
390122	01.1112	390181	01.0780	390249	01.0926	400102	01.1409	420032	00.9670
390123	01.1827	390183	01.0877	390252	00.9553	400106	00.9730	420033	01.2314
390125	01.1557	390184	01.0885	390256	01.5966	400109	01.0307	420035	00.7530
390126	01.1840	390185	01.1734	390258	01.1709	400111	01.0435	420036	01.1498

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
420037	01.2072	430011	01.2367	440005	00.9741	440068	01.0608	440153	00.9072
420038	01.0168	430012	01.2206	440006	01.2140	440069	01.1786	440156	01.2045
420039	01.0852	430013	01.1218	440007	00.9742	440070	00.9428	440157	00.8618
420040	01.2113	430014	01.1859	440008	01.0197	440072	01.1189	440159	01.1659
420042	01.0619	430015	01.0692	440009	00.9796	440073	01.1616	440160	00.9943
420043	01.0862	430016	01.2583	440010	01.0073	440074	00.9255	440161	01.4440
420044	01.1061	430017	01.1471	440011	01.2228	440078	00.9158	440162	01.0773
420048	01.0083	430018	00.9374	440012	01.2148	440079	00.8233	440166	01.2439
420049	01.0498	430020	00.9559	440014	00.9472	440081	01.1289	440167	01.1474
420050	00.9785	430022	00.9151	440015	01.4255	440082	01.6104	440168	00.9984
420051	01.4088	430023	00.9270	440016	00.9920	440083	00.8872	440170	01.2196
420053	01.1172	430024	01.0184	440017	01.2594	440084	01.1015	440171	00.9873
420054	01.1167	430025	00.9820	440018	01.1167	440087	00.8880	440173	01.1285
420055	01.0294	430026	00.9692	440019	01.4133	440090	00.9906	440174	00.9177
420056	01.1437	430027	01.5753	440020	01.0237	440091	01.2807	440175	01.0251
420057	01.0924	430028	00.9743	440022	01.1011	440095	00.9679	440176	01.1385
420059	01.1147	430029	00.9064	440023	00.9304	440100	01.0390	440177	00.9051
420061	01.0509	430030	01.0336	440024	01.1068	440102	01.0260	440178	01.1724
420062	01.0776	430031	00.9391	440025	01.0668	440103	01.0897	440180	00.9542
420064	01.0449	430033	00.9984	440026	01.1444	440104	01.3647	440181	01.0186
420065	01.1970	430034	01.0694	440029	01.1820	440105	00.8537	440182	00.9045
420066	00.9522	430036	01.0670	440030	01.0610	440109	01.0612	440183	01.2291
420067	01.0984	430037	00.9133	440031	01.0204	440110	01.0025	440184	01.0983
420068	01.1708	430038	01.0871	440032	00.9680	440111	01.1936	440185	01.0878
420069	01.0062	430039	00.9772	440033	01.0497	440113	01.0888	440186	00.9992
420070	01.1623	430040	00.9671	440034	01.2267	440114	01.0104	440187	00.9460
420071	01.1999	430041	00.9949	440035	01.1411	440115	01.0561	440189	01.4024
420072	00.8729	430042	00.9903	440038	00.9364	440117	00.8828	440191	01.1065
420073	01.1796	430043	01.0662	440039	01.4833	440120	01.2081	440192	01.0630
420074	00.9982	430044	00.8900	440040	00.9028	440121	01.1294	440193	01.0764
420075	00.9996	430047	01.0803	440046	01.0295	440125	01.2029	440194	01.0958
420076	01.0510	430048	01.0635	440047	00.9286	440130	01.1159	440196	00.9940
420078	01.3855	430049	00.9102	440048	01.3071	440131	01.0418	440197	01.2988
420079	01.3360	430054	00.9295	440049	01.3374	440132	00.9800	440200	00.9935
420080	01.2368	430056	00.9183	440050	01.0647	440133	01.3473	440203	00.9603
420081	01.0195	430057	00.9365	440051	00.9855	440134	01.0545	440204	01.0886
420082	01.2893	430060	01.0297	440052	00.8776	440135	01.1794	450002	01.2255
420083	01.1806	430062	00.8933	440053	01.1716	440136	01.0946	450004	01.0913
420084	00.7131	430064	00.9813	440054	00.9543	440137	01.0490	450005	00.9924
420085	01.2204	430065	00.9102	440055	01.0508	440141	00.9559	450007	01.2959
420086	01.1751	430066	01.0230	440056	00.9405	440142	00.8524	450008	01.2581
420087	01.3211	430072	01.1075	440057	00.9373	440143	00.9854	450010	01.2079
420088	01.1542	430073	01.0584	440058	01.0514	440144	01.0448	450011	01.2314
420089	01.1721	430076	01.0349	440059	01.0788	440145	00.9618	450013	01.3306
430004	01.0255	430077	01.2937	440060	01.0396	440146	00.9481	450014	01.0483
430005	01.1707	430080	00.9065	440061	01.1327	440147	00.8323	450015	01.3842
430007	01.0480	430087	00.8628	440063	01.1841	440148	00.9997	450016	01.3972
430008	01.1949	440001	01.0439	440064	00.9513	440150	01.2045	450018	01.3617
430009	01.0636	440002	01.3256	440065	01.0208	440151	01.1002	450019	01.1681
430010	00.9612	440003	01.0827	440067	01.0867	440152	01.3450	450020	01.0698

