

(5)(a) *Training Provider:* Engineering Continuing Education University of Washington.

Address: GG-13, Seattle, WA 98195, Contact: Susan G. Stone, Phone: (206) 543-5539.

(b) *Approved Courses:*

Inspector/Management Planner (contingent from 1/26/88 to 6/1/90 only).

Inspector/Management Planner (full from 2/8/88 to 6/1/90 only).

(6)(a) *Training Provider:*

Environmental Health Sciences Lake Washington Vo-Tech.

Address: 11605 132nd Ave., NE., Kirkland, WA 98034, Contact: Dave Rodewald, Phone: (206) 828-5643.

(b) *Approved Courses:*

Inspector/Management Planner (full from 4/11/88).

Inspector/Management Planner Refresher Course (contingent from 1/14/89).

Inspector/Management Planner Refresher Course (full from 1/27/89).

Project Designer (contingent from 12/11/89).

(7)(a) *Training Provider:*

Environmental Management, Inc.

Address: P.O. Box 91477, Anchorage, AK 99509, Contact: Debra Chrisman or Gordon Randall, Phone: (907) 272-8056.

(b) *Approved Course:*

Inspector/Management Planner (full from 4/18/88).

(8)(a) *Training Provider:* Hazcon, Inc.

Address: 4636 Marquial Way S., Suite 215, Seattle, WA 98134, Contact: Mike Krause, Phone: (206) 763-7364.

(b) *Approved Courses:*

Inspector/Management Planner (contingent from 3/1/88).

Inspector/Management Planner (full from 4/4/88).

Inspector/Management Planner Refresher Course (contingent from 1/18/89).

Inspector/Management Planner Refresher Course (full from 1/30/89).

(9)(a) *Training Provider:* Heavey

Engineers, Inc.

Address: 113 Russell St., P.O. Box 832, Stevenson, WA 98648-0832, Contact: Bernard Heavey, Phone: (509) 427-8936.

(b) *Approved Courses:*

Inspector/Management Planner (contingent from 4/13/88).

Inspector/Management Planner (full from 5/2/88).

Inspector/Management Planner Refresher Course (contingent from 1/18/89).

Inspector/Management Planner Refresher Course (full from 3/10/89).

(10)(a) *Training Provider:* NAC Corporation/Northwest Asbestos Consultants.

Address: 1005 Northwest Galveston, Suite E, Bend, OR 97701, Contact: Dale Schmidt, Phone: (503) 389-9727.

(b) *Approved Courses:*

Inspector/Management Planner Refresher Course (contingent from 4/25/89).

Inspector/Management Planner Refresher Course (full from 7/24/89).

(11)(a) *Training Provider:* Northwest Envirocon, Inc.

Address: P.O. Box 169, Washougal, WA 98671, Contact: Debbie Stevison, Phone: (503) 659-8899.

(b) *Approved Courses:*

Inspector/Management Planner (contingent from 4/13/88).

Inspector/Management Planner (full from 5/2/88).

(12)(a) *Training Provider:* PBS Environmental Building Consultants, Inc.

Address: 1220 South West Morrison, Portland, OR 97205, Contact: Kelly Strother, Phone: (503) 248-1939.

(b) *Approved Courses:*

Inspector/Management Planner (contingent from 2/4/88).

Inspector/Management Planner (full from 3/14/88).

Inspector/Management Planner Refresher Course (contingent from 3/14/89).

Inspector/Management Planner Refresher Course (full from 6/30/89).

Project Designer (contingent from 6/9/89).

Project Designer (full from 6/19/89).

Project Designer Refresher Course (contingent from 10/25/89).

Project Designer Refresher Course (full from 9/18/90).

(13)(a) *Training Provider:* South East Regional Resource Center, Inc.

Address: 210 Ferry Way, Suite 200, Juneau, AK 99801, Contact: William Suss, Phone: (907) 586-6806.

(b) *Approved Courses:*

Inspector/Management Planner Refresher Course (contingent from 4/18/89).

Inspector/Management Planner Refresher Course (full from 6/1/90).

(14)(a) *Training Provider:* Specialized Environmental Consulting, Inc.

Address: P.O. Box 363, Wauna, WA 98395, Contact: Raymond Donahue, Phone: (206) 857-3222.

(b) *Approved Courses:*

Inspector/Management Planner Refresher Course (contingent from 3/7/89).

Inspector/Management Planner Refresher Course (full from 3/20/89).

(15)(a) *Training Provider:* University of Alaska, Mining & Petroleum Training Services.

Address: 155 Smith Way, Suite 104, Soldotna, AK 99669, Contact: Dennis D. Steffy, Phone: (907) 262-2788.

(b) *Approved Courses:*

Inspector/Management Planner (contingent from 2/16/88).

Inspector/Management Planner (full from 4/11/88).

Inspector/Management Planner Refresher Course (contingent from 1/14/89).

Inspector/Management Planner Refresher Course (full from 4/2/91).

(16)(a) *Training Provider:* Valley Research Corporation.

Address: 1299 E. 2400 St., Hagerman, ID 83332, Contact: Leon Urie, Phone: (208) 837-6437.

(b) *Approved Courses:*

Contractor/Supervisor (contingent from 10/20/89).

Contractor/Supervisor (full from 6/8/90).

(17)(a) *Training Provider:* Washington Association of Maintenance & Operations Administrators, WAMOA.

Address: 12037 Northeast Fifth, Bellevue, WA 98005, Contact: Colin MacRae, Phone: (206) 455-6054.

(b) *Approved Courses:*

Inspector/Management Planner Refresher Course (contingent from 4/25/89).

Inspector/Management Planner Refresher Course (full from 7/24/89).

Dated: August 15, 1991.

Mark A. Greenwood,

Director, Office of Toxic Substances.

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Part III

Department of Agriculture

Food and Nutrition Service

7 CFR Parts 271 and 273

Food Stamp Program: Establishment of Outcome-Based Performance Standards for the Employment and Training Program; Proposed Rule

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

7 CFR Parts 271 and 273

[Amendment No. 341]

Food Stamp Program; Establishment of Outcome-Based Performance Standards for the Employment and Training Program

AGENCY: Food and Nutrition Service, USDA.

ACTION: Proposed rule.

SUMMARY: This rule proposes to amend the Food Stamp Program regulations by establishing new performance standards for the Food Stamp Employment and Training (E&T) Program as mandated by the Hunger Prevention Act of 1988 (Pub. L. 100-435). The statute requires the Secretary of Agriculture to establish performance standards to be measured by the employment outcomes of E&T participants and to be based on the degree of success reasonably expected of State agencies in helping E&T participants achieve self-sufficiency. The proposed performance standards would replace the current performance standards that require State agencies to place a minimum percentage of eligible E&T participants into program components. The Department anticipates that the change in performance standards would significantly affect Food Stamp E&T Programs operated by State agencies, as focus shifts beyond participation in E&T to the employment results of program participation. The Department would hold State agencies accountable for implementing the performance measurement system as required by the final rulemaking.

DATES: Comments on this proposed rulemaking must be received on or before October 29, 1991, to be assured of consideration.

ADDRESSES: Comments should be submitted to Ellen Henigan, Supervisor, Work Program Section, Food Stamp Program, Food and Nutrition Service, USDA, 3101 Park Center Drive, room 718, Alexandria, Virginia 22302. All written comments will be open to public inspection at this same address during regular business hours (8:30 a.m. to 5 p.m., Monday through Friday).

FOR FURTHER INFORMATION CONTACT: Questions regarding this proposed rulemaking should be directed to Ellen Henigan at the above address or by telephone at (703) 756-3762.

SUPPLEMENTARY INFORMATION:
Classification*Executive Order 12291 and Secretary's Memorandum 1512-1*

This action has been reviewed under Executive Order 12291 and Secretary's Memorandum No. 1512-1. The Department has classified this action as designated nonmajor. The annual effect of this action on the economy would be less than \$100 million. This action would not result in major increases in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions. It would not have significant adverse effects on competition, investment, productivity and innovation or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. This rule would have a beneficial effect on employment in that it would serve to improve the operations of the Food Stamp Employment and Training Program, thereby improving efforts to assist food stamp recipients to obtain and retain employment.

Executive Order 12372

The Food Stamp Program is listed in the Catalog of Federal Domestic Assistance under No. 10.551. For the reasons set forth in the final rule and related notice to 7 CFR part 3015, subpart V (48 FR 29115, June 24, 1983), this program is excluded from the scope of Executive Order No. 12372 which requires intergovernmental consultation with State and local officials.

Regulatory Flexibility Act

This action has also been reviewed with regard to the requirements of the Regulatory Flexibility Act of 1980 (5 U.S.C. 601 through 612). Betty Jo Nelsen, Administrator of the Food and Nutrition Service, has certified that this rule would not have a significant economic impact on a substantial number of small entities. State and local welfare agencies would be affected to the extent that they must administer their employment and training programs in a manner that meets the minimum performance standard and must collect certain participant data to measure this performance standard.

Paperwork Reduction Act

The reporting and recordkeeping requirements contained in 7 CFR 273.7(c) of this regulation come under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). This rule proposes two models for the implementation of outcome-based performance standards under the Food Stamp E&T Program. Comments

received in response to the proposed rule will determine which model will be selected. Both models would require changes to the current reporting requirements. The title, description, and respondent description of the information collections for each model are shown below with an estimate of the annual reporting and recordkeeping burdens. Included in the estimate is the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Model A

Title: Employment and Training (E&T) Program Report.

Description: Public Law 100-435 mandates the establishment of performance standards that are outcome-based rather than performance-based. Consequently, this rulemaking proposes the collection and reporting of data not currently collected under the Food Stamp E&T Program while retaining most of the reporting and recordkeeping requirements associated with the current Form FNS-583 (OMB No. 0584-0339). Data would continue to be reported on a quarterly basis. Form FNS-583 would be revised to accommodate the new reporting and recordkeeping requirements.

Description of Respondents: State agencies.

Estimated Annual Reporting and Recordkeeping Burden: Proposed burden estimates associated with the need for 53 State welfare agencies to submit the proposed information collection on individuals on a quarterly basis is estimated to average 685.655 hours, per respondent, for a total burden of 145,359 hours annually. An additional .025 hours (42,500 annual hours) is estimated to be needed to work register 1,700,000 individuals on an annual basis. These combined information collection activities are estimated to require a total of 187,859 hours annually. The burden estimate for the current information collection (OMB No. 0584-0339) is 231,827 hours annually.

Model B

Title: Employment and Training (E&T) Program Report.

Description: Under Model B, State agencies would be required to submit quarterly reports as well as an annual report. The quarterly reports would include baseline and outcome data for the treatment and control group samples. The annual report would include the results of the State agencies' impact analysis of the outcome data

collected for the treatment and control group samples. Like Model A, this rulemaking proposes the collection and reporting of data not currently collected under the Food Stamp E&T Program while retaining most of the reporting and recordkeeping requirements associated with the current Form FNS-583 (OMB No. 0584-0339). Form FNS-583 would be revised to accommodate the new reporting and recordkeeping requirements—part A would incorporate the quarterly reporting requirements and part B would be used for the annual reporting requirements.

Estimated Annual Reporting and Recordkeeping Burden: Proposed burden estimates associated with the need for 53 State welfare agencies to submit the proposed information collection for the quarterly report is estimated to average 1084.628 hours, per respondent, for a total burden of 229,941.14 hours annually. The proposed burden estimates associated with the need for 53 State welfare agencies to submit the proposed information collection for the annual report is estimated to average 2.375 hours, per respondent, for a total burden of 125.916 hours annually. An additional .025 hours (42,500 annual hours) is estimated to be needed to work register 1,700,000 individuals on an annual basis. These combined information collection activities are estimated to require a total of 272,567.05 hours annually. (Note: This burden estimate does not include estimates of time needed for computer programming and operation and the development and execution of the sampling and random assignment methodologies.) The burden estimate for the current information collection (OMB No. 0584-0339) is 231,827 hours annually.

Both Models

Title: Revision to E&T Plan.

Description: State welfare agencies are required pursuant to 7 CFR 272.2 to plan and budget program operations and establish objectives for the next year. The basic components of the State Plan of Operation are the Federal/State Agreement, the Budget Projection Statement, the Program Activity Statement, and certain attachments as specified at 7 CFR 272.2 (c) and (d). One such attachment to the Plan is the E&T plan. The requirement in § 273.7(c)(5)(viii) of this action that a State agency which opts to offer an education component under its E&T program must revise the E&T plan to specify the goals or improvements expected by the education component does not alter or change current burden estimates approved under OMB No. 0584-0083 for the overall State Plan of

Operation. Certain portions of the State Plan of Operation are required to be updated annually, this includes the E&T plan, while others are required to be updated when a significant change occurs. The revision to the E&T plan resulting from this action is not required to be submitted separate from the annual update. Current burden approval for the State Plan of Operation estimates that State agencies will submit State Plan of Operation revisions or updates to various components of the State Plan of Operation at least once annually, regardless of the reason for the revision/update.

Description of Respondents: 53 State welfare agencies.

Estimated Annual Reporting and Recordkeeping Burden: Current burden estimates associated with the need for 53 State welfare agencies to submit revisions/updates on various components of the State Plan of Operation at least once annually is estimated to average 10 hours, per respondent, for a total burden of 530 hours annually.

As required by section 3504(h) of the Paperwork Reduction Act of 1980, the Department has submitted a copy of this proposed rule to Office of Management and Budget for its review of these information collection requirements. Other organizations and individuals desiring to submit comments regarding this burden estimate or any other aspect of these information collection requirements, including suggestions for reducing the burdens, should direct them to the Department of Agriculture, Food and Nutrition Service, Food Stamp Program, Program Development Division (address above); and to the Office of Information and Regulatory Affairs, Office of Management and Budget, room 3208, New Executive Office Building, Washington, DC 20503, Attn: Laura Oliven, Desk Officer for FNS.

Background

Overview

This rule proposes to establish new performance standards for the Food Stamp E&T Program as mandated by the Hunger Prevention Act of 1988 (Pub. L. 100-435). The statute requires the implementation of standards based on the employment outcomes of E&T participants no later than October 1, 1991. These proposed standards would replace the current participation-based standards at 7 CFR 273.7.

The Hunger Prevention Act of 1988 provided specific instruction that the performance standards established by the Secretary take into account certain factors. The factors, or measures, by

which the Department must evaluate employment outcomes include job placement rates, wage rates, job retention rates, households ceasing to need food stamp benefits, improvements in household members' educational levels and the extent to which persons elect to participate. The Act also required that State agencies should be encouraged to serve individuals with the greatest barriers to employment.

The Department strove to design a performance measurement system which satisfies the legislative mandate while still being sensitive to the limited amount of funding which goes into the Food Stamp E&T Program and the administrative burden associated with a system which collects sufficient data to respond to the mandate.

As the regulation development proceeded it became increasingly clear that fulfilling the legislative requirements precludes administrative simplicity. The Department is eager to receive specific suggestions from commenters on alternative designs which comport with the Act and can be implemented through a less elaborate system than the two proposed in this rulemaking.

The Department is also open to ideas about ways the Food Stamp Act of 1977 could be amended to allow for a performance system which would require fewer State resources and enable closer conformity with the Department of Health and Human Services' (DHHS) Job Opportunities and Basic Skills (JOBS) Program (42 U.S.C. 3601 *et. seq.*). One such idea is a statutory amendment to delay implementation of the E&T outcome-based performance standard system until DHHS has developed and implemented its outcome-based performance standard system for the JOBS program.

Two Models

There are many ways to comply with the directives in the Act and measure outcomes of E&T activities. This rule is unusual in that it proposes two alternative approaches to outcome-based standards. Both conform to the spirit of the Act and are feasible to implement nationwide. Both incorporate methods of encouraging service to persons regarded as hard to employ.

Model A is based largely on the performance standards of the Job Training and Partnership Act (JTPA) Program (29 U.S.C. 1501 *et. seq.*) administered by the Department of Labor (DOL). In the development of Model A the Department was guided by the objective that the performance

standards should define a minimally acceptable level of performance expected of State agencies. This is the basic objective of the DOL in setting the standards for JTPA.

Model A relies on measures of gross outcomes which are measured for individuals as of the time they terminate E&T participation. The model uses regression adjustments to control for factors affecting outcomes which are beyond the control of State E&T managers. It sets a national point of departure for each of four measures, and then provides for State-specific adjustments for economic and demographic factors and for characteristics of the persons served.

By using termination from an activity as a reference point, State flexibility is enhanced and there is no disincentive to place persons in long-term components. This point of measurement provides quick feedback to program operators who would know, within a short period of time, whether or not the activity was successful in producing the employment goal.

Model A gives State agencies a goal to strive for in each measure, which would let program operators know how the measures of their program fare compared to others nationwide. Although this model would let State agencies view their outcomes against a national goal, the net impacts of E&T programs would not be discernable. Future evaluations would have to be undertaken by the Department or others to determine the net impact of the E&T intervention.

Model B measures the impact of the program using randomly assigned treatment and control groups within each State. With this model State program managers would be able to ascertain whether or not participants are closer to self-sufficiency for having taken part in the Food Stamp E&T Program within the State. Because samples would be representative at the State level, applicability of the measures at the local level would be limited.

Use of a randomly assigned control group in each State permits estimation of unbiased measures of the effect the State agency's program had on the outcomes of participants, compared to what would have occurred in the absence of the program, i.e., the net impact of the E&T intervention.

Data for the control and treatment groups would be collected for essentially the same outcome measures used in Model A. These measures will be described in detail later in this preamble. The Department proposes to collect these data in the month of

assignment to the sample and six months later.

Treatment and control groups within States, if randomly assigned, eliminate the need to adjust for interstate economic and demographic differences, as well as for differences in the characteristics of the E&T population.

The Department is proposing that a statistically significant finding of no effect or a positive effect (i.e., a higher result for the treatment group than for the control group) would be the standard for each measure for the first two years of this system. A statistically significant finding of a negative effect (i.e., a higher result for the control group than for the treatment group) would be an indicator of poor program performance.

This preamble will first discuss the evolution of the proposed models and their commonalities, and follow with overviews of each model and detailed descriptions of various aspects of outcome-based performance standard systems, including how these aspects would be dealt with by Models A and B. The proposed regulation language is separated into two different versions, one for each model.

The public is encouraged to judge both models on their merits, and provide comments on each, and which is the preferred model. The Department is eager to ascertain the public's perception of the overall value of each model as an evaluation mechanism, the anticipated cost, and reporting burden. Ideas for alternate measurement systems are welcome and encouraged, as well as suggestions for future modifications. The Department intends to choose one model by which all State agencies would be judged.

As State agencies comment on the proposed rule, the Department would appreciate discussion of the relative merits of the various other Federal employment programs, to provide a suitable context for evaluating the Food Stamp E&T Program. State agencies may describe the relative priority of each program within the State, populations served and the findings of any relevant evaluations. Suggestions on how funds could be used more effectively are welcome.

In addition, the Department invites State agencies to indicate the target populations they currently serve or plan to serve, as well as current sources of training funds, e.g., State-financed training programs for General Assistance (GA) participants, etc.

Goals

Among the most fundamental issues addressed by the Department are the

definition of the goals of the performance standards system and the ramifications of selecting different outcome measures on the types of programs State agencies might offer.

The performance standard systems proposed in this rule are compatible with a wide range of State-designed E&T programs and include incentives for State agencies to give priority service to work registrants over persons who volunteer, and within the work registrant group required to participate in E&T, to give priority service to persons with greater barriers to employment. To encourage the State agencies to operate meaningful programs, the Department proposes a requirement that each State agency annually serve at least ten percent of the E&T mandatory population.

Both models propose to measure outcomes of State agencies' E&T programs in terms of the number of participants that find jobs (job entries), the average hourly wage paid to participants, the number of the Food Stamp case closures and the extent of educational improvements.

Pursuant to section 404(d) of the Hunger Prevention Act, the Department sought input from other Federal, State and local agencies operating similar programs, as well as members of the academic community and representatives of food stamp households. In particular, great attention was given to establishing conformity, when possible, in the policies, definitions and practices used by DOL for the JTPA program and by DHHS for the JOBS program.

The Department expects the performance standards system to evolve over time to reflect the benefit of experience with the new system, additional research, and ongoing exchanges of information with administrators of JTPA, JOBS and other related programs and with other experts. Modifications to the system can be expected in the form of updated standards as new information becomes available, refined definitions and new and revised measures. This is consistent with the approach used by DOL for the JTPA program.

The Department also recognizes that implementing the new performance standards system would be a major effort for State agencies particularly in terms of the new data reporting requirements. In addition, many State agencies may want to modify their programs to offer different types of services. Therefore, the Department's proposed rule acknowledges the need for an initial transition period during

which State agencies would continue development of their reporting systems and gain experience with the new reporting forms.

Current Performance Standards

The current performance standard at 7 CFR 273.7(o) is based on the provisions of the Food Security Act of 1985 (Pub. L. 99-198) which authorized the establishment of the Food Stamp E&T Program. The statute mandated national performance standards that were to be based on placing a minimum percentage of eligible participants into E&T program components, not to exceed 50 percent of the eligible population. In setting acceptable levels of performance, the Department was directed to allow variations of the performance standards among State agencies and to consider the cost to State agencies, as well as the extent of volunteer participation.

In December 1986, the Department issued final rules for the E&T program (51 FR 47378). Annual performance standards were established, beginning with Fiscal Year (FY) 1989. The current standard reflects the mandate of Public Law 99-198 for process-based

standards, that is, the standard set a minimum level of the number of nonexempt work registrants that State agencies must place in E&T activities. In keeping with the mandatory nature of the program required by the statute and the emphasis within the Food Stamp Program on work registration requirements for eligible food stamp recipients, the Department's approach to the design of the Food Stamp E&T Program was to encourage State agencies to serve as many persons as possible. The current performance standard reflects this broad-based approach. The performance standard was set at 35 percent for FY 1989 and 50 percent for FY 1990, as described at 7 CFR 273.7(o)(7). For FY 1991, the performance standard remains at 50 percent.

Under the current standard, a State agency's annual performance rate is determined by a formula that calculates the number of "placements" in E&T activities as a percentage of the number of persons eligible to be placed. The number of placements in the numerator of the equation includes three categories of participants: the number of

nonexempt work registrants (referred to as mandatory E&T participants) who actually began an E&T component; the number of mandatory E&T participants who failed to comply with E&T requirements and were sent a notice of adverse action (NOAA) or were denied certification; and the number of exempt work registrants who voluntarily participated in E&T activities. NOAAs and denied certifications are counted as placements in recognition of the effort and expense that State agencies incur in attempting to serve these participants. In this formula, a placement occurs when a person begins an E&T component, is sent a NOAA, or is denied certification during the year. Thus, under the current system, it is possible that one participant may account for several placements.

The denominator of the equation is called the "base of eligibles" and it includes all food stamp work registrants not exempt from E&T plus the number of volunteers who participated during the year. The formula may be summarized as:

$$\frac{\text{Mandatory Participants} + \text{Volunteers} + \text{NOAAs}}{(\text{Work Registrants} - \text{Exemptions}) + \text{Volunteers}} = \text{Performance Rate}$$

Statutory Changes to Performance Standards

The Hunger Prevention Act of 1988 requires the Department to develop new performance standards based on the degree of success that State agencies may reasonably be expected to achieve in helping individuals to achieve self-sufficiency. The new standards must be implemented by State agencies by October 1, 1991, at which time the current participation-based standard would expire.

The Secretary must coordinate the new performance standards with those of JTPA and JOBS, taking into consideration the differing characteristics of the households served by the different programs. In addition, the performance standards must take into account several factors, including: The extent of volunteer participation in the E&T program, job placement rates, wage rates, job retention rates, the number of households ceasing to need food stamps, and improvements in educational levels among household members.

The Secretary is also directed to establish performance standards which

encourage State agencies to serve those individuals having greater barriers to employment and consequently greater difficulties in achieving self-sufficiency. The new performance standards must be designed to include guidelines permitting appropriate variations that take into account differing conditions in different States, to include varying unemployment rates and rates of volunteer participation. Finally, Public Law 100-435 provides for variance of the national performance standards in any State as necessary to take into account specific economic, geographic, and demographic factors in a given State, the characteristics of the population to be served in the State, and the types of services to be provided by the State.

The impact of this statutory change on the Food Stamp E&T Program is significant. Although certain basic aspects of E&T would be unaffected by the new standards (such as the mandatory nature of E&T for those subject to the requirements and the types of components State agencies may offer, as described in the Food Stamp Act of 1977, as amended), Congress clearly intended the Department to make some fundamental changes to

national E&T policy. The Department anticipates that the change from process-based to outcome-based standards would have a major impact on the decisions made by State agencies in designing and operating the Food Stamp E&T Program. The statutory requirements proposed by this rule would influence the mix of components State agencies choose to offer and the participants targeted for E&T services and would increase the level and complexity of data reporting requirements.

Development of the Proposed Performance Standards

Sources to be Consulted

In section 404(d) of Public Law 100-435, Congress directed the Secretary to develop performance standards for the E&T program after consultation with the Office of Technology and Assessment, the Secretaries of Labor and Health and Human Services, appropriate State officials, other experts, and representatives of food stamp households. To meet this mandate, the Department retained the services of a consultant who solicited responses from

the statutorily identified sources on an array of issues addressed in the development of the new performance standards. The consultant conducted research on various issues and conferred with a total of 15 different sources by mail and at two meetings. The information which the consultant provided, after the independent evaluation of the solicited input, proved very valuable, and the issues, comments, and recommendations made in the consultant's reports will be discussed throughout this preamble.

Commissioner's Meeting

Catherine Bertini, the Assistant Secretary for Food and Consumer Services, also met with the Commissioners from six State agencies to discuss the impact the outcome-based performance standards would have on their States. The issues and information informally discussed and opinions expressed proved to be very useful and were taken into consideration with respect to numerous issues in this proposed rule.

Coordination With JOBS and JTPA

In addition to the consultant's reports and the informal input from the Commissioners, the Department contacted DOL and DHHS to learn more about the ways in which new E&T performance standards could be coordinated with performance standards of JTPA and JOBS. A brief summary of each program follows.

The Family Support Act of 1988 (Pub. L. 100-485) authorized the JOBS program under title IV-F of the Social Security Act. JOBS replaces other title IV work programs for recipients of the Aid to Families with Dependent Children (AFDC) Program such as the Work Incentive Program (WIN) and the WIN Demonstrations. JOBS is a comprehensive employment and training program with the purpose of helping AFDC recipients obtain the education, training, and employment that will help them avoid long-term welfare dependency. JOBS was to have been implemented by all States by October 1, 1990, but States do not have to fully implement the program statewide until October 1992. Like the Food Stamp E&T Program, JOBS is mandatory for those participants who are not otherwise exempt by law or for other reasons as determined by States. States must offer a variety of services including education, job readiness, job skills training, and job development and job placement activities. JOBS participants receive extensive support services including reimbursements for child care, transportation, and other work-related

expenses. Federal funding for JOBS in FY 1991, 1992, and 1993 is authorized at \$1 billion per year. By FY 1995, funding will reach \$1.3 billion.

Initial performance standards for the JOBS program are process-based; States must meet a participation rate of seven percent in FY 1990 and 1991, with an increase in the rate every two years up to a maximum of 20 percent by 1995. These participation standards encompass much more intensive participation requirements compared to E&T components. The computation period for calculating the rates also changes over these years, starting with annual rates for FY 1990 and becoming monthly in FY 1994. Recommendations for outcome-based performance standards are due to Congress on October 1, 1993. Since the JOBS performance standards are unlikely to focus on outcomes for several years, there are few opportunities for coordination between E&T outcome-based standards and those of JOBS, at least for the initial implementation. However, in view of the tremendous effort that States will be expending in the next several years to implement JOBS, the Department and DHHS are discussing the ongoing coordination efforts for JOBS and E&T, including, when possible, conformity in data reporting definitions.

In 1982, Congress established in Public Law 97-300, the JTPA program as the core of the nation's system for providing employment and training services to low-income persons. The JTPA Title II-A Adult and Youth Program most closely resembles E&T and serves about one million persons annually, 90 percent of whom are economically disadvantaged adults and youth. The funding level for FY 1991 is \$1.8 billion. The average program cost per participant in 1990 was \$2,300. By contrast, the Food Stamp E&T Program also serves about one million participants annually, at approximately \$135 per participant, and total budgeted Federal funds will not exceed \$140 million in FY 1990. While E&T is a mandatory program that has emphasized low cost interventions such as job search, JTPA is a program for which participants volunteer, that emphasizes more intensive interventions such as on-the-job training activities and classroom training.

JTPA has had outcome-based performance standards in effect since 1983; the standards are based on the Act's premise that "job training is an investment in human capital and not an expense." 29 U.S.C. 1516(a). In assessing the return on this investment, the JTPA

legislation directs DOL to measure reductions in welfare dependency, increases in employment, and increases in earnings. Initially, the performance standards focused primarily on the outcomes attained upon completion of training. Gradually, DOL added more measures designed to capture the longer-term effects of JTPA training. Beginning in Program Year 1990 which began July 1, 1990, JTPA Title II-A standards for adult and youth welfare programs will focus exclusively on postprogram outcomes, relying on a 13-week follow-up period for measuring outcomes, as a way of emphasizing the importance of long-term employability development.

Although both the JOBS and JTPA programs are analogous to the Food Stamp E&T Program, only JTPA has an outcome-based performance standards system currently in place. Therefore, to learn about the process for developing outcome-based performance standards, the Department looked to the experience of DOL in establishing outcome-based performance standards for the JTPA Title II-A Programs.

JOBS and JTPA Evaluations Now Underway

Research is currently being performed to evaluate JOBS and JTPA, both of which have considerably more funding than the Food Stamp E&T Program. Both evaluations use a classical experimental design involving random assignments to treatment and control groups.

The JOBS Evaluation involves ten sites and approximately 45,000 individuals randomly assigned over 12 to 18 months. Follow-ups will continue for up to five years. The eight-year study, scheduled to end in 1997, will analyze the impacts on recipients and their children in terms of employment and earnings, reduced need for assistance, recidivism, and educational improvements as well as an analysis of the cost-effectiveness of JOBS.

The JTPA Evaluation involves the random assignment of more than 30,000 applicants to treatment and control groups in over 16 locally administered sites. Follow-ups are scheduled at 18, 27 and 30 months from the point of random assignment. The six year study will look at JTPA services to determine their overall effect on the JTPA population and certain subgroups of that population. Although this is a national evaluation, the results from this evaluation will not be nationally representative.

Goals of the Performance Standard System

The language of Public Law 100-435 provides some guidance for the development of appropriate goals for the performance standards system. A key phrase in the Hunger Prevention Act directs the Department to base the standards on the degree of success that States have in " * * * helping individuals to achieve self-sufficiency * * * ". The Department hopes that State agencies will consider this proposed rule with a view to how the proposed performance standards would affect their ability to help eligible participants become self-sufficient through employment.

Design Issue: Greater State Flexibility

In addition to the change from process-based to outcome-based standards, Public Law 100-435 mandates other fundamental changes to the E&T performance standard system, including encouraging services to participants who have greater barriers to employment and placing more emphasis on educational improvements.

The Department recognizes the importance of State flexibility in designing a system to accommodate these changes. The Senate stated in its report on the Hunger Prevention Act that "(s)tate flexibility is an essential part of the employment and training program, as the most effective employment and training programs are generally those to which states are most strongly committed and which they design themselves. The performance standards to be developed are intended to reinforce, not restrict, state flexibility." S. Rep. No. 100-397, 100th Cong., 2d Sess. 19 (1988).

Design Issue: Establishing Priority of Service

Given the need for greater State flexibility, the proper role for the Department is to encourage State agencies to operate meaningful programs that meet the intent of the Hunger Prevention Act. In doing so, the Department has balanced the need for State flexibility against the need to define basic national objectives for E&T, a task that is inherent in setting national outcome-based performance standards. Thus, the Department's approach is to establish reasonable parameters that define a meaningful program, particularly regarding both the number and characteristics of participants to be served. Within the proposed parameters, State agencies would be able to shape their E&T programs to match the needs of their eligible populations.

The Department notes that the basic mandatory nature of the Food Stamp E&T Program, as it was initially established by Congress in 1985, remains unchanged by Public Law 100-435. The Food Stamp E&T Program was intended to be a job seeking and training requirement primarily for food stamp work registrants. 7 U.S.C. 2015(d). Thus, for purposes of the outcome-based performance standard system, the Department intends to continue the current policy that emphasizes service to food stamp work registrants. The proposed performance standard system has been designed with the work registrant population in mind and establishes a general priority of service based on a participant's work registration status: Mandatory E&T participants who are defined as having greater barriers to employment would receive the highest priority; second in priority status are mandatory E&T participants who are not identified as having greater barriers to employment; and third, are those exempt from work registration who choose to participate in E&T of their own volition.

Design Issue: Data Source for E&T Program and Participants

In developing this proposed rule, the Department relied heavily on data collected for the national Evaluation of the Food Stamp Employment and Training Program (throughout this report referred to as the national E&T Evaluation). This evaluation was conducted in response to the Congressional mandate to evaluate the effectiveness of E&T, pursuant to section 16(h)(5)(B) of the Food Stamp Act of 1977, as amended.

The final report, which was released to Congress on November 28, 1990, details the effect of E&T on employment, income, and food stamp dependency and provides an assessment of the E&T program's cost-effectiveness.

The national E&T Evaluation was conducted with a nationally representative sample of 53 local food stamp agencies and included over 13,000 food stamp recipients. Individuals were randomly assigned to one of two groups—a treatment group required to enroll in E&T and a control group excluded from participation. The majority of participants in the treatment group were assigned to low intensity services such as job search (51 percent) and job search training (27 percent). Only 22 percent were assigned to more intensive components such as education or work experience. Consequently, the services sought by the control group outside of the E&T program were not much different from the treatment group.

The evaluators collected information on participants when they were first assigned to a treatment or control group and then interviewed them every four months for a year. The results are nationally representative of the program in 1988, the first full year of program operation.

The report concludes that E&T had no discernible effect on the likelihood of participants finding work, the amount of time worked, their average wages, or total income earned. Although over half of the E&T participants had some type of employment a year after E&T assignment, researchers noted a similar employment rate for the control group.

In addition, E&T did not affect the proportion of clients receiving food stamps, cash assistance, or the amount of cash assistance, but it did reduce food stamp benefits by an average of \$65 per participant per year. The reduction in food stamp benefits appears related to participants leaving the program earlier or having their benefits reduced because of noncompliance.

The cost of E&T, averaging only about \$135 per participant, was quite modest. However, because E&T had no significant effect on participants' employment and earnings, the program was not cost-effective in its first full year of operation.

The evaluators conclude that meeting the employment and training needs of Food Stamp Program participants is a tough challenge. E&T serves a highly mobile population, many of whom are in and out of the labor market for brief periods of time. About half of those in E&T obtain jobs on their own.

The findings indicate that substantial changes are required for the E&T program to yield a net benefit to either participants or taxpayers. It is apparent that the E&T population consists of some individuals who will obtain employment and leave the food stamp rolls by themselves, and others who have barriers to employment that cannot be overcome by the types of services (i.e., predominantly low intensity) provided through E&T.

Definition of Terms

Following are some of the basic terms that will be used throughout this preamble discussion and proposed rule. Although the Department sought where possible to use definitions that are familiar to the employment and training community, it was necessary to adapt terms to make sense within the context of the Food Stamp E&T Program.

Model A:

Baseline month refers to the month in which an eligible E&T participant (mandatory or volunteer) participates in an E&T assessment. Data on such characteristics as sex, race, marital status, household size and receipt of GA and unemployment compensation would be collected at the time of the E&T assessment.

Base of E&T terminations refers to the denominator that is proposed for use in the calculation of the Model A measures. For the entered employment rate and the food stamp case closure rate, a State agency's performance on a measure would be determined by dividing the number of positive outcomes (i.e., number of job entries and case closures) by all of the E&T terminations. For the wage rate, the denominator would be a subset of all E&T terminations, those terminations who are employed and reporting incomes. For the education improvement rate, the denominator would also be a subset of all terminations, the number of E&T participants who are terminating from educational activities.

E&T termination refers to the point in time when an E&T participant completes an assigned employment and training activity. If the individual does not complete the component or activity, termination would be considered to be the day that he/she last attended or performed a scheduled E&T activity.

E&T terminations are all E&T participants who begin an E&T activity or component and either complete or do not complete the activity for any reason, including getting a job or leaving the Food Stamp Program. Individuals who are assigned to E&T but never show up for the activity (i.e., "no shows") would not be considered "participants" and therefore not counted in this outcome-based system. State agencies remain obligated with regard to "no shows" to follow through with the appropriate action as required by the current regulations at 7 CFR 273.7(g).

Entered employment, for purposes of the performance standards, is defined as employment an E&T terminations has begun by the end of the month following the month of E&T termination, that is unsubsidized, involves no less than 20 scheduled hours of work a week, and is expected to last at least 30 days. Unsubsidized employment means that the wage or salary is not provided by another Federal, State, or local program as an intended benefit of that program.

Measurement period refers to the amount of time that State agencies would be allowed to report positive outcomes of participants after E&T

termination. The measurement period would vary according to the measure being proposed.

Model B

Baseline month refers to the month in which an eligible E&T participant (mandatory or volunteer) is randomly assigned to the treatment group or the control group sample. Random assignment would occur at the point that the State agency determines which nonexempt persons and volunteers would be selected to participate in an E&T program component. A treatment group member may actually begin participation in the E&T program in a later month. Baseline month data would be collected for all members of the treatment group (i.e., not just sample members) and the control group sample.

Entered employment, for purposes of the performance standards, means that an individual in the treatment group sample or the control group sample is or was employed anytime between the baseline month and end of the follow-up month. Employment begun prior to the baseline month would not be counted. For individuals with multiple jobs between the baseline and follow-up months, only one job per individual would be counted—the highest paying job. The employment would be unsubsidized, involve no less than 20 scheduled hours of work per week, and have lasted or be expected to last at least 30 days. Unsubsidized employment means that the wage or salary would not be provided by another Federal, State or local program as an intended benefit of that program.

The follow-up month is six months after the baseline month. For example, if April is the baseline month, the follow-up month is October. State agencies would collect for every member of the treatment group and control group sample information on their employment and Food Stamp Program status as of the follow-up month. State agencies would also collect for every member of the treatment group information on their educational status as of the follow-up month. This information collection is referred to as a follow-up interview.

A negative effect is when an outcome measure for the treatment group is less than the control group measure.

A positive effect is when an outcome measure for the treatment group is greater than the control group measure.

Random assignment is the method by which individuals are assigned to either the treatment or control group samples. The basic criterion in selecting a random sample is that each person in the entire universe (e.g., E&T mandatories who would be placed into

activity for which they could be sanctioned if they fail to comply) stands an equal (or known) chance of being selected into the sample. Randomization eliminates the problem of unobserved differences between the comparison groups (e.g., differences in motivation) which might otherwise bias findings on program effects.

A statistically significant difference in the number of persons employed means that, based on a reasonable probability (usually five percent), the difference between the employment measures estimated for the control and treatment samples is greater than the difference that could occur by chance, due to the natural variability of the E&T population from which the samples are drawn.

The treatment and control groups are randomly assigned comparison groups whose experiences only differ in terms of whether they are allowed or denied access to a food stamp E&T treatment. In this proposed regulation, the treatment group is the segment of the nonexempt and volunteer E&T population that is randomly assigned to the E&T program (i.e., treatment) and is expected to comply with E&T program requirements. The treatment group sample is a simple random sample of the persons in the treatment group. The control group sample is a random sample of nonexempt E&T persons and volunteers who are not permitted to participate in the E&T program. Members of the control group sample may receive employment and training services that are available to persons outside of the Food Stamp E&T Program. Comparisons of the employment and food stamp receipt of the two groups provide estimates of the effectiveness of the E&T program.

Both Models

E&T volunteers are currently defined at 7 CFR 273.7(f)(4)(iii) as participants who would not be disqualified from the Food Stamp Program for failure to comply with E&T requirements. The Department is proposing, for clarification, to add other criteria to that definition. The Department proposes to exclude as volunteers those food stamp recipients who are exempt from work registration, pursuant to 7 CFR 273.7(b)(1) (iii) and (v), because they are subject to and participating in title IV of the Social Security Act or Unemployment Insurance employment programs. Food stamp recipients other than those exempted through 7 CFR 273.7(b)(1) (iii) and (v) may be considered volunteers if they are assessed, referred to an approved food

stamp E&T component and tracked through the component in the State Food Stamp E&T Program. In proposing these restrictions on who may be counted as a volunteer for performance purposes, the Department seeks to establish that the nonpublic assistance population is given priority by the Food Stamp E&T Program. The Department also seeks to secure accountability by proposing that the performance system only take into account persons with whom the Food Stamp E&T Program has had contact, and therefore, may legitimately take credit for serving.

A *hard to employ* person is a potential E&T mandatory participant who, as of the determination in the baseline month, has not completed high school or earned an equivalency degree and who has not been employed in the 12 months prior to the baseline month.

A *measure* quantifies an aspect of program performance. An outcome-based measure quantifies a particular result expected from participation in an employment and training program. Examples of outcome-based measures are the percentage of persons who become employed or the average wage rate of such persons. By contrast, a process-based measure quantifies an aspect of the process of participation in an E&T program, such as the percentage of eligible individuals who participate or the completion rate for a specific activity.

Positive outcome refers to the instance when an E&T participant meets the intended goal being measured, e.g., a positive outcome for the entered employment rate is starting a job.

A *standard* is the minimally acceptable numerical level of performance that is established for each measure. For example, the standard for the measure of food stamp case closures may be a five percentage point increase in the average number of case closures which is statistically significant at the five percent level.

Overview of Model A

The objective of Model A is to measure the State agencies' success in meeting specific performance goals. These goals or performance standards would be adjusted to account for varying conditions within each State. The Department proposes to rely on measures of gross (as opposed to net) outcomes which are measured as of the time of an individual's termination from E&T. At the point of termination, defined specifically in the descriptions of the measures later in this preamble, the Department proposes that State agencies ascertain (1) whether or not the individual is employed, (2) if employed,

the average hourly wage, and (3) whether the individual's food stamp household is still receiving benefits, or whether the case has closed. If the State agency offers an education component, and the individual participated in this, the State agency should determine whether the criteria for successful completion have been met. Credit would be given to State agencies for the proportion of successful outcomes as compared to the base of eligibles, or potential positive outcomes.

The Department proposes to give more credit for job entries and for wages above the minimum wage that are achieved by persons with greater barriers to employment. The Department proposes to give less credit for job entries and for educational attainments achieved by persons who are not mandatory E&T participants (i.e., volunteers). The specific definitions of the measures, the rationale for the credit weights, and the associated data reporting items are discussed in detail below.

The Department proposes to set a national standard for each measure. For the initial period of October 1, 1991 through September 30, 1993, the Department would base the numeric levels on both an analysis of a database from the national evaluation of the E&T program and on consultation with experts in the fields of education and employment and training. Thereafter, the national standard for each measure would be derived from State agency reported data; data from the first year after implementation, FY 1992, would be used to set the national standards for FY 1994 and 1995. The intent is to set the levels so that 75 percent of the State agencies would have exceeded the standard in the previous period. These standards are relative standards and performance against such standards gives no evidence that the programs caused the outcomes.

To account for the effect on State agency's performance of various factors that are beyond the control of State and local program administrators such as State labor market conditions and the characteristics of E&T participants, the Department proposes to adjust the national standards for each State agency. For the initial period, the national standards for the entered employment rate, average hourly wage rate and food stamp case closure rate would be adjusted for each State agency to account for cross-State differences in labor markets and demographic factors during these periods using data from national sources. Beginning with FY 1994, the national standards would be adjusted for each State agency to reflect

the effect of E&T participant characteristics on the outcome measures. The adjustments would be updated annually based on State agency reported data to reflect the effects of these external factors on the likely outcomes of E&T participation. The Department also plans to continue work on the adjustment model and to monitor State agency reported data as the basis for revised standards for FY 1994 and 1995.

Overview of Model B

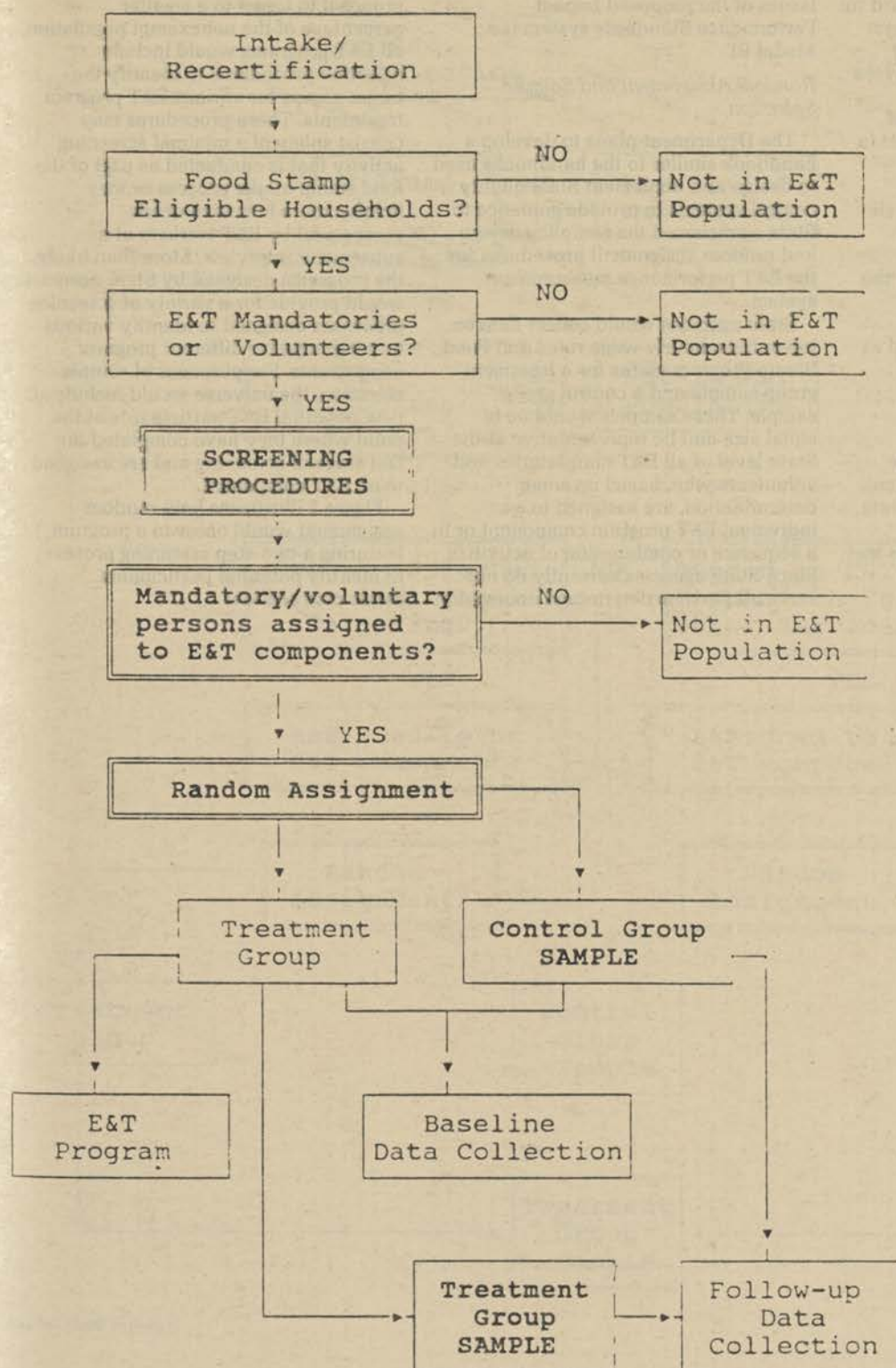
The objective of Model B is to determine the impact of each State agency's E&T program on participants' job entries, hourly wage rates, Food Stamp Program status and educational attainments. The impact of State programs would be measured by comparing these outcomes (except for educational attainments) for a randomly assigned sample of persons who are selected to participate in an E&T program component (the treatment group sample) with the outcomes for a randomly assigned sample of persons who are from the same population but who are not selected for the E&T program for the duration of the measurement period (the control group sample). Data on employment, hourly wage rates and Food Stamp Program status would be collected for all persons in the control and treatment group samples six months following the baseline month in which assignment to the E&T program occurred. The comparisons between the control and treatment group samples should yield unbiased estimates of aggregate net differences for each of the outcome-based performance measures; these would be interpreted as measures of whether the State agency's program had any effect on those outcomes, as compared to what would have happened in the absence of the program. As will be discussed later in this preamble, educational attainments would be measured for the entire treatment group but not the control group sample and State agency performance on this measure would be assessed using a different standard.

To secure against bias resulting from preferential attention to persons assigned to the treatment group sample, a random sample of all persons assigned to the treatment group in the baseline month would not be selected until six months later when the follow-up data collection occurs. The treatment group sample would be randomly drawn without regard to the actual participation patterns of the treatment group members during the measurement

period. This includes persons randomly assigned to a component who never begin it, persons who begin a component but never complete it, and persons who complete the component. To implement this, State agencies would be required to maintain lists of all persons selected each month to participate in the E&T program (that is, the sample universe). However, random assignment from this universe to the control group sample would occur in the baseline month, which is prior to when actual participation would have begun. Figure 1 illustrates the proposed approach.

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FIGURE 1



As with Model A, the Department proposes to give greater credit for the job entries and wage rates of the hard to employ, and less credit for volunteers.

The Department is proposing that State agencies conduct impact analyses and report these findings to the Department at the end of each fiscal year. This analysis is described later in this preamble in the discussion on reporting requirements.

The Department would expect each State agency to show a statistically significant finding of no effect or a positive effect for each measure for the first two years of this system. A statistically significant finding of a negative effect would be interpreted as an indicator of poor program performance. These standards are expected to change in the future as further data on State agency performance is gathered. If the State agency offers an education component, the Department would expect the State agency to affirm that a minimal standard of successful completion is met by members of the treatment group participating in this component.

The following four sections discuss in more detail the key features and design issues of the proposed Impact Performance Standards system (i.e., Model B).

Random Assignment and Sample Selection

The Department plans to develop a handbook similar to the handbooks used to design and implement State quality control systems to provide guidance to State agencies on the sampling design and random assignment procedures for the E&T performance measurement system.

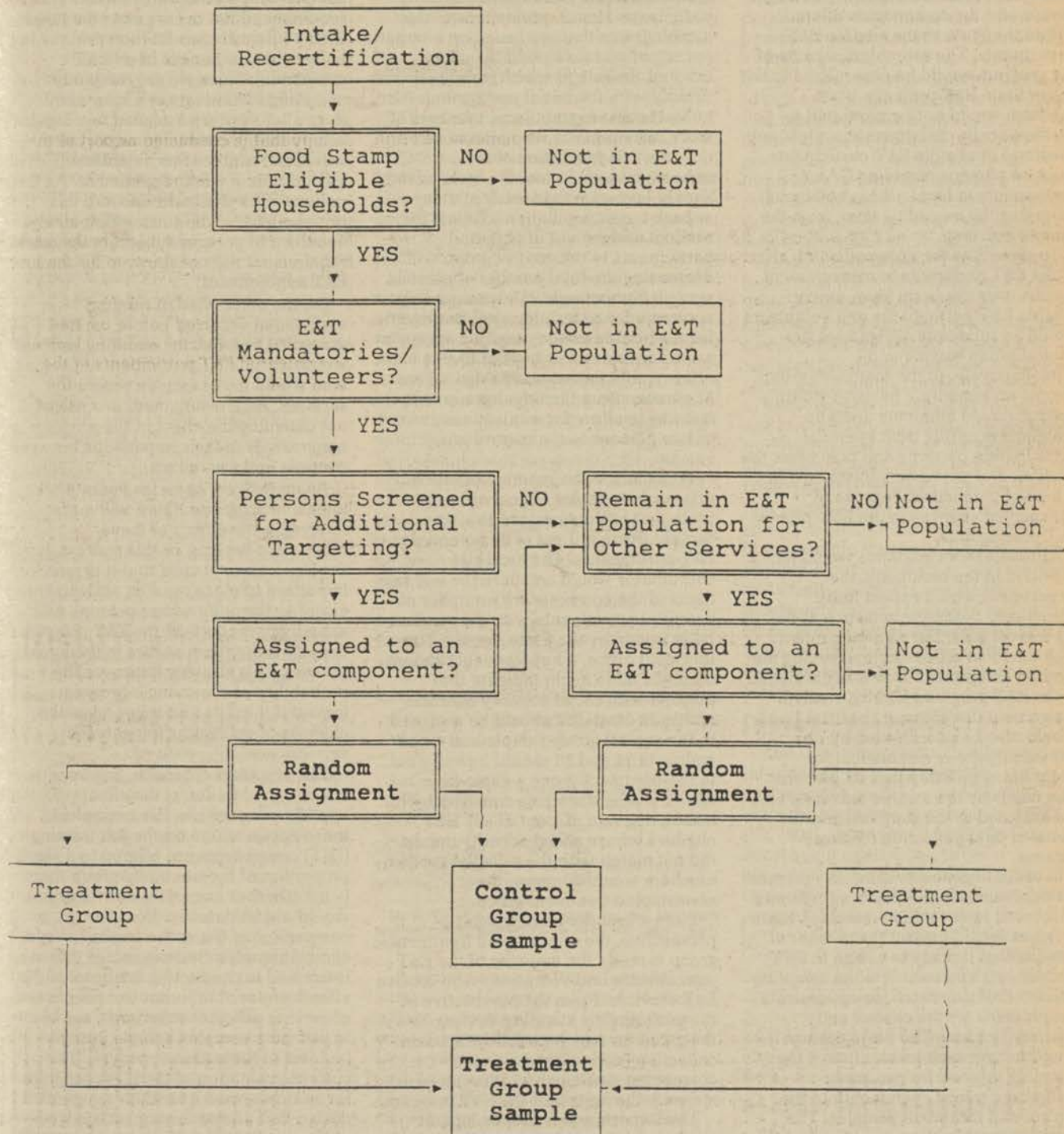
State agencies would collect data on job entries, hourly wage rates and Food Stamp Program status for a treatment group sample and a control group sample. These samples would be of equal size and be representative at the State level of all E&T mandatories and volunteers who, based on some determination, are assigned to an individual E&T program component or to a sequence or combination of activities. Since State agencies currently do not serve all persons determined nonexempt

for E&T, and given that State agencies would have greater flexibility under this proposal to target to a smaller percentage of the nonexempt population, all E&T programs would include selection procedures to identify the target groups for various E&T program treatments. These procedures may consist solely of a minimal screening activity that is conducted as part of the food stamp intake process or may involve more intensive needs assessment by E&T workers at a subsequent interview. More than likely, the programs designed by State agencies would provide for a variety of screening processes designed to identify various target groups for different program components. For purposes of sample selection, the universe would include all new potential E&T participants at the point where they have completed the last stage of screening and are assigned to an E&T component.

Figure 2 illustrates how random assignment would occur in a program featuring a two-step screening process to identify potential participants.

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FIGURE 2 - RANDOM ASSIGNMENT PROCEDURES



The samples would be representative at the State, not the local level, and thus, would reflect the diversity of the target groups and the components offered within the State to the eligible E&T participants. The estimated impacts of the program would be generalized to the entire State E&T program. State agencies would not be permitted to systematically discriminate against any subgroup of eligible E&T participants (such as persons receiving GA or participants in local offices with small programs) by excluding them from the sample universe.

To distribute the data collection effort of the E&T performance measurement system over the fiscal year, newly eligible E&T participants and volunteers would be randomly assigned to the control group sample and, retrospectively, to the treatment group sample on a monthly basis. A monthly system should eliminate analytic problems resulting from seasonal participation patterns and minimizes the likelihood of dramatic adjustments in sampling procedures because of unexpected changes in the flow of new E&T participants.

Although more guidance would be provided in the handbook, the Department would expect State agencies to designate someone at the State level to be the point of contact with the local offices for overseeing the random assignment of persons assigned to the E&T program. Ideally, random assignment decisions at the local level should also be coordinated by one individual who is responsible for maintaining monthly logs on persons who compose the sample universe, who are assigned to the samples, and the status of data collection for these persons.

In order to generate samples that meet the minimum sample size requirements (discussed later in this preamble), State agencies would project the number of persons that it plans to assign to E&T components and calculate the sampling interval that generates the appropriate sample sizes for the control and treatment groups. The State agency would inform each local office of the sampling interval for randomly assigning persons each month to the control and treatment samples. The resulting sample sizes would reflect the local office's relative share of the total population selected to participate in the E&T program. Site-specific random assignment tables would be used to determine the treatment or control group status of each newly eligible E&T participant.

Since some persons may not comply with the referral to an E&T component,

the estimated number of persons assigned to the E&T program would be greater than the number who actually participate. Hence, projections of the sample frame that are based on a target participation rate should take into account the rate at which persons do not comply with the initial assignment. Also, in States that exempt large numbers of work registrants or who plan to serve only a small proportion of the nonexempt population, the State agency should take care to identify a large enough target population to allow for random assignment of potential participants to the control group without decreasing the total number of persons served. For example, if a local agency contracts for 50 training slots per month for the hard to employ and the agency's sampling interval is 2 out of 50, the local office would assess and assign at least 52 persons from the target group to the training to allow for random assignment of two persons to the control group sample.

To illustrate the general operational approach, consider a local office in a State that has determined that its sampling rate is 1 out of 50 potential E&T participants. The local site coordinator would compare the last two digits of the social security number of potential participants with the random table issued by the State agency. For this local office, a hypothetical random numbers table might indicate that persons with social security numbers ending in 01 and 87 should be assigned to the control group sample and those ending in 14 and 55 should be assigned to the treatment group sample (this would produce samples consistent with a sampling rate of 1 out of 50). E&T eligibles whose social security number did not match with the selected random numbers would compose the nonsampled treatment group.

From a broader management perspective, the nonsampled treatment group is really the majority of the E&T mandatories and volunteers who receive E&T services. From the perspective of the performance standard system, this is the group for which no follow-up data collection (except for education component participants) is required to measure the impact of the E&T program.

The Department is proposing that random assignment occur at the point in a State agency's program when it has identified the population that is required or volunteers to comply with an assignment to a work program component such as job search, classroom training or work experience. This is not necessarily the first point at which a nonexempt work registrant could be sanctioned for failing without

good cause to participate in the E&T program. Persons may elect not to comply with a screening or assessment requirement that occurs after the Food Stamp intake/recertification process but before the assignment to an E&T component. Since we are randomly assigning individuals at a later point (e.g., after they are assigned to a service component) the measurement system would not capture this potential effect of a Food Stamp work requirement. As the national E&T Evaluation found, this initial effect can be substantial; almost one-third of persons subject to the work requirement did not show up for the first E&T appointment.

On the other hand, if random assignment occurred before the E&T screening process, the resulting samples would include large numbers of persons who would never receive program services. As a result, there is a risk of not detecting the effect of the program components in the comparisons between controls and treatments.

As more State agencies operate intensive programs, there will more interest in the effects of these alternative designs. In this context, it is the Department's view that it is more important to place random assignment closer to the point where persons will actually participate in the E&T program activity rather than earlier in the intake process. This strategy improves the probability of observing a program impact if it exists and it improves the chances of estimating impacts for services actually received.

The proposed approach, however, is not designed to detect the effects of specific components. For example, in those States where on-the-job training (OJT) components are offered to a small proportion of the treatment group there is the risk that any OJT gains achieved would not be detected from the comparison of the entire treatment and control samples. State agencies that are interested in conducting analyses of the effectiveness of different treatments and of serving different subgroups, can elect to use more complex sample designs (subject to State plan approval). The current evaluation of the JTPA program, for example, uses a random assignment design that allows for impact analyses of three categories of activity streams in which the predominant activity is either classroom occupational skills training, on-the-job-training, or all other activities such as job search assistance, work experience, and stand-alone education.

Design Restrictions

To secure the integrity of the performance evaluation design, persons

assigned to the control group sample, similar to persons not served by E&T though eligible or mandatory, would not be provided any E&T program services, even as a volunteer, for the six-month data collection period. This exclusion includes any referrals to other programs that would not have occurred in the absence of the E&T program.

To minimize the prohibition of services to persons randomly assigned to the control group sample, no individual would be assigned to a control sample more than once.

Potential Treatment Bias

While it is obvious that persons in the control group sample would be identified prior to the time when actual E&T services begin, the Department is concerned that prior identification of persons in the treatment group sample may result in preferential services to this group. That is, State agencies may focus more E&T resources on the treatment cases selected for the performance evaluation. This would bias the results in favor of a finding of a program effect. There are two alternatives that would safeguard against a treatment bias of this nature. The first approach would require State agencies to collect baseline and the follow-up outcome data for the entire treatment group. This would be a costly data collection effort if outcome data in the follow-up period are based on interviews.

The second approach, and the one the Department is proposing, is to require State agencies to wait and draw the treatment group sample at the end of the tracking period, that is, at the start of the follow-up data collection month. To implement this approach, State agencies would be required to record basic characteristics information for all persons that are assigned to the E&T program rather than just a sample of persons in the treatment group. State agencies would also be required to record for this larger group (in E&T case records, for example) information that would assist in contacting the subsequently sampled persons for the six-month follow-up interview. This might include telephone numbers, verified addresses and names of important reference persons. This information would be particularly important for tracking the outcomes of persons who are assigned to a component but never begin or drop out of the component, and who would otherwise be difficult to locate six months later. In addition to this basic baseline information, State agencies would be required to maintain monthly lists of the treatment cases as they go

through the randomization process, in order to have appropriate sample frames for the later selection of treatment sample observations. Once the sample of persons in the treatment group are selected, the State agency would be required to extract the baseline information from the case records for the treatment group sample members and conduct follow-up interviews.

Comments are requested on the likelihood of a treatment bias and on the feasibility of drawing the sample at the end of the six-month follow-up period.

Minimum Sample Sizes

The unit of random assignment would be any food stamp household that contains at least one nonexempt or volunteer E&T participant. Although the outcomes of interest affect both individuals (employment and educational gains) and households (food stamp benefit status), the household unit would be selected because it eliminates the possibility of assigning different household members to different groups and, therefore, interfering with normal household decision-making processes that might result in artificial differences between treatment and control group samples.

The Department is proposing the following minimum sample sizes for State agencies with small, medium and large E&T programs:

MINIMUM STATE SAMPLE SIZES FOR EACH OF THE TREATMENT AND CONTROL GROUPS

Average annual No. of E&T eligibles (N)	Minimum annual sample sizes (n)
60,000 or greater	3,400
10,000 to 59,999	$n = 1,000 + [.048 (N - 10,000)]$
less than 10,000	1,000

Note: Combined sample sizes for the treatment and control groups would be twice the above numbers.

A sample size of 3,400 in large States would be sufficient to allow detection of a three percentage point overall program impact on participants' employment at a five percent level of statistical significance, with 80 percent power. That is, if the true program impact on employment rates is three percentage points, the State agency's sample has an 80 percent chance of detecting a statistically significant effect.

The Department is proposing smaller sample sizes for State agencies with smaller programs since they would also have less resources to devote to the cost of the data collection. Although this means a reduction in sample precision, the proposed minimum sample size of

1,000 in small States would be sufficient to allow detection of a five percentage point overall program impact on participants' employment at a five percent level of statistical significance, with 80 percent power.

State agencies may find it necessary to pull extra sample points to guarantee that there would be sufficient observations in the event that the nonresponse rate in the follow-up interviews is substantial. (The attrition rate that occurred in the national E&T Evaluation as of the first four-month follow-up period was substantial).

These levels of precision are proposed because of the concern that few or no State agencies would find any significant positive results with smaller sample sizes. By way of comparison, a sample size of 900 in large States and 300 in small States would be sufficient to allow detection, respectively, of six and ten percentage point differences at the five percent level of statistical significance, with 80 percent power. The Department is interested in comments that provide more guidance on the correct tradeoff between the cost of larger sample sizes which improve the probability of detecting a program effect and smaller sample sizes which can detect only larger effects but which may be more appropriate given the size of the State agency's program and the expected benefits from the program effects.

Overview—Both Models

The Department plans to disseminate information on State agencies' performance on the four proposed outcome measures. For the initial period (FY 1992), there would be no financial consequences attached to State agencies' performance, although the Department would hold State agencies accountable for implementing the performance measurement system by October 1, 1991, as required by the Food Stamp Act of 1977, as amended (7 U.S.C. 2015(a)(4)(L)(iii)). Beginning FY 1993, the performance data collected would be used to determine State agency eligibility for incentive funding or if fiscal sanctions are warranted.

Breadth of Service Requirement

There is no conclusive research at this time which indicates that for large caseload programs such as the Food Stamp E&T Program, intensive, long-term interventions to a limited number of people yield greater success ratios than short-term interventions with larger numbers. According to Judith Gueron and Daniel Friedlander, "Are High-Cost Services More Effective than Low-Cost

Services?", 1990, Manpower Demonstration Research Corporation, the evidence suggests that a program that provides primarily low-cost services (as long as they are above a certain threshold level of intensity) to as many people as possible may have the greatest aggregate impact on earnings or welfare payments. Using the same resources to serve fewer people with higher-cost components may produce lower aggregate effects, but may help program enrollees achieve higher average earnings.

It is the Department's view that a meaningful program should reach a reasonable number of persons, and to encourage that this happens, this rule proposes to require State agencies to serve no less than ten percent of the E&T mandatory population. That is, at least ten percent of the E&T mandatory population would begin participation (i.e., be placed) in an E&T component. In Model B, persons assigned to the treatment group sample would be included in this count; control group sample members would not be included since they do not begin a component. In both models, a State agency that provides for voluntary participation in the E&T program would be credited with serving volunteers by including the number of volunteer persons placed in both the numerator and denominator of the breadth of service measure.

The ten percent minimum level of service stands as a safeguard against inordinately low levels of service. It is not the level of service recommended or encouraged by the Department. On the contrary, the Department would like to see State agencies provide services to as many work registrants as possible. The performance standard models depicted in this rulemaking do not discourage broad-based programs, nor, in the Department's view, do they inhibit State agency flexibility.

For State E&T plans to be approved, State agencies would be required to address how the minimum percentage of mandatory participants would be served. Accordingly, this rulemaking proposes to amend 7 CFR 273.7(c)(4) to require State agencies to address the breadth of service requirement in the E&T plans.

The proposed calculations would not include a ten percent reduction to the base to account for short-term participants, as is allowed under the participation-based performance standards at 7 CFR 273.7(c)(5)(ii) of the current regulations. The Department does not believe that the ten percent reduction to the base is warranted, given the minimal level of service that would now be required of State

agencies. However, in accordance with current Food Stamp Program legislation (section 6(d)(4)(D)(i)) and accompanying regulations at 7 CFR 273.7(f)(2)(i), State agencies are allowed to exempt from work registration those food stamp recipients who participate for 30 days or less.

To determine compliance with this requirement, the Department proposes the following which is applicable under both Model A and Model B: State agencies would report in accordance with the proposed quarterly reporting requirements specified in 7 CFR 273.7(c)(6) of this rule, the cumulative number of mandatory participants and the cumulative number of voluntary participants who started an E&T component (as approved by FNS in the State agency's plan) during the fiscal year. The aggregate of these numbers would be the numerator of the breadth of service measure.

State agencies would also report the total number of nonexempt work registrants during the fiscal year. This number, plus the number of voluntary participants who were counted in the numerator, would be the denominator.

If a State agency fails to serve at least ten percent of its E&T mandatory population as specified in its State E&T plan, the Department may attach financial consequences to the noncompliance. The Department's authority to suspend or disallow Federal funds to State agencies in cases of noncompliance with the food stamp regulations is established in section 11(g) of the Food Stamp Act of 1977, as amended (7 U.S.C. 2020(g)). This rule proposes to calculate the dollar amount to be disallowed as follows: The State agency's 100 percent Federal E&T allocation for the pertinent year would be reduced proportionately to the percentage below the ten percent level that the State agency's actual level of service fell. No formal warning would be required, however, appeal and administrative review provisions of 7 CFR 276.1(b) would apply.

Voluntary Participation

Public Law 100-435 requires the Department to take rates of voluntary participation into account in measuring outcomes and also in adjusting the performance standards for State agencies. Current regulations at 7 CFR 273.7(f)(4) describe volunteers as participants who are not disqualified from the Food Stamp Program for failure to comply with an E&T requirement. State agencies are allowed to serve voluntary participants, and under the current performance standards, State agencies receive credit for placing them

into components. This rulemaking offers two new proposals affecting the definition and administrative processing of volunteers.

It has long been the Department's policy that in providing E&T services, priority should be given to food stamp work registrants. This is the population specified in the Food Stamp Act of 1977, as amended, as subject to work requirements and to sanctions for failure to comply. 7 U.S.C. 2015(d).

To emphasize service to work registrants, the Department proposes to count volunteer outcomes in the entered employment and educational improvement measures (described in subsequent paragraphs of this preamble) less than the outcomes of mandatory participants. Under both models, the Department proposes to give State agencies half credit for each volunteer job placement or educational outcome. Calculations showing the proposed method of counting volunteer job placements and educational outcomes are included with the discussions of these measures appearing later in this preamble.

Processing Effort for Volunteers

For both Models A and B the Department proposes to require State agencies to assess, refer, and track all E&T volunteers in order to count toward E&T performance only those outcomes associated with food stamp E&T participation. Without this requirement, State agencies could take credit for the outcomes of food stamp recipients who have no contact with the Food Stamp E&T program but might have successfully participated in JOBS, JTPA or some other work program. The requirement to assess, refer, and track all participants should not impinge on State agencies' design flexibility; such activities are fundamental to any system State agencies use to report accurately the outcomes of all E&T participants, mandatory as well as volunteers.

No Concurrent Participation in Other Employment and Training Programs

Another concern about voluntary participation involves the coordination between food stamp E&T and other work programs. The Department recognizes that an integrated work program makes the best use of Federal and State dollars for many State agencies, and is very interested in encouraging linkages between the E&T and other work programs. At the same time, it is the Department's view that it is important that the outcome-based performance standard system clearly distinguish food stamp E&T participants

from participants of other work programs. This would guarantee that each program accurately measures its own performance and that of its target group.

Therefore, for purposes of reporting E&T outcomes, the Department proposes to clarify the definition of volunteers at 7 CFR 271.2 to exclude food stamp recipients who are exempt from work registration, pursuant to 7 CFR 273.7(b) (iii) and (v), because they are subject to and participating in title IV of the Social Security Act or Unemployment Insurance employment programs. Excluded as volunteers would be food stamp recipients who are actively participating either on a mandatory or voluntary basis in the JOBS program or the Federal-State unemployment compensation system. However, persons who are subject to JOBS but who are not participating in JOBS can elect to participate in the E&T program as volunteers. This would include recipients in areas where no JOBS program operates. Other food stamp recipients could be counted as volunteers if they are first processed through E&T channels—assessed, referred, and tracked for E&T purposes, even if these persons are subsequently referred to components of other work programs.

The Department is interested in receiving comments on the issues surrounding coordination and integration with other work programs, especially with regard to E&T voluntary participation. There will be larger and more complex integration issues to be faced in the future, particularly when the JOBS program adopts outcome-based performance standards. Thus, the Department expects that it will be necessary to revisit volunteer and coordination issues after the initial food stamp outcome standards have been implemented.