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450021	01.5173	450082	01.0157	450150	01.0788	450221	01.0819	450320	01.2249
450022	00.9913	450083	01.3159	450151	01.0682	450222	01.2520	450321	01.0157
450023	01.3570	450084	01.1260	450152	01.2816	450224	01.1124	450322	00.8863
450024	01.1998	450085	01.0931	450153	01.3613	450229	01.3371	450324	01.3594
450025	01.3912	450087	01.2969	450154	01.1825	450230	01.0773	450325	01.2158
450027	01.1170	450090	01.2182	450155	01.2511	450231	01.4142	450327	00.9635
450028	01.2507	450092	01.2917	450157	01.1054	450233	00.9861	450328	00.9693
450029	01.1955	450094	01.1768	450160	00.8550	450234	00.9524	450330	01.1962
450031	01.1866	450095	01.1103	450162	01.3935	450235	01.2193	450331	01.0263
450032	01.1725	450096	01.4080	450163	01.0722	450236	01.0740	450332	01.2406
450033	01.4960	450097	01.2774	450164	00.9872	450237	01.3607	450334	01.0228
450034	01.4045	450098	01.0770	450165	01.0543	450239	01.1225	450337	01.0310
450035	01.3621	450099	01.1718	450166	01.0386	450241	00.9740	450338	01.2604
450037	01.2547	450101	01.2556	450169	00.9109	450242	01.0587	450340	01.2113
450039	01.1473	450102	01.4001	450170	01.1451	450243	00.9697	450341	00.9250
450040	01.4546	450104	01.1344	450174	01.1537	450246	00.9801	450342	00.9662
450041	01.0079	450107	01.2258	450175	01.1241	450248	01.0771	450343	01.1102
450042	01.4779	450108	01.0467	450176	01.1262	450249	01.0059	450346	01.2473
450043	01.2170	450109	01.0258	450177	01.1062	450250	00.9890	450347	01.1493
450044	01.5300	450110	01.2068	450178	00.9978	450253	01.0504	450348	01.0829
450045	01.1834	450111	01.2934	450179	01.0619	450256	00.9680	450349	01.2703
450046	01.2931	450112	01.1975	450181	00.9637	450258	00.8999	450351	01.2843
450047	01.1247	450113	01.0796	450182	00.8937	450259	01.1182	450352	01.1988
450048	01.0667	450115	01.1201	450183	01.1677	450263	01.1398	450353	01.1930
450050	01.0380	450116	01.0753	450184	01.3536	450264	00.9343	450355	01.0045
450051	01.5758	450118	01.3014	450185	00.9869	450268	01.1293	450357	01.1848
450052	01.1163	450119	01.2064	450187	01.3319	450269	01.0062	450358	01.6608
450053	01.0392	450121	01.2064	450188	01.0400	450270	01.0474	450359	00.8300
450054	01.4780	450122	00.9723	450190	01.1988	450271	01.1573	450362	01.0031
450055	01.1552	450123	01.1624	450191	01.2438	450272	01.1638	450365	01.0897
450056	01.3780	450124	01.4337	450192	01.0885	450275	01.0092	450366	01.2853
450057	01.1707	450126	01.2616	450193	02.0452	450276	01.0645	450369	01.1478
450058	01.3650	450128	01.2428	450194	01.1018	450278	00.9469	450370	01.0816
450059	01.2039	450130	01.3619	450195	01.2349	450280	01.2739	450371	01.0777
450060	01.2856	450131	01.1668	450196	01.2444	450281	01.3650	450372	01.2583
450063	01.0024	450132	01.3408	450197	01.1557	450283	01.0374	450373	01.0820
450064	01.3651	450133	01.2105	450200	01.2234	450286	01.2038	450374	00.8477
450065	01.0309	450134	01.1586	450201	01.0528	450288	01.1443	450376	01.3426
450066	01.3767	450135	01.3864	450203	01.1659	450289	01.1172	450378	01.2744
450068	01.3425	450137	01.1864	450206	01.0481	450292	01.1499	450379	01.3962
450070	01.0799	450140	00.9603	450207	01.1799	450293	00.9842	450381	01.0756
450072	01.1157	450141	00.9632	450208	01.1261	450296	01.0336	450388	01.4323
450073	01.0849	450142	01.1657	450209	01.2121	450299	01.2699	450389	01.1523
450074	01.1169	450143	01.0568	450210	01.1043	450303	00.9588	450391	01.1553
450076	01.1237	450144	01.1308	450211	01.1623	450305	00.8652	450393	01.2811
450077	00.9797	450145	01.0474	450213	01.2404	450306	01.0979	450394	01.1738
450078	01.0582	450146	00.9021	450214	01.1189	450307	01.1620	450395	01.0700
450079	01.3315	450147	01.2405	450217	01.0366	450309	01.1542	450399	01.0370
450080	01.1682	450148	01.2279	450218	01.0785	450315	01.2856	450400	01.1528
450081	01.1256	450149	01.2698	450219	01.0796	450317	00.9540	450403	01.2841

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 21 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450410	01.0500	450537	01.1918	450629	00.7779	450698	00.9036	460021	01.2185
450411	01.0506	450538	01.3057	450630	01.5312	450700	00.9723	460022	00.9975
450415	01.1373	450539	01.1908	450631	01.5240	450702	01.2440	460023	01.1351
450416	01.2190	450544	01.2109	450632	00.9251	450703	01.0875	460024	01.0020
450417	00.9174	450545	01.2856	450633	01.4349	450704	01.1744	460025	00.9249
450418	01.2794	450546	01.2404	450634	01.2052	450705	00.9396	460026	00.9841
450419	01.1955	450547	00.9613	450635	01.2702	450706	01.1987	460027	00.9117
450422	00.7865	450550	01.1261	450638	01.3840	450709	01.1294	460029	00.9286
450423	01.1947	450551	01.0152	450639	01.2232	450711	01.3448	460030	01.0626
450424	01.1079	450557	00.9970	450641	00.9146	450712	00.8095	460032	00.9998
450425	00.9875	450558	01.6413	450643	01.1135	450713	01.1874	460033	00.9097
450429	00.9838	450559	00.9888	450644	02.3840	450715	01.2138	460035	00.9523
450431	01.3545	450561	01.3221	450646	01.1861	450716	01.1277	460036	00.9619
450438	01.2137	450563	01.1452	450647	01.6844	450717	01.1950	460037	00.9739
450440	00.9148	450565	01.1407	450648	01.1230	450718	01.1296	460039	00.9044
450446	00.9762	450568	01.0259	450649	01.0119	450719	01.0880	460041	01.1858
450447	01.2435	450569	01.0644	450651	01.3982	450723	01.2205	460042	01.2806
450450	01.0344	450570	01.0050	450652	00.9581	450724	01.3433	460043	01.2245
450451	01.1956	450571	01.2702	450653	01.3225	450725	00.8773	460044	01.1416
450454	00.9503	450573	01.1007	450654	01.0180	450726	00.9649	460046	01.1079
450457	01.4254	450574	00.9224	450656	01.1857	450727	01.1857	470001	01.1489
450458	00.9158	450575	01.0818	450658	01.0108	450728	01.0816	470003	01.6099
450460	01.0071	450578	00.9814	450659	01.3612	450729	00.9720	470004	01.0813
450462	01.3690	450580	01.1254	450660	01.4812	450730	01.2971	470005	01.1945
450464	00.9543	450581	01.1325	450661	01.0309	450732	01.0226	470006	01.1404
450465	01.1372	450583	00.9969	450665	01.1010	450733	01.1982	470008	01.1337
450467	01.1069	450584	01.2319	450666	01.2779	450734	01.1446	470010	01.0926
450469	01.2444	450586	01.1638	450667	00.9445	450735	00.9138	470011	01.2409
450472	01.1642	450587	01.1785	450668	01.4009	450737	00.9416	470012	01.1606
450473	01.0253	450590	00.9148	450670	01.1317	450739	01.1608	470013	01.0624
450475	01.1381	450591	01.1155	450672	01.3892	450742	01.2153	470015	01.1572
450476	00.9701	450596	01.1276	450673	01.0255	460001	01.4939	470016	01.0441
450481	01.0198	450597	01.1134	450674	00.9617	460003	01.4526	470018	01.0930
450484	01.1480	450600	00.9925	450675	01.1519	460004	01.4497	470020	00.9849
450486	01.0151	450603	00.8612	450677	01.2658	460005	01.2550	470023	01.2368
450488	01.0346	450604	01.2166	450678	01.2920	460006	01.2075	470024	01.1140
450489	01.1469	450605	01.2048	450679	00.9839	460007	01.1671	490001	00.9479
450492	00.9847	450607	00.9997	450681	01.4409	460008	01.1703	490002	00.9389
450493	00.9861	450609	01.0110	450682	01.1778	460009	01.5022	490003	00.7651
450497	01.1823	450610	01.2879	450683	01.2908	460010	01.7114	490004	01.1869
450498	00.9523	450613	01.0520	450684	01.1966	460011	01.1337	490005	01.2719
450508	01.2749	450614	01.0337	450685	01.2121	460012	01.4163	490006	01.1572
450513	00.9869	450615	00.9932	450686	01.3122	460013	01.4315	490007	01.5827
450514	01.1083	450617	01.3618	450687	01.0987	460014	01.0885	490008	01.0328
450517	00.9885	450620	01.2280	450688	01.1103	460015	01.2163	490009	01.5216
450518	01.1524	450621	01.0121	450690	01.2262	460016	00.8987	490010	01.1421
450523	01.3206	450623	01.0187	450691	01.2584	460017	01.2709	490011	01.1865
450530	01.2284	450626	01.1676	450694	01.1624	460018	00.8813	490012	01.0920
450534	00.9719	450627	01.1332	450696	01.2160	460019	01.0697	490013	01.0815
450535	01.2012	450628	00.9771	450697	01.2648	460020	00.9857	490014	01.4038