Encouraging Service to Persons With Greater Barriers to Employment

Public Law 100-435 requires that the performance standards encourage State agencies to serve those with greater barriers to employment and self-sufficiency. The statute does not define what constitutes greater barriers to employment, nor does it specify the degree to which State agencies should be encouraged to target resources to persons with greater barriers. Accordingly, the Department proposes both a definition of those with greater barriers to employment and a method within each of the two models for encouraging State agencies to serve these persons.

Defining the Target Group

The Department looked to a number of sources offering possible definitions of hard to employ individuals within the population eligible for E&T services. The sources included the consultant's reports, the JOBS and JTPA programs, and available research findings on characteristics and participation behaviors of the E&T population. The task of defining a target group of hard to employ individuals is difficult. As the consultant's reports pointed out, the entire eligible population of food stamp work registrants and volunteers is considered hard to employ in comparison to the general public.

During initial solicitation of sources by the consultant, a comprehensive list of characteristics was suggested for consideration. These characteristics included: Lack of high school diploma or equivalency, illiteracy, limited English proficiency, poor work history, long-term food stamp dependency, homelessness, disability or handicap, learning disability, substance abuse, and criminal record. As these characteristics were considered, the majority of sources reporting to the consultant counseled against using a multiple definition consisting of so many serious barriers to employment as to require more intensive and costly interventions than is realistic given the E&T program's limited funding resources. Therefore, the consultant concluded that the Department should focus on fewer characteristics that can be easily ascertained at E&T assessment and for which research has demonstrated a direct link to employability. The factors that emerged included lack of high school diploma or equivalency, poor work history, and long-term food stamp dependency. With regard to long-term food stamp dependency, some sources reporting to the consultant discussed allowing State agencies to target E&T resources to people who have been receiving food stamps for at least six months as an administratively simple method of selecting participants who are hard to employ.

The Department considered research findings on long-term food stamp dependency as a source for factors to include in the definition of the hard to employ group. Currently, there are no findings that identify the characteristics of long-term food stamp recipients so that these persons could be easily identified at food stamp application and targeted for E&T services. Two studies address characteristics of work registrants: A recent study involving four sites in two States, "Long-Term Participation in the Food Stamp Program

by Work Registrants", Research Triangle Institute, 1989, and another study based on a less recent, national database "The Dynamics of Food Stamp Program Participation", Abt Associates, 1989. The findings from the more recent study show that even though approximately half of all work registrants participated for only three months, the majority of food stamp benefits go to work registrants with multiple spells of participation and to those with single spells of participation lasting six months or longer. Although these findings suggest that it would be cost effective to target E&T resources to those work registrants who participate more frequently or for longer periods of time, the study was not able to identify a set of characteristics, using information routinely available in casefiles, that would predict which recipients would stay on the program for a long time. Also, the study did not examine the relationship between long-term food stamp receipt and employment outcomes.

The Department also looked at definitions of the targeted groups used by the JOBS and JTPA programs. The Social Security Act defines the target group under JOBS to include custodial parents under age 24 with no high school or equivalency or little/no work history in the last year, families in which the youngest child is within two years of ineligibility for AFDC, and families that have received AFDC benefits for 36 of the last 60 months. Although this definition is appropriate for the JOBS program, it does not match the characteristics of the food stamp E&T mandatory population which in comparison has a higher turnover rate and fewer dependents. JTPA is required to serve welfare recipients, defined as those receiving AFDC, GA, or Refugee Cash Assistance, and high school dropouts on an equitable basis relative to their proportion of the population. In an effort to improve targeting to the hard to employ, DOL published new requirements on May 16, 1990 for State agencies to report information about termines with barriers to employment including those with multiple barriers, defined as those having three out of the following 12 characteristics: School dropout (i.e., no high school diploma or equivalent), limited English proficiency, handicapped/disabled, offender, reading skills below seventh grade proficiency, math skills below seventh grade proficiency, long-term AFDC dependency (24 of last 30 months), homelessness, JOBS program participants, lack of significant work history (not the same employer for more

than three months of last two years), substance abuse, and pregnant/parenting teen. 55 FR 20330 (1990). The Department notes with interest DOL's choice of characteristics and would like commenters to address the feasibility of State agencies collecting information on some or all of these potential barriers that may be characteristic of food stamp E&T participants (substituting for AFDC dependency a measure of food stamp dependency, such as received food stamps for six out of the twelve prior months).

The Department analyzed data collected from the national E&T Evaluation which is composed of the first follow-up survey responses conducted four months after a randomly selected group of work registrants entered the E&T program. The analysis focused on the consequences of two barriers to employment: The absence of a high school diploma (or its equivalent) and no work history in the 12 months prior to E&T assessment. Regression models were estimated to determine the effect of these characteristics on the employability and wages of the participant in the month they left the E&T program, while controlling for the effects of other economic and demographic factors such as the unemployment rate and population density.

The Department considered two definitions of the target group. The first includes only E&T participants that had neither recent work history nor a high school diploma (or equivalent). This group, representing 24 percent of all participants, was less than half as likely to get jobs compared to the participants with recent work history or a high school degree. That is, the employment rate, adjusted to control for differences in other economic and demographic factors, was 19 percent for this group compared to 39 percent for persons who either had a high school diploma or recent work history or both. The second more broadly defined group includes participants who had either no recent work history or no high school degree. This group, representing 70 percent of all participants, had an employment rate (adjusted for other factors) of 28 percent compared to 47 percent for terminees who had both a high school diploma and a recent work history.

The Department considered the ramifications of the size of the target group. The broader definition which covers 70 percent of participants improves the likelihood of recognizing most of the persons who are hard to employ. This may be an important consideration in defining the hard to

employ, at least initially, given the limitations of currently available data on other characteristics that might usefully identify the hard to employ (e.g., information on literacy levels and the quality of recent work history). On the other hand, inclusion of most of the eligible population in the hard to employ category dilutes the purpose of focusing on a subgroup with greater barriers to employment. Given that the majority of the E&T eligible population may be considered hard to employ in some capacity, it may be appropriate to use a definition that focuses attention on persons with greater barriers to employment in comparison to other eligible participants.

After careful consideration of this information, the Department proposes to define the hard to employ group as E&T mandatory participants who at the initial assessment do not have a high school diploma or equivalency and who have not worked in the 12 months prior to the E&T assessment. This definition would be the same for both Models A and B. The classification of hard to employ would be reserved for the E&T mandatory population in keeping with the policy of encouraging service to mandatories. It is important, at least initially, to base the definition of the hard to employ on sound empirical evidence. However, the Department is most interested in receiving comments on appropriate factors to use in defining the hard to employ as well as the size of the group that is appropriate for targeting.

The Department wants to discourage State agencies from "creaming" the pool of possible participants, i.e., serving the most employable to show better outcome results. Broad-based service requirements ameliorate this type of targeting because so many persons must be served. However, for reasons elaborated upon earlier, the Department has chosen to give State agencies the flexibility that comes with lower breadth of service requirements. The Department proposes to combat the tendency to cream by infusing its performance systems with mechanisms designed to encourage service to the hard to employ.

Extra Credit for Serving Those With Greater Barriers

The Department considered two ways in which State agencies could be encouraged to serve the hard to employ group—eliminating disincentives to serving the target group or providing direct incentives to serving the target group. The former method would involve adjusting the national standards through regression analyses in order to hold

State agencies harmless for serving those with greater barriers. This is the method used in the JTPA program. In addition, Public Law 100-435 requires the Department to adjust the standards to account for various factors that may affect State agencies abilities to meet national standards. The consultant's reports emphasized that removing disincentives to serving the hard to employ is not necessarily the same as encouraging State agencies to serve people whose positive outcomes are less certain. In addition, the sources reporting to the consultant thought that most State agency managers would prefer a simpler method in which they could easily calculate the extra credit they can expect to receive for the positive outcomes of the target group.

The Department agrees with the conclusions of the consultant's reports and proposes the latter method by which State agencies would be provided extra credit for the positive employment and wage outcomes of those defined as being hard to employ.

For both models the Department is proposing to weight the positive outcomes of the hard to employ so that the resulting score not only compensates for the lower likelihood of success for this group but would produce a higher score than the outcomes of persons without these barriers. The weight used for extra credit would initially be based on analysis of data from the national E&T Evaluation. As the weights would be applied differently to each measure, for each model, the specifics are discussed below in the context of each proposed measure.

Model A: To encourage State agencies to provide service to persons who have greater barriers to employment and for whom positive outcomes are less likely, outcomes by hard to employ persons would be weighted more heavily in the calculation of credits than those considered not hard to employ. Job entries and wage rates of those determined at the E&T screening or assessment to be hard to employ, would receive three times the credit as job entries and case closures of those considered not hard to employ. Further description of this calculation procedure is found in the discussions of measures appearing later in this preamble.

Model B: Job entries by persons in the hard to employ target group would be weighted by a factor of three and higher paying jobs obtained by target group members would be more heavily credited (by half the amount that the hourly wage rate exceeds the minimum wage) in the calculation of the overall average hourly wage rate. (The same

weights are proposed for Model A and are discussed in detail later in this preamble.) The above credits would be applied to the respective outcomes of volunteers and hard to employ target members in both the control group sample and the treatment group sample. To apply the credits to successes achieved by persons only in the treatment group would exaggerate the effect of the E&T program. By applying the credits to both samples, a net effect would occur only if more hard to employ persons achieve positive outcomes in the treatment group sample than in the control group sample.

Long Term Participation

The Department proposes to require State agencies to report the number of E&T participants/terminees who received food stamps for at least six months out of the twelve months prior to E&T assessment. The Department would analyze these data to determine if long-term food stamp dependency should be added to the definition of hard to employ and how this factor should be weighted. The public is invited to comment on the merits of this proposal and on the difficulty of providing information on prior food stamp receipt. The Department welcomes any research findings on the relationship between length of stay on the Food Stamp Program and barriers to employment.

Measurement Issues

Criteria Used to Select Measures

The Department considered several criteria in choosing the proposed measures for which specific standards would be set. First, the measures must respond to the statutory requirements. In addition, the measures should relate to the goals of the program, be simple and sensible to program staff, be feasible to implement within the time constraints imposed by the statute for implementation, minimize data collection costs, and be as consistent as possible with comparable measures used in JTPA and JOBS.

Factors Selected as Measures

Public Law 100-435 mandates six factors that must be taken into account: job placement rates, wage rates, job retention rates, households ceasing to need food stamp benefits, the extent of volunteer participants served by State agencies, and improved educational levels of household members. The Department interprets this mandate to mean that each of these factors must be accounted for in some way in the performance standard system, not that each factor must constitute a separate

measure. Accordingly, the Department proposes four initial measures that together take all six factors into account. These measures are: Entered employment rate, average wage rate, rate of food stamp case closures, and educational improvements.

Factors Not Included as Separate Measures

At this time, the Department is not proposing separate measures for volunteer participation or job retention. Instead, the level of volunteer participation would be incorporated into the calculation for each of the four proposed measures.

Data on wage rates should provide a good indication of the quality of jobs that participants are entering. Wage rates, along with the rates of food stamp case closures of E&T participants (terminees for Model A), serve as proxies for the quality indicator that job retention rates are intended to capture—E&T's success in helping participants become self-sufficient. The Department notes that JTPA established a precedent for using related measures to assess job retention and that DOL collected data on postprogram outcomes for several years before setting standards for these measures. Similarly, the Department plans to conduct further analyses of issues pertaining to job retention using the data collected for the national E&T Evaluation.

The consultant's reports pointed out that the collection of data on job retention, other than that proposed in this rulemaking, could be extremely costly. Collecting such information on job retention would require State agencies to operate a separate, costly data collection system which would involve either follow-up surveys or data matches (assuming problems of timeliness and coverage can be resolved) or both. In addition, there is a risk of high nonresponse rates because of the difficulty of tracking and interviewing this population. These issues argue strongly for using alternative indicators of job retention in the initial years and for continuing research on the feasibility of a more direct and less expensive measure.

Establishing a Measurement Period for Counting Outcomes

The measurement period refers to the amount of time within which State agencies would be allowed to track the outcomes of participants. In Model A, the measurement period begins at E&T termination; in Model B, the period begins in the baseline month.

Model A: The Department proposes to allow State agencies to report outcomes

that occur up to one month after the month of E&T termination for the measures of entered employment rates, wage rates, and educational improvements. This measurement period conforms to the amount of time that States will be allowed under the JOBS program to count employed hours of JOBS participants toward the participation standard.

The Department decided that where possible it is important to conform to the approach and time period used in JOBS since in most States, the same agency will be tracking both JOBS and E&T participants. In contrast, JTPA allows a longer measurement period within which to count outcomes of participation. While JTPA measures youth outcomes at the point of termination from the program, local program operators are allowed to place participants in an inactive status once a year for up to 90 days before either referring them to another component or terminating them. Thus, for youth programs, JTPA allows a window of 90 days between the end of actual program activity and the counting of outcomes. With follow-up measures for JTPA adult programs, the outcomes are measured up to six months after completion of actual program activity.

This rulemaking proposes that State agencies would have three months after the month of termination to report outcomes for the food stamp case closure rate. The measurement period is longer for this measure to allow sufficient time to capture the case closures for those E&T terminees who find employment by the end of the month following the month of termination.

Model B: The point at which a person terminates E&T is not a factor in the Model B evaluation. Instead, the Department proposes that State agencies conduct follow-up interviews with control and treatment sample cases six months after random assignment to ascertain whether the participant was or is employed, if so, at what wage rate, food stamp case status and educational achievements.

The Department gave careful attention to the length of time which should elapse between the baseline and follow-up interviews. The national E&T Evaluation and other studies have shown that it takes on average about three to four months for persons to complete a short-term intervention because of the lags that are inherent in normal processing functions. Therefore, a six-month observation period is sufficient for capturing the effects of

programs emphasizing shorter-term components.

On the other hand, a six-month follow-up may not be sufficient for capturing the effects of more intensive, long-term components, particularly those addressing basic skill deficiencies, such as education. A number of persons would still be participating in their components six months after random assignment. Studies of programs emphasizing higher cost services suggest that the value of these programs is the long-term effects on employment; for example, programs show greater earnings increases in the second year compared to the first year after treatment.

A single interview at seven or eight months might be more successful in capturing the effect of longer-term interventions. However, the Department has concerns about attrition and the validity of the responses of those in short-term intervention. As the national E&T Evaluation shows, the number of individuals who become inaccessible would increase with each passing month.

Despite concerns, the Department rejected the idea of multiple waves of follow-up surveys, which might capture both the short and longer-term effects, as too costly. The increased burden on local offices and on the participants themselves may not be justified. With this in mind, the Department is proposing that only one follow-up interview be conducted with each member of the sample, in the sixth month after the point of random assignment.

The Department is very interested in receiving comments on this issue. Although a follow-up period of six months has been proposed, the Department is interested in receiving suggestions on follow-up periods of other lengths. In particular, the Department is interested in the feasibility of using varying follow-up periods for the different measures. For example, a shorter follow-up period (e.g., four months) might be preferred for less intensive interventions, such as job search, while a longer period (e.g., eight months) might be preferred for longer, more intensive components, such as education. Commenters should discuss the advantages and disadvantages of their suggestions (i.e., the effects of attrition vs. ability to capture outcomes of long-term components).

Base of Measurement—Universe

Model A: This rulemaking proposes to measure outcomes against the base of E&T trainees or a subset of trainees. This would include all those participants

who started an E&T component and then either completed the activity or stopped participating in E&T or the Food Stamp Program for reasons including employment. Alternative bases might include all E&T mandatory participants or all work registrants. The consultant's reports recommended using E&T trainees as the base because this compares the number of positive outcomes in terms of persons actually served by E&T. This provides a basis of comparison between different programs, ranging from broad-based to intensive and targeted.

Model B: Because the Department proposes to assess the impact of the E&T program at a specified time, i.e., six months after assignment to a treatment or control group, the point of E&T termination is not a factor, as it is in Model A, and thus a different base, or universe should be used.

The Department proposes that for Model B State agencies collect baseline data for a treatment group sample and a control group sample. These samples would be of equal size and would be representative at the State level of all E&T trainees who, based on some initial determination, are required to comply with a placement into an E&T program component, in addition to volunteers. If a State agency refers all persons determined nonexempt for E&T an upfront job search component, then the universe consists of all of these mandatory participants plus any volunteers for job search activities. If a State agency elects to serve only a portion of the nonexempts and volunteers, the universe for drawing the control and treatment samples consists of only this portion of the E&T mandatory and volunteer population.

All areas of a State which are not geographically exempt from E&T would be required to be included in the process of selecting sample cases. In addition, this rule proposes that State agencies may not systematically discriminate against any subgroup of eligible E&T participants (such as persons also receiving GA) by excluding them from the sample universe.

Proposed Measures of Performance

1. Entered Employment Rate. This measure addresses job placement rates, as required by the statute. The proposed entered employment measure is a standard measure of success for employment and training programs; it is already used by several State agencies in measuring E&T outcomes.

The Department proposes to count employment if an E&T participant is working no less than 20 hours a week in an unsubsidized job that is expected to

last at least 30 days. A 20 hour minimum per week is proposed to be consistent with the current food stamp definition of employment, found at 7 CFR 273.7(n), pertaining to voluntary quit. It also conforms to the 20 hour standard for counting hours of participation of JOBS participants in States' participation rates, as described in the JOBS regulations at 45 CFR 250.78. Although the objectives for tracking job entries differ between food stamp E&T and JOBS, adopting the same concept of hours reduces the potential for confusion about what is an acceptable job. By establishing a 30-day requirement for expected job retention, a minimal level of job quality is assured. The sources reporting to the consultant expressed concern that inclusion of day-labor and other short-term jobs could severely distort the employment measure and promote low quality jobs. Similarly, requiring the job to be unsubsidized by any local, State, or Federal agency (as does JTPA) provides some level of assurance that the job is not dependent on direct government support.

Model A: The definition of the entered employment rate (EER) for Model A is proposed to be the annual number of E&T participants who begin employment, as defined above, by the end of the month following the month of termination of E&T activity as a percentage of all E&T trainees counted during the fiscal year.

All trainees would count equally in the base or denominator. The base of trainees includes those hard to employ mandatory, not hard to employ mandatory, and voluntary E&T participants who either completed or started but did not complete E&T activities.

State agencies would be able to count in the numerator of the equation the jobs of any E&T trainees who begin employment during the measurement period, including those who did not complete the required activity. The numerator would include the job entries of E&T trainees, with different weights applied to job entries of the three groups of E&T trainees: the hard to employ mandatorys, not hard to employ mandatorys, and volunteers.

Regression-adjusted employment rates were calculated for the hard to employ trainees and the not hard to employ trainees from the national E&T Evaluation. Those who are not included in the hard to employ category as proposed to be defined had an employment rate of 2.1 times higher than the hard to employ. Based on this analysis, the Department proposes to

weight the job entries of the mandatory participants who meet the definition of hard to employ (HTE) by 3, which provides almost one point extra credit over and above the level needed to equalize the employment rates of the two groups of terminees. The job entries of mandatory participants who are not hard to employ (NHTE) would be weighted at 1, and the job entries of volunteers would be weighted at .5. The calculations for the entered employment rate as proposed may be expressed as follows:

$$EER = \frac{(3 \times \#HTE \text{ mandatory jobs}) + \#NHTE \text{ mandatory jobs} + (.5 \times \#volunteer \text{ jobs})}{HTE \text{ mandatory} + NHTE \text{ mandatory} + volunteer \text{ terminees}}$$

Model B: The Department proposes that for a State agency to receive credit toward the annual entered employment rate, an individual in either of the sample groups would have to begin employment anytime between the baseline month and the end of the follow-up month. Employment begun prior to the baseline month would not be counted for the purposes of the outcome-based performance system. If an individual has two or more jobs, only one job would be counted—the highest paying job. To be counted, the employment should be no less than 20 hours a week, unsubsidized, and have lasted or be expected to last at least 30 days.

As with Model A, the employment of hard to employ persons would be weighted by 3, job entries of the not hard to employ would be weighted 1 and the job entries of volunteers would be weighted .5. These values would be assigned to both the treatment and control group samples.

The Department proposes to determine the EER in Model B by ascertaining, six months after the baseline month, how many persons in the treatment and control samples entered employment, as defined above. The statewide aggregate data would then be compared to see if the difference is statistically significant.

2. Average Wage Rate. The average wage rate measure is proposed to be defined as the regular time hourly rate of pay (or the hourly equivalent in the case of a salaried position) for employed E&T participants. Public Law 100-435 requires that wage rates be taken into account in the outcome-based performance standard system. The average wage rate measure is an indicator of the quality of jobs that E&T participants obtain. This measure corresponds to a similar measure JTPA used from Program Years 1984 to 1989.

Unlike the entered employment rate calculations, volunteer wage rates would not be weighted differently from the wages received by mandatorys. Many of the same conditions proposed for counting employment in the entered employment measure for both models would apply to the wage rate measure as well.

Since State agencies would receive extra credit in the employment rate measure for job placements obtained by hard to employ terminees (for Model A) and participants (for Model B), the Department proposes to give extra credit in this measure to the persons within this category who receive wage rates above a minimum threshold (i.e., higher quality jobs). The threshold proposed is the Federal minimum wage of \$4.25 per hour which will be effective October 1, 1991. Although the Fair Labor Standards Amendments of 1989 which increased the minimum wage also established a lower training wage, we expect that most individuals who find jobs would receive at least the minimum wage. The extra credit weight would be applied to the portion of the hourly wage rates received by the hard to employ that exceeds the Federal minimum wage. For example, if the hourly wage rate of a hard to employ mandatory terminee is \$5.25, extra credit would be applied to the \$1.00 of the wage which exceeds the Federal minimum wage in effect October 1991.

The extra credit for the initial year would be half of the amount that exceeds the Federal minimum wage. Using the above example of a \$5.25 hourly wage of a hard to employ mandatory terminee, the State agency would receive extra credit of 50 cents for this wage rate ($\$1.00 \times .5$). This is based on an analysis of the wages of E&T participants from a dataset of the national E&T Evaluation that shows the average hourly wage rate of hard to employ participants, as we are proposing to define them at 7 CFR 271.2, is above the prevailing minimum wage but by a smaller amount than the wages of participants who are not hard to employ.

Model A: Wage rates would be counted for E&T participants who are employed during the measurement period whether or not they completed the required activity, if the job meets the proposed definition of employment. If a terminee has more than one job, State agencies would count only the wage rate of the highest paying job.

The average wage rate is proposed to be the average regular time hourly wage rate (including the extra credit portion) of employed terminees reporting wages.

The calculation would involve two steps. First, the portion of wages received by the hard to employ (HTE) mandatory terminees that exceeds the minimum wage would be calculated. The equation for making this calculation is expressed as follows:

$$\text{Portion of hourly wage rate exceeding minimum wage} = (\text{total hourly HTE wages}) - (\$4.25 \times \text{employed HTE reporting wages})$$

Second, half of this amount would be added to the entire amount of hourly wages paid to both hard to employ mandatory terminees and all other mandatory and voluntary terminees. The result is a weighted average hourly wage rate for terminees who become employed and report their wages. The equation for this calculation may be expressed as:

$$\text{Average hourly wage rate} = \frac{(.5 \times \text{portion exceeding minimum wage}) + HTE \text{ wages} + NHTE \text{ mandatory wages} + volunteer \text{ wages}}{HTE + NHTE \text{ mandatory} + volunteer \text{ employed terminees}}$$

Model B: Wage rates may be counted only for employment the participant began between the baseline month and the end of the follow-up month. If an individual has more than one job, State agencies would count only the wage rates of the highest paying job. The average wage rate is proposed to be the average regular time hourly wage rate (including the extra credit portion for the hard to employ) of volunteers and mandatory participants in the sample groups.

As with Model A, the proposed calculation of performance for this measure would involve four steps. First, the portion of wages received by the hard to employ mandatory participants that exceed the minimum wage would be calculated, separately, for the treatment and control samples as follows:

$$\text{Portion of hourly wage rate exceeding minimum wage} = (\text{total hourly HTE wages}) - (\$4.25 \times \text{employed HTE reporting wages})$$

Second, for each sample group, half of this amount would be added to the entire amount of hourly wages paid to both hard to employ mandatory participants and all other mandatory and voluntary participants. The equation for this calculation may be expressed as:

$$\text{Average hourly wage rate} = \frac{(.5 \times \text{portion exceeding minimum wage}) + HTE \text{ wages} + NHTE \text{ mandatory wages} + volunteer \text{ wages}}{HTE + NHTE \text{ mandatory} + volunteer \text{ employed participants}}$$

3. Rate of Food Stamp Case Closures.

This measure is proposed to account for "households ceasing to need benefits". While the information on the rate of food stamp case closures would not directly answer the question of how many recipients "cease to need" food stamps, it is a measure of reduced welfare dependency and a feasible approach for meeting the statutory directive. In the absence of any other information that speaks to the ultimate goal of E&T, which is to help people become self-sufficient, it is the Department's view that it is important to include this proxy measure. In fact, it would be extremely difficult to construct an affordable measure that could directly capture "ceasing to need benefits". This information is more appropriately investigated through a formal evaluation of the program, which the Department is considering conducting after the outcome-based performance standards have been in effect for several years.

The sources reporting to the consultant were divided on the issue of whether food stamp benefit reduction amounts should be included with the measure of case closure rates. Of great concern was that the rate of reduced benefits should also be measured because the wage rates of employed E&T trainees may not be high enough to cause ineligibility for food stamp benefits, thus some positive movements toward self-sufficiency would not be recognized if only case closures are measured. Despite these considerations, the Department decided in favor of simplifying the measure to capture only case closures.

The Department also recognizes that not all case closures are caused by employment of E&T participants, but by other changes in household circumstances as well. Once again, the burden and cost of isolating case closures specifically precipitated by the employment of a family member caused the Department to use a broader construction of "ceasing to need benefits."

Model A: The outcome is proposed to be defined as the percentage of E&T mandatory and voluntary trainees whose food stamp cases are closed as of the end of the third month following the month of E&T termination. All E&T trainees would be treated equally in both the numerator and denominator of this measure, although State agencies would be required to separate volunteer and mandatory case closures. The mandatory trainees who meet the definition of hard to employ would not be counted separately in this measure.

The equation for calculating the case closure rate may be expressed as:

$$\text{Case closure rate} = \frac{\text{\#all mandatory cases closed} + \text{\#voluntary cases closed}}{\text{all mandatory trainees} + \text{voluntary trainees}}$$

Model B: The outcome is proposed to be defined as the percentage of E&T mandatory and voluntary participants whose food stamp cases are closed prior to and into the follow-up month. The cases of all participants in the sample groups would be treated equally, that is, equal credit would be given for case closures of the hard to employ, not hard to employ, and volunteers.

The percentage of case closures in the treatment sample and control sample would be compared.

4. Educational Improvements. Several sources consulted by the Department urged FNS to propose an education measure based on their interpretation of the importance given to education in the Hunger Prevention Act of 1988 as a whole. One obstacle to establishing an education measure for the initial implementation of the outcome-based system is the lack of data relevant to the E&T population that could be used to set an initial standard. However, after considering the issues involved, the Department agrees that it is appropriate to include an education measure. In addition to the food stamp statutory requirement to take educational improvements into account, other programs are addressing the problem of poor basic literacy and math skills as primary barriers to employment for low-income persons. For example, education for AFDC parents under 20 is a centerpiece of the new JOBS program.

The Department proposes a multi-definitional approach to account for "increases in household members' educational levels". Acceptable educational improvements that may be counted toward the educational standard include: (1) completion of no fewer than 64 hours of classroom training in one or more educational components during the fiscal year; (2) achievement of a high school diploma or equivalency (i.e., GED); or (3) achievement of State-defined educational goals that are comparable to the gains expected from completing the hours of classroom training required in (1) above. Because of this flexible approach, State agencies that offer education components would need to specify in their State E&T plans which of these three definitions they plan to use in counting educational outcomes of E&T participants. State agencies may choose any one or more of the three definitions of educational outcomes.

State agencies that choose to use State-defined educational goals exclusively would need to explain these State-defined goals thoroughly in their State E&T plans, focusing on the justification of this approach and demonstrating that the State-defined goals are equivalent to the gains expected from at least 64 hours of classroom training.

For purposes of counting outcomes for this measure, acceptable educational activity would include completion of any single educational component or combination of educational components currently approved by FNS, including Adult Basic Education (ABE) classes, English as a Second Language, and GED preparation courses, among others. However, participation in components that do not focus on basic educational skills would not count toward meeting the 64 hour requirement. To clarify the focus of educational components on basic skills, the Department proposes to define basic skills at 7 CFR 273.7(f)(1)(vi) as reading, writing, mathematics, speaking, listening, and problem solving skills. This list of six basic skills was recommended by an interagency work group composed of staff from the Departments of Education, Health and Human Services, and Labor, which examined issues of defining literacy and basic skills for Federal agencies involved in literacy programs.

State agencies may elect to use one of the three definitions for any particular educational outcome, but they may count the outcome only once per intervention. This proposal would guarantee that educational outcome data are not inflated. For example, a State agency may choose reading improvement of one grade level as a State-defined goal. An E&T trainee (Model A) or participant (Model B) would then meet this goal by spending over 64 hours in a reading class. In this instance, the accomplishment could only be counted as one outcome, either as meeting the State-defined goal of improving reading ability by one grade level or as completing 64 hours of classroom training. Other educational accomplishments, however, represent completion of several educational outcomes. For example, an individual may take GED preparation classes as part of a State-defined educational goal; at a later time, the individual may take and pass the GED test. In this instance, completion of the GED preparation classes and the successful passing of the GED test would count as two educational outcomes.

Completion of 64 hours of classroom training serves as the minimally acceptable level of effort for this

measure. The purpose in setting a minimum number of hours is to establish a quantifiable level of effort that seems reasonable in comparison to the effort a State agency would expend in helping participants find a job. The number of hours proposed for completion of educational activity is based on an average of four hours per week spent in ABE classes multiplied by a median average of 16 weeks that work registrants participate in the Food Stamp Program. Department of Education staff estimated that the weekly average number of hours spent in ABE varies between four and six hours, although they cautioned that there are no nationally-derived averages at this time. The median average length of food stamp participation for work registrants was estimated from recent research findings.

The Department recognizes that 64 hours of educational instruction may not be sufficient to address major deficiencies in basic skills, however, the mobility of the E&T population may make even the completion of 64 hours a challenge. Moreover, the Department recognizes that this is a process-based measure that is defined solely in terms of the quantity of effort in an education component without regard for the quality of the effort. While it would be more desirable to measure successful completion of an education component, or better yet, actual gains in knowledge or basic skills, there is no consensus on how that would be accomplished, and pre- and post-testing of educational gains could be very expensive. The Department is requesting comments on ideas for an educational measure that more closely approximates the actual measurement of educational attainments within a reasonable range of costs.

The Department considered a number of options for an educational measure, including defining educational improvements strictly in terms of uniform national goals, such as the achievement of high school equivalency or increases in one grade level or several grade levels as measured by nationally-recognized standardized tests. Alternatively, State-defined goals were considered as a separate option. Both approaches have merit.

The advantage of defining educational outcomes from a national perspective, as the consultant's reports pointed out, is that it would facilitate cross-State comparisons and keep the measure meaningful to policy makers and the public. Given the fact, however, that the educational system in this country is largely controlled at the State and local level, it makes sense to recognize this

diversity and to give State agencies flexibility to utilize existing educational resources at the local level. Furthermore, a measure that is limited to a few outcomes, such as attainment of a GED, could discourage State agencies from securing educational opportunities for E&T participants through existing organizations, and it could also discourage service to E&T participants who may be most in need of educational assistance, such as those who cannot read. Thus, the Department concludes that proposing a measure that combines the advantages of several definitions of educational improvements would provide State agencies with the flexibility to make the best use of community educational resources for E&T participants. In particular, the Department is concerned that the education measure allow State agencies to receive credit for working with E&T participants who cannot read or who lack other basic educational skills.

Helping people become self-sufficient through education can be a very expensive and long term process that may exceed the limited resources available to the E&T program. It is the Department's view that the proposed approach is valid given these considerations, the enormous range and variation of educational services and activities, and the lack of empirical data on education and the E&T population. The Department notes that two major studies on basic literacy in the United States may soon provide valuable information. These two concurrent but separate surveys of literacy, are funded by the Departments of Education and Labor and are being conducted by the Educational Testing Service in Princeton. The results from these studies are expected to be released in the near future. They will be considered in future revisions to the education outcome measure.

Another Department of Education study, released in January 1990, attempted to define "basic skills" and "literacy". This study recommends a common, uniform baseline level to define deficiency in basic skills and literacy and promotes consistency in terms used by the various Federal agencies with basic skills and literacy programs. Legislation has recently been proposed that incorporates some of the recommendations from this study, including a definition of "literacy". The intent of this proposed legislation is to enhance the literacy and basic skills of adults by guaranteeing that all adults acquire the basic skills necessary to function effectively and achieve the greatest possible opportunity in their

work and in their lives and to strengthen and coordinate adult literacy programs. The Department will review all future legislation concerning adult literacy with the intent of incorporating them, as appropriate, in future E&T program regulations and policies.

Because State agencies are not required to offer educational components, this measure would be used only if education is part of a State agency's E&T program and the State agency chooses to measure educational outcomes.

The Department does not propose to provide extra credit for the educational outcomes of the hard to employ mandatory terminees. Since one of the barriers defining the latter group is no high school diploma or GED, it is presumed that this is the group that State agencies would be likely to involve in educational activities.

As discussed earlier in the preamble, the Department proposes to allow a partial credit of .5 for the educational outcomes of volunteers. The reason for this proposal is to make clear that the Department envisions priority of service will be with work registrants.

Model A: The educational improvement rate would be calculated for all mandatory and voluntary educational terminees as:

$$\text{Educational improvement rate} = \frac{\# \text{mandatory terminees} + (\text{voluntary terminees} \times .5)}{\text{who completed 64 hours, or got GED's, or met State goals/all educational mandatory + voluntary terminees.}}$$

The Department's proposal limits the denominator to educational terminees in order to assess educational outcomes in relation to the persons who actually participated in educational activities. One drawback to using this denominator is the question of how to count the outcomes of educational terminees who drop out of educational components because they got jobs or left the Food Stamp Program. The Department does not believe it would be appropriate to count this positive outcome as an educational improvement, even though the educational instruction may have assisted the individual in getting the job. Since E&T educational terminees would be included in the denominators of the other three measures, the positive outcome of a job would be counted toward the entered employment rate. Anticipating the possibility that E&T participants may not complete educational activity for a variety of reasons, including getting a job or leaving the Food Stamp Program, it is the Department's view that it is more

appropriate to address these considerations in setting the standard, rather than to dilute the educational measure.

Model B: The classic experimental design used throughout Model B does not lend itself to an evaluation of educational improvement due to its impracticality. For example, pre- and post-testing, the preferred means of data collection, is prohibitive due to cost and would be burdensome to achieve, especially for the control group. Moreover, data collection for the control group would rely heavily, by default, on recall information from control group participants since collateral information would not be available or would be difficult to obtain. Recall information is less reliable and the Department is reluctant to use unreliable data to determine performance levels upon which funding would be based. Therefore, the Department is not proposing a comparison of the outcomes of the treatment and control groups for this measure. Instead, this outcome would be defined as the number of persons who began an educational component and achieved educational improvements as a percentage of all persons who began an educational component. Thus, this measure would examine the performance of treatment group participants only, similar to Model A, and would not track the educational improvements of control group participants.