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
490015	01.2335	490088	01.0749	500015	01.2248	500075	01.2624	510012	01.0609
490017	01.2516	490089	00.9967	500016	01.3459	500076	01.2865	510013	01.1178
490018	01.0953	490090	01.1650	500017	01.1745	500077	01.2213	510014	01.1645
490019	01.1373	490091	01.2181	500019	01.1464	500078	01.2571	510015	00.9668
490020	01.0197	490092	01.0880	500020	01.2186	500079	01.1411	510016	00.9906
490021	01.1066	490093	01.1899	500021	01.3496	500080	00.9561	510018	01.1223
490022	01.2028	490094	01.0793	500023	01.1358	500084	01.1269	510019	00.8780
490023	01.1382	490095	01.1936	500024	01.3214	500085	01.0409	510020	01.0527
490024	01.4047	490097	01.0840	500025	01.8917	500086	01.2730	510022	01.4006
490027	01.0381	490098	01.2012	500026	01.2476	500087	01.2476	510023	01.0197
490028	01.1406	490099	01.0609	500027	01.4868	500088	01.2773	510024	01.1852
490029	01.0819	490100	01.2293	500028	00.9678	500089	01.0904	510025	00.9405
490030	01.1490	490101	01.0901	500029	00.9462	500090	00.8906	510026	00.9656
490031	01.0601	490104	00.8512	500030	01.3436	500092	01.0688	510027	01.1060
490032	01.6038	490105	00.8645	500031	01.1683	500093	01.1297	510028	01.1014
490033	01.1914	490106	00.9408	500033	01.2590	500094	01.1652	510029	01.1290
490035	01.0502	490107	01.1371	500034	01.0630	500096	01.1415	510030	01.0845
490037	01.0796	490108	00.9423	500035	01.3385	500097	01.0295	510031	01.1744
490038	01.1073	490109	00.8442	500036	01.2087	500098	00.8900	510033	01.1900
490040	01.1883	490110	01.0472	500037	01.0752	500100	01.0634	510035	00.9627
490041	01.1376	490111	01.0578	500039	01.2103	500101	00.9330	510036	01.1656
490042	01.1363	490112	01.4024	500040	01.1557	500102	00.9871	510038	01.0643
490043	01.1417	490113	01.0776	500041	01.2157	500104	01.1747	510039	01.1453
490044	01.1636	490114	01.0443	500042	01.2139	500106	00.8779	510040	01.0102
490045	01.1253	490115	01.0595	500043	01.1359	500107	01.1233	510043	01.0647
490046	01.2324	490116	01.0471	500044	01.7901	500108	01.6028	510045	00.8546
490047	01.1093	490117	00.9860	500045	01.1417	500109	01.1229	510046	01.2810
490048	01.2023	490118	01.4439	500046	01.2746	500110	01.2335	510047	01.1705
490050	01.1690	490119	01.2194	500048	00.8947	500114	01.2893	510048	01.1111
490052	01.3321	490120	01.2442	500049	01.2346	500118	01.1931	510050	01.1510
490053	01.2049	490122	01.1471	500050	01.1491	500119	01.2542	510053	00.9994
490054	01.0793	490123	01.1031	500051	01.3726	500122	01.2577	510054	00.9034
490055	00.8856	490124	01.2198	500053	01.1122	500123	00.8361	510055	01.1826
490057	01.1876	490125	00.9572	500054	01.7028	500124	01.2393	510058	01.1903
490059	01.2713	490126	01.1030	500055	01.0040	500125	01.2434	510059	00.8316
490060	01.0082	490127	01.0233	500057	01.1932	500129	01.5164	510060	01.1223
490063	01.3814	490129	01.0499	500058	01.2598	500132	00.9727	510061	01.0431
490066	01.0359	490130	01.1495	500059	01.2549	500133	01.1469	510062	01.1250
490067	01.1135	490131	00.9183	500060	01.1096	500135	01.1551	510063	01.2277
490069	01.1725	500001	01.3090	500061	01.1017	500139	01.1500	510064	01.0663
490071	01.1602	500002	01.3322	500062	01.0217	510001	01.3715	510065	01.0075
490073	01.1557	500003	01.2474	500064	01.4033	510002	01.1586	510066	01.0958
490074	01.2634	500005	01.5250	500065	01.1387	510003	01.0665	510067	01.1553
490075	01.1711	500007	01.2742	500068	00.9845	510004	01.0003	510068	01.1123
490077	01.1260	500008	01.9605	500069	01.0206	510005	00.9895	510070	01.1219
490078	00.9311	500009	01.2840	500070	01.0996	510006	01.1871	510071	01.2529
490079	01.1091	500010	01.1657	500071	01.0947	510007	01.2848	510072	01.1053
490083	00.7464	500011	01.2084	500072	01.1755	510008	01.1588	510074	00.9492
490084	01.0591	500012	01.3834	500073	01.1381	510009	01.1057	510076	00.9475
490085	01.0518	500014	01.5119	500074	01.1857	510011	00.9010	510077	00.9974