Acceptable educational improvements that may be counted for this measure are: 1) completion of no fewer than 64 hours of classroom training in one or more educational components during the fiscal year; 2) achievement of a high school diploma or equivalency (i.e., GED); or 3) achievement of State-defined educational goals that are comparable to the gains expected from completing the hours of classroom training required in (1) above. The Department is proposing a national standard to assess the performance of State agencies who elect to provide educational components. This standard is discussed below.

Setting National Standards

Model A: It is the Department's view that initially the objective of the performance standard system should be to define a minimally acceptable level of performance expected of State agencies. This is the basic objective of DOL in setting the standards for the JTPA program. The minimal levels for the proposed national standards should be thought of as departure points, since these levels would be adjusted for each State agency to account for the effect on

State agencies' performance by certain factors that vary across States. The proposed adjustment process is described in subsequent paragraphs of this preamble.

Although the Department considered other approaches to setting the initial standards, the decision to set standards at the 25th percentile is consistent with the statutory requirement to set the standards at levels that State agencies can reasonably be expected to achieve. This does not preclude the Department, however, from using a different approach in future years such as calculating higher standards to distinguish outstanding performance. These standards are relative measures of State agencies' performance and do not distinguish between State agencies that had positive, negative or no impact on the desired outcome measures.

Except for an initial period from October 1991 through September 1993, national standards would be derived from performance data reported by State agencies for a previous period. The Department proposes to base national standards for FY 1994 and FY 1995 on State agencies' scores on each measure during the first year (October 1991 through September 1992). Following the example set by JTPA, the Department proposes to set the national standards at the 25th percentile. This means that in the prior period, 75 percent of the State agencies exceeded the national standards and are expected to perform as well in subsequent years. The Department intends to make public the revised national standards for FY 1994 and FY 1995 in the spring of 1993. Thereafter, national standards for the performance measures would be updated every other spring based on reported performance in the most recent prior fiscal year for which data are available. Thus, the Department would issue new national standards in spring 1995 for FY 1996 and FY 1997 based on analysis of data for FY 1994.

For the first two years, October 1, 1991 through September 30, 1993, standards for the entered employment rate, average wage rate, and food stamp case closure rate would be based on the Department's analysis of a database from the national E&T Evaluation. Since the national E&T Evaluation sample was representative of the nation as a whole rather than of the participating States, additional calculations were necessary in order to estimate what the 25th percentile would be for each of the three measures if aggregate State-level data were available. The educational improvement standard is based on the judgment of experts in the fields of

employment and training programs and adult education because data from the national E&T Evaluation are not adequate to assess educational outcomes.

For the initial period of October 1991 through September 1993, the Department proposes to set the following standards:

- Entered employment rate—25 percent of all E&T terminées;
- Average wage rate—\$4.45 (5 percent above the minimum wage of \$4.25 that will be effective on October 1, 1991);
- Case closure rate—20 percent of all E&T terminées;
- Educational improvement rate—25 percent of all E&T terminées completing educational components.

At the close of each fiscal year, State agencies' performance on each outcome measure would be compared to the respective standard for that measure. To promote fairer judgments of State agencies' performance, the national standards for each measure would be adjusted for each State agency to account for the effect on the program performance of State differences, as required by Pub. L. 100-435.

The Adjustment Process

The amendments made to section 6(d)(4) of the Food Stamp Act by Public Law 100-435 contain two clauses pertaining to this requirement. The new paragraph 6(d)(4)(L)(ii)(IV) requires the Secretary to include guidelines permitting appropriate variations that account for differing conditions, including unemployment rates and rates of voluntary participation, that may exist in different States. Referencing the adjustments provided for under (L)(ii)(IV), Congress further describes in paragraph (L)(iv) other allowable factors to be used to vary the standards in any State. These factors include specific economic, geographic, and demographic factors in the State, the characteristics of the population to be served, and the types of services to be provided. In the process of choosing appropriate variables for adjusting the standards, the Department considered factors mentioned in both clauses.

Adjusting Standards Using Multiple Regression Models

In the development of an appropriate adjustment methodology for the Model A outcome-based performance standards, the Department studied the approach developed by DOL in JTPA. The DOL adjustment model allows for systematic variation of the JTPA performance standards applied to local service delivery areas (SDAs), in an

effort to make standards equitable across localities that serve participants with different characteristics and face different economic conditions. The DOL adjustment model holds SDAs harmless for operating in a difficult environment or for serving clients that have greater barriers to employment. Conversely, the model holds SDAs to more stringent standards if they operate in an easier environment or serve more job-ready clients. DOL uses a multiple regression model to determine the quantitative relationship between participant characteristics and local economic factors on the one hand and each of the measures of performance on the other.

The purpose of regression-based adjustments is to control for factors that affect a State agency's performance but are not under the control of the State agency. The multiple regression adjustment model is based on the assumption that the program outcome of an individual depends on a series of causal factors or explanatory variables (such as education, work experience, local unemployment rate, etc.). The causal factors can be thought of as "predicting" the level of the outcome

measure. The regression procedure essentially determines a "weight" for each causal variable so that the difference between the performance outcome and the weighted sum of the causal factors across all individuals in the sample is minimized. After the weights are determined for each causal variable, the departure point for a standard may then be adjusted (raised or lowered) for each State agency by determining the amount by which the State agency differs from the national average for each factor in the model, multiplying the differences by the regression-determined weight for each factor, and summing the result across all factors in the model.

An example might be helpful in describing the regression-based adjustment process. Assume a State agency has a higher percentage of families below the poverty line compared to the national average and that a higher proportion of its program termines are female compared to the incidence of this characteristic among all termines in the national sample. Since the model, which is based on the average national experience, shows that

both factors are associated with lower average wages, the model predicts that this State agency would achieve a lower score on the wage rate, all other things remaining equal to the national experience. The reasons for this lower score—higher percentage of families in poverty and the effect of gender—are ones that can be considered out of the State agency's control. The adjustment process provides a methodology for calculating how much the State value on these factors differs from the national average value on these factors, and the model indicates how much effect these differences would have on the State agency's score on the average wage measure. The predicted difference in the score is the State adjustment; it is applied to the national departure point to tailor the national standard to the State agency's circumstances. In this example, the adjustment produces a State standard that is lower than the national departure point.

Exhibit A presents an illustrative worksheet for calculating the adjusted standard for a hypothetical State agency for the average wage rate standard.

EXHIBIT A.—ILLUSTRATIVE ADJUSTMENT WORKSHEET

[State: hypothetical; performance measure: average hourly wage rate; period: FY 1994]

A. State factors	B. Value of State factors	C. National average	D. Difference (B minus C)	E. Weights	F. Effect of State factors on standard (E times D)
Proportion Female.....	.600	.469	.131	-.471	-.082
Proportion under age 21.....	.200	.128	.072	-.399	-.029
Proportion Married.....	.290	.291	-.001	.463	.000
Proportion Receiving UI.....	.020	.043	-.023	2.965	-.068
Population Density (thousands per sq. mile).....	.550	.353	.197	.122	.024
Proportion of Families Below Poverty.....	.100	.097	.003	-5.420	-.016
G. Total.....					-.15
H. National Departure Point.....					*** \$4.75
I. Adjusted State Standard (G + H).....					\$ 4.60

*** Hypothetical national standard for FY 1994.

The DOL adjustment model is a complex system that reflects a comprehensive and sophisticated data reporting system that has been developed over a period of ten years. One drawback to the adoption of a multiple regression adjustment model patterned after the DOL model is that most State agencies would have to develop new data reporting systems to capture the information needed to make the necessary adjustments. As the consultant's reports pointed out, overly fine adjustments of the standards are misguided if sufficient dollars are not available to provide a meaningful level of program services.

Another concern about the DOL adjustment process is that the adjusted

State standards are calculated at the end of the fiscal year when the actual values of the adjustment factors are known. State agencies would know prior to the fiscal year the national standards, the factors that would be used for the State adjustments, and the weights for the adjustment factors. State agencies would also be collecting information on some of the factors and reporting these to the Department. As State agencies gain experience with the adjustment process, they would be able to anticipate how economic conditions and characteristics of clients served would be reflected in their respective State adjustments. However, the retrospective timing of the State adjustments may cause some uncertainty until State

agencies become familiar with the data and how the values for these data affect their standards.

Although these considerations are valid, it is the Department's view that a multiple regression model is the best way of adjusting national standards objectively so that equitable comparisons can be made between State agencies, as required by the statute. The Department addresses these concerns about the multiple regression model in this preamble.

Proposed Regression-Based Adjustments

The Department proposes to adopt the JTPA method of adjusting national standards but with several

modifications. First, since extra credits are added to State agencies' scores for positive outcomes achieved by persons with greater barriers to employment, States' standards would not be adjusted down for the effects of these factors (no high school diploma and no recent work history) on performance. In a sense, the prospective adjustments in the scores substitute for the retrospective adjustments in State standards for these factors. It is the Department's view that the extra credit approach (details discussed in earlier sections of this preamble) more directly rewards State agency managers, and that it simplifies the regression model, since fewer variables are needed to control for the negative effect on performance of serving the hard to employ.

Second, for an initial period (October 1991 through September 1993), the Department proposes to base State adjustments on those economic and demographic factors for which data are currently available from national sources such as the Bureau of Census and Bureau of Labor Statistics. That is, adjustments are limited to variables for which prior State-level data exist and which State agencies can use to anticipate the effect of these factors on its standards in the initial period. For example, State agencies would know past unemployment rates but would not know the characteristics of E&T trainees proposed to be collected until a later point in time. State agencies would be required to report information on the characteristics of E&T trainees beginning October 1991 but these data would not be reflected in the State adjustments until FY 1994.

The Department recognizes the importance of balancing the need to adjust standards with the need to limit cost and complexity of the data reporting requirements. As will be discussed below, State data reporting is limited only to variables found statistically significant and of sufficient impact to be included in the model. Following the example of DOL, the adjustment models would be re-estimated annually to reflect the most recent information on State factors and to assess the importance of these factors in the adjustment process. Information on the first major revision, incorporating State reported data for the first year, would be available in the spring of 1993. Thereafter, information on the revised models would be made public to the State agencies on an annual basis.

In order to select the factors for inclusion in the initial adjustment model and to identify the State reported-data items needed for development of

subsequent adjustment models, the Department conducted an analysis using data from the national E&T Evaluation. The following sections discuss this analysis.

Factors Considered in the Adjustment Models

Using data on E&T trainees from the national E&T Evaluation, the Department tested a number of factors to determine which were likely candidates to adjust the standards for three measures—entered employment rate, average wage rate, and food stamp case closure rate. Initially, a full model was tested for each measure that included many personal characteristics and local economic factors that were hypothesized as affecting performance. The set of factors tested was based on (1) existing evidence of effect on employment, earnings, or welfare dependency, (2) variables used for the DOL adjustment models, and (3) the availability of relevant data from the national E&T Evaluation data base. Personal characteristics that were tested in the full models included age, gender, race, marital status, high school completion, primary language other than English, welfare receipt (AFDC, GA, and unemployment compensation), employment in the previous year, and household size. Economic, geographic, and demographic factors tested in the full models included population density, unemployment rate, percentage of families below poverty, percent of employment in manufacturing, and average annual earnings in retail trade. Variables which did not reflect the expected relationship or whose weights were small relative to their standard errors were dropped and a revised model was estimated for each of the three measures. The empirical results were fairly consistent with JTPA findings. These initial analyses were presented to the various sources consulted for the reports and were considered reasonable by the majority.

Two factors required by Public Law 100-435 to be used to adjust the standards, rates of voluntary participation and the types of services provided, would be reflected in separate adjustments to each State agency's performance standards rather than included in the multiple regression adjustment. Voluntary participation is treated separately because of insufficient data in the database analyzed from the national E&T Evaluation. In order to consider voluntary participation for future adjustments, the Department proposes to require State agencies to report for each measure the number of trainees

who are volunteers. Until State-level data on volunteers is available to incorporate into the multiple regression models, the Department's proposal to provide twice as much credit for work registrants' job entries and educational outcomes as those of volunteers, would, in effect, provide an adjustment to States' performance standards for service to volunteers, by directly adjusting the measurement of performance.

The Department is accounting for differences in the types of services by independently measuring outcomes achieved between education and noneducation components. The inclusion of an educational measure in the performance standards system recognizes some important ways in which State agency performance may be affected by the types of services provided. The educational improvement rate, as proposed, emphasizes considerable flexibility in allowing State agencies to define educational goals and to count E&T participants' successful achievement of those State-defined goals toward the educational standard.

Factors Selected for the Adjustment Models

Regression models were reestimated for each measure using as control factors the proposed definition of hard to employ trainees (high school dropouts and not employed in the previous 12 months) and several variables to represent other individual characteristics and local economic factors. The individual characteristics that were included in the reestimated models were those that had been indicated as statistically significant during earlier tests. The factors included in the final models which would be the basis for the Department's proposals for adjusting State's standards and for setting State data reporting requirements are as follows:

- **Entered Employment Rate:** the number of hard to employ trainees, number of trainees who are GA recipients, number of trainees who are minorities (defined as Black (not Hispanic), Hispanic, American Indian or Alaskan native, Asian or Pacific Islander), the most recent State unemployment rate, the percent employment in manufacturing, and the average earnings in retail trade.
- **Average Wage Rate:** the number of hard to employ trainees, number of female trainees, the number of married trainees, the percent of trainees who receive unemployment compensation, population density by State, the percent of families below poverty by State.

• **Case Closure Rate:** the number of female terminees, the number of terminees who are minorities, the number of terminees who have not been employed in the 12 months prior to E&T assessment, the household size of terminees, the State unemployment rate.

Adjusting National Standards From FY 1992 Through FY 1993

For the first two years after the implementation of the outcome-based performance standards, October 1991 through September 1993, the Department proposes to adjust the national standards for the entered employment rate, average wage rate, and case closure rate for each State agency to account for differences in economic, geographic, and demographic factors during these periods using a more limited set of factors with data from national sources. The national standards would be adjusted using the following data: entered employment rate—State unemployment rate, percent employment in manufacturing, and average earnings in retail trade; average wage rate—population density per square mile and percent of families below the poverty level; and case closure rate—State unemployment rate.

Adjusting National Standards for FY 1994 and Beyond

Beginning with FY 1994, the Department proposes to implement the complete adjustment methodology including adjustments for terminnee characteristics as reported by State agencies. Using State reported data from the first year on terminnee characteristics and economic, geographic, and demographic data available from national sources, the Department would reestimate adjustment weights for the entered employment rate, average wage rate, case closure rate, and the educational improvement rate (if sufficient data on educational outcomes have been reported by State agencies). Adjustments made in subsequent fiscal years would follow the same format: data reported by a State agency from the previous fiscal year may be used to estimate a State's standards for the current year, and retrospective adjustments would be determined after the current year data has been submitted. The retrospective adjustments would be considered the final levels of performance expected of the State agency.

State agency reported data from the first year after implementation (October 1991 through September 1992) would be used to reestimate the national weights for the regression models. If data reporting requirements are delayed until

April 1, 1992, reestimated weights would be based on the second half of FY 1992. The Department would announce the FY 1994 national standards and the reestimated weights for the adjustment models in the spring of 1993. At that time, the Department would also release each State agency's final adjusted standards for the three performance measures for the first year of operation of the outcome-based performance measurement system. State agencies may anticipate their adjusted standards for FY 1994 by applying the new weights to the values of the factors in the first year. State agencies are also encouraged to monitor data on the adjustment factors during the fiscal year to judge the effects of external factors on performance. The adjustments made after the close of the fiscal year would be considered the final levels of performance expected of the State agency.

Model B: Model B differs from Model A (except for the educational improvement measure) in that there is no standard for each measure by which the State agency's performance would be evaluated. Under Model B, the State agency's performance would be evaluated through a comparison of the treatment and control group's performance for each of the measures. The net difference between the performance of the two groups would be the State agency's overall performance for each measure. Upon testing for statistical significance, the net impact for each measure would result in a finding of a positive effect, no effect or a negative effect. Therefore, the standard for each measure would be the same, i.e., initially, a positive effect or no effect.

For the educational improvement measure, a national standard is being proposed—25 percent of all educational component participants should achieve one of the educational improvements goals. This standard is modeled after the standard proposed under Model A. As under Model A, the State agencies' performance on this measure would be compared to the standard at the close of each fiscal year. Beginning with FY 1994, to promote fairer judgments of State agencies' performance, the national standard for this measure would be adjusted for each State agency to account for the effect on program performance of State differences (assuming there are sufficient data on educational outcomes to support estimation of adjustments).

In addition, the Department would study the data collected under this measure in order to make appropriate

adjustments to the national standard in the future. One such adjustment may be to allow additional credit for State agencies achieving outstanding performance under this measure.

Random assignment to the treatment and control group samples means that easily measured differences between the groups (race, gender, education) and unobservable differences between the two groups would be eliminated. Therefore, the impact of each State agency's E&T program on job entries, hourly wage rates and Food Stamp Program status can be isolated more readily. As a result, the legislative requirement to adjust for differences across States in external factors that may affect performance (participant characteristics, demographics, economic conditions, etc.) is already accounted for in the design of the Model B impact performance standards.

Reporting Requirements

Implementation of the outcome-based performance measurement system as proposed in both models within this rulemaking would substantially expand reporting requirements for State agencies. For example, State agencies would be evaluated on their performance on at least three measures (four measures, if educational components are part of the State agency's E&T program) instead of the current one measure (persons placed into components). In addition, State agencies would be required to report certain characteristics data and other program information. To capture the expanded data elements that are proposed to be collected, FNS proposes to revise the current Form FNS-583, Employment and Training Program Report. In Model B, revised Form FNS-583 would be supplemented with an annual report.

The Department recognizes that implementing a new data reporting system would be a great effort for State agencies. In determining the data items to be included in the quarterly reporting forms of both models, the Department carefully weighed the merits of a more inclusive list of data items against a more restricted list. A more inclusive list accommodates the need within Model A, for example, to adjust national standards for each State to account for the effects of factors that are out of the control of State and local administrators. This promotes a more equitable system and responds to the provisions in the Hunger Prevention Act of 1988 regarding State-level adjustments. Similarly, in Model B, quarterly data requirements are

proposed to guarantee that State agencies properly implement random assignment and follow-up data collection. This protects the internal validity of each State agency's impact analysis and promotes fairer comparisons of E&T program impacts across State agencies.

Although many State agencies already collect data on some of these items, the new system under either Model A or Model B would be burdensome to many. Fewer data items would lessen this burden. It is the Department's view that the proposed data reporting requirements reflect the appropriate balance between these two concerns. Comments on this issue are invited.

Interim Reporting Requirements

Both Models: State agencies would be required to implement the new outcome standards on October 1, 1991. The Department recognizes that for an initial period, the State agencies would be monitoring and refining their procedures for collecting the required data items and generating the State-level measures required in the new data reporting forms. Rather than detract from this effort, the Department plans to delay implementation of the new reporting requirements until April 1, 1992 and would require State agencies to comply with the requirements of the current Form FNS-583, Employment and Training Program Report, for the period October 1991 through March 1992.

Ongoing Reporting Requirements

Model A: The Department proposes to retain the current quarterly reporting cycle for E&T data, except that State agencies would be allowed 60 days, rather than the current 45 days, to submit the reports after the end of each quarter.

The Department proposes to amend 7 CFR 273.7(c)(6) to require State agencies to report information falling into three categories on a quarterly basis: data on the work registrant population, data on the numbers of E&T trainees and their positive outcomes as proposed to be measured, and characteristics of the E&T trainees that FNS would use to adjust each State agency's performance standards. Like the current reporting format, quarterly data would also be reported cumulatively.

The following is a discussion of the Department's rationale in proposing specific data items to be reported under Model A:

Work registrant population. The Department proposes to continue reporting requirements on aspects of the work registrant population. These data provide general information on State

agencies' E&T programs that are of interest to Congress and the public, and the information would be used by the Department for program management purposes, such as calculating the percentage of nonexempt work registrants served by State agencies to determine whether the ten percent breadth of service requirement was met. The Department is proposing to require State agencies to report on a quarterly basis information that is currently required to be reported annually with the fourth quarter report. This information is the number of persons exempted from the E&T program, separated by the type of exemption and the number of persons beginning components, separated by each component offered by the State agency.

State agencies would be required to report the following data on the work registrant population:

- The number of work registered persons in the State on October 1;
- The number of participants who were work registered (i.e., only newly work registered persons or persons work registered 12 months from their last work registration);
- The number of work registrants exempted by the State agency from E&T participation, separated by the specific reasons for the exemptions;
- The number of volunteers who began an E&T component, separated by component;
- The number of E&T mandatory participants who began an E&T component, separated by component; and
- The number of work registrants sent a NOAA for failure to comply with E&T requirements as well as the number of applicants who were denied food stamp certification or recertification for failure to comply with E&T requirements.

Numbers of E&T trainees and positive outcomes. The Department proposes for Model A to require State agencies to report the data items listed below which are grouped by the corresponding performance standard or purpose:

- The number of hard to employ mandatory, the number of not hard to employ mandatory, and the number of voluntary participants who terminated from E&T activity during the quarter—provides the denominator for the entered employment rate, and the food stamp case closure rate;
- The number of total mandatory (hard to employ and otherwise) and voluntary E&T participants who terminated from educational components during the quarter—provides the denominator for the educational improvement rate;

- The total number of mandatory (including hard to employ and otherwise) and voluntary E&T participants who terminated from each of the E&T components (other than education) during the quarter—provides general program information;

- The number of hard to employ mandatory, not hard to employ mandatory, and voluntary trainees who during the quarter entered employment, as defined in 7 CFR 271.2, by the end of the month following the month of termination—provides the numerator for the entered employment rate;

- The aggregated hourly wage rates each quarter of all employed E&T trainees reporting wages and the aggregated hourly wage rates for three groups: not hard to employ mandatory, voluntary, and hard to employ mandatory (two aggregated wage rate numbers would be reported for the hard to employ mandatory group, the aggregated wage rates for all hard to employ trainees and the aggregated wage rates for those whose wages are at or above the Federal minimum wage)—provides the numerator for the average wage rate;

- The total number of employed E&T trainees reporting wages each quarter, including subtotals of three groups of employed E&T trainees: not hard to employ mandatory, voluntary, and those hard to employ mandatory trainees provides the denominator for the average wage rate;

- The total number each quarter of mandatory (hard to employ and otherwise) and voluntary E&T trainees whose food stamp cases were closed by the end of the third month following the month of termination—provides the numerator for the food stamp case closure standard; and

- The number each quarter of mandatory (hard to employ and otherwise) and voluntary E&T trainees who completed 64 hours of educational instruction, the number of mandatory (all inclusive) and voluntary trainees who attain a high school diploma or a GED, and the number of mandatory (all inclusive) and voluntary trainees who met State-defined educational goals—provides the numerator for the educational improvement standard.

Characteristics of E&T trainees. Information on the characteristics of E&T trainees would be used by the Department in Model A to make the proposed regression-based adjustments to each State agency's performance standards (for the entered employment rate, wage rate, and food stamp case closure rate) and to reassess weights for

extra credit for the hard to employ. Therefore, the Department proposes to require State agencies to submit on a quarterly basis the number of E&T terminees with the following characteristics noted at the E&T assessment:

- Receipt of GA benefits;
- Minority (defined as Black (not Hispanic), Hispanic, American Indian or Alaskan native, Asian or Pacific Islander);
- Female;
- Married;
- Receipt of unemployment compensation;
- Unemployed during the 12 months prior to E&T assessment;
- No high school diploma or equivalency at E&T assessment;
- Receipt of food stamp benefits for six out of the last 12 months prior to E&T assessment (not necessarily consecutive);
- Average household size of E&T terminees as of the E&T assessment.

Time Frames for the Model A Reporting Requirements. To give State agencies time to design and implement new reporting systems the Department is proposing that the second quarter of FY 1992 (which ends March 31, 1992 with reports due by May 15, 1992) would be the last quarter in which State agencies are required to report information using Form FNS-583. Beginning with the third quarter of FY 1992, which covers the period of April 1 through June 30, 1992, State agencies would report information on a newly designed form which reflects the needs of the outcome-based performance standard system.

State agencies would be required to report the outcomes measured for each participant that terminated in each quarter. Reports would be due the first of the month following 60 days after the end of the quarter. This provides adequate time to report all job entries and hourly wage rates of E&T terminees in the prior quarter and to report the number of terminees who attained education goals in the prior quarter. This does not, however, provide enough time to capture all of the case closure outcomes for the terminees of the prior quarter; the measurement period for case closures is three months after the month of E&T termination. To account for this time lag, the Department proposes to require State agencies to report these outcomes in both the current and the next quarterly report. For example, State agencies would be required to report by March 1 the number of terminees in the prior quarter ending in December and their job entries, wage rates, food stamp case

closures, and educational attainment outcomes. State agencies would also be required to report by June 1 the number of terminees in the quarter ending the previous December who left the Food Stamp Program and were not previously reported because of the time lag.

Fiscal year totals would be available the first of the month following 60 days after the end of the fiscal year for all measures except case closures. The Department considered two options—to wait another two months for final year numbers or to base the case closure measure on terminees during the period of July through June, instead of the Federal fiscal year of October through September. Due to the time delay in assessing State agencies' overall assessment, which in future years may be tied to incentive funding, the Department proposes to use a July through June year for the case closure rate.

The Department considered a reporting system in which State agencies report the outcomes as of the period they occur regardless of when the person terminated from the program. For example, the State agencies would report all terminees for the period January through March and also all outcomes that occurred in that period, many of which would reflect the results for terminees in the prior two quarters. In the aggregate, this approach would produce meaningful measures after State agencies' E&T programs are fully implemented and the pattern of program exit rates and program outcomes are fairly stable. In the interim, however, this approach would produce statistics that would be difficult to interpret. This affects the usefulness of the information for managing the program. It also affects the Department's ability to detect in a timely manner any reporting errors.

A reporting system that links outcomes to the terminees is not more burdensome since linkages are necessary to collect the information. The Department will closely watch the progress of DHHS in the implementation of a sample-based reporting system that will be used for JOBS reporting.

Model B: Baseline Data Collection. Baseline data would be collected from all E&T mandatory participants and volunteers who are randomly assigned to either the control group sample or the entire treatment group (from which a sample would be subsequently drawn). The data would be collected at the point food stamp recipients are assigned to the control group sample and the treatment group and include a limited number of items on basic characteristics. This characteristics information would include E&T status as

a volunteer or mandatory; whether the person completed high school or obtained a GED and was employed in the 12 months preceding assignment to the sample; race; gender; whether children were present in the household; and Food Stamp Program status. The characteristics information has several uses. First, it would be used to identify volunteers and the hard to employ whose outcomes are weighted differently than others in the calculation of the outcome measures. Basic characteristics information on race, gender and the presence of children in the household would be used to test whether randomization succeeded in generating treatment and control samples that are representative of the same population. Finally, information on long-term food stamp reciprocity may be used to revise the definition of hard to employ persons in future rulemaking.

In addition to the above required data items, the Department is proposing that State agencies also collect certain information from the individual to allow the State agency to contact the individual during the six-month follow-up month. This information would include the address and telephone number, if any, of the individual and the name, address and telephone number of a contact person who would know the whereabouts of the individual in six months.

Collection of Follow-up Data on Outcomes. State agencies would conduct follow-up interviews with control and treatment sample cases six months after random assignment. The State agencies would collect data on job entries, hourly wage rate and Food Stamp Program participation for every member in the control group sample and the treatment group sample (which is drawn from lists of persons assigned to the treatment group in the baseline month). In addition, State agencies would collect data on education outcomes for every member in the treatment group who participated in an education component during the six-month measurement period. It is presumed that State agencies would use food stamp administrative data files to collect information on case closures. State agencies may also use food stamp or E&T case records to obtain information on employment and educational outcomes. However, the Department expects, that in most instances, State agencies would conduct interviews with persons randomly assigned to the appropriate groups to determine employment and educational status as of the follow-up month. Interviews would be conducted through

face-to-face interview, by telephone or by mail. If the State agency is unable to contact an individual or no response is received from an individual by the end of the follow-up month, the State agency would report that individual as nonresponsive. Additional guidelines would be issued on appropriate procedures for conducting interviews and obtaining adequate response rates.

The Department is proposing a single six-month follow-up survey. Studies have shown that it takes an average of three to four months for persons to complete a short-term intervention because of the lags that are inherent in normal processing functions. Therefore, a six-month observation period is sufficient for capturing the effects of programs emphasizing shorter-term components. On the other hand, a six-month follow-up may not be sufficient for capturing the effects of more intensive, long-term components. Studies of programs emphasizing higher cost services suggest that the value of these programs is the long term effects on employment. For example, some studies of these programs show greater increases in earnings in the second year compared to the first year.

The Department rejected the idea of multiple waves of follow-up surveys, which might capture both the short and longer-term effects, as too costly. A single but longer follow-up period would result in unacceptably long reporting lags which affect the usefulness of this system for program planning and budgetary decisions. State agencies may elect to perform more rigorous evaluations.

The following data items would be collected in the follow-up month for persons in the treatment group sample:

- E&T program status: left E&T; participating in E&T; never participated in E&T (no shows and exempted);
- Employment begun anytime between the baseline month and the end of the follow-up month and whether employment is expected to last (or has lasted) 30 days;
- Average hourly wage;
- Food Stamp Program status as of the follow-up month.

The following data items would be collected in the follow-up month for persons in the control group sample:

- Employment begun anytime between the baseline month and the end of the follow-up month and whether employment is expected to last (or has lasted) 30 days;
- Average hourly wage;
- Food Stamp Program status as of the follow-up month.

The following data item would be collected in the follow-up month from persons in the entire treatment group:

- Educational attainment since baseline month.

Impact Analysis of Baseline and Follow-up Data. State agencies would conduct the impact analysis and report these findings along with essential information to support the findings in their annual report at the end of the fiscal year. The report would be due the first of the month following 120 days after the end of the fiscal year and would be based on all baseline and follow-up data collected for the persons randomly assigned to the control and treatment group samples during that fiscal year. The State agencies' reports would show for both the control and treatment group samples the mean values of the three outcome measures (employment, wage rate and Food Stamp Program status) and the results of tests for significant differences between the means. The Department intends to provide more guidance to the State agencies on how the analysis should be conducted and on other related analytic matters.

The Department is concerned about potentially high rates of nonresponse to the six-month follow-up survey. In the national E&T Evaluation, first wave follow-up surveys were completed for only 66 percent of the original sampled individuals. Similar rates of nonresponse were found in the previous Work Registration/Job Search Demonstrations. Three major factors contributed to the nonresponse problem. The greatest problem was locating respondents who turned out to be an extremely mobile population. Once persons were located in the national E&T Evaluation, cooperation with the survey was not a major problem. The mobility of the food stamp population is one of the striking differences with the population served by either JTPA or JOBS. The second problem was limited verification of the addresses obtained during the baseline interviews. The last problem, which adversely affected response rates in particular sites, was the large contingent of homeless individuals in the samples.

If the resulting analytical sample is not representative of the E&T participant universe because of the nonresponse problem, the comparisons would produce biased estimates of the effect of the State agency's E&T program. In the national E&T Evaluation, additional statistical adjustments were developed to account for survey nonresponse using participants' baseline characteristics. In order to judge whether State samples

are representative, State agencies should conduct comparisons of the characteristics of the treatment and control samples in the baseline observation month with respondents in the samples in the follow-up observation month.

If State agencies' analyses show excessively high rates of attrition in the data collection over the six-month period, the Department will examine the implications of using administrative data sources for collecting the follow-up outcome data. The two most readily available sources of data of this sort are State food stamp automated files and Unemployment Insurance (UI) Wage files.

The Department presumes that whenever possible State agencies would rely on their State food stamp files to collect information on household's Food Stamp Program status. Reliance on matches with UI Wage files for capturing employment outcomes in the follow-up period may result in more representative samples for the impact analysis. However, this improvement would require serious tradeoffs on other important dimensions of the performance system. First, there is no alternative to interviews for obtaining outcomes on educational attainments. Therefore, a system relying solely on administrative data would preclude the use of an education outcome measure in the performance standard system. Second, findings based on matches with UI data would aggravate the reporting lag by another six to nine months. Data for households randomly assigned to samples in FY 1993, for example, would not be available for analysis and reporting until the third quarter of FY 1995 (i.e., when follow-up data for the September 1993 cohorts are collected and, ultimately, incorporated into the analysis files). Finally, since wage data are reported for entire quarters, the employment measures would have to be modified accordingly.

There are currently several studies near completion that examine the feasibility of using UI wage data for evaluating the performance of JTPA programs. The Department will continue to monitor the progress of these studies.

Model B Reporting Requirements. Implementation of the outcome-based performance measurement system as proposed under Model B would alter the reporting requirements for State agencies. The Department proposes that each State agency would be required to submit two reports. The first report would be submitted on a quarterly basis and would contain monthly work registrant and E&T participant data

(similar to the current Form FNS-583), quarterly aggregate data on education outcomes and quarterly aggregate data on persons randomly assigned to the control group sample and the treatment group sample. Like the current reporting format, data would be reported cumulatively. The second report would be an annual report presenting the results of the State agency's impact analysis of outcome data collected for the treatment and control group samples in the six-month follow-up month. This report would also include data that supports the State agency's analysis and limited information on participation in the E&T program by persons in the treatment group sample.

Quarterly Reports. Under the proposed reporting requirements, the State agencies would still be required to collect and report most of the data on work registrants and E&T participants currently being reported via Form FNS-583. This data would provide general information on State's E&T programs that are of interest to Congress and the public, and the information would be used by the Department for program management purposes, such as calculating the percentage of E&T mandatories served by State agencies to determine whether the ten percent breadth of service requirement was met.

For consistency, the Department proposes to require State agencies to report on a quarterly basis information that is currently required to be reported annually with the fourth quarter report. This information is the number of persons exempted from the E&T program, separated by the type of exemption and the number of persons beginning a component, separated by each component offered by the State agency.

For purposes of assessing State agencies' performance based on the job entry, wage rate and Food Stamp status measures, the Department proposes State agencies report aggregate baseline characteristics information and follow-up outcome data for these measures for all persons in the control group sample and in the treatment group sample. These data would be reported for each quarter's sample on a quarterly basis. For the reporting quarter October through December, for example, this includes aggregate baseline characteristics data and outcome data for those persons randomly assigned to the control group sample in the previous April through June quarter. This also includes aggregate baseline characteristics data and outcome data for those persons randomly assigned to the treatment group sample from lists of

persons assigned to the E&T program in the previous April through June quarter.

As part of the quarterly reporting requirements, State agencies would be required to report certain items for three categories of persons in the samples: volunteers, persons who meet the definition of hard to employ, and the remainder, persons who are determined mandatory but do not meet the definition of hard to employ (i.e., not hard to employ E&T mandatories). These items would include the number of persons randomly assigned to the treatment and control group samples and the outcome date for these sample members. It is the Department's view that quarterly reporting of these items for these subgroups is needed to guarantee that State agencies are collecting the necessary information to conduct the impact analysis for the annual report.

For purposes of assessing State agencies' performance based on the education measure, the Department proposes State agencies report quarterly the aggregate number of persons randomly assigned to the entire treatment group who began an educational component and the aggregate number of the subset of this group that met the educational goal by the follow-up month. State agencies would be required to report these data items for two categories of persons in the group: volunteers and mandatory participants.

The Department proposes to amend 7 CFR 273.7(c)(6) to require State agencies to report the following data on the work registrant population:

- The number of work registered persons in the State on October 1;
- For each month, the number of persons work registered (i.e., only newly work registered persons or persons work registered 12 months from their last work registration);
- For each month, the number of work registrants exempted by the State agency from participation in E&T (enumerated by the specific reasons for the exemptions);
- The number of work registrants sent a NOAA for failure to comply with E&T requirements as well as the number of applicants who were denied food stamp certification or recertification for failure to comply with E&T requirements;
- The number of E&T mandatory participants who began an E&T component (as approved by FNS in the State agency's E&T plan);
- The number of voluntary participants who began an E&T component.