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

TABLE 3D : HOSPITAL CASE MIX INDEXES FOR COST REPORTING PERIODS BEGINNING IN FY1987 PAGE 23 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
510080	00.9437	520051	01.6768	520116	01.1119	530006	01.0903		
510081	01.0151	520053	01.0491	520117	01.0240	530007	01.1810		
510082	00.9709	520054	01.1011	520118	00.9370	530008	01.0768		
510084	00.9699	520056	01.1258	520120	01.0173	530009	01.0392		
510085	01.1383	520057	01.0850	520121	01.0274	530010	01.0686		
510086	01.0004	520058	01.0907	520122	01.0129	530011	01.1873		
520001	01.2564	520059	01.2320	520123	01.0765	530012	01.4136		
520002	01.2540	520060	01.1432	520124	01.0952	530014	01.1296		
520003	01.1329	520062	01.1916	520126	00.9266	530015	01.1064		
520004	01.2628	520063	01.2328	520127	00.9422	530016	01.1172		
520006	01.0985	520064	01.3930	520130	00.9797	530017	00.9429		
520007	01.0683	520066	01.1874	520131	01.0939	530018	01.0423		
520008	01.1746	520068	00.9821	520132	01.1962	530019	00.9077		
520009	01.3156	520069	01.2111	520134	01.0401	530022	01.0237		
520010	01.0721	520070	01.2540	520135	00.9544	530023	00.9157		
520011	01.1012	520071	01.1394	520136	01.3746	530024	01.0068		
520012	00.9831	520074	01.0801	520138	01.6740	530025	01.2337		
520013	01.2198	520075	01.2845	520139	01.2532	530026	01.1011		
520014	01.1754	520076	01.1756	520140	01.3105	530027	00.9788		
520015	01.1966	520077	01.0775	520141	01.0120	530029	01.0934		
520016	01.0373	520078	01.2193	520142	00.9465	530031	00.9567		
520017	01.1046	520081	01.2206	520143	01.0334	530032	00.9759		
520018	01.1005	520082	01.2150	520144	00.9892				
520019	01.1881	520083	01.4238	520145	01.0671				
520020	01.3339	520084	01.0724	520146	01.1752				
520021	01.1635	520087	01.4048	520148	01.1442				
520022	01.0612	520088	01.1729	520149	01.0785				
520024	00.9991	520089	01.2566	520151	01.0116				
520025	01.0975	520090	01.1199	520152	01.1309				
520026	01.0899	520091	01.3479	520153	01.0399				
520027	01.1958	520092	01.1165	520154	01.1236				
520028	01.3055	520094	01.3587	520156	01.0896				
520029	00.9801	520095	01.2119	520157	01.0499				
520030	01.3711	520096	01.1669	520159	00.9490				
520031	01.1672	520097	01.2411	520160	01.6914				
520032	01.1610	520098	01.5468	520161	01.0327				
520033	01.1988	520100	01.1087	520167	01.1716				
520034	01.2232	520101	01.1224	520170	01.1499				
520035	01.1610	520102	01.1134	520171	00.9675				
520037	01.5429	520103	01.2561	520173	01.1305				
520038	01.1756	520104	00.8933	520174	01.3299				
520039	01.0417	520105	00.9702	520175	00.7773				
520040	01.2548	520107	01.1882	520177	01.3250				
520041	01.0950	520109	01.0349	520178	01.2083				
520042	01.0851	520110	01.0468	520184	00.7029				
520044	01.2866	520111	01.0995	530001	01.0927				
520045	01.4440	520112	01.0898	530002	01.1657				
520047	00.9605	520113	01.1869	530003	00.9091				
520048	01.2729	520114	01.1055	530004	01.0428				
520049	01.6844	520115	01.1455	530005	01.0684				