The Department proposes to amend 7 CFR 273.7(c)(6) to require State agencies to report for each quarter the following aggregate baseline characteristics information for the treatment and control group samples:

- The number of persons randomly assigned to the treatment or control group samples who are:
 - (1) Volunteers, hard to employ (i.e., E&T mandatory participants who as of the baseline month do not have a high school diploma or equivalency and who have not worked in the 12 months prior to the baseline month) and not hard to employ mandatory E&T participants;
 - (2) White, Black (not Hispanic), Hispanic, other minority;
 - (3) Female;
 - (4) In food stamp households that contain children under eighteen;
 - The number of persons identified as receiving food stamps for at least six of the twelve months prior to the baseline month.
- The Department proposes to amend 7 CFR 273.7(c)(6) to require State agencies to report the following aggregate outcome data for the same treatment and control group samples:
- The number of persons who met the definition of employment in the follow-up month and who are volunteers, hard to employ and not hard to employ mandatory E&T participants;
 - The aggregated hourly wage rates of volunteer, hard to employ and not hard to employ mandatory E&T participants;
 - The number of persons with reported wages used to calculate the aggregated hourly wage rate, separated by volunteers, hard to employ and not hard to employ mandatory E&T participants;
 - The number of persons whose food stamp case was closed as of the follow-up month, separated by volunteers, hard to employ and not hard to employ mandatory E&T participants.
- The Department proposes to amend 7 CFR 273.7(c)(6) to require State agencies that offer an educational component to report the following aggregate data for all persons randomly assigned to the treatment group in a quarter:
- The number of total mandatory (hard to employ and otherwise) and voluntary E&T participants who began an educational component in the six-month measurement period—provides the denominator for the educational improvement rate.
 - The number of mandatory (hard to employ and otherwise) and voluntary E&T participants who began an educational component in the six-month measurement period and who met an educational attainment goal by the

follow-up month as measured by completion of 64 hours of educational instruction, completion of high school or receipt of a GED, or the accomplishment of other educational goals as defined in the State E&T plan and approved by FNS—provides the numerator for the education improvement rate.

State agencies would be allowed 60 days after the end of the quarter, rather than the current 45 days, to submit the quarterly reports. This change has been proposed to allow the State agencies more time to compile and reconcile reports from the various reporting locations within the State. It is the Department's view that 60 days would be adequate to accomplish this task.

Annual Report. The annual report would present the results of the State agency's impact analysis of outcome data collected for the treatment and control group samples in the six-month follow-up period. State agencies would be required to report data that provide the basis for the determination of whether there is a statistically significant difference in the outcome measures for the control and treatment group samples.

The Department proposes to amend 7 CFR 273.7(c)(6) to require State agencies to report, in the aggregate, the data items listed below for both the sample of persons randomly assigned to the control group during each baseline month and the persons who were assigned to the E&T program during each baseline month and subsequently randomly assigned to the treatment group sample:

- The percentage of the sample members who began employment anytime between the baseline month and the end of the follow-up month;
- Whether the employment rates are different at a five percent level of statistical significance;
- The number of persons in the samples for whom follow-up employment data were obtained;
- The average hourly wage rate of persons employed anytime between the baseline month and the end of the follow-up month;
- Whether the mean wage rates are different at a five percent level of statistical significance;
- The number of persons in the samples for whom follow-up hourly wage rate data were obtained;
- The percentage of sample members in households whose food stamp case was closed by or in the follow-up month;
- Whether the case closure rates are different at a five percent level of statistical significance;

- The number of persons in the samples for whom follow-up food stamp case closure data were obtained.

The State agencies would also be required to collect and report the following management information for persons in the treatment group sample over the fiscal year:

- The percentage of the members of the treatment group sample who did not comply with the initial E&T program requirement (i.e., no shows), who were subsequently excused or exempted from the E&T program, who were no longer participating in the E&T program as of the follow-up month, and who were participating in the E&T program as of the follow-up month.

State agencies would be allowed 120 days after the end of the last follow-up period (April through September for the last baseline month of March) to submit the annual report. A longer time frame has been proposed for the annual report to allow the State agencies sufficient time to complete their analysis of the net effect of the E&T program on the three outcome measures. It is the Department's view that 120 days would be adequate to accomplish this task and still allow enough time for the Department to calculate and release the incentive funding amounts for the coming fiscal year.

State agencies would maintain for a period of three years all data analysis files and related documentation necessary to validate the State agencies' impact analysis findings for each fiscal year.

Time Frames for the Model B Reporting Requirements. Under the proposed system, the reporting period for the performance standard system would be the 12-month period of October through September. Data reported in this period would include all baseline and follow-up data for the persons randomly assigned to a control or treatment group status in the preceding period of April through March as part of the food stamp and E&T intake process.

State agencies would begin sampling for the baseline month of April 1992. State agencies would not be required to do random assignment in the period October 1, 1991 to March 31, 1992. This allows a six-month period for the State agencies to implement and test the new performance standard system. The Department is proposing this six-month test period to guarantee the validity of the data generated under the new system. During the six-month test period, the Department proposes that the current reporting requirements remain in effect and the State agencies continue to report via Form FNS-583.

Beginning in the April through June 1992 quarter, State agencies would submit a quarterly report similar to Form FNS-583 but revised to include baseline and outcome data on persons assigned to the sample groups and education data on the relevant subset of the treatment group. For the quarters of April through June and July through September, the State agencies would submit the proposed quarterly report but report only on work registrant data for those quarters. Beginning with the October through December 1992 quarter, the State agencies would submit all data proposed for the quarterly report. This first complete quarterly report would include work registrant data for the October through December period, baseline data for persons assigned to sample groups for the April through June 1992 samples, and outcome data collected in October through December 1992 from the appropriate cohorts assigned the prior April through September period. This report would be the first quarterly report to be used for evaluating State program effects.

The quarterly reports would be due the first of the month following 60 days after the end of the quarter. Below is a schedule showing the report to be used and the due dates of all reports beginning October 1, 1991.

REPORTING SCHEDULE

For reporting period	Use	Due
October–December 1991.	Current form FNS-583.	2/15/92
January–March 1992.	Current form FNS-583.	5/15/92
April–June 1992.....	Proposed quarterly report (work registrant data only).	9/1/92
July–September 1992.	Proposed quarterly report (work registrant data only).	12/1/92
October–December 1992.	Proposed quarterly report (all data).	3/1/93

The proposed annual report would be due the first of the month following 120 days after the end of the last follow-up period. Therefore, the first annual report would be due February 1, 1994 and would include an analysis of outcome data collected from the cohorts of the samples for the April 1992 through March 1993 period. This time frame would allow for the use of FY 1992 performance data (i.e., data from the April 1992 through March 1993 samples) in the computation of FY 1995 incentive funding.

Assessment of Overall Performance

The Department would like commenters to address the merits of the two proposed systems of combining performance measures to evaluate overall performance of a State agency.

Model A: The Department is proposing that Model A have two cutoff points for defining the performance level for each measure. An outstanding score would be any score above the upper cutoff, and an unsatisfactory score would be below the lower cutoff. Both the upper and lower limits would be adjusted using multiple regression analysis for each State agency based on the reported characteristics of its E&T trainees and other economic, geographic, and demographic factors. Scores in between would be deemed satisfactory.

State agencies would receive a score for each of three measures, entered employment rate, average wage rate, and food stamp case closure rate. For each measure, a State agency would receive two points for outstanding performance, one point for satisfactory performance, and zero points for unsatisfactory performance. By adding the scores on the individual measures, the Department would be able to define an overall measure of performance. The overall measure of performance could be used as a basis for qualifying for incentive funding in the future, or in the case of unsatisfactory performance, it could signal the need for corrective action or indicate possible sanctions.

The Department is proposing to grade overall performance by using two points and five points as the lower and upper cutoff points. State agencies with a total score less than two would have performed unsatisfactorily. State agencies scoring from two to four points would be considered satisfactory, and State agencies with five or more points would be outstanding.

Model B: Under Model B the Department proposes to measure the success of a program by assessing the positive outcomes the treatment group achieves over the control group. A measure of overall success in achieving nationally established standards would not necessarily equate with eligibility for incentive funding.

To measure overall performance of each State agency, the Department has designed a system which would rate performance on each measure, independently, and then combine them into one composite score.

The Department proposes to establish a point system rating State agency achievement in each of the three measures (four, if a State agency elects

to operate and evaluate an education measure).

If the treatment group achieves a positive outcome that is statistically significant for any of the three evaluation measures, it would be considered a positive effect (+) worth two points. State agencies that achieve a greater positive effect may receive extra credit. For each measure, an average would be taken of all the statistically significant positive effects. State agencies with positive effects that are at or above the average would receive an additional two points. Thus, State agencies that achieve outstanding results would be rewarded for their success with a total of four points per measure.

If there is no statistically significant difference between the outcomes of the treatment and control groups, there would be a null effect (0), worth one point. If the control group actually achieved greater positive outcomes than the treatment group, it would be considered a negative effect (-) and given zero points.

With regards to the education measure, the Department proposes to award two points to State agencies whose score on this measure exceeds the national standard. In addition, an average would be calculated of all State agencies' scores on the educational measure for purposes of distinguishing above and below average performers. State agencies that achieved educational attainment scores above the national average (or above 25 percent if the national average is below 25 percent) would receive an additional two points for outstanding results.

The best score a State agency could achieve based on all four outcome measures would be 16 points. The highest score a State agency could achieve if it did not operate an education component would be twelve points resulting from outstanding positive outcomes (four points each) in the three evaluation measures. If a State agency's E&T program did not achieve any significant positive or negative outcomes, it would receive one point in each of its three measures, resulting in a score of three points. If the State agency operates an education component and exceeds the national standard, its score would be two or four points higher.

The Department is proposing for an initial period that the State standard for each performance measure is a statistically significant finding of no effect or a positive effect. The initial period would include the second half of FY 1992, FY 1993 and FY 1994. The Department intends, however, to propose an increase in the standards to

a statistically significant finding of a positive effect beginning FY 1995. By this time, State agencies' procedures for random assignment and sample selection should have improved enough to guarantee the detection of true program effects. This also provides sufficient time for the State agencies to implement program design changes that would result in more effective E&T programs.

Differential Credits for Outcomes of Volunteers and Persons Defined as Hard to Employ

The Department intends to apply the same differential credits proposed in Model A to the positive outcomes of volunteers and persons defined as hard to employ. The definitions of volunteers and the hard to employ group remain the same although the reference month for establishing volunteer and target group status is the month in which baseline data are collected (in Model A, the reference point is the E&T screening or assessment). To briefly restate the Model A proposal, job entries and educational gains achieved by voluntary participants would receive half credit compared to the same outcomes achieved by mandatory E&T participants. The Department proposes these weights to provide incentives for State agencies to allocate E&T resources to mandatory participants over volunteers.

Evaluating State Agency Performance Incentives

Section 16(h)(7) of the Food Stamp Act of 1977 (as amended) provides that the Secretary of Agriculture shall develop and transmit to the Congress a proposal for modifying the rate of Federal payments to reflect the relative effectiveness of the various State agencies in carrying out their E&T programs. The Department intends to submit this report upon publication of this rule in final form.

Below is a discussion of the Department's proposals under Models A and B for the distribution of incentive funds using State performance data following implementation of the proposed outcome-based performance standard system. However, under both models, the data needed to determine each State agency's share of the incentive funding under the new system would not be available until FY 1994. Therefore, the Department proposes that the current procedures under 7 CFR 273.7(d)(1)(B) for the distribution of incentive funding be followed through FY 1994.

The Department envisions that funding for future fiscal years would be based, in part, upon how well State agencies meet the expected objectives of the performance standard system. State agencies' performance for a given year would be reflected in incentive funds incorporated into their 100 percent grants allocated two fiscal years later. Thus, for example, FY 1995 100 percent funding would be affected by FY 1993 performance. This process is similar to the current performance-based funding system.

Model A: To be eligible to receive a portion of the 100 percent Federal \$15 million incentive money, the Department is proposing that State agencies not score unsatisfactorily on any of the performance measures, and achieve at least one outstanding score.

To determine the amount of incentive funding a State agency would receive, the Department would multiply the State agency's overall point score by the number of E&T placements made in the fiscal year. The State agency would then receive a portion of the \$15 million incentive funds based on its score, in proportion to the scores of other eligible State agencies.

Model B: To be eligible to receive a portion of the 100 percent Federal \$15 million incentive money, the Department is proposing that a State agency achieve at least two statistically significant positive and no negative scores on the three evaluation measures or achieve at least one statistically significant positive and no negative scores on the three measures and meet or exceed the standard for the education measure. Therefore, State agencies that keep track of educational outcomes in addition to entered employments, wage rates and food stamp case closures have an increased opportunity to achieve eligibility for enhanced funding.

To determine the amount of incentive funding a State agency would receive, the Department would multiply the State agency's composite point score by the number of E&T placements made in the fiscal year. This system would capture the magnitude of the program operated in addition to the degree of success achieved.

An example would be a State agency that achieved a composite point score of four and placed 5,000 persons into E&T components, and another State agency which received four points, but placed 10,000 persons. The first State agency would receive half the credit of the second State agency, i.e., 20,000 versus 40,000. These figures would then be used by the Department to proportionately divide the \$15 million in incentive funds.

Sanctions

The Food Stamp Act of 1977, as amended, states that the Secretary may impose fiscal sanctions if a State agency does not comply with the performance standards as promulgated by regulation. 7 U.S.C. 2015(d)(4)(M)(ii).

The Department has concerns about the immediate applicability of the level of the standards established in both models through this proposed rulemaking. We recognize the newness of both of the proposed systems and the lack of operational data on which the initial standards would be based. The reporting requirements contained in this proposed rule vary considerably from the current requirements, where State agencies report only process-based information. Thus, the Department plans to proceed cautiously in attaching consequences to State agency performance.

As proposed in this rulemaking, performance data reported in the first year of the new system (FY 1992) would not be used to determine sanctions. This would allow a period during which State agencies can implement changes to their programs and their data management systems. Also, this time would provide FNS with the perspective necessary to properly assess performance.

Although no consequences would be attached to initial performance, the Department does intend to closely monitor the data submitted by State agencies and to evaluate performance against the initial standards. Since the data submitted would be used to derive future standards, the Department would use the initial start-up period to evaluate the reliability of the data reported by State agencies. Reporting problems can be identified and hopefully alleviated. To evaluate State agency performance, the Department would compare each State agency's performance on each measure against the respective adjusted standard (for Model A) or the control group (for Model B, but using the Model A approach for the education measure).

The Department proposes to begin using performance data collected during FY 1993 to determine if fiscal sanctions are warranted. As proposed in this rulemaking, the current provisions for good cause determinations would be retained.

The Department also proposes to continue to sanction State agencies for failure to efficiently and effectively administer the E&T program, as required under 7 CFR 276.1(a)(4). First, the Department proposes to elaborate on the language of 7 CFR 273.7(p)(1) by specifying that failure to efficiently and effectively administer the E&T program

includes failure on the part of a State agency to sanction noncompliant mandatory participants. Also, the Department proposes to revise 7 CFR 273.7(p)(1) to specify that a State agency may be sanctioned for failure or refusal to collect or submit to FNS data needed for the calculation of the State agency's performance standards. This proposal underscores the important role that the data collection efforts by the State agencies would play in establishing outcome-based performance standards. Finally, the revised 7 CFR 273.7(p)(1) would also provide for a State agency to be sanctioned when there is a lack of documentation to substantiate State agency performance or expenditures. This is not a creation of new policy by the Department, but merely an elaboration of the concept of efficient and effective administration, emphasizing the Department's commitment to program integrity.

The Department is also proposing a penalty for a State agency's failure to meet the proposed ten percent breadth of service requirement. The Department would disallow State agency Food Stamp Program administrative funds equivalent to the percentage difference between the ten percent standard and the level of service achieved by the State agency as applied to the State agency's 100 percent Federal E&T allocation for the pertinent year.

List of Subjects

7 CFR Part 271

Administrative practice and procedure, Food Stamps, Grant programs—social programs.

7 CFR Part 273

Administrative practice and procedure, Aliens, Claims, Food Stamps, Fraud, Grant programs—social programs, Penalties, Reporting and recordkeeping requirements, Social security, Students.

Accordingly, 7 CFR parts 271 and 273 are proposed to be amended by one of the following models:

Model A

1. The authority citation for parts 271 and 273 continues to read as follows:

Authority: 7 U.S.C. 2011–2031

PART 271—GENERAL INFORMATION AND DEFINITIONS

2. § 271.2 is amended by removing the definitions of *Base of Eligibles* and *Placed in an employment and training program*, and by adding the definitions of *Baseline month*, *Employment and training (E&T) terminée*, *Employment*

and training (E&T) volunteer, Entered employment, Hard to employ, and Termination month in alphabetical order to read as follows:

§ 271.2 Definitions.

Baseline month refers to the month in which an eligible E&T participant (mandatory or volunteer) participates in an E&T assessment. Data on such characteristics as sex, race, marital status, household size and receipt of GA and unemployment compensation shall be collected at the time of the E&T assessment.

Employment and training (E&T) terminnee means a participant who begins employment and training activity and either completes the activity or stops attending for other reasons. Participants who are assigned to E&T but never show up for an activity are not terminees and are not counted in the outcome-based performance measurement system.

Employment and training (E&T) volunteer is a participant who shall not be disqualified from the Food Stamp Program for failure to comply with employment and training requirements. Food stamp participants who are exempt from work registration, pursuant to § 273.7(b)(1) (iii) and (v), because they are subject to and participating in title IV of the Social Security Act or Unemployment Insurance employment programs may not be counted as volunteers of a State agency's employment and training program. Food stamp recipients other than those exempted through § 273.7(b)(1) (iii) and (v) may be considered volunteers if they are assessed, referred to an approved food stamp E&T component and tracked through the component by the food stamp E&T program.

Entered employment, for purposes of the employment and training performance standards, means work that an E&T terminnee has begun by the end of the month following the month of E&T termination, that is unsubsidized by any Federal, State, or local government program as an intended benefit, involves no less than 20 scheduled hours of work a week, and is expected to last at least 30 days.

Hard to employ describes an E&T mandatory participant who, as of the E&T assessment, has not completed high school or its equivalent and has not been employed in the 12 months prior to E&T assessment.

Termination month means the month in which a participant ends employment and training activity required by the State agency or in which the individual voluntarily participated. If the individual does not complete the activity, termination will be the date the individual last attended or participated in the activity.

PART 273—CERTIFICATION OF ELIGIBLE HOUSEHOLDS

3. In § 273.7:

a. Paragraphs (c)(4)(v), (c)(4)(vii) and (c)(4)(viii) are revised;

b. The introductory text of paragraph (c)(6) is revised, paragraphs (c)(6) (i) through (v) are redesignated as paragraphs (c)(6)(i) (A) through (E), respectively, and new introductory text of paragraph (c)(6)(i) is added;

c. Paragraph (c)(7) is redesignated as paragraph (c)(6)(ii) and is revised;

d. The introductory text of paragraph (c)(8) and paragraphs (c)(8)(i) and (c)(8)(ii) are redesignated as introductory text of paragraph (c)(6)(iii) and paragraphs (c)(6)(iii)(A) and (c)(6)(iii)(B), respectively, and the introductory text of paragraph (c)(6)(iii) is revised;

e. A new paragraph (c)(6)(iv) is added;

f. A new paragraph (c)(7) is added;

g. Paragraphs (c)(9), (c)(10), and (c)(11) are redesignated as paragraphs (c)(8), (c)(9), and (c)(10), respectively;

h. Paragraph (d)(1)(i)(B) is revised;

i. A new paragraph (f)(1)(vi) is added;

j. A new sentence is added to the end of paragraph (f)(4)(ii);

k. A new paragraph (f)(4)(v) is added;

l. Paragraph (o) is amended by revising the introductory paragraph, revising paragraphs (o)(1) through (o)(6), and removing paragraphs (o)(7) and (o)(8);

m. The heading of paragraph (p) is revised and new introductory text is added after the heading;

n. Paragraph (p)(1) is amended by adding a new sentence to the end of the paragraph and adding new paragraphs (p)(1)(i) and (p)(1)(ii);

o. Paragraphs (p)(2) and (p)(3) are revised;

The additions and revisions read as follows:

§ 273.7 Work requirements.

(c) State agency responsibilities.

(4) * * *

(v) Information about work registrants and E&T participants, including the following:

(A) The estimated number of newly work registered persons and persons re-registered 12 months from their last work registration for the year;

(B) The estimated number of nonexempt work registrants (i.e., mandatory E&T participants) expected to begin a component;

(C) The estimated number of volunteers expected to begin a component;

(D) The estimated number of notices of adverse action expected to be issued for failure to comply with E&T requirements (including the number of denials of certification expected);

(E) The estimated number of not hard to employ mandatory, hard to employ mandatory, and volunteer terminees from employment and training activities; and

(F) The State agency shall specify in its E&T plan that a minimum of ten percent of its mandatory E&T terminnee population will be served on an annual basis.

(vii) The method the State agency will use to guarantee that all work registrants are re-registered every twelve months after initial work registration.

(viii) If a State agency plans to offer education components, as defined in paragraph (f)(1)(vi) of this section, it must specify in the State E&T plan the educational goals or improvements expected of the E&T terminees involved in education components. Acceptable educational improvements that may be counted as positive outcomes toward the education standard are completion of 64 hours of classroom instruction in one or more educational components, attainment of a high school diploma or equivalency (GED), or alternate educational goals as defined in the State E&T plan. The State agency must explain how the alternative educational goals are comparable to the educational gains associated with the completion of 64 classroom hours of instruction or attainment of a GED.

(6) The State agencies shall submit reports to FNS as follows:

(i) Each State agency shall submit quarterly reports (Form FNS-583) to FNS no later than 45 days after the end of each Federal fiscal quarter through and including the quarter ending March 31, 1992. These reports shall contain monthly figures for the number of:

(ii) Through Fiscal Year 1992, State agencies shall submit annually, on their first quarterly report (Form FNS-583),

the number of work registered persons in that State as of October 1 of the new fiscal year.

(iii) Through Fiscal Year 1991, State agencies shall submit annually, on their final quarterly report (Form FNS-583) the following information:

(iv) Effective for the quarter beginning April 1, 1992, the State agencies shall submit quarterly reports to FNS no later than the first of the month following 60 days after the end of each quarter containing information on the work registrant population and other general program information, the number of participants who terminated from E&T and their outcomes as specified in paragraph (o) of this section, and characteristics of E&T terminations. Specific items to be reported on a quarterly basis include:

(A) The number of work registered persons in the State on October 1;

(B) The number of persons work registered (i.e., only newly work registered persons or persons work registered 12 months from their last work registration in accordance with paragraph (a) of this section);

(C) The number of work registrants exempted by the State agency from participation in E&T, separated by the specific reasons for the exemptions;

(D) The number of volunteers who began a component, separated by component;

(E) The number of E&T mandatory participants who began a component, separated by component;

(F) The number of work registrants sent a notice of adverse action for failure to comply with E&T requirements, and the number of applicants who were denied food stamp certification or recertification for failure to comply with an E&T component;

(G) The number of voluntary, hard to employ mandatory, and not hard to employ mandatory terminations from approved E&T components, including those terminations who are Food Stamp Program applicants in State agencies that operate a component for applicants;

(H) The number of E&T participants who terminated from each approved E&T component offered by the State agency;

(I) The number of E&T terminations who by their status as not hard to employ mandatory, hard to employ mandatory, and voluntary participants, entered employment, as defined in § 271.2, by the end of the month following the termination month;

(J) The number of employed E&T terminations reporting wages and their total aggregated hourly wage rates,

including subtotals of the number of mandatory terminations not considered hard to employ who entered employment and their aggregated hourly wage rates, the number of volunteer terminations who entered employment and their aggregated hourly wage rates, and the number of employed mandatory terminations who are considered hard to employ and their aggregated hourly wage rates as well as their aggregated hourly wage rates above the Federal minimum wage;

(K) The number of E&T terminations whose food stamp cases were closed by the end of the third month following the termination month;

(L) The number of E&T terminations who by their status as mandatory (hard to employ and otherwise) or voluntary participants completed 64 hours of education instruction, completed high school or received a GED, and who met other educational goals as defined in the State E&T plan and approved by FNS;

(M) Characteristics of E&T terminations, including but not limited to the number of terminations who, as determined at the E&T assessment: received GA benefits; are minorities (defined as Black (not Hispanic), Hispanic, American Indian, Alaskan native, Asian or Pacific Islander); are female; are married; received unemployment compensation; were unemployed during the 12 months prior to the E&T assessment; did not have a high school diploma or GED prior to the E&T assessment; received food stamp benefits for 6 out of the 12 months prior to the E&T assessment; and

(N) The average household size of all E&T terminations reported pursuant to paragraph (c)(6)(iv)(H) of this section.

(7) The State agencies shall implement an outcome-based performance standards system in accordance with paragraph (o) of this section.

(d) *Federal financial participation.*

(1) *Employment and training grants.*

(i) * * *

(B) The Secretary shall allocate \$15 million of the Federal funds available each fiscal year for unmatched employment and training grants as follows:

(1) Through Fiscal Year 1994, each State agency's share of the \$15 million shall be based on the ratio of the number of E&T mandatory participants placed (as defined in paragraph (o)(5)(iii) of this section) in a State agency's Food Stamp E&T Program to E&T mandatory participants placed in all State agencies in the calendar year that ends nine months before the beginning of the fiscal year. For example, Fiscal Year 1991 funding shall be based on mandatory

participants placed in Calendar Year 1989.

(2) Beginning in Fiscal Year 1995, a State agency's eligibility for such funding shall be determined in accordance with paragraph (o)(5)(ii) of this section. The amount of funding to be received by a State agency each fiscal year shall be determined by multiplying the overall score a State agency receives on its overall assessment of performance measures by the number of placements into E&T components in a given fiscal year. This number shall be used as a ratio applied to the scores of all other State agencies eligible to receive part of the \$15 million.

(f) *Employment and training programs.* * * *

(1) *Components.* * * *

(vi) Educational programs or activities to improve basic skills of those subject to the program as specified under paragraph (f) of this section. Basic educational skills include reading, writing, mathematics, speaking, listening, and problem solving. Allowable educational activities may include, but are not limited to, high school or equivalent educational programs, remedial education programs to achieve a basic literacy level, instructional programs in English as a second language, and achievement of State-defined educational goals. Only educational components that directly enhance the employability of the participants are allowable. A direct link between the education and job-readiness must be established for a component to be approved.

(4) *Voluntary participation.* * * *

(ii) * * * Persons exempt from work registration through paragraph (b)(1)(iii) or (b)(1)(v) of this section shall not be counted or reported as volunteers toward the State agency's performance level.

(v) All persons considered E&T volunteers for performance standard purposes, as defined at § 271.2, must be assessed, referred to an FNS-approved E&T component activity, and tracked by the Food Stamp E&T Program.

(o) *Performance standards.* The Secretary shall establish performance standards to be implemented by State agencies on October 1, 1991, that shall be measured by employment and education outcomes and shall be based on the degree of success that may be reasonably expected of State agencies

in carrying out employment and training programs.

(1) *Measures of performance.* Under the outcome-based performance standards system effective October 1, 1991, State agencies' employment and training programs shall be evaluated based on the following measures of performance:

(i) *Entered employment rate.* The entered employment rate is defined as the number of E&T termines who enter employment, as defined in § 271.2, by the end of the month following the termination month as a percentage of all mandatory and voluntary E&T termines counted during the reporting period. The job entries of three groups of E&T termines will receive different weights. Job entries of mandatory participants who meet the definition contained in § 271.2 for being hard to employ will be multiplied by a weight of 3, job entries of mandatory participants who are not hard to employ will be multiplied by a weight of 1, and job entries of voluntary participants will be multiplied by a weight of .5. The E&T termines in the denominator of this equation will be counted equally;

(ii) *Average wage rate.* This outcome measures the hourly wage rates of employed E&T termines who report wages. The average wage rate shall be calculated by adding the straight-time hourly wages of all employed E&T termines and dividing by the number of employed mandatory and voluntary termines reporting wages. State agencies shall receive extra credit equal to .5 of the portion of the hourly wage rates of hard to employ mandatory termines above the Federal minimum wage, as established by the Fair Labor Standards Amendments of 1989 (Pub. L. 101-157). The hourly wage rates of voluntary and mandatory termines who are not hard to employ shall be added in the numerator without adjustments. Employed E&T termines reporting wages in the denominator of this equation shall also be weighted equally. To be counted in this measure, the job for which the terminer is receiving the reported wage must meet the criteria for entered employment defined in § 271.2. If an E&T terminer reports more than one job, the State agency shall count only the wage of the highest paying job;

(iii) *Rate of food stamp case closures.* This outcome is defined as the percentage of E&T mandatory and voluntary termines whose food stamp cases are closed by the end of the third month following the termination month; and

(iv) *Educational improvement rate.* This outcome is defined as the number of mandatory and voluntary E&T

terminees who achieved educational improvements as a percentage of all mandatory and voluntary E&T termines who participated in educational activities. This is a subset of the total number of E&T termines reported by the State agency, as required in paragraph (c)(6)(iv)(I) of this section. Acceptable educational improvements that may be counted as positive outcomes for this measure include:

(A) Completion of no fewer than 64 hours of classroom training in one or more educational components during the fiscal year (hours that may be counted include completion of education components approved by FNS, as specified in paragraph (f)(1)(vi) of this section);

(B) Achievement of a high school diploma or equivalency; or

(C) Achievement of an alternative educational goal as defined by the State agency in its E&T plan and approved by FNS.

(2) *National standards.* The Secretary shall set a minimal level of expected performance for each of the four measures of performance described in paragraph (o)(1) of this section. The minimal level shall be set at the 25th percentile of the scores for each of the performance measures as reported by State agencies in a previous fiscal year. The national standards shall serve as departure points for further adjustments calculated by FNS on a State-by-State basis as described in paragraphs (o)(3)(i) and (3)(ii) of this section.

(i) *Standards for initial period.* For the first two years after implementation of the outcome-based performance standards, October 1, 1991 through September 30, 1993, the annual national standards shall be as follows for each fiscal year:

(A) Entered employment rate—25 percent of all E&T termines;

(B) Average wage rate—\$4.45 per hour;

(C) Food stamp case closure rate—20 percent of all E&T termines; and

(D) Educational improvement rate—25 percent of all E&T termines who participated in educational components.

(ii) *National standards for FY 1994 and beyond.* Beginning with Fiscal Year 1994, the national standards shall be updated at least every other year based on State agency reported performance from the second prior fiscal year. Reported performance from Fiscal Year 1992 (October 1991 through September 1992) or from any part of Fiscal Year 1992, will be used to set the standards for Fiscal Years 1994 and 1995. During Fiscal Year 1993, FNS will notify State agencies in writing of the revised national standards effective for Fiscal

Years 1994 and 1995. During Fiscal Year 1995, FNS will again issue revised national standards that will be effective for Fiscal Years 1996 and 1997; the revised standards shall be based on State agency reported performance from Fiscal Year 1994. For each standard, State agencies will be ranked according to their weighted scores to establish the 25th percentile.

(3) *Adjusting national standards for State variations.* At the close of each fiscal year, FNS will adjust the national standards in effect during the fiscal year for each State agency to account for the effect of State differences on program performance. The adjustments will be based on a statistical analysis of the effects on State agency performance of external factors that vary across States. A State agency's standard will be adjusted by determining the amount by which the State data differs from the national averages for the factors used in the statistical analysis. The retrospective adjustments shall establish the final levels of performance expected of each State agency.

(i) *Adjusting national standards during the initial period.* FNS will adjust for each State agency the national performance standards for the entered employment rate, the average wage rate, and the food stamp case closure rate that are in effect during the initial period from October 1, 1991 through September 30, 1993, as described in paragraph (o)(2)(i) of this section. Two annual adjustments will be made retrospectively to the three national standards using the most recent available data for State-level economic, geographic, and demographic factors. The first adjustment will cover the first 12 months, October 1991 through September 1992; based on these adjustments, FNS will issue final standards for Fiscal Year 1992 for each State agency during Fiscal Year 1993. The second adjustment will cover Fiscal Year 1993; FNS will issue final standards for Fiscal Year 1993 for each State agency during Fiscal Year 1994. The standards will be adjusted as follows:

(A) Entered employment rate—Adjusted for each State's unemployment rate, percent of employment in manufacturing, and average earnings in retail trade;

(B) Average wage rate—Adjusted for each State's population density per square mile and percent of families below the poverty line; and

(C) Food stamp case closure rate—Adjusted for each State's unemployment rate.

(ii) *Adjusting standards for FY 1994 and beyond.* Beginning with the national standards effective for Fiscal Year 1994, as specified in paragraph (o)(2)(ii) of this section, FNS will retrospectively adjust the standards for each State agency using State agency reported data for that fiscal year on the characteristics of E&T terminees, as required in paragraph (c)(6) of this section, as well as economic, demographic, and geographic data that is available to FNS from other sources. During Fiscal Year 1995, FNS will notify State agencies of their final adjusted standards for Fiscal Year 1994. Adjustments made in subsequent fiscal years will follow the same format: data reported by State agencies will be used to adjust their standards retrospectively for that fiscal year; final standards for each fiscal year will be issued in the next fiscal year. The standards, as finally adjusted for each fiscal year, shall be the levels of performance at which State agencies will be held accountable and will be evaluated by FNS for compliance with the performance standard system.

(4) *Assessment of performance.* A State agency's performance for each measure shall be scored at one of three levels—outstanding, satisfactory, or unsatisfactory. Upper and lower cutoff points shall be established by FNS delineating outstanding, satisfactory and unsatisfactory performance for each measure. State agencies shall receive two points for outstanding performance, one point for satisfactory performance and zero points for unsatisfactory performance on each measure. Overall performance shall be assessed by totaling the number of points each State agency receives on the individual measures. State agencies with a total score of five or more points shall have an outstanding overall performance rating. State agencies scoring between two and four points shall receive a performance rating of satisfactory and State agencies with less than two points in total scoring shall receive an unsatisfactory performance rating.

(5) *Incentive funding.* (i) Through Fiscal Year 1994, a State agency shall receive incentive funding, in accordance with paragraph (d)(1)(i)(B)(1) of this section, based on the number of E&T mandatories placed in a Food Stamp E&T Program.

(ii) Beginning Fiscal Year 1995, a State agency shall be eligible for incentive funding if at least one measure received an outstanding score and no measure received an unsatisfactory score. The State agency's share of incentive funding shall be determined by multiplying the overall point score a

State agency receives on its overall assessment of performance measures by the number of placements into E&T components in a given fiscal year, in accordance with paragraph (d)(1)(i)(B)(2) of this section.

(iii) For the purposes of this paragraph, State agencies may consider a person placed in an E&T program if the person commences an E&T component, is assigned to a component but fails to begin that component and is denied certification or is sent a notice of adverse action for the noncompliance. A notice of adverse action sent for noncompliance with work registration, optional workfare, or voluntary quit shall not count as a placement. Assigned persons who have good cause for noncompliance shall not be counted as placed. If the good cause for the noncompliance is temporary (less than 60 days), the person shall be referred again to a component as soon as practicable. If the good cause represents a situation or condition which will continue for 60 days or more, the person shall be considered exempt by the State agency. If a participant reports to a component which involves several months, that individual would be counted as placed in the initial month only. Each time a participant is placed in a different component after having completed a prior component, he/she may be counted as placed. If participation in one type of E&T component is not continuous, the participant may be counted as having been placed more than once in the same component. If an E&T mandatory participant does not comply with E&T requirements, and a notice of adverse action is sent, the person is counted as placed in the month the notice of adverse action is mailed.