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH NOVEMBER 1989.

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BILLING CODE 4120-03-C

federal register

Friday
April 20, 1990

Part VI

The President

Proclamation 6116—National Farm Safety Week, 1990

Memorandum of April 18, 1990—Delegation of Authority To Ratify Office of Thrift Supervision Actions Taken Before April 9, 1990

Digest

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Presidential Documents

Title 3—

The President

Proclamation 6116 of April 18, 1990

National Farm Safety Week, 1990

By the President of the United States of America

A Proclamation

During the 1990's, our Nation's strength and prosperity will largely depend—as they have in the past—upon a strong agricultural base. The abundance of low-cost, high-quality food and fiber produced by our farmers and ranchers is vital to sustaining the health and well-being of the American people, as well as the Nation's economic productivity and competitiveness.

Tragically, however, those Americans engaged in agricultural production continue to bear a high rate of accidental death, injury, and illness. The costs in terms of lost productivity are enormous; the toll in personal suffering and loss is immeasurable.

Far too many farming and ranching accidents involve children, who are at increased risk from workplace hazards. Compounding the severity of many farming-related injuries and illnesses is the geographic distance of farms and ranches from municipal emergency assistance. When an accident, fire, or other crisis occurs, the time that must be spent waiting for help can make a situation life-threatening. Injuries and death from occupational accidents and illnesses are all the more tragic because most are preventable.

Advances in science and technology have made agricultural tools and chemicals safer, but these advances alone cannot eliminate all the safety risks of farming. As always, farmers and ranchers, workers, and their family members must take responsibility for implementing the steps necessary to establish and maintain a safe and healthy farming or ranching operation.

Work-related injuries and illness often can be prevented through simple, sensible measures that involve little or no extra time, effort, or expense. These measures include the proper and consistent use of standard protective equipment; controlling exposure to toxic chemicals and gases; and training everyone on the ranch or farm in safety procedures and first aid.

The busy harvest season is a most fitting time to express our concern and our appreciation for the Nation's farmers and ranchers. During National Farm Safety Week, we renew our support for programs designed to protect their health and safety. All of these hardworking Americans should be able to reap the fruits of their labor with a sense of achievement and security.

NOW, THEREFORE, I, GEORGE BUSH, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim the week of September 16 through September 22, 1990, as National Farm Safety Week. I urge all persons who live and work on farms and ranches to make their safety and health—on the job, on the road, at home, and at leisure—a priority. I also urge them to protect their children, not only by instruction in safe practices but also by personal example. I call upon agricultural organizations to strengthen their support for community health and safety programs, and I encourage all Americans to take part in appropriate activities in observance of National Farm Safety Week as we acknowledge the many contributions that men and women in agriculture make to our Nation.

IN WITNESS WHEREOF, I have hereunto set my hand this eighteenth day of April, in the year of our Lord nineteen hundred and ninety, and of the Independence of the United States of America the two hundred and fourteenth.

George Bush

[FR Doc. 90-9451
Filed 4-19-90; 12:29 pm]
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Presidential Documents

Memorandum of April 18, 1990

Delegation of Authority To Ratify Office of Thrift Supervision Actions Taken Before April 9, 1990

Memorandum for the Director of the Office of Thrift Supervision

By the authority vested in me as President of the United States by the Constitution and laws of the United States, including section 301 of title 3 of the United States Code, I hereby delegate to the Director of the Office of Thrift Supervision my authority to ratify actions taken on behalf of, or in the name of, the Office of Thrift Supervision or its Director before April 9, 1990.

This memorandum shall be published in the **Federal Register**.

George Bush

THE WHITE HOUSE,
Washington, April 18, 1990

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federal register

Friday
April 20, 1990

Part VII

Department of Health and Human Services

Centers for Disease Control

Requirement for a Special Permit To Import Cynomolgus, African Green, or Rhesus Monkeys Into the United States; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers For Disease Control

Requirement for a Special Permit to Import Cynomolgus, African Green, or Rhesus Monkeys into the United States

AGENCY: Centers for Disease Control (CDC), Public Health Service, HHS.

ACTION: Notice of CDC Requirement for Special Permit to Import Cynomolgus, African Green, and Rhesus Monkeys into the United States.

SUMMARY: Effective immediately, no person may import into the United States, nor distribute out of quarantine, any cynomolgus (*Macaca fascicularis*), African green (*Cercopithecus aethiops*), or rhesus (*Macaca mulatta*) monkeys unless accompanied by a special permit issued in advance by the Director, CDC. This special permit requirement is separate from, and in addition to, continued compliance with existing regulations pertaining to the importation of nonhuman primates which are contained in 42 CFR 71.53, including the isolation and quarantine measures made mandatory on March 15, 1990.

This special permit procedure, authorized under Sections 361 to 368 of the Public Health Service Act and 42 CFR 71.54, is based upon the current determination by the Director, CDC, that these three species of monkeys are capable of being an animal host or vector of human disease. In order to receive a special permit to import any of these three species of primates, at least thirty days prior to proposed importation, a registered importer of nonhuman primates must submit to the Director, CDC, a written plan which specifies the steps that will be taken to prevent exposure of persons and animals during the entire importation and quarantine process for the arriving nonhuman primates. Importation cannot occur until receipt of written approval of the plan by the Director, CDC.

BACKGROUND: Beginning in November 1989, a number monkeys imported into the United States were found to have been infected with a filovirus related to Ebola virus from Africa. This virus has been isolated directly from cynomolgus monkey blood and tissues and antibody to the virus has been detected in cynomolgus, African green, and rhesus monkeys.

On January 19, 1990, CDC published in the *Morbidity and Mortality Weekly Report* (MMWR) interim guidelines for handling nonhuman primates during transit and quarantine (MMWR 1990;39:22–4,29–30). Based upon additional developments during the next two months, CDC notified all importers by letter of March 15, 1990, that compliance with these isolation and quarantine standards was made a mandatory condition for continued registration as an importer of nonhuman primates under 42 CFR part 71. On March 23, 1990, an announced public meeting (55 FR 10288) was held in Atlanta, Georgia, to allow all interested parties to comment concerning (1) actions taken to date to prevent the importation of filoviruses into the United States and their transmission to animal handlers; (2) potential impact of the imposition of a temporary ban on the importation into the United States of cynomolgus monkeys; and (3) additional disease control measures.

On April 4, 1990, CDC reported that four animal handlers at a quarantine facility in the United States had demonstrated serologic evidence of recent infection with the strain of this virus isolated from infected cynomolgus monkeys (MMWR 1990;39:30).

Recent serologic evidence indicates that approximately 5–10% of cynomolgus, African green, and rhesus monkeys coming into the United States have previously been infected with a filovirus—this is true irrespective of their origins in Africa or Asia (Philippines, Indonesia, and China).

Considering information currently available, CDC concludes that these three species are capable of being an animal host or vector of human disease. Until further information can obtained about the risk of human illness following infection and about the means of transmission of filoviruses from monkeys to humans, public health practice requires that more stringent precautions now be applied with respect to the importation of these three species.