(6) *Breadth of service.* Beginning Fiscal Year 1992, each State agency shall be required to serve (i.e., assign to a component) no less than ten percent of the E&T mandatory participants. The rate of service shall be calculated as follows: The total number of E&T mandatory participants and volunteers who began a component as a percentage of the total number of nonexempt work registrants in the State plus the volunteers who began a component, as reported by the State agency in accordance with the quarterly reporting requirements in paragraph (c)(6)(iv) of this section.

(p) *State agency noncompliance with E&T program requirements.*

Sanctionable actions for State agency noncompliance with the E&T program requirements of this section shall

include but are not limited to the actions listed below.

(1) * * * Failure to effectively and efficiently administer the program includes:

(i) Failure to sanction mandatory participants for noncompliance and lack of documentation for performance or expenditure data submitted to FNS;

(ii) Failure or refusal to collect or submit to FNS data necessary to provide information for calculation of the State agency's performance standards;

(2) If a State agency fails to meet its established performance goals, FNS shall determine whether there was good cause for the noncompliance. Good cause for State agency noncompliance is specified in § 276.6. Lack of E&T funding at the 100 percent Federal level shall not constitute good cause. If FNS finds that there was not sufficient good cause for the State agency's failure to meet its performance goals, FNS may disallow Federal administrative funds.

(3) Failure to meet the ten percent breadth of service requirement may result in the disallowance of administrative funds. The dollar amount of the funds disallowed shall be calculated in the following manner:

(i) FNS shall calculate the percentage of E&T mandatory participants served by the State agency;

(ii) The percentage difference between the ten percent breadth of service and the level of service achieved by the State agency shall be applied to the State agency's 100 percent Federal E&T allocation for the pertinent year;

(iii) This amount shall be disallowed from the State agency's Food Stamp Program administrative funds as specified in § 276.4(c), except that no formal warning is required. Appeal and administrative review provisions of § 276.1(b) shall apply.

Model B

1. The authority citation for parts 271 and 273 continues to read as follows:

Authority: 7 U.S.C. 2011-2031.

PART 271—GENERAL INFORMATION AND DEFINITIONS

2. Section 271.2 is amended by adding the definitions of *Baseline month*, *Employment and training (E&T) volunteer*, *Entered employment*, and *Hard to employ* in alphabetical order to read as follows:

§ 271.2 Definitions.

* * * * *

Baseline month refers to the month in which an eligible E&T participant (mandatory or volunteer) is randomly

assigned to the treatment group or the control group sample. Random assignment shall occur at the point the State agency determines which nonexempt persons and volunteers will be selected to participate in an E&T program component. A treatment group member may actually begin participation in the E&T program in a later month. Baseline month data will be collected for all members of the treatment group and the control group sample.

Employment and training (E&T) volunteer is a participant who shall not be disqualified from the Food Stamp Program for failure to comply with employment and training requirements. Food stamp participants who are exempt from work registration, pursuant to § 273.7(b)(1) (iii) and (v), because they are subject to and participating in Title IV of the Social Security Act or Unemployment Insurance employment programs may not be counted as volunteers of a State agency's employment and training program. Food stamp recipients other than those exempted through § 273.7(b)(1) (iii) and (v) may be considered volunteers if they are assessed, referred to an approved food stamp E&T component and tracked through the component by the food stamp E&T program.

Entered employment, for purposes of the performance standards, means that an individual in the treatment or control group samples began employment anytime between the baseline month and the end of the follow-up month. Employment begun prior to the baseline month shall not be counted. For individuals with multiple jobs between the baseline and follow-up months, only one job per individual shall be counted. The employment must be unsubsidized by any Federal, State, or local government program as an intended benefit, involve no less than 20 scheduled hours of work per week, and has lasted or is expected to last at least 30 days.

Hard to employ describes a potential E&T mandatory participant who, as of the determination in the baseline month, has not completed high school or earned an equivalency degree and who has not been employed in the 12 months prior to the baseline month.

PART 273—CERTIFICATION OF ELIGIBLE HOUSEHOLDS

3. In § 273.7:

- a. Paragraphs (c)(4)(v), (c)(4)(vii) and (c)(4)(viii) are revised;

b. The introductory text of paragraph (c)(6) is revised, paragraphs (c)(6) (i) through (v) are redesignated as paragraphs (c)(6)(i) (A) through (E), respectively, and new introductory text of paragraph (c)(6)(i) is added;

c. Paragraph (c)(7) is redesignated as paragraph (c)(6)(ii) and is revised;

d. The introductory text of paragraph (c)(8) and paragraphs (c)(8)(i) and (c)(8)(ii) are redesignated as introductory text of (c)(6)(iii) and paragraphs (c)(6)(iii)(A) and (c)(6)(iii)(B), respectively and the introductory text of paragraph (c)(6)(iii) is revised;

e. A new paragraph (c)(6)(iv) is added;

f. A new paragraph (c)(7) is added;

g. Paragraphs (c)(9), (c)(10), and (c)(11) are redesignated as paragraphs (c)(8), (c)(9), and (c)(10), respectively;

h. Paragraph (d)(1)(i)(B) is revised;

i. A new paragraph (f)(1)(vi) is added;

j. A new sentence is added to the end of paragraph (f)(4)(ii);

k. A new paragraph (f)(4)(v) is added;

l. Paragraph (h)(5) is revised;

m. Paragraph (o) is amended by revising the introductory text, revising paragraphs (o)(1) through (o)(5), and removing paragraphs (o)(6) through (o)(8);

n. The heading of paragraph (p) is revised and new introductory text is added after the heading;

o. Paragraph (p)(1) is amended by adding a new sentence to the end of the paragraph and adding new paragraphs (p)(1)(i), (p)(1)(ii), and (p)(1)(iii);

p. Paragraphs (p)(2) and (p)(3) are revised.

The additions and revisions read as follows:

§ 273.7 Work requirements.

(c) State agency responsibilities.

(4) * * *

(v) Information about work registrants and E&T participants, including the following:

(A) The estimated number of newly work registered persons and persons re-registered 12 months from their last work registration for the year;

(B) The estimated number of nonexempt work registrants (i.e., mandatory E&T participants) expected to begin a component;

(C) The estimated number of volunteers expected to begin a component; and

(D) The estimated number of notices of adverse action expected to be issued for failure to comply with E&T requirements (include the number of denials of certification expected).

(vii) The method the State agency will use to guarantee that all work registrants are re-registered every twelve months after initial work registration.

(viii) If a State agency plans to offer education components, as defined in paragraph (f)(1)(vi) of this section, it must specify in the State E&T plan the educational goals or improvements expected of the E&T participants involved in education components. Acceptable educational improvements that may be counted as positive outcomes toward the education standard are completion of 64 hours of classroom instruction in one or more educational components, attainment of a high school diploma or equivalency (GED), or alternate educational goals as defined in the State E&T plan. The State agency must explain how the alternative educational goals are comparable to the educational gains associated with the completion of 64 classroom hours of instruction or attainment of a GED.

(6) The State agencies shall submit reports to FNS as follows:

(i) Each State agency shall submit quarterly reports (Form FNS-583) to FNS no later than 60 days after the end of each Federal fiscal quarter through and including the quarter ending March 31, 1992. These reports shall contain monthly figures for the number of:

(ii) Through Fiscal Year 1992, State agencies shall submit annually, on their first quarterly report (Form FNS-583), the number of work registered persons in that State as in October of the new fiscal year.

(iii) Through Fiscal Year 1991, State agencies shall submit annually, on their final quarterly report (Form FNS-583) the following information:

(iv) Effective for the quarter beginning April 1, 1992, each State agency shall submit to FNS a quarterly report of monthly work registrant and E&T participant data, including aggregate baseline and outcome (except education) data on individuals assigned to the treatment and control group samples and outcome data on educational attainment for the treatment group. The State agencies shall also submit to FNS an annual report including the results of an impact analysis of the outcome data collected for the treatment and control group samples, the data that supports the analysis and limited data on participants in the treatment group sample.

(A) The quarterly report shall include outcome (except education) data collected from the treatment and control group samples during each follow-up month in the quarter and outcome data on educational attainment collected from the treatment group during each follow-up month in the quarter, in accordance with paragraphs (o)(1)(v) of this section. The quarterly report shall also include baseline data collected for the baseline month from persons assigned to the treatment or the control group samples in accordance with paragraph (o)(1)(iii) (A) through (C) of this section and work registrant and E&T participant data collected in accordance with paragraph (o)(1)(iv) of this section. The quarterly report shall be submitted no later than the first of the month following 60 days after the end of the reporting period. For the quarters of April through June and July through September 1992, the State agency shall only report work registrant data collected in accordance with paragraph (o)(1)(iv) of this section. For subsequent quarters, the State agencies shall submit all data required by this paragraph.

(B) The annual report shall include the results of an impact analysis of outcome (except education) data collected at the follow-up interview in accordance with paragraph (o)(1)(v) of this section. The annual report shall also include the basis for the determination of whether there is a statistically significant difference in the estimates of the outcome measures for the control and treatment group samples. The first annual report shall be due February 1, 1994 (120 days after the end of the last follow-up month). The report shall include the following data:

(1) The total number of respondents separated by E&T participation status (i.e., currently participating; no longer participating; never participated) for volunteers, hard to employ and not hard to employ mandatory E&T participants;

(2) The total number of responses for each measure of performance separated by quarter and treatment or control group;

(3) The entered employment rate, the average wage rate and the food stamp case closure rate for the treatment and control groups separated by quarter; and

(4) The results of the test for a statistical significant difference at a five percent level for each measure of performance.

(7) The State agencies shall implement an outcome-based performance standards system in accordance with paragraph (o) of this section.

(d) *Federal financial participation.*

(1) *Employment and training grants.*

(i) * * *

(B) The Secretary shall allocate \$15 million of the Federal funds available each fiscal year for unmatched employment and training grants as follows:

(7) Through Fiscal Year 1994, each State agency's share of the \$15 million shall be based on the ratio of the number of E&T mandatories placed (as defined in paragraph (o)(4)(iii) of this section) in a State agency's Food Stamp E&T Program to E&T mandatory participants placed in all States in the calendar year that ends nine months before the beginning of the fiscal year. For example, Fiscal Year 1991 funding shall be based on mandatory participants placed in Calendar Year 1989.

(2) Beginning in Fiscal Year 1995, a State agency's eligibility for such funding shall be determined in accordance with paragraph (o)(4)(iii) of this section. The amount of funding to be received by a State agency each fiscal year shall be determined by multiplying the overall score a State agency receives on its overall assessment of performance measures by the number of placements into E&T components in a given fiscal year. This number shall be used as a ratio applied to the scores of all other State agencies eligible to receive part of the \$15 million.

* * *

(f) *Employment and training programs.* * * *

(1) *Components.* * * *

(vi) Educational programs or activities to improve basic skills of those subject to the program as specified under paragraph (f) of this section. Basic educational skills include reading, writing, mathematics, speaking, listening, and problem solving. Allowable educational activities may include, but are not limited to, high school or equivalent educational programs, remedial education programs to achieve a basic literacy level, instructional programs in English as a second language, and achievement of State-defined educational goals. Only educational components that directly enhance the employability of the participants are allowable. A direct link between the education and job readiness must be established for a component to be approved.

* * *

(4) *Voluntary participation.* * * *

(ii) * * * Persons exempt from work registration through paragraph (b)(1)(iii) or (b)(1)(v) of this section shall not be counted or reported as volunteers

toward the State agency's performance level.

* * *

(v) All persons considered E&T volunteers for performance standard purposes, as defined at §271.2, must be assessed, referred to an FNS-approved E&T component activity, and tracked by the Food Stamp E&T Program.

* * *

(h) *Ending disqualification.* * * *

(5) Refusal to comply with a State agency (or its designee) assignment as part of an FNS approved employment and training program, including participation in a treatment or control group—compliance with the assignment or an alternative assignment by the State agency, including the provision of all information required from treatment and control group participants.

* * *

(o) *Performance standards.* The Secretary shall establish performance standards to be implemented by State agencies on October 1, 1991, that shall be measured by employment and education outcomes and shall be based on the degree of success that may be reasonably expected of State agencies in carrying out employment and training programs.

(1) *Design of treatment/control data collection.* As part of the outcome-based performance standards system, each State agency shall design and implement a data collection system using randomly assigned treatment and control group samples. Food stamp recipients and applicants shall be randomly assigned to either a treatment group or a control group sample in accordance with paragraph (o)(1)(i) of this section from volunteer and mandatory E&T participants who are selected to participate in an E&T program component such as, but not limited to, job search, job search training, basic adult education, vocational training or workfare. Baseline data shall be collected at the point of assignment (baseline month) to the treatment group or control group sample in accordance with paragraphs (o)(1)(iii) and (iv) of this section. Each State agency shall maintain lists of the households with individuals assigned to the treatment group from which a random sample shall be selected six months later. This shall be the treatment group sample. Follow-up data on outcome measures shall be collected during the month following six months after the baseline month in accordance with paragraph (o)(1)(v) of this section.

(i) *Sampling.*—(A) *Sampling plan.* Each State agency shall develop a

sampling plan which demonstrates the integrity of its sampling procedures for generating the control group sample in the baseline month and the treatment group sample in the follow-up month from the sample frame established in the baseline month. The sampling plan shall be submitted to FNS for approval as part of the State agency's State Plan of Operation in accordance with §272.2(e)(4). In addition, all sampling procedures used by the State agency, including frame composition, construction, and content shall be fully documented and available for review by FNS.

(1) *Content.* The sampling plan shall include a complete description of the frame, the method of sample selection, and methods for estimating characteristics of the population and their sampling errors. The description of the sample frame shall include: source, availability, accuracy, completeness, components, location, form, frequency of updates, deletion of cases not subject to sample, and structure. The description of the methods of sample selection shall include procedures for: estimating the size of the universe population and target populations within this universe, overpull, computation of sampling intervals, generation of random assignment decision tables for identifying sample cases, correcting over- or undersampling, and monitoring random assignment and the resulting samples.

(2) *Criteria.* Sampling plans must meet the following criteria:

(i) Conformance to principles of probability sampling (i.e., each unit in the population shall have a known, nonzero probability of selection, and computational methods of estimation shall lead to a unique estimate for each sample);

(ii) Document methods for estimating characteristics of the population and their sampling errors;

(iii) Contain population estimates with the same or better precision as would be obtained by a simple random sample of the size specified in paragraph (o)(1)(i)(B) of this section;

(iv) Describe all weighting procedures and their effects on data analysis and reporting requirements;

(v) Specify and explain the basis for the sample size chosen by the State agency; and

(vi) Specify and explain the basis for the approximate number of sample cases to be selected each month if other than one-twelfth of the sample size.

(3) *Design.* The state agency shall specify the sampling design in its sampling plan in accordance with paragraph (o)(1)(i)(A) of this section.

(B) Sample size.

(1) *Minimum sample size.* The treatment and control group samples shall be representative at the State level of all E&T mandatories, who are selected to participate in an E&T program component, and volunteers. The State agency shall use the chart below to determine the sample size of the treatment and control groups. The size of the sample for each of the two groups shall be determined separately. The samples shall be equal in size.

Average annual No. of E&T eligibles (N)	Minimum annual sample sizes (n)
60,000 or greater	3,400
10,000 to 59,999	$n = 1,000 + [0.048(N - 10,000)]$
less than 10,000	1,000

(2) *Unanticipated changes.* Since the planned numbers of persons to be selected for E&T participation must be estimated at the beginning of each fiscal year, unanticipated changes can result in the need for adjustments to the sample size. Recognizing the difficulty of forecasting the level of potential E&T eligibles, State agencies will not be held accountable if the actual number of persons selected to participate in an E&T program component during the random assignment period of April through March is less than 20 percent larger than the estimated universe used to determine sample size. If the actual number of persons selected to participate in an E&T program component (i.e., the actual universe) is more than 20 percent larger than the estimated universe, State agencies will be held accountable for using the larger sample size appropriate for the actual levels.

(3) *Alternative designs.* The sample size determination assumes that State agencies will use a simple random sample design. State agencies interested in obtaining more precise results with more complex sample designs may use an alternative design with FNS approval. To receive FNS approval, proposals for alternative designs must provide population estimates with equivalent or better precision than would be obtained had the State agency reviewed simple random samples of the sizes specified by paragraph (o)(1)(i)(B) of this section.

(C) *Sample selection.* The selection of cases for the outcome-based performance standards system shall be made monthly. Each month the State agency shall select approximately one-twelfth of its required sample using random assignment procedures, unless

FNS has approved other numbers of cases specified in the sampling plan.

(1) *Substitutions.* Once a case has been identified for inclusion in the sample by a predesigned sampling procedure, substitutions are not acceptable. The case must be randomly assigned to either a treatment or control group sample or dropped from the samples if selected in error.

(2) *Corrections.* Excessive undersampling must be corrected during the reporting period. Excessive oversampling may be corrected at the State agency's option. Cases that are dropped from the sample to compensate for oversampling shall be reported as not subject to sampling. Because corrections must not bias the sample results, cases which are dropped to compensate for oversampling must comprise a random subsample of all cases selected. Cases which are added to the sample to compensate for undersampling must be randomly selected from the entire frame in accordance with the procedures specified in paragraphs (o)(1)(i)(B) and (C)(7) of this section. All sample adjustments must be fully documented and available for review by FNS.

(D) *Sample universe.* The sample universe consists of all newly certified or recertified food stamp households that contain at least one work registrant that is nonexempt for the E&T program or a person who meets the definition of a volunteer and that the State agency determines will be assigned to an individual E&T program component or to a sequence or combination of activities (not including screening or assessment). All areas of a State which are not geographically exempt from E&T shall be included in the universe, even if no services are being offered in those areas. State agencies may not exclude any category of eligible E&T participants (such as persons also receiving General Assistance) from the sample universe. For State agencies that plan to serve a larger proportion of a certain group, such as the hard to employ, than their incidence in E&T mandatory population, the sample universe will include this target group as well as all others that will be subject to an E&T program component requirement.

(E) *Sample frames.* The State agency shall guarantee that its sample frame accurately reflects the sample universe. Complete coverage of the sample universe, as defined in paragraph (o)(1)(i)(D) of this section, must be assured so that every household subject to sampling from the universe has an equal or known chance of being selected. The sample frame shall list all

cases who met the description of the universe, as specified in paragraph (o)(1)(i)(D), for the baseline month. For example, the frame for the first baseline month of April 1992 shall list all households containing the volunteers and mandatory E&T participants who are determined subject to an E&T program requirements during the month of April.

(ii) *Random assignment.* The State agency shall randomly assign cases sampled in accordance with paragraph (o)(1)(i) of this section and the State agency's sampling plan as approved by FNS to either the treatment group or the control group sample. Random assignment shall occur at the point an individual is assigned or volunteers to participate in an individual E&T program component or a sequence or combination of activities (not including screening or assessment).

(A) *Treatment group.* Baseline data shall be collected on all individuals assigned to the treatment group in accordance with paragraphs (o)(1)(iii) and (iv) of this section. Beginning with the first follow-up month of October 1992, a sample of cases assigned to the treatment group in the corresponding baseline month of April 1992 shall be randomly assigned to the treatment group sample in accordance with paragraph (o)(1)(i) of this section and the State agency's sampling plan as approved by FNS. Outcome (except education) data shall be collected for individuals assigned to the treatment group sample in accordance with paragraph (o)(1)(v) of this section. Outcome data on educational attainments shall be collected for all individuals in the treatment group who participated in an education component, in accordance with paragraph (o)(1)(v) of this section.

(B) *Control group sample.* Baseline and outcome (except education) data shall be collected from individuals assigned to the control group sample in accordance with paragraphs (o)(1)(iii), (iv), and (v), respectively. Individuals within a household assigned to the control group shall not receive food stamp E&T services on a volunteer basis for a period of six months from assignment to the control group sample nor shall they be assigned to another control group sample in any subsequent period.

(iii) *Collecting baseline data.* The State agency shall collect baseline data for each individual assigned to the treatment group and the control group sample. This data shall be collected for the baseline month and shall be reported in accordance with paragraph

(c)(6)(iv) of this section. The following data shall be collected:

(A) The number of volunteer and mandatory E&T participants selected to participate in an E&T program component;

(B) The number of persons randomly assigned to the treatment group and control group sample who are:

(1) Volunteers; hard to employ (i.e., E&T mandatory participants who in the baseline month do not have a high school diploma or equivalency and who have not worked in the 12 months prior to the assessment); and not hard to employ mandatory E&T participants;

(2) White; Black (not Hispanic);

Hispanic; other minority;

(3) Female;

(4) In households with children under eighteen.

(C) The number of persons identified as receiving food stamps for at least 6 of the 12 months prior to E&T assessment; and

(D) The address, telephone number, if any, of the individual in the treatment group or control group sample, and the name, address and/or telephone number of a nonhousehold member who would know the individual's future whereabouts.

(iv) *Collecting other data.* The State agency shall collect the following data on work registrants and E&T participants on a monthly basis and report this data in accordance with paragraph (c)(6)(iv) of this section:

(A) The number of work registered persons in the State on October 1;

(B) The number of persons work registered (i.e., only newly work registered persons or persons work registered 12 months from their last work registration in accordance with paragraph (a) of this section);

(C) The number of work registrants exempted by the State agency from participation in E&T, separated by the specific reasons for the exemptions;

(D) The number of volunteers who began a component, separated by component;

(E) The number of E&T mandatory participants who began a component, separated by component; and

(F) The number of work registrants sent a NOAA for failure to comply with E&T requirements, and the number of applicants who were denied food stamp certification or recertification for failure to comply with an E&T component.

(v) *Collecting outcome data.* (A) The State agencies shall conduct a follow-up interview with each person in the treatment and control group samples to obtain outcome data. This follow-up interview shall be conducted during the

follow-up month which is the sixth month following the baseline month. For example, the follow-up month for the baseline month of April is October. The interview may be conducted through a face-to-face interview, by telephone or by mail. If the State agency is unable to contact an individual or no response is received from an individual by the end of the follow-up month, the State agency shall report that individual as nonresponsive. The following data shall be collected during the follow-up month and reported in accordance with paragraph (c)(6)(iv) of this section:

(1) *Data collected from persons in the treatment and control group samples.*

(i) The total number of responses for each measure of performance for the treatment and control group samples;

(ii) The number of persons who began employment anytime between the baseline month and the end of the follow-up month, separated by volunteers, hard to employ and not hard to employ mandatory E&T participants;

(iii) The aggregated hourly wage rates of volunteer, hard to employ and not hard to employ mandatory E&T participants;

(iv) The number of persons with reported wages used to calculate the aggregated hourly wage rate, separated by volunteers, hard to employ and not hard to employ mandatory E&T participants;

(v) The number of persons whose households did not receive food stamp benefits for the follow-up month, separated by volunteers, hard to employ and not hard to employ mandatory E&T participants.

(2) *Data collected from persons in the treatment group sample only.* The State agency shall collect data on the E&T participation status of volunteers, hard to employ and not hard to employ mandatory E&T participants separated by those:

(i) Currently participating;

(ii) No longer participating; and

(iii) Never participated.

(3) *Data collected from persons in the treatment group.*

(i) The total number of mandatory (hard to employ and not hard to employ) E&T participants and volunteers who were selected to participate in an educational component in the baseline month and began participation in the educational component in the six-month period between the baseline and follow-up months—provides the denominator for the education improvement rate;

(ii) The total number of mandatory (hard to employ and not hard to employ) E&T participants and volunteers who began an educational component and

who met an educational attainment goal by the follow-up month as measured by completion of 64 hours of educational instruction, completion of high school or receipt of a GED, or the accomplishment of other educational goals as defined in the State E&T plan and approved by FNS—provides the numerator for the education improvement rate.

(B) The State agency may collect and report to FNS additional data that may be used for diagnostic purposes.

(2) *Measures of performance.* Under the outcome-based performance standards system effective October 1, 1991, State agencies' employment and training programs shall be evaluated based on the following measures of performance. Separate rates will be calculated for the treatment and control group samples for the first three measures. The fourth measure will be calculated for the entire treatment group.

(i) *Entered employment rate.* The entered employment rate is defined as the number of persons in the treatment or control group samples who began employment, as defined in §271.2, anytime between the baseline month and the end of the follow-up month divided by the total number of persons assigned to the treatment or control group sample. The job entries (the numerator) of the three categories of E&T participants comprising the treatment and control groups will receive different weights. Job entries of sample members who meet the definition of mandatory participants and the definition contained in §271.2 for being hard to employ will be multiplied by a weight of 3, job entries of sample members who meet the definition of mandatory participants who are not hard to employ will be given a weight of 1, and job entries of volunteer will be weighted by a factor of .5. All persons assigned to the samples (the denominator) shall receive equal weight.

(ii) *Average wage rate.* This outcome measures the hourly wage rates of employed persons in the treatment and control group samples who report wages. The average wage rate shall be calculated by adding the straight-time hourly wages of all employed persons in the treatment and control group samples and dividing by the number of employed persons in the two sample groups who report wages. State agencies shall receive extra credit equal to 50 percent of the portion of the hourly wage rates above the Federal minimum wage, as established by the Fair Labor Standards Amendments of 1989 (Pub. L. 101-157) for persons who meet the definition of mandatory and hard to employ in the treatment and control group samples.

The hourly wage rates of volunteers and persons who meet the definition of mandatory and not hard to employ shall be added in the numerator without adjustments. Employed persons in the treatment and control group samples reporting wages in the denominator of this equation shall also be weighted equally. To be counted in this measure, the employment must meet the criteria for entered employment at §271.2. If a person in the treatment or control group sample reports more than one job, the State agency shall count only the wage of the highest paying job.

(iii) *Food stamp case closure rate.* This outcome is defined as the percentage of persons in the treatment and control group samples whose food stamp case were closed as of the month in which the follow-up interview was conducted.

(iv) *Educational improvement rate.* This outcome is defined as the number of persons in the treatment group who began an educational component and achieved educational improvements as a percentage of all persons in the treatment group who began an educational component. Acceptable educational improvements that may be counted for this measure include:

(A) Completion of no fewer than 64 hours of classroom training in one or more educational components during a 12 month period (hours that may be counted include completion of education components approved by FNS, as specified in paragraph (f)(1)(vi) of this section);

(B) Achievement of a high school diploma or equivalency; or

(C) Achievement of an alternative educational goal as defined by the State agency in its E&T plan and approved by FNS.

(3) *Assessment of performance.* The overall performance of the State agency's E&T program shall be determined through a comparison of the treatment and control groups' performance for the entered employment rate, average wage rate and food stamp case closure rate described in paragraph (o)(2) of this section. The net difference in performance between the two groups shall result in a positive effect, a negative effect or no effect. The educational improvement rate, as described in paragraph (o)(2) of this section, shall be calculated for the entire treatment group which is all persons selected to participate in an E&T component and not randomly assigned to the control group sample in the baseline month.

(i) *Performance standards.* (A) For the initial period, which includes the second half of Fiscal Year 1992, Fiscal Year

1993, and Fiscal Year 1994, the performance standard for the entered employment measure, the average wage measure and the food stamp case closure measure shall be a statistically significant finding of no effect or a positive effect. For the educational improvement measure, the national standard shall be 25 percent of all E&T participants who began an educational component.

(B) Beginning Fiscal Year 1995, the performance standard for the entered employment measure, the average wage measure, and the case closure measure shall be a statistically significant finding of a positive effect. For the educational improvement measure, the national standard shall be 25 percent of all E&T participants who began an educational component.

(ii) *Performance scores.* The performance outcome for each measure shall receive a numerical score.

(A) Statistically significant differences between the estimates of the entered employment rate, average wage rate and the food stamp case closure rate for the treatment and control group samples shall be assigned a numerical score as follows:

(1) A positive effect shall be assigned a numerical score of two points. State agencies that achieve a greater positive effect may receive additional credit. For each measure, an average shall be taken of the statistically significant positive effects achieved by the State agencies. Positive effects that are at or above the average for each measure shall be assigned an additional two points (i.e., a total numerical score of four points);

(2) A result that shows no effect shall be assigned a numerical score of one point;

(3) A negative effect shall be assigned a numerical score of zero points.

(B) Tests for statistically significant differences between the estimates of the entered employment rate, average wage rate and the food stamp case closure rate for the treatment and control group samples shall be at the five percent level.

(C) For the educational improvement measure, rates at or above 25 percent shall be assigned a numerical score of two points. An average shall be taken of all educational improvement rates achieved by the State agencies. Scores at or above the national average or above 25 percent, whichever is higher, shall be assigned an additional two points. Rates below 25 percent shall be assigned a score of zero points.

(D) A composite score shall be determined by adding the numerical scores of each of the four measures.

(4) *Incentive funding.* (i) Through Fiscal Year 1994, a State agency shall receive incentive funding, in accordance with paragraph (d)(1)(i)(B)(1) of this section, based on the number of E&T mandatories placed in a Food Stamp E&T Program.

(ii) Beginning Fiscal Year 1995, a State agency shall be eligible for incentive funding if at least two measures had a statistically significant positive effect and no measure had a statistically significant negative effect or if at least one measure had a statistically significant positive effect, no measure had a statistically significant negative effect and the standard for the education measure is met or exceeded. The State agency's share of incentive funding shall be determined by multiplying the composite score a State agency receives, in accordance with paragraph (o)(3)(ii)(C) of this section, by the number of placements into E&T components in a given fiscal year, in accordance with paragraph (d)(1)(i)(B)(2) of this section.

(iii) For the purposes of this paragraph, State agencies may consider a person placed in an E&T program if the person commences an E&T component, is assigned to a component but fails to begin that component and is denied certification or is sent a notice of adverse action for the noncompliance. A notice of adverse action sent for noncompliance with work registration, optional workfare, or voluntary quit shall not count as a placement. Assigned persons who have good cause for noncompliance shall not be counted as placed. If the good cause for the noncompliance is temporary (less than 60 days), the person shall be referred again to a component as soon as practicable. If the good cause represents a situation or condition which will continue for 60 days or more, the person shall be considered exempt by the State agency. If a participant reports to a

component which involves several months, that individual would be counted as placed in the initial month only. Each time a participant is placed in a different component after having completed a prior component, he/she may be counted as placed. If participation in one type of E&T component is not continuous, the participant may be counted as having been placed more than once in the same component. If an E&T mandatory participant does not comply with E&T requirements, and a notice of adverse action is sent, the person is counted as placed in the month the notice of adverse action is mailed.

(5) *Breadth of service.* Beginning Fiscal Year 1992, each State agency shall be required to serve no less than ten percent of the E&T mandatory participants. The rate of service shall be calculated as follows: the total number of E&T mandatory participants and volunteers who began a component as a percentage of the total number of nonexempt work registrants in the State plus volunteers who began a component, as reported by the State agency in accordance with the quarterly reporting requirements in paragraph (c)(6)(iv) of this section.

(p) *State agency noncompliance with E&T program requirements.* Sanctionable actions for State agency noncompliance with the E&T program requirements of this section shall include but are not limited to the actions listed below.

(1) * * * Failure to effectively and efficiently administer the program includes:

(i) Failure to sanction mandatory participants for noncompliance and lack of documentation for performance or expenditure data submitted to FNS;

(ii) Failure or refusal to collect or submit to FNS data necessary to provide information for calculation of the State agency's performance standards and to

provide information on the impact analysis for assessing the State agency's performance;

(iii) Failure or refusal by the State agency to properly sample and/or randomly assign individuals to a treatment group sample or control group sample in accordance with paragraphs (o)(1) (i) and (ii) of this section.

(2) If a State agency's performance was unsatisfactory (i.e., two or three measures show a statistically significant negative effect), FNS shall determine whether there was good cause for the noncompliance. Good cause for State agency noncompliance is specified in § 276.6. Lack of E&T funding at the 100 percent Federal level shall not constitute good cause. If FNS finds that there was not sufficient good cause for the State agency's unsatisfactory performance, FNS may disallow Federal administrative funds.

(3) Failure to meet the ten percent breadth of service requirement may result in the disallowance of administrative funds. The dollar amount of the funds disallowed shall be calculated in the following manner:

(i) FNS shall calculate the percentage of E&T mandatory participants served by the State agency.

(ii) The percentage difference between the ten percent breadth of service and the level of service achieved by the State agency shall be applied to the State agency's 100 percent Federal E&T allocation for the pertinent year;

(iii) This amount shall be disallowed from the State agency's Food Stamp Program administrative funds as specified in § 276.4(c), except that no formal warning is required. Appeal and administrative review provisions of § 276.1(b) shall apply.

Dated: August 22, 1991.

Betty Jo Nelsen,

Administrator, Food and Nutrition Service
[FR Doc. 91-20596 Filed 8-29-91; 8:45 am]

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Friday
August 30, 1991

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412 and 413

Medicare Program; Changes to the
Inpatient Hospital Prospective Payment
System and Fiscal Year 1992 Rates; Final
Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-711-F]

RIN 0938-AE90

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1992 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system. In addition, in the addendum to this final rule, we are describing changes in the amounts and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. We are also setting forth the new target rate percentages for determining rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system.

This final rule also responds to the comments we received concerning changes to hospital payments made in a January 7, 1991 final rule with comment. These changes include midyear changes to the inpatient hospital prospective payment system that implemented several provisions of section 4002 of the Omnibus Budget Reconciliation Act of 1990.

In addition, this final rule responds to comments received concerning changes in the procedures and criteria of the Medicare Geographic Classification Review Board (MGCRRB) that were set forth in a June 4, 1991, final rule with comment period.

EFFECTIVE DATE: The provisions of this final rule are effective on October 1, 1991.

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

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SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

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

B. Summary of January 7, 1991 Notice and Final Rule With Comment Period

On September 4, 1990, we published a final rule (55 FR 35990) to implement the prospective payment system for Federal fiscal year (FY) 1991. After publication of the September 4, 1990 final rule, two pieces of legislation that affected payment for hospitals were enacted. These are the Continuing Resolution of October 1, 1990 (Pub. L. 101-403) and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508), enacted October 1, 1990 and November 5, 1990, respectively.

On January 7, 1991, we published two documents in the Federal Register in response to these public laws. A notice entitled Legislative Changes Concerning Payment to Hospitals for Federal Fiscal Year 1991 (56 FR 562) announced the provisions of section 115 of Public Law 101-403 and sections 4001(a) and (c), 4002(e) and (f), 4007, 4151, and 4158 of Public Law 101-508 that were self-implementing and were effective before January 1, 1991. That notice announced the following changes in payment under the prospective payment system:

- The regional floor provision was extended through discharges occurring on or before September 30, 1993. A budget neutrality adjustment factor of

.99819 for the regional floor provision was applied to the payment rates that were effective October 1, 1990 through October 20, 1990. Effective October 21, 1990, the regional floor provision was no longer subject to budget neutrality.

- The offset for physician assistant services was eliminated. This provision would have allowed the Secretary to reduce DRG payments for services performed by physician assistants in the part of the hospital that is subject to the prospective payment system.

- A freeze was applied in the level of Medicare Part A payments and in the level of payment for graduate medical education per resident for the period October 21, 1990 through December 31, 1990. The market basket percentage increase applicable to prospective payment hospitals was deemed to be 0 percent for discharges occurring on or after October 20, 1990 and before January 1, 1991. The hospital-specific rate applicable to sole community hospitals and Medicare-dependent, small rural hospitals was reduced to remove the market basket percentage increase reflected in the hospital-specific rate applicable to discharges during this period. For hospitals excluded from the prospective payment system, the market basket percentage increase was deemed to be 0 percent for the portion of cost reporting periods occurring during the period October 21, 1990 through December 31, 1990. The percentage change in the Consumer Price Index for All Urban Consumers that is applicable to graduate medical education (GME) per resident amounts was deemed to be 0 percent for the payment of Medicare inpatient GME costs for the portion of cost reporting periods occurring during the period October 21, 1990 through December 31, 1990.

- The use of the area wage index applicable to prospective payment hospitals that was in effect on September 30, 1990 was extended to discharges occurring on or after October 1, 1990 through December 31, 1990.

Also on January 7, 1991, we published a final rule with comment period, Mid-Year FY 1991 Changes to the Inpatient Hospital Prospective Payment System (56 FR 568), to implement several provisions of section 4002 of Public Law 101-508 that affect Medicare payment for inpatient hospital services and that took effect with discharges occurring on or after January 1, 1991. That final rule with comment period implemented the following legislative changes to the inpatient hospital prospective payment system:

• The percentage increase in the standardized amounts applicable to rural hospitals for discharges occurring on or after January 1, 1991 and before October 1, 1991 is the market basket percentage increase minus 0.7 percentage points (that is, 4.5 percent). The percentage increase in the average standardized amounts applicable to large urban hospitals and other urban hospitals for the same period is equal to the market basket percentage increase minus 2.0 percentage points (that is, 3.2 percent).

• For discharges occurring on or after January 1, 1991 and before October 1, 1993, the hospital wage index will be based solely on the 1988 hospital wage survey data with no phase-in period. Therefore, the 1-year phase-in of the updated wage index that would have limited the percentage change in a wage index value to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value was eliminated. In addition, we incorporated all corrections of wage data that had been identified since publication of the September 4, 1990 final rule.

• The methodology under section 1886(d)(8)(C) for determining the wage index applicable to rural counties whose hospitals are treated as urban under sections 1886(d)(8)(B) or (d)(10) of the Act was revised. Effective for discharges occurring on or after January 1, 1991, if including the wage data for the redesignated hospitals reduces the wage index value for an urban area by more than one percentage point, the wage index value for that urban area is to be calculated and applied separately to hospitals located in that urban area (excluding the redesignated hospitals). In lieu of a county-specific wage index value, the hospitals that are redesignated are to use the wage index value of the MSA that results from including the wage data of the redesignated hospitals in the determination. The wage index value for the redesignated hospitals cannot be less than the Statewide rural wage index value. The revised methodology has already been applied to hospital reclassifications under section 1886(d)(8)(B) of the Act and is applicable to reclassifications under section 1886(d)(10) of the Act that are effective with discharges occurring on or after October 1, 1991.

• The sunset provision that would have ended all adjustments to hospitals that serve a disproportionate share of low income patients effective October 1, 1995 was repealed. In addition, the disproportionate share payments

applicable to certain hospitals were increased as follows:

- For discharges occurring on or after January 1, 1991 and before October 1, 1993, urban hospitals with 100 or more beds and rural hospitals with 500 or more beds that have a disproportionate patient percentage greater than 20.2 percent will receive 5.62 percent plus 70 percent of the difference between the hospital's disproportionate patient percentage and 20.2 percent. For discharges occurring on or after October 1, 1993 and before October 1, 1994, these hospitals will receive 5.88 percent plus 80 percent of the difference between the hospital's disproportionate patient percentage and 20.2 percent. Effective with discharges occurring on or after October 1, 1994, these hospitals will receive 5.88 percent plus 82.5 percent of the difference between the hospital's disproportionate patient percentage and 20.2 percent.
- For urban hospitals with 100 or more beds or rural hospitals with 500 or more beds and a disproportionate patient percentage of 20.2 percent or less, the hospital's disproportionate share adjustment will be increased to 2.5 percent plus 65 percent of the difference between its disproportionate share patient percentage and 15 percent effective with discharges occurring on or after October 1, 1993.
- The disproportionate share adjustment 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 will be increased from 30 to 35 percent for discharges occurring on or after October 1, 1991.

(The standardized amounts were not restandardized to take into account the effect of these additional payments to disproportionate share hospitals.)

The comment period for the January 7, 1991 final rule with comment period ended on March 8, 1991. We received two comments in response to that document. Both comments concern the interaction of the Medicare Geographic Classification Review Board (MGCRCB) and changes to the hospital wage index, which was not an issue raised in the January 7, 1991 document. Therefore, we are not responding to these comments here. However, we are responding to these comments below in section II of this preamble, in the comments and responses to the June 4, 1991 final rule with comment concerning the MGCRCB.

C. Summary of the Provisions of the June 3, 1991 Proposed Rule

On June 3, 1991, we published a proposed rule in the *Federal Register* (56 FR 25178) to further amend the prospective payment system as follows:

• We proposed changes for FY 1992 DRG classifications and weighting factors as required by section 1886(d)(4)(C) of the Act. This section requires that we adjust the DRG classifications and relative weights at least annually.

• We proposed a revised wage index for discharges occurring on or after October 1, 1991 that incorporated all reclassifications of hospitals based on decisions made by the Medicare Geographic Classification Review Board (MGCRCB) as of March 30, 1991. The proposed wage index also incorporated all corrections of errors that have been identified in the survey wage data since the construction of the wage index implemented in the January 7, 1991 final rule (56 FR 568).

• We discussed several current provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning:

- Payment for hemophilia blood clotting factor.
- Retroactive adjustments for provisionally excluded rehabilitation hospitals and units.
- Outlier payments.
- Rural referral center criteria.
- Indirect medical education costs.
- Ceiling on rate of hospital cost increases.
- Direct graduate medical education payments.
- Funding of depreciation (We note that, although our proposed changes concerning funding of depreciation were set forth in the June 3, 1991, proposed rule, we are not addressing comments received on this issue in this final rule. Instead, in order to provide the reader with a more complete contextual basis for reviewing the funded depreciation policy, we are addressing the comments on funded depreciation in the final rule setting forth a prospective payment system for capital-related costs, published elsewhere in this issue of the *Federal Register*.)

• In the addendum to the proposed rule, we set forth changes to the amounts and factors for determining the FY 1992 prospective payment rates. We also proposed new target rate percentages for determining the rate-of-increase limits for cost reporting periods beginning in FY 1992 for hospitals and

hospital units excluded from the prospective payment system.

- In appendix A of the proposed rule, we set forth an analysis of the impact that the changes described in the proposed rule would have on affected entities.

- In appendix B of the proposed rule, we set forth our initial estimate of an update factor for FY 1992 for both prospective payment hospitals and hospitals excluded from the prospective payment system, as required by section 1886(e)(3)(B) of the Act.

- In appendix B of the proposed rule, we provided our recommendation of the appropriate percentage change for FY 1992, as required by sections 1886(e)(4) and (e)(5) of the Act, for the following:

- Large urban, other urban, and rural average standardized amounts for hospital inpatient services paid for under the prospective payment system.
- Hospital-specific rates applicable to sole community hospitals and Medicare-dependent small, rural hospitals.
- Target rate-of-increase limits on the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the prospective payment system.

In addition, we discussed in detail in the proposed rule the March 1, 1990 recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by the provisions of section 1886(e)(2)(A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986 and thereafter. In addition, section 1886(e)(2)(B) of the Act, as added by section 4002(g) of Public Law 101-508, directs ProPAC to make recommendations regarding changes in each of the Medicare payment policies under which payments to an institution are prospectively determined. In particular, the recommendations relating to the inpatient hospital prospective payment system are to include recommendations concerning the number of DRGs used to classify patients, adjustments to the DRGs to reflect severity of illness, and changes in the methods under which hospitals are paid for capital-related costs. As set forth in section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2)(A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We printed ProPAC's March 1, 1991 report, which includes its

recommendations, as Appendix D of the proposed rule. The recommendations, and the actions we proposed to take with regard to them (when an action is recommended), were discussed in detail in the appropriate sections of the preamble or the appendices of the proposed rule.

Set forth below in sections III, IV, and V of this preamble, the addendum to this final rule, and the appendices are detailed discussions of the June 3, 1991 proposed rule, the public comments received in response to that proposal, and the responses to those comments as well as any changes we will be making.

D. Number and Types of Public Comments Received in Response to the June 3, 1991 Proposed Rule

A total of 373 items of correspondence containing comments on the June 3, 1991 proposed rule were received timely. Approximately 75 percent of the letters we received were protesting the inappropriateness of the current DRG classification and relative weight for the replacement of automatic implantable cardioverter defibrillators. Of the remaining letters, the main areas of concern addressed by commenters were the following:

- The effects of the geographic reclassification of hospitals on the FY 1992 wage index and payments to urban hospitals.
- The rate of increase in the market basket and the update to the standardized amounts.
- The proposed revisions to rate-of-increase limits for hospitals and units excluded from the prospective payment system.
- Other requests for changes in DRG classification and relative weights.

II. Summary of June 4, 1991 Final Rule with Comment Period and Discussion of Public Comments

A. Background

On June 4, 1991, we published a final rule with comment period (56 FR 25458) setting forth the procedures and criteria to be used by the MGCRB in issuing its decisions concerning the geographic reclassification of hospitals. That final rule responded to public comments on the September 6, 1990 interim final rule (55 FR 36754) on the geographic classification of hospitals. In addition, the June 4, 1991 document implemented provisions of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508, enacted on November 5, 1990) concerning the MGCRB. The June 4, 1991 final rule with comment period made the following changes to the September 6, 1990 interim final rule:

- The definition of a sole community hospital (SCH) was revised to state that a hospital located in either a large urban area or an other urban area can qualify for SCH status if it is located more than 35 road miles from the nearest like hospital. However, if a hospital's status as a rural referral center (RRC), sole community hospital, or a Medicare-dependent small rural hospital (MDH) is dependent upon its being located in a rural area, it will lose its special status if it qualifies for reclassification to an urban area for its standardized amount.

- Beginning October 1, 1991, for applications for geographic reclassification that will be effective in FY 1993, all hospitals in a county located in an urban area can apply jointly for reclassification to another urban area.

- Changes were made in the MGCRB and administrative review procedures, including the addition of review of an MGCRB decision on the motion of the Administrator.

- Because hospitals could not know at the time they submitted applications for geographic reclassification to the MGCRB on how their wage index values would be computed under section 1886(d)(8)(C) of the Act as amended by section 4005(h)(1)(A)(ii) of Public Law 101-508, hospitals were allowed to withdraw their applications even though an MGCRB decision had been made. A request for withdrawal of an application after issuance of an MGCRB decision was permitted only for a FY 1992 application, provided that the request for withdrawal was received within 60 days of publication of the June 4, 1991 final rule with comment period, that is, by August 5, 1991. We also added § 412.273, which provides that for application periods subsequent to the FY 1992 application period, a hospital or group of hospitals may withdraw its application at any time before the MGCRB issues a decision.

B. Discussion of Public Comments Concerning the June 4, 1991 Final Rule

We received 28 letters in response to the June 4, 1991 final rule with comment period. Most of the commenters addressed the impact of geographic reclassification on payments to hospitals. Comments and responses concerning the effects of reclassifications on the calculation of the wage index are discussed in section IV of this final rule. Other comments on the June 4, 1991 final rule with comment period are discussed below. We are responding in this section to comments that we received concerning discretionary review by the Administrator of MGCRB decisions.

Although only indirectly related to the changes that we made in the June 4, 1991 final rule, we are also responding to comments concerning the effect of reclassification on a hospital's status as a rural referral center or sole community hospital and issues raised concerning the timetable for reclassification requests and withdrawals in relation to the proposed and final notices of the prospective payment rates that will be applicable to the fiscal year for which reclassification is requested. We believe these comments concern issues that warrant further clarification. We received no comments regarding the guidelines for urban to urban group reclassifications.

Comment: One commenter asserted that the June 4, 1991 final rule with comment period is procedurally flawed and therefore invalid because the procedures for discretionary review by the Administrator of MGCRB decisions were published in final without the opportunity for notice and comment, as required by the Administrative Procedure Act (APA). (See 5 U.S.C. 500 through 553.)

Response: As noted in the June 4, 1991 final rule with comment period (56 FR 25460), section 1886(d)(10)(C)(iii)(II) of the Act provides explicit authority for the review of an MGCRB decision on the motion of the Secretary. Ordinarily, we would have implemented this authority through a notice of proposed rulemaking to afford a period for public comment. However, this procedure may be waived when the agency finds that notice and public comment procedures are impracticable, unnecessary, or contrary to the public interest. Furthermore, section 4207(j) of Public Law 101-508 permits a waiver of the notice of proposed rulemaking when necessary to implement the provisions of Title VI of that law, which includes the provision in question.

We found it to be necessary and in the public interest to waive the notice of proposed rulemaking since it was the only way we could properly implement this administrative review scheme for Federal FY 1992. Advance notice of rulemaking would have undermined the statutory objective. The MGCRB faced a statutory deadline of March 30, 1991 for issuing decisions on hospital reclassifications for FY 1992. If hospitals were to receive the benefits of reclassification for that fiscal year, it was vital to have procedures and Administrator review procedures so that applications could be processed in a fair and timely manner. Timely adjudication was also essential to ensure that the budget neutrality requirement imposed

by Congress in section 1886(d)(6) of the Act would be met for Federal FY 1992 prospective payment system rates. Thus, we believe that a waiver of the notice of proposed rulemaking and prior public comment procedures in order to implement the procedures for discretionary review of MGCRB decisions by the Administrator was necessary and justified.

Comment: One commenter stated that the regulations at § 412.278 do not conform with the statute because the statute does not support an open-ended time period for the Administrator to "appeal" a decision of the MGCRB. The commenter believes that section 1886(d)(10)(C)(iii)(II) of the Act requires that any further consideration of a decision issued by the MGCRB can be based only on an appeal of such decision and that the regulations should establish a deadline by which the Administrator must provide notice of intent to appeal an MGCRB decision. Another commenter, noting the importance of the time factor in the MGCRB decisionmaking and review process, recommended that the Administrator be required to notify a hospital of his or her "intent to review" within 15 days from the date of the MGCRB's decision. Finally, the first commenter believes that HCFA has created a "regulatory scheme" that delays the effectiveness of MGCRB decisions for 105 days in all cases.

Response: We first want to clarify that the Administrator's right to review MGCRB decisions on a discretionary basis is not an "appeal right." Section 4002(h)(2)(B)(iv) of Public Law 101-508 amended section 1886(d)(10)(C)(iii)(II) of the Act to require that MGCRB decisions be subject to section 557(b) of the Administrative Procedure Act (APA) (5 U.S.C. 557(b)), which defines the decisional relationship between the agency head and the officers making the initial decision. Consistent with section 557(b) of the APA, a decision of the MGCRB will be the final agency decision unless the hospital makes an appeal or the Administrator decides to review the decision on his or her own motion. This procedure is similar to the discretionary review procedure provided under 42 CFR 405.1875 for decisions issued by the Provider Reimbursement Review Board (PRRB). The time limits provided in the regulations take into account that the Administrator is the final authority on MGCRB decisions, not a party to the MGCRB proceedings.

We recognize the need for establishing time limits for both MGCRB proceedings and the Administrator's

review. This is necessary to meet statutory deadlines and to ensure that all reclassifications are final in time for determining the revised wage index values, revised standardized amounts and the budget neutrality adjustment for the upcoming Federal fiscal year. For that reason, we established the 105-day time period for the Administrator's review of MGCRB decisions. As we noted in the preamble to the June 4, 1991 final rule (56 FR 25467), the statute does not prescribe a period for the Administrator to issue decisions on cases reviewed at his or her discretion. However, we required that the Administrator's decision be issued within 105 days of the MGCRB decision to ensure that these cases are decided within a time period identical to those decided on appeal. (The time period for decisions that are appealed consists of the 15 days in which the hospital may appeal the decision to the Administrator plus the 90-day period prescribed for the Administrator's consideration of the appeal.) This 105-day time limit ensures that hospitals whose MGCRB decisions are reviewed by the Administrator, whether on appeal or on the Administrator's own motion, will have a final agency decision within 105 days of the MGCRB decision. The date on which the Administrator issues the notice of review does not affect the overall 105-day time limit.

We recognize the commenter's concern that hospitals be notified early in the 105-day review period whether the Administrator will exercise own motion review. However, we are retaining the flexible rule under § 412.278(c)(2) of the regulations providing that the Administrator "promptly notify" the hospital of his or her decision to review the MGCRB decision. This standard was chosen to enable the Administrator to exercise his or her discretion with respect to a multitude of cases that, because of the statutory time constraints imposed on the MGCRB, may be issued within a very short time span. The Administrator may be faced with hundreds of cases at one time on which a decision to exercise discretionary review must be made. We believe this circumstance warrants a flexible rule. In addition, we note that the need to complete discretionary review within the 105-day timeframe for decision itself provides a strong inducement for the Administrator to issue the required notice of review to the hospital as soon as possible following the MGCRB's decision. Under § 412.278(c)(3), the hospital has 15 days from the receipt of the notice of review to submit a response in writing to the

Administrator, which the Administrator considers in making his or her decision. In order for the Administrator to issue his or her decision within the time limit, the notice of review must be issued as quickly as possible.

Comment: We received two comments in response to the January 7, 1991 interim final rule with comment period concerning the corrections made to the wage index data. These commenters stated that the deadline for filing applications to the MGCRB should be extended for hospitals that would qualify for reclassification based on these corrected data. They argued that otherwise they would be unfairly penalized because they were unaware that corrections would be made to the data and, therefore, did not apply to the MGCRB by the filing deadline. The commenters indicated that a cutoff date should be applied to the data so that it would be clear to hospitals whether they should apply for reclassification.

Response: The deadline for filing applications to the MGCRB is mandated by the provisions of section 1886(d)(10) of the Act. As we explained in the June 4, 1991 final rule (56 FR 25477), we believe it is appropriate for the MGCRB to use the latest corrected wage data in making its determination. Since the inception of the prospective payment system, it has been our practice to make midyear corrections to the wage index. Our handling of corrections to the wage index data is specifically addressed in § 412.63(p). Therefore, hospitals reasonably should have anticipated that midyear corrections to the wage index would be made and that these corrections would have an impact on hospital reclassification decisions. Hospitals should have considered the possible effects of midyear corrections, when deciding whether to file an application with the MGCRB. We believe this situation is different from other situations relating to geographic classification that hospitals could not have reasonably been expected to anticipate.

Comment: A few commenters took issue with the provision under § 412.73 that allows a hospital to withdraw its application for geographic reclassification only before a decision has been rendered by the MGCRB. One commenter suggested that hospitals be permitted to withdraw their MGCRB applications within 60 days after publication of the annual notice of proposed rulemaking concerning changes to the prospective payment system. This would permit hospitals to assess the impact of reclassification based on the proposed rule.

Response: We agree with the commenter that hospitals should be afforded an additional opportunity to withdraw their reclassification requests. Because hospitals cannot know in advance how the reclassifications will affect their wage index values at the time they submit applications to the MGCRB for the following fiscal year, we are revising § 412.273 to allow hospitals to withdraw their applications up to 45 days after the publication of the annual proposed notice of changes to the prospective payment system. Hospitals will be permitted to withdraw their applications during that time period even if an MGCRB decision has already been made. However, a hospital may not use the withdrawal provision, in effect, to modify its application, i.e., a hospital cannot request a different reclassification to an alternate area within the same Federal fiscal year. A hospital that wishes to be reclassified to an alternative area will have to submit a new application to the MGCRB for the following Federal fiscal year.

We note that we are establishing a 45-day deadline for withdrawal requests instead of a 60-day deadline (such as the one afforded in the June 4, 1990 interim final rule for FY 1992 reclassifications (see discussion above)) in order to provide reasonable time to take the withdrawals into account in developing the final wage index and prospective payment rates. Although we believe that the notice of proposed rulemaking will provide information that will be useful to hospitals in deciding whether to withdraw their reclassification request, we caution that the proposed wage index values will change in the final rule to take into account the impact of any withdrawal requests and of any MGCRB decisions that were not issued in time to be taken into account in the proposed rule. A hospital that requests that its application be withdrawn may not request that the MGCRB decision be reinstated after publication of the final notice of prospective payment rates.

Comment: One commenter requested clarification concerning the wage index value a hospital will receive if it is reclassified to an area from which all hospitals previously located in the area have been reclassified. Another commenter suggested that hospitals that have been reclassified to such an area should receive the same wage index value as the hospitals previously located in that area will receive after their reclassification.

Response: If all hospitals previously located in an area are reclassified, another hospital reclassified into that area will receive a wage index value

derived from its own wage data and the data of any other hospital or hospitals that are also reclassified to that area. However, consistent with section 1886(d)(8)(C)(iii) of the Act, a reclassified hospital's wage index value cannot be reduced as a result of reclassification below the Statewide rural wage index value for the State in which the hospital is located.

It is possible that several hospitals located within the same geographic area will have different wage index values; for example, some hospitals geographically situated in the same area may be reclassified to different areas and other hospitals in the area may not apply or qualify for reclassification.

Comment: Several commenters disagreed with our position on the impact of reclassification for purposes of the standardized amount for rural referral centers (RRCs) and sole community hospitals (SCHs). In particular, the commenters objected to our policy that an RRC or SCH that accepts reclassification of its standardized amount is voluntarily terminating its special status as an RRC or SCH if that status is dependent upon the hospital being located in a rural area. The commenters believe that a hospital's special status as an RRC or an SCH should be temporarily suspended during a term of reclassification of the standardized amount and immediately reinstated should the hospital not be reclassified for subsequent years. One commenter believes that we were granting a single exception to this policy in establishing a provision that allows rural SCHs that are located at least 35 miles from the nearest like hospital to retain their SCH status upon acceptance of reclassification.

Response: As we noted in the September 6, 1990 interim final rule with comment period (55 FR 36761), a rural hospital that is reclassified for purposes of its standardized amount is considered urban for all purposes except the wage index. This is because the hospital is reclassified as urban for purposes of section 1886(d)(2)(D) of the Act. The provisions of section 1886(d)(2)(D) of the Act define the terms "rural area" and "urban area" for purposes of section 1886(d) of the Act. Therefore, a hospital that is reclassified to an urban area for purposes of section 1886(d)(2)(D) of the Act is reclassified as urban for purposes of section 1886(d) of the Act. Since some of the criteria for both RRC and SCH status include a requirement that a hospital be located in a rural area, a hospital that applies for and is approved for reclassification to an urban area cannot continue to meet special status

requirements applicable only to hospitals located in rural areas.

As we also discussed in the June 4, 1991 final rule with comment period, a hospital's special status as an RRC or an SCH was granted because, at the time of its application, the hospital demonstrated that it met certain criteria designed to identify particular categories of hospitals. That is, as noted at 56 FR 25482:

* * * (E)ach of the special status adjustments is designed to recognize the special needs and patient characteristics of particular categories of hospitals * * *. For instance, RRC status is granted to those hospitals that draw patients from widely diverse geographical areas and offer a broad range of sophisticated services to large number of patients. SCH status is available to those hospitals that are isolated by distance, weather conditions, or travel time or that receive a high percentage of the inpatient market share compared to other hospitals in their service area.

Thus, each of these special status adjustments was created to recognize the special characteristics of particular categories of hospitals, and the qualifying criteria for each adjustment are framed to identify those hospitals that should receive the adjustment. A hospital's patient characteristics and operating procedures (and, thus, its ability to meet the qualifying criteria) may be altered either since it initially qualified for the special payment status or during its period of geographic reclassification. We, therefore, believe it is reasonable to require a hospital to demonstrate that it meets the criteria for a special payment adjustment when its (geographic) reclassification status ends.

Thus, we continue to believe that, when an RRC or an SCH accepts geographic reclassification of its standardized amount, it is, except in limited instances (see 56 FR 25483), voluntarily giving up its status as an RRC or an SCH. If such a hospital is not subsequently approved for another term of reclassification, it must reapply for its special status. That is, a hospital must meet the provisions at § 412.96(a) to requalify for RRC status or the provisions at § 412.92(b)(4) to requalify for SCH status. The criteria must be met as of the first day of the period for which the hospital is seeking the special status.

In regard to the commenter who believes that we granted a single exception to this policy by stating that rural SCHs that are located at least 35 road miles from the nearest like hospital will not lose their SCH status, we note that this was not an exception to our policy on the effects of geographic reclassification on SCH, RRC, or MDH status. Instead, it was a revision in our overall policy concerning the criteria to acquire SCH status. Our prior policy

was that, effective October 1, 1993, no urban hospital could qualify for SCH status except those that had acquired SCH status prior to October 1, 1993 and had continuously maintained that status, and those that were granted SCH status by virtue of a court order. However, we revised that policy in the June 4, 1991 final rule with comment period to provide that any hospital that is located at least 35 road miles from the nearest like hospital can qualify for SCH status, whether located in a rural or urban area. Since such a hospital's status is not dependent upon its being located in a rural area, it would not voluntarily give up its status as an SCH by accepting geographic reclassification of its standardized amount. This is the same rationale that we applied to RRCs approved under § 412.96(b)(2), since those criteria are similarly applicable to both urban and rural hospitals (56 FR 25483). Thus, because some criteria for both SCH and RRC status are available to hospitals located in both rural or urban areas, geographic reclassification of a hospital qualifying under these criteria will not result in loss of the hospital's special status.

Comment: Several commenters requested clarification regarding the timing requirements for hospitals that have voluntarily terminated their RRC status in favor of geographic reclassification and wish to requalify for RRC status. Section 1886(d)(5)(C)(i) of the Act requires that applications for RRC status be filed in the 3-month period preceding the start of a hospital's cost reporting period. The commenters noted that, for hospitals with cost reporting periods beginning October 1 that anticipate that they will not be reclassified for a second term, the 3-month period falls during a time when they would still technically be considered urban due to reclassification. The commenters asked whether such hospitals could apply on or after July 1 for RRC status to be effective October 1 based on the fact that they would again be considered rural when their term of reclassification expired.

Response: We agree with the commenters that, in the scenario described above, it would be inequitable to deny RRC status to a hospital based on its status at the time it applies rather than its status on what would be the earliest effective date of RRC status. That is, notwithstanding its urban classification, if a hospital has not applied for or anticipates that it will not be approved for continued reclassification of its standardized amount, and if it has a cost reporting period beginning on or after October 1 and before December 31, it may submit

its application for RRC status on or after July 1 and before October 1, but no earlier than 3 months prior to the start of its cost reporting period. Assuming that all of the other applicable criteria are met, the HCFA regional office will approve the hospital's request for RRC status contingent upon its reverting to rural status effective October 1.

Comment: One commenter disagreed with the following statement in the June 4, 1991 final rule with comment (56 FR 25483):

Since an RRC's standardized amount is already based on the other urban amount, we anticipate that there will be few qualified RRCs seeking geographic reclassification for purposes of their standardized amount. Only those RRCs that meet the requirements to be reclassified to a large urban standardized amount would benefit from reclassification.

The commenter pointed out that, since geographic reclassification of the standardized amount means that a hospital is considered to be urban for all purposes except the wage index, an RRC might seek reclassification of its standardized amount to become eligible for disproportionate share payments or, in some instances, it might benefit from additional Medicaid payments as an urban hospital.

Response: We agree with the commenter. In the situations cited above, it may be to an RRC's advantage to obtain reclassification of its standardized amount even though it will result in the loss of its RRC status.

Comment: One commenter noted that a hospital may lose its RRC status either because of failure to meet the RRC triennial review criteria that are effective for cost reporting periods beginning on or after October 1, 1992 (see § 412.96(f)) or because of acceptance of reclassification for purposes of its standardized amount. The hospital may then subsequently be unable to requalify as an RRC. The commenter requested that such a hospital be permitted to continue to use the special access rules for RRCs and SCHs at § 412.230(a)(4) for purposes of geographic reclassification. That is, the commenter believes that a hospital that has been an RRC at any time should be permitted to qualify for reclassification of its standardized amount without having to meet the general adjacency and proximity criteria in § 412.230.

Response: We do not agree with this commenter's suggestion. As noted in the June 4, 1991 final rule with comment (56 FR 25482), we amended § 412.230(a)(4) to provide that hospitals that lose their RRC or SCH status by virtue of reclassification may continue to qualify for subsequent terms of geographic

reclassification under the special access provision rules even though they have relinquished their special status as RRCs or SCHs by accepting reclassification for the first year.

However, we do not believe that this consideration should be extended indefinitely. If a hospital that qualified for reclassification of its standardized amount under the special access rule for RRCs and SCHs is not reclassified for a consecutive term, it will not subsequently be able to qualify for reclassification using the special access rule unless it regains status as an RRC or SCH. Thus, in the situation described by the commenter (that is, a hospital that has terminated its RRC status by accepting geographic reclassification of its standardized amount or that has lost its RRC status due to its inability to meet the triennial review criteria for continued RRC classification), the hospital may not qualify for geographic reclassification using the special access rule.

As indicated in the June 4, 1991 final rule with comment period (56 FR 25472), the purpose of the special access rule is to ensure the financial viability of RRCs and SCHs and the maintenance of access to tertiary care for beneficiaries in relatively isolated rural areas. We believe that hospitals that are unable to meet either the criteria to requalify for one of these special status adjustments or the criteria to maintain qualification for one of the adjustment categories should not be treated differently from any other rural hospital that has never met the criteria for RRC or SCH status.

Comment: Several commenters stated that, given the impact of geographic reclassifications on payments to urban hospitals, we should suspend implementation of the final MGCRCB rule and extend the application deadline for FY 1993 in order to allow time to reevaluate the appropriateness of the guidelines. In addition, a number of commenters pointed out potential problems with the application process in future years. For example, some were concerned that because an annual update to the wage index will be implemented in FY 1994, hospitals would be unable to ascertain whether or not they should apply for reclassification during FY 1993 since they would be unable to determine the impact of new wage data on their wage index values at the time they would be applying. Finally, there are issues involving the implementation of the revised Metropolitan Statistical Area (MSA) definitions which will be released by the Office of Management and Budget (OMB) in June of 1992 and

the issue of how these new designations will be handled in conjunction with the geographic reclassifications.

Response: As we indicated in the June 4, 1991 final rule with comment period (56 FR 25470), we intend to evaluate the reclassifications made under the current guidelines and to propose such revisions as may be appropriate for future application cycles. However, this review process will require a considerable amount of analysis as well as public notice and comment prior to implementation. Moreover, any revisions to the guidelines need to be reviewed in conjunction with potential refinements to the labor market area definitions. We are unable to complete this review process in time to revise the guidelines for the application period for the FY 1993 reclassifications. However, we will take into consideration the issues raised by the commenters and will address these issues as part of our review and in any future notice of proposed rulemaking.

We do not have the legal authority to extend the application deadline for FY 1993 reclassifications. Moreover, in order to process the large number of applications in a timely manner, the MGCRCB must receive all materials by October 1, 1991. This deadline is necessary to allow a sufficient amount of time for the MGCRCB to issue decisions on hospital applications for reclassification by March 30, 1991, as required by section 1886(d)(10)(c)(iii)(I) of the Act.

Finally, we are concerned that the revised MSA definitions that will be issued by OMB in June of next year will create problems with respect to the reclassifications due to the reconfiguration of the MSAs. For example, it is likely that some MSA areas will gain or lose counties, which would affect the adjacency and proximity qualifications of hospitals that have applied for reclassification. Some MSAs also will likely be divided into two or more MSAs or merged with other MSAs, which could create problems in determining the proper MSA to which a hospital should be reclassified. In addition, some previously urban counties may become rural under the revised MSA designations. These counties may not have applied for redesignation, but might well have done so had they known the results of the revised MSA designations. These problems as well as other potential problems will be compounded by the fact that the new MSAs will not be announced until June.

Our current policy for adopting changes in the MSA designations is to

recognize these changes at the beginning of the Federal fiscal year (October 1) following the effective date of the change announced by OMB (see § 412.63(b)(4)). However, if we implement the new MSA designations in FY 1993, the prospective payment proposed rule that will be published in May 1992 will not reflect these changes (which will be announced in June) and hospitals will not be able to determine the impact of the revised MSA designations until publication of the final rule. Given the budget neutrality constraints in section 1886(d)(6) of the Act, and the specific methodology for constructing the wage index, we cannot allow hospitals to request changes in their reclassification status after the final rule is published. A possible solution would be to delay implementation of the revised MSAs until the beginning of FY 1994, the time when the next update to the wage index is implemented. This would allow us to publish the proposed wage index along with the new MSA configurations. We are soliciting public comment on possible acceptable approaches to implementing the revised MSA definitions as well as on potential changes to the reclassification guidelines. We will consider comments that we receive by October 29, 1991. In developing the proposed rule concerning changes to the prospective payment system for FY 1993 and any proposed rulemaking document that we issue concerning the reclassification guidelines. Comments should be mailed to the following address: Reclassification Issues, 1-H-1 East Low Rise, 6325 Security Blvd., Baltimore, MD 21207, Attn: Lana Price.

III. Changes to DRG Classifications and Weighting Factors

A. Background

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

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

Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors annually beginning with discharges occurring in FY 1988. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 1991 are discussed below.

B. DRG Reclassification

1. General

Cases are currently classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to four additional diagnoses, and up to three procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

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

Currently, there are 487 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

Except for a few special cases, principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and

medical DRGs. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (hereafter CC). Generally, GROUPEER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not done in an operating room are not listed as operating room (OR) procedures in the GROUPEER decision tables. However, there are a few non-OR procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

We proposed to make several changes to the DRG classification system. These proposed changes and the comments we received concerning them as well as our responses are set forth below. We received two comments that were unrelated to the proposals we made, as follows:

Comment: A commenter requested that a DRG be created for a new procedure being developed to revascularize occluded coronary bypass grafts. The commenter claims that this procedure, which involves the use of a device that has been submitted to the Food and Drug Administration for approval, is less invasive and traumatic than revascularization using coronary bypass surgery. The commenter is concerned that without a new DRG category for this and similar technology, medical device innovation will never have the opportunity to establish itself. The commenter believes that this procedure would result in a net cost savings by reducing the cost of performing the revascularization and the rehabilitation. In addition, the commenter stated that this type of new technology should be encouraged by establishing a DRG that will allow payment at a level sufficient to encourage graft salvage rather than repeat bypass surgery.

Response: HCFA considers the effects of new technology and changes in practice patterns on resource use when revising the DRG classification system and recalibrating the DRG relative weights. New technologies are incorporated into the prospective payment system and into the DRGs based on the types of cases and procedures they are used in, using the procedure and diagnosis codes on the Medicare bill. When this new device is approved by the FDA, the procedure in which the device is used will be coded using the current ICD-9-CM procedure codes and, thus, will continue to be

classified to the same DRG or DRGs to which that code currently is classified. If use of the device results in a change in the procedure itself, it is possible that a new ICD-9-CM code will be created to describe the procedure. In that case, we would evaluate the cases in which the procedure is used and assign the procedure code to a DRG that contains cases that are similar both clinically and in terms of resource use. One example of DRG classification changes that were made based on new technology and changes in treatment patterns is the changes we made in MDC 5 (Diseases and Disorders of the Circulatory System) in the September 4, 1990 final rule (55 FR 36021-36024.)

The effect of new technology on resource use is also taken into account in the annual update factor and in the recalibration of the DRG relative weights. The prospective payment system annual update factor is meant to recognize, among other factors, the impact of new technologies. In determining our recommended update factor, as required by section 1886(e)(4) of the Act, we include factors for changes in productivity and science and technology advancement as well as changes in practice patterns. (See appendix B of this final rule for our FY 1992 recommended update factor.) Also, the DRG relative weights are recalibrated each year based on the latest available charge data in order to ensure the distribution of Medicare payments across DRGs based on average resource costs. As charges for new technologies such as the one the commenter describes are incorporated into our data base, the DRG weights reflect the changes in the relative resource intensity among the DRGs.

Although the commenter is concerned that utilization will be discouraged if a new, higher-weighted DRG is not created for this new technology, we note that this has not been the case with other technologies. In fact, as new technologies are introduced, we often discover that the high cost of the technology is somewhat balanced by a savings either in other treatment costs or a reduction in length of stay. Therefore, in keeping with our longstanding policy on the treatment of new technologies, we do not plan to create a new DRG for this new device.