IMPLEMENTATION PROCEDURES: Under the authority of section 362 of the Public Health Service Act (42 U.S.C. 265) and 42 CFR 71.54, and in addition to the provisions of 42 CFR 71.53 for registration of importers of nonhuman primates, effective immediately, no person may import into the United States, nor distribute out of quarantine, any cynomolgus, African green, or rhesus monkeys unless accompanied by a special permit issued in advance by the Director, CDC.

In order to receive a special permit to import any of these three species, no less than thirty days in advance of proposed importation, a registered importer must submit to the Director, CDC, a written plan which specifies the steps that the importer will take to prevent filovirus exposure of persons and animals during the entire importation and quarantine process. CDC will review all special permit plans on a case-by-case basis and will grant approvals in accordance with prudent public health practice at the time of evaluation. Importation cannot occur until receipt of written approval of the plan by the Director, CDC.

The United States Customs Service will not allow entry into the United States of any shipments of these three species of monkeys not accompanied by a copy of the special permit issued by CDC.

SPECIAL PERMIT PLANS: Any plan submitted to CDC by a registered importer for the importation and quarantine of monkeys covered under this special permit arrangement must address disease prevention procedures to be carried out in every step of the chain of custody of such monkeys, from the time of embarkation at the country of origin until delivery of these animals safely out of quarantine.

The elements (referenced by number) to be addressed by any special permit plan must include, at a minimum:

A. Basic Information
1. Number and species of monkeys
2. Origin of monkeys (country, exporter, address)
3. Anticipated use of monkeys—scientific, educational, or exhibition
4. Name and exact location of quarantine facility
5. Means of individually identifying monkeys

B. Transit Information
1. Specific itinerary with names, dates, flights, and responsible parties to contact at every step of travel, including all ground transportation
2. Description of caging
3. Procedures to protect and train transport workers
4. Procedures to prevent contamination of other articles and cargo during transit, including physical separation of cages from other cargo
5. Procedures to decontaminate aircraft, vessel, and/or vehicles following transport
6. Proposed use, if any, of transit holding facilities and steps to be taken to protect workers, as well as animals, from disease exposure at each holding facility to be used en route

C. Isolation and Quarantine Precautions
1. Worker protection plan to include:
a. Written infection-prevention program
b. Hazard evaluation and worker communication procedures
c. Training requirements for workers
d. Infection-prevention methods (e.g., personal protective equipment, work practices, housekeeping)
e. Medical surveillance and medical assessment and treatment of workers

2. Physical security procedures of quarantine area
3. Disinfection procedures for apparel, supplies, equipment, waste, etc., and disposal of remains of dead animals
4. Description of caging and room arrangement
5. Description of procedures to be used to assure the integrity of the isolation of each lot of animals in the quarantine unit
6. Record-keeping and reporting procedures

D. Procedures for testing of quarantined animals
1. Testing at entry into quarantine
2. Testing prior to release from quarantine
3. Record-keeping and reporting procedures
4. Description of laboratory methodology and laboratory to be used
5. Quarantine decision logic if positive serology or seroconversion occurs
6. Post mortem procedures for animals dying during quarantine

E. Such additional information as the importer feels will be useful in reviewing the plan

The Director, CDC, may request clarification or additional information, if needed. CDC anticipates that initial approvals of special permits will be made on a shipment-by-shipment basis. As this process evolves and more experience develops, CDC may subsequently grant special permits on a broader basis for multiple shipments and/or specific intervals of time.

In submitting plans for approval, registered importers should indicate to CDC any specific information that CDC should consider proprietary pertaining to origins of monkeys, customer lists, and similar proprietary information. However, applicants should be aware that CDC intends generally to share publicly large portions of the application in order to expedite dialogue pertaining to the developing technical issues on appropriate quarantine and disease prevention methodology.

CDC recognizes that the lack of current knowledge about certain aspects of the present situation make risk assessment and risk management decisions particularly difficult. Interested parties should realize that as new information becomes available, appropriate disease prevention practices may be altered to reflect such additional input. Since this special permit procedure may also have to be changed to reflect unanticipated developments CDC will make every effort to provide timely communication to the public of pertinent data.

EFFECTIVE DATE: Immediately.

FOR FURTHER INFORMATION OR TO REQUEST SPECIAL PERMITS, CONTACT: Mr. Charles R. McCance (404–639–1455), Director, Division of Quarantine, Centers for Disease Control, Atlanta, Georgia 30333.

Dated: April 17, 1990.

William L. Roper,

Director, Centers for Disease Control.

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