Comment: We received comments requesting that we review the absence of surgical partitioning in MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders). The commenters are concerned that the surgical cases that group to MDC 20

based on a principal diagnosis of alcohol/drug use are underpaid.

Response: When the MDC 20 DRGs were revised effective for FY 1988, we analyzed the need for a surgical DRG and did not believe that it was necessary. However, preliminary investigation of the FY 1990 MEDPAR file indicates that a review of the surgical cases that group to MDC 20 is warranted. We note that this is the only MDC besides MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period) which consists almost entirely of low-volume DRGs, for which there is no classification provision for cases with surgical procedures. Therefore, we will include this topic on our analysis agenda for FY 1993.

2. Reassignment of Acute Myocardial Infarction (AMI)

Effective with discharges on or after October 1, 1989, we required the use of a new fifth digit subclassification within the diagnostic category 410 (Acute myocardial infarction). (See Table 6A—New Diagnosis Codes, in section IV of the addendum to the September 1, 1989 final rule (54 FR 36547).) This subclassification distinguishes an initial episode of care from a subsequent episode of care. A fifth digit of "1" (initial episode of care) is used to designate the acute phase of care of an AMI regardless of the location of the treatment. It also includes cases that are transferred for care and treatment within the acute phase of care. Any subsequent episode of care for another AMI is also assigned a fifth digit of "1." All of these cases are assigned, as they have been in the past, to DRG 121 or 122 (Circulatory Disorders With AMI With and Without Cardiovascular Complications, Discharged Alive) or DRG 123 (Circulatory Disorder With AMI, Expired) or, in the case of a pacemaker implantation, to DRG 115 (Permanent Cardiac Pacemaker Implant With AMI, Heart Failure or Shock).

A fifth digit of "2" is used to designate observation, treatment, or evaluation of AMI within 8 weeks of onset, but following the acute phase, or in the healing state in which the episode of care may be for related or unrelated conditions. All of these cases are currently assigned to DRGs 132 or 133 (Atherosclerosis)¹ if AMI, subsequent

episode of care, is identified as the principal diagnosis. We also assign principal diagnosis with a fifth digit of "0" to these DRGs. The fifth digit "0" is used when the episode of care is unspecified in the medical record.

With the availability of the FY 1990 Medicare provider analysis and review file (MEDPAR) data, we are able to assess the appropriateness of assigning the nonacute AMI cases to DRGs 132 and 133. Based on our analysis, we proposed to reclassify the nonacute AMI cases effective with discharges occurring on or after October 1, 1991. The average charges for these AMI cases are higher than the average charges for the other cases assigned to DRGs 132 and 133. Because the nonacute AMI cases are not clinically cohesive with any specific set of cases in other MDC 5 medical DRGs, we proposed to reassign them to DRGs 144 and 145 (Other Circulatory Diagnoses). The average charges of the cases currently assigned to these DRGs are fairly equivalent to the average charges for the nonacute AMIs. Although we are somewhat reluctant to move these cases from a more well-defined DRG to the "other" category, we believe that the action is justified by the fact that these cases would be underpaid if they remained in DRGs 132 and 133.

Comment: The comments we received concerning this issue were all supportive of the change we proposed to make. However, one commenter was confused about which codes are to be reclassified from DRGs 132 and 133 to DRGs 144 and 145; that is, is only the fifth digit "0" moving, the fifth digit "2," or both of them? The same commenter agreed with our statement in the proposed rule (56 FR 25182) that there are probably coding inaccuracies to blame for the preponderance of "0" (unspecified episode of care) fifth digits in the cases assigned to DRGs 132 and 133 but also stated that the coding terminology in Volume I of the ICD-9-CM manuals is problematic and open to differing interpretations. The commenter was interested in the type of educational action we intend to take.

Response: Both the "0" and "2" fifth digits are being reclassified from DRGs 132 and 133 to DRGs 144 and 145. As we stated in the proposed rule (56 FR 25182), the unspecified fifth digit "0" is being reported almost five times more often than the second episode of care fifth digit "2". This is an unusually high percentage of unspecified cases because medical record coders use the unspecified code only when they are unable to determine from the medical record which specific code to use. We

are concerned that the higher charges being reported in this category may not be reliable and may actually represent some percentage of first episode of care fifth digit "1" cases.

Because HCFA does not have the lead responsibility for the diagnosis codes that are included in Volume I of the ICD-9-CM manuals (see detailed discussion of these manuals below in section III.B.10 of this preamble), we can not initiate any changes to the terminology in that volume. We intend to discuss necessary changes with the National Center of Health Statistics (NCHS), the agency that does have the lead responsibility for the diagnosis codes. In the meantime, we will prepare an article for *Coding Clinic for ICD-9-CM (Coding Clinic)* published quarterly by the American Hospital Association (AHA). *Coding Clinic* provides specific diagnosis and procedure information and guidelines that are helpful for determining proper coding. Although it is true that this type of advice must, by its nature, take place only after problems have been identified, we do believe that it is an appropriate way to rectify a situation in which codes are being used improperly. In addition, comments or requests for information about diagnosis and procedure codes should be directed to the NCHS (for diagnosis codes) and HCFA (for procedure codes) at the addresses set forth below in section III.B.10 of this preamble.

Comment: Another commenter believes that a certain number of acute phase AMIs (denoted with a fifth digit "1") are incorrectly assigned to DRGs 121 and 122. This commenter described the situation in which a patient with an AMI is transferred (after initial stabilization) from one hospital to another for diagnostic work-up. These patients receive cardiac catheterization at the second hospital and are then transferred to a third hospital for surgery. Because these patients stay in the second hospital only 2 to 3 days and are not similar in resource intensity to the other acute phase AMI patients who receive only medical treatment and thus stay in the second hospital for several more days, the commenter believes that the transferred patients should be classified in DRG 124. This commenter also suggested that we place an MCE edit on the fifth digit "0" AMI cases to help clarify what types of cases are being coded to that digit and to ensure correct hospital coding.

Response: The commenter is probably correct in stating that the transferred AMI patients are less resource intensive than the patients who remain at the

¹ A single title combined with two DRG numbers is used to signify pairs, the first DRG of which is for cases with CC and the second of which is for cases without CC. If a third number is included, it represents cases of patients who are age 0-17.

hospital for an entire course of treatment. However, the DRG system is designed to accommodate this type of case. If the patient is transferred to another prospective payment hospital, the transferring hospital is paid a per diem rate for each day of the patient's stay, not to exceed the full DRG rate. The per diem rate is determined by dividing the appropriate payment rate by the geometric mean length of stay for the DRG to which the case is assigned. Thus, a patient who is assigned to either DRG 121 or 122 and stays in the second hospital for only 2 to 3 days for diagnostic workup will receive less than one-quarter of the usual payment rate in the case of DRG 121 and approximately one-third of the DRG 122 payment rate.

We note that if the patient remained in the hospital for the full average length of stay and, thus, the transferring hospital received the full DRG payment, the result would be that, in this case, the hospital had received payment in excess of costs for the case. In a system built on averages, this situation occurs some of the time. The hospital, no doubt, treats some cases in DRGs 121 and 122, as well as other DRGs, where the payment received is less than the cost. These two types of cases balance each other and allow the hospital to receive, on average, payments equal to resources required to treat Medicare patients.

With regard to the comment that we use the MCE to review all AMI cases coded with the fifth digit "0", we believe that such a major undertaking is premature. We hope that the education we have already begun as well as future instruction, coupled with medical record coders becoming more familiar with the AMI codes, will be enough to correct the situation. We note that the only AMI data we have is from the first year the codes were used. It is not unusual for some miscoding to take place when we introduce new codes. It often takes some time to familiarize and educate coders when a coding change is made. If we discover that future MEDPAR data continue to indicate a problem with AMI coding, we will reconsider the commenter's suggestion.

3. Major Joint and Limb Reattachment Procedures (DRG 209)

Effective October 1, 1989, we introduced new procedure codes to distinguish initial hip replacement procedures from revision of hip replacement procedures. (See Table 6B—New Procedures Codes, in section IV of the addendum to the September 1, 1989 final rule (54 FR 36549).) In response to comments we received concerning that change, we agreed to review the charges for these procedures

as part of our analysis of DRG changes for FY 1992. Our review of the FY 1990 MEDPAR data has revealed that, although the initial hip replacements cases assigned to DRG 209 are less expensive than the revision procedures, the difference is not enough to justify our creating a separate DRG or reassigning the revision cases.

However, during our review, we did note that the cases assigned to DRG 209 fall into two distinct groups based on the procedure performed and the corresponding average charges. The procedures of the lower extremity (that is, hip, thigh, leg, knee, ankle, and foot) have charges that are approximately 50 percent higher than those of the upper extremity (that is, shoulder, elbow, arm, wrist, and hand). Based on this finding, we proposed to assign each of these groups of procedures to a separate DRG. We also proposed to revise DRG 209 by changing the title to "Major Joint and Limb Reattachment Procedures of Lower Extremity" and removing the upper extremity procedures from this DRG assignment. As proposed, DRG 209 would include only the remaining lower extremity procedures as follows:

- 81.51 Total hip replacement
- 81.52 Partial hip replacement
- 81.53 Revision of hip replacement
- 81.54 Total knee replacement
- 81.55 Revision of knee replacement
- 81.56 Total ankle replacement
- 84.26 Foot reattachment
- 84.27 Lower leg or ankle reattachment
- 84.28 Thigh reattachment

We proposed to create a new DRG, DRG 491 (Major Joint and Limb Reattachment Procedures of Upper Extremity). We proposed to assign the upper extremity procedures from DRG 209 to DRG 491. These procedures are as follows:

- 81.73 Total wrist replacement
- 81.80 Total shoulder replacement
- 81.81 Partial shoulder replacement
- 81.84 Total elbow replacement
- 84.23 Forearm, wrist, or hand reattachment
- 84.24 Upper arm reattachment

All the comments we received on this issue supported our proposed revision to DRG 209. However, some commenters requested various other changes as follows:

Comment: One commenter noted that our analysis of charge data for initial hip replacement surgery and revision hip replacement surgery failed to address an important issue; that is, the difference in resource use for cases with revision or replacement of infected internal prostheses compared to initial replacement cases. The commenter included the results of a study that demonstrates that there are substantial

differences between the costs of revision or replacement of existing prostheses due to sepsis and initial joint replacement surgery. Based on the results of the study, the commenter recommended that HCFA reconsider its proposal and establish a separate DRG for these cases.

Response: In our analysis of DRG 209, we identified variation between initial hip replacement and hip replacement revisions, as well as differences between procedures performed on upper extremities compared to those performed on the lower extremities, as measured by total charges. While it is true that we did not directly address the issue of infection occurring with joint replacement surgery, these cases were included in the procedure codes we evaluated. The revision cases, which include revision due to infection, did incur higher charges than those for the initial replacement. However, as stated in the June 3, 1991 proposed rule (56 FR 25183), the difference between these cases was not considered large enough to warrant creating a new DRG.

We believe that any higher resource use incurred by hospitals for revision of hip replacement due to sepsis or infection is best addressed through the addition to our present system of refined CC categories. We intend to address this issue through our refinements to the DRG system to reflect variation in the severity of illness among patients, which will most likely involve the addition of catastrophic or major CCs as separate CC categories.

Comment: One commenter suggested that, in addition to the changes we proposed, major limb reattachment procedures be separated and assigned to a new and separate DRG. The commenter believes that these procedures are clinically different from and have much higher costs associated with them than major joint replacement procedures. The commenter stated that limb reattachments usually require teams of surgical specialists to reconstruct the bones, blood vessels, and major nerves, as well as provide for adequate skin coverage, and that relatively few hospitals are prepared to deal with these cases. The commenter also stated that limb reattachments are comparatively rare and are usually performed as emergency procedures rather than on an elective basis, as are major joint replacements.

Response: When we performed our analysis of DRG 209 based on FY 1990 MEDPAR data, we did not consider nor analyze the possibility of separating the reattachment procedures. We note that there are DRGs in MDC 24 (Multiple

Significant Trauma) that contain major limb reattachment procedures. These DRGs are often assigned to emergency cases. We note that for FY 1992 DRG 209 has a relative weight of 2.3795 and DRG 491 has a weight of 1.5633, while DRG 485 (Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma) has a weight of 3.0632. These weights do seem to indicate that reattachment and joint procedures are more expensive when performed under emergency conditions.

Although we are unable to thoroughly evaluate this suggestion for a possible change for FY 1992, we will add the commenter's request to our FY 1993 DRG analysis agenda. While it may not be appropriate to establish a separate DRG for a rare (low or no volume) type of case, we will evaluate the most appropriate DRG classification for major limb reattachments, considering both the resources involved and the clinical nature of the procedure.

4. Chemotherapy (DRG 410)

Under the DRG classification system, patients admitted for chemotherapy for cancer (principal diagnosis of V58.1 (Chemotherapy) or V67.2 (Chemotherapy follow-up)) are assigned to DRG 410 (Chemotherapy) regardless of the type of cancer indicated by the secondary diagnosis. Therefore, DRG 410 represents a significantly heterogeneous group of cases that not only vary clinically in terms of diagnosis, prognosis, and severity but also vary widely in resource consumption, as measured by hospital charges.

Based upon an analysis of the cases assigned to DRG 410, we found that the acute leukemia patients incurred significantly higher charges than patients with other types of cancer. Therefore, we proposed the addition of a DRG for chemotherapy patients with a secondary diagnosis of acute leukemia. As proposed, this new DRG 492 (Chemotherapy with Acute Leukemia as Secondary Diagnosis) would consist of patients with a principal diagnosis code of V58.1 or V67.2 and a secondary diagnosis code of acute leukemia (204.00, 204.01, 205.00, 205.01, 206.00, 206.01, 207.00, 207.01, 208.00, or 208.1). Cases with a principal diagnosis of V58.1 or V67.2 and any other secondary diagnosis would continue to be assigned to DRG 410, with the DRG title revised to "Chemotherapy Without Acute Leukemia as Secondary Diagnosis."

We note that effective October 1, 1991, a fifth digit will be added to the existing diagnosis codes for leukemia, making it possible to distinguish between cases in remission and those

not in remission. (See Table 6a—New Diagnosis Codes, in section IV of the addendum to this final rule.) We will continue to assign these cases to the same DRGs we did when they were coded using four digits. Thus, all acute leukemia cases admitted for chemotherapy would be classified in DRG 492, whether they are in remission or not. When we have collected data using the new codes and are able to analyze the cases in remission compared to those not in remission, we will evaluate whether it will be necessary or appropriate to consider further distinctions in DRG assignment.

Comment: While our recommendation to restructure DRG 410 by creating a new DRG met with much approval, only one commenter offered unqualified support. The remaining commenters supported the direction of placing acute leukemia patients in a separate DRG, but indicated there are increasing numbers of inpatients with other types of cancer for whom this distinction may also be appropriate and suggested we consider broader classification than just leukemia. A few commenters recommended that we create another DRG for chemotherapy with testicular cancer, in addition to the proposed DRGs 410 and 492; one of these commenters suggested further changes in the titles to reflect "intensive" (with leukemia or testicular cancer) and "nonintensive" chemotherapy because these titles would help set a framework for future changes in these DRGs.

Other suggestions for expanding the classification of chemotherapy included creating a DRG for chemotherapy with chronic leukemia, as well as a separate DRG for lymphoma and one for kidney cancer. The commenters stated that these patients may often have chemotherapy admissions ranging from several days to several weeks depending on the medication and dosage of the treatment. One commenter requested that we establish a flexible system that will allow for expanding DRGs with the development of new treatment therapies.

Response: In our analysis of the FY 1990 MEDPAR data, we thoroughly evaluated the types of cases that group to DRG 410. We looked at each of the secondary diagnoses that occasioned the chemotherapy admission. This included an analysis of both acute and chronic leukemia as well as testicular and kidney cancer and lymphoma. We also investigated the possibility of splitting DRG 410 by CCs, with CCs defined by a secondary diagnosis of a noncancer condition. On completion of this analysis, the most appropriate classification revision was the creation

of a DRG for chemotherapy with acute leukemia as a secondary diagnosis. Only those cases had consistently much higher charges and longer lengths of stay as compared to the average case in DRG 410. None of the other suggested revisions result in as meaningful a difference in charges, length of stay, or reduction in variance. Testicular cancer, typically a disease of younger men age 20 to 40, had too few Medicare cases to warrant consideration for a separate DRG; in addition, the average charge of the testicular cancer cases in the MEDPAR file was not much higher than the charge for the average case in DRG 410 and was well within the variance for the DRG (even after the removal of the leukemia cases).

When we analyzed the possibility of splitting DRG 410 by presence or absence of a CC, we found that the vast majority of cases assigned to DRG 410 had a CC. That is, the patients who receive chemotherapy as hospital inpatients for a cancerous condition had another condition besides the cancer that qualified as a CC. Therefore, we believe it would be inappropriate to split DRG 410 by CC since most of the cases would be classified to the CC DRG and the resulting weight would be very similar to that of the current DRG 410.

With regard to title changes for DRGs 410 and 492, we believe that changing the titles of the new DRGs to "intensive" and "nonintensive" chemotherapy is premature. At this time, the only group of cases that we have moved out of DRG 410 is the acute leukemia group. In keeping with our established policy of creating DRG titles that explain as clearly as possible the cases contained in that DRG, we believe that the proposed titles are the most appropriate. As we do further evaluation in the coming years of the cases that remain in DRG 410, we may decide to separate other groups of chemotherapy patients from DRG 410. If we do, we will explore other DRG titles that would more clearly represent the cases that have been reclassified. We understand the commenter's theory that we have made a change that separates acute leukemia from the other cancers because the course of treatment for acute leukemia is much more resource intensive than is the treatment for the other cancers. Even so, we would prefer to do more analysis of the cases in DRG 410 before we made a broader classification statement through a title than we have in the proposed rule and this document.

We will continue to monitor the performance of the chemotherapy DRGs to ensure that this classification is the most appropriate. As we have stated

often in previous prospective payment documents, the goal of the DRG system is to group patients with similar resource consumption, as measured by changes and length of stay, as well as comparable clinical conditions. The DRG system is flexible in that, with weights based on charges submitted by hospitals, each DRG reflects the resources used by that specific DRG relative to all other DRGs. As new expensive chemotherapy treatments are added to the inpatient regimen, these charges will be included in the MEDPAR file and will be used in the annual analysis of the DRG classifications.

Comment: One commenter, while agreeing that chemotherapy for acute leukemia patients is clearly more intense than for other types of cancer patients, suggested that rather than creating a new DRG for chemotherapy with acute leukemia as secondary diagnosis, we should assign these patients (except those with V67.2 (Chemotherapy follow-up)) to DRG 405 (Acute Leukemia Without Major OR Procedure Age 0 - 17) and DRG 473 (Acute Leukemia Without Major OR Procedure Age > 17). The commenter stated that assigning those cases involving acute leukemia to DRGs 405 and 473, whether the leukemia is the principle or secondary diagnosis, would more appropriately combine cases involving similar treatment and resource utilization. Because V67.2 is used to code an admission that is solely for follow-up examination and because no therapeutic treatment is given, the commenter also recommended that we reexamine the proper DRG assignment for cases with a principal diagnosis of V67.2.

Response: We have considered this recommendation and evaluated the suggested DRGs in comparison to proposed DRG 492. The classification of cases with a principal or secondary diagnosis of acute leukemia to DRGs 405 and 473 would result in a relatively large overpayment to the patients receiving chemotherapy with a secondary diagnosis of acute leukemia while not lowering the weight and, thus, payment to the cases currently assigned to DRGs 405 and 473. The final relative weight for DRG 473 is significantly higher than that for DRG 492. In addition, the few chemotherapy patients that would be assigned to DRG 405 would receive a much lower payment than the DRG 492 assignment. These differential weights reflect wide variations in average charges and lengths of stay (LOS) based on the FY 1990 MEDPAR file as follows:

DRG	Average charge	Average LOS	Final weight
405*	\$13,797	13.0	1.0281
473	21,019	17.3	3.3381
492	16,209	13.9	2.5737

* We note, however, that there were only three Medicare cases reported for DRG 405 in the FY 1990 MEDPAR file.

Based upon this analysis, we do not believe that it would be appropriate to assign the chemotherapy for acute leukemia cases to DRGs 405 and 473. Even though the patients assigned to all three DRGs are suffering from acute leukemia and may be similar clinically, the differences in the average charges and LOS indicate that the treatment received by the different groups of patients is not comparable in terms of resource use.

Concerning the commenter's suggestion that we review the classification of patients with a principal diagnosis of V67.2, we note that there were under 100 of these cases in the FY 1990 MEDPAR file while there were over 100,000 cases with a principal diagnosis of V58.1. Therefore, these cases have little impact on the average charges and, thus, the relative weight for DRG 410. However, we agree with the commenter that these cases and the actual chemotherapy may not be clinically comparable and we intend to examine this issue in a future DRG evaluation.

Comment: One commenter stated that it made no sense to single out leukemia from other cancers in creating separate DRGs. This commenter believes that to have a fair hospital inpatient payment program, it is necessary to have one that matches payments to the actual costs of care provided—not to some average cost of care. Further, this commenter stated that the use of classification techniques and statistical analysis ranging from percentiles to multivariate cluster analysis would be simple and effective. HCFA was urged to follow common sense business and economic principles in making DRG changes.

Response: What this commenter has recommended is similar to the cost-based payment system that we used for many years prior to the implementation of the prospective payment system. Because the cost-based system made payment to a hospital based on the actual cost incurred by the hospital in caring for Medicare beneficiaries, there was little incentive for hospitals to make any economies or to investigate more efficient ways of providing care. The result of this was increasing health care costs that were threatening to interfere with the ability of Medicare to meet the

growing health care financing needs of the elderly and disabled.

While an averaging system does, in fact, result in cases that are underpaid in terms of costs, it also results in a balancing number of cases that are overpaid, with the majority of cases paid close to actual cost. Therefore, this methodology provides incentives for efficient care that were lacking in the cost-based method of payment. While we do intend to continue our refinement of the DRG system in order to achieve, as closely as possible, payment equity at the case level as well as at the hospital level, we do not anticipate nor do we advocate a return to a cost-based system of payment.

Comment: Some commenters urged us to continue work on improving the payment system for inpatient chemotherapy and to continue the study of the chemotherapy DRGs to determine how they might better accommodate existing and future therapies.

Response: As we noted above, we plan to monitor the performance of the classification change for chemotherapy patients who have a secondary diagnosis of acute leukemia compared to those having chemotherapy without a secondary diagnosis of acute leukemia. We will continue to evaluate the impact of other cancers, as well as other noncancer secondary diagnoses, on the resource consumption in these DRGs. As new therapies are introduced and identified, their effect on total charges will be evaluated.

5. Multiple Significant Trauma (MDC 24)

We added a new MDC 24 (Multiple Significant Trauma) to the DRG system effective October 1, 1990, with four DRGs to classify multiple significant trauma cases. Discharges with a principal diagnosis of trauma (diagnosis codes 800.00 through 904.9, 910.0 through 929.9, and 950.0 through 959.9) group to MDC 24 if at least two significant trauma diagnosis codes from two different body site categories are reported as either principal or secondary diagnoses. We recognize eight different body site categories: head, chest, abdomen, kidney, urinary, pelvis and spine, upper limb, and lower limb. The eight body site categories and the diagnosis codes associated with each category were set forth in Table 6h of section IV of the addendum to the September 4, 1990 final rule (55 FR 36137). The DRGs in MDC 24 are the following:

DRG 484 Craniotomy for Multiple Significant Trauma

DRG 485 Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
 DRG 486 Other OR Procedures for Multiple Significant Trauma
 DRG 487 Other Multiple Significant Trauma

Since the implementation of this change, we have discovered that there were some omissions in our list of diagnosis codes by body site. Although these codes were included as principal diagnosis codes that will allow a case to group to MDC 24, they were not included in any of the body site categories. Thus, we proposed to add these diagnosis codes to the appropriate body site category as follows: Codes 839.00 through 839.18 (Dislocation of cervical vertebrae) to the "Pelvis and Spine" body site; codes 874.10 (Open wound to larynx and trachea, complicated) and 874.11 (Open wound of larynx, complicated) to the "Chest" category; and code 927.9 (Crushing injury of upper limb, unspecified site) to the "Upper Limb" category. We also proposed to move diagnosis code 874.12 (Open wound of trachea, complicated) from the "Head" to the "Chest" category and diagnosis code 954.9 (Injury to unspecified nerve of trunk) from the "Upper Limb" to the "Pelvis and Spine" category. These latter codes were incorrectly assigned in the September 4, 1990 final rule.

In addition, we proposed to move three hip replacement procedures (procedure codes 81.51 (Total hip replacement), 81.52 (Partial hip replacement), and 81.53 (Revision of hip replacement)) from DRG 486 to DRG 485 because these procedures are similar clinically and in terms of resource use to the cases assigned in DRG 485.

Comment: We received a comment supporting the proposed changes to MDC 24. However, the commenter recommended that these multiple trauma DRGs be revised to separate major joint replacement cases from limb reattachment cases since these two groups of cases are significantly different clinically and in terms of resources used.

Response: As noted above in our response to a similar comment on our DRG 209 proposal, we will include this item on our FY 1993 DRG analysis agenda.

6. Addition of HIV-Related Conditions to MDC 25 (HIV Infections)

A new MDC 25 for Human Immunodeficiency Virus (HIV) Infections was added as a part of our FY 1991 DRG changes, which became effective October 1, 1990. HIV infections are identified by diagnosis codes 042.0 through 042.9 (HIV infection with

specified conditions), 043.0 through 043.9 (HIV infection causing other specified conditions), and, 044.0 through 044.9 (Other HIV infection). (See discussion in the September 4, 1990 final rule (55 FR 36019).) Cases are assigned to DRGs for HIV infection when the principal diagnosis is one of the HIV infection diagnosis codes (listed above) or when one of these codes is a secondary diagnosis and the principal diagnosis is a condition related to HIV infection (see below).

The three DRGs for HIV-infected patients are as follows:

DRG 488 HIV with Extensive OR Procedure
 DRG 489 HIV with Major Related Condition
 DRG 490 HIV with or without Other Related Condition

The OR procedures allowed for DRG 488 are all OR procedures other than nonextensive OR procedures (those procedures that result in assignment to DRG 477 when the procedure is unrelated to the principal diagnosis). If the HIV-related condition involves a disease or disorder of the central nervous system, a malignancy, an infection, or other major related condition, the case is assigned to DRG 489. The remaining cases, with or without an HIV-related condition, group to DRG 490.

The HIV-related conditions qualifying for classification to MDC 25 are limited to those conditions identified by the Centers for Disease Control (CDC) as being HIV related. These conditions are listed in Volume 1 of ICD-9-CM in the "Includes Only" notes under diagnosis codes 042.0, 042.1, 042.2, 043.1, 043.3, and 044.0. In addition, we listed all the HIV-related conditions in Table 6i in section IV of the addendum to the September 4, 1990 final rule (55 FR 36137). In that document, we stated that as CDC updated and expanded the list of HIV-related conditions, we would add any changes made to our classification system (55 FR 36021).

Effective October 1, 1991, CDC will expand the list of diagnoses identified as HIV-related conditions, and they will be added to the ICD-9-CM "Includes only" notes under the HIV infection diagnosis codes. We proposed to add these diagnoses to our list of HIV-related conditions. Thus, effective for discharges occurring on or after October 1, 1991, if any of these conditions is listed as principal diagnosis with a secondary diagnosis of HIV infection, it will be assigned to MDC 25 and one of the HIV DRGs. We have listed these additional HIV-related conditions in Table 6i, Additional HIV-Related Conditions Necessary for Assignment to MDC 25, in section IV of the addendum

to this final rule. In that table, we have indicated which conditions are considered to be major and thus would be assigned to DRG 489 when no extensive OR procedure is performed.

We received only one comment on this issue, which supported our changes to MDC 25. Thus, we are incorporating our proposal into this final rule unchanged.

7. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. It is, therefore, necessary to have a decision rule by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most to least resource intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

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

A surgical class can be composed of one or more DRGs. For example, in MDC 5, the surgical class "heart transplant" consists of a single DRG and the class "coronary bypass" consists of two DRGs. Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class, therefore, involves weighting each DRG for frequency to determine the average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5, and that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average

resource utilization to that with the lowest, with the exception of "other OR procedures" as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the Grouper searches for the most resource-intensive procedure, which may sometimes occur in cases involving multiple procedures, this result is unavoidable.

We would like to point out, notwithstanding the foregoing discussion, that there are a few instances where a surgical class with a smaller average relative weight is ordered above a surgical class with a higher average relative weight. For example, the "other OR procedures" surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs regardless of the fact that the weighting factor for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The "other OR procedures" class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the weighting factors are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we proposed to modify the surgical hierarchy as set forth below.

a. In MDC 8, we proposed to reorder Biopsies (DRG 216) above Hip and Femur Procedures Except Major Joint (DRGs 210, 211, and 212) and Amputations (DRG 213). In addition, we proposed to add the new Major Joint and Limb Reattachment Procedures of Upper Extremity (DRG 491) below Amputations. We also proposed to move Knee Procedures (DRGs 221 and 222) above Lower Extremity and Humerus Procedures Except Hip, Foot and Femur (DRGs 218, 219, and 220).

b. In the pre-MDC DRGs, we proposed to reorder Bone Marrow Transplant (DRG 481) above Tracheostomy Without

Mouth, Larynx or Pharynx Disorder (DRG 483).

We received two comments concerning surgical hierarchy. One comment supported our proposed reordering of DRG 481 above DRG 483, while another commenter protested the changes made to MDC 8.

Comment: We received a comment from an association of pediatric hospitals regarding two of the changes that we proposed in the MDC 8 surgical hierarchy. The commenter believes that the proposal to reorder Biopsies (DRG 216) above Hip and Femur Procedures Except Major Joint (DRGs 210, 211, and 212) is not supported by the average costs for these procedures in a pediatric population. The commenter states that the average costs for pediatric patients in DRG 216 (Biopsies) and in DRG 212 (Hip and Femur Procedures Except Major Joint Age 0-17) are similar. However, the average cost for DRG 216 is driven by a subgroup of very expensive patients, and the typical patient in DRG 216 is actually less expensive than the typical patient in DRG 212. Although the commenter did not oppose the proposal to reorder Knee Procedures (DRGs 221 and 222) above Lower Extremity and Humerus Procedures Except Hip, Foot and Femur (DRGs 218, 219, and 220), the commenter stated that the average costs of these two surgical classes are very similar for pediatric patients. Thus, the proposed change is not necessary for that population.

Response: The surgical hierarchies are based on Medicare charge data and are tailored to the Medicare population. Based on the final recalibration and the updated FY 1990 MEDPAR file, we have determined that it remains appropriate to implement the changes to the MDC 8 surgical hierarchy as proposed. While our charge data for DRG 216 does show a greater range of charges (that is, lower minimum and higher maximum charges) than DRGs 210 through 212, we need to account for the charges of all cases (that is, the expensive cases as well as the less expensive cases). We use an averaging process to determine the ordering of the surgical hierarchy. The difference in the average charges of these two surgical classes (\$1414) is significant enough to justify reordering DRG 216, with an average charge of \$12,799, above DRGs 210 through 212, with a combined average weighted charge of \$11,385.

8. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications or comorbidities (CCs). This list was

developed by physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In preparing the original CC list, a substantial CC was defined as a condition that, because of its presence with a specific principal diagnosis, would increase the length of stay by at least one day for at least 75 percent of the patients.

Based upon clinical review by our medical consultants and analysis of the charge data in the FY 1990 MEDPAR file, we proposed to revise the list of diagnoses that are considered to be CCs as follows:

• We proposed to add the following diagnoses to the CC list:

- 293.81 Organic delusional syndrome
- 293.82 Organic hallucinosis syndrome
- 293.83 Organic affective syndrome
- 453.8 Venous embolism and thrombosis of other specified veins
- 453.9 Venous embolism and thrombosis of unspecified site
- 696.0 Psoriatic arthropathy
- 733.81 Malunion of fracture
- 733.82 Nonunion of fracture

Each of these diagnosis codes will be considered a CC for any principal diagnosis not shown in Table 6g. Additions to the CC Exclusions List (see discussion of CC Exclusions list, in section IV of the addendum below).

• We proposed to delete the following diagnoses from the CC list:

- 318.2 Profound mental retardation
- 429.0 Myocarditis, unspecified
- 447.0 Arteriovenous fistula, acquired
- 448.0 Hereditary hemorrhagic telangiectasia
- 457.2 Lymphangitis
- 500 Coal worker's pneumoconiosis
- 501 Asbestosis
- 502 Pneumoconiosis due to other silica or silicates
- 503 Pneumoconiosis due to other inorganic dust
- 504 Pneumonopathy due to inhalation of other dust
- 505 Pneumoconiosis, unspecified
- 571.1 Acute alcoholic hepatitis
- 607.1 Balanoposthitis
- 607.2 Other inflammatory disorders of penis
- 607.3 Priapism
- 619.0 Urinary-genital tract fistula, female
- 619.1 Digestive-genital tract fistula, female
- 619.2 Genital tract-skin fistula, female
- 619.8 Other specified fistulas involving female genital tract
- 619.9 Unspecified fistula involving female genital tract
- 683 Acute lymphadenitis
- 708.0 Allergic urticaria
- 788.0 Renal colic
- 790.8 Viremia, unspecified

Each of these diagnoses will no longer be considered a CC for any principal diagnosis.

We proposed a limited revision of the CC Exclusions List, which includes corrections of errors in the existing list, addition of a number of excluded CCs, and deletion of a number of excluded CCs. These proposed changes were made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6g and 6h in section IV of the addendum to this final rule contain the revisions to the CC Exclusions List that are effective for discharges occurring on or after October 1, 1991. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6g—Additions to the CC Exclusions List. Currently, the indented diagnoses are recognized by the GROUPER as valid CCs for the asterisked principal diagnosis but will be excluded and thus ignored by the GROUPER beginning with discharges on or after October 1, 1991.

CCs that are deleted from the list are in Table 6h—Deletions from the CC Exclusions List. Currently, the indented diagnoses are excluded and are not recognized by the GROUPER as valid CCs for the asterisked principal diagnosis but, except for those diagnoses that are being removed from the CC list altogether, will be recognized as valid CCs beginning with discharges on or after October 1, 1991.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for \$67.00 and on microfiche for \$16.50, plus \$3.00 for shipping and handling. A request for the FY 1988 CC Exclusions List, which should include the identification accession number ((PB) 88-133970), should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161, or by calling (703) 487-4650.

Users should be aware of the fact that all revisions (that is, FYs 1989, 1990, and 1991 revisions) to the CC Exclusions List and those in Tables 6g and 6h of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1991.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The DRG Definitions Manual, Eighth Revision, which includes the changes in this document, is available for \$195.00, which includes \$15.00 for shipping and handling. This manual may be obtained by writing 3M/HIS at: 3M/HIS, 100 Barnes Road, Wallingford, Connecticut 06492, or by calling (203) 949-0303.

Comment: One commenter, while in agreement with the additions to the CC list, did not agree with several of the deletions from the CC list. This commenter requested that we describe how we analyzed the charge data in deciding which CCs to delete from the CC list. The commenter also inquired whether the cases with diagnoses deleted from the CC list had different charges and length of stays than other cases in the same DRG.

Response: Our method for determining which diagnoses to delete from the list of CCs consisted primarily of three steps. First, we established a subgroup of patients in those DRGs with CC/non-CC pairs where the diagnosis under consideration was the only CC for that case. Then we compared the average charge for that subset of patients to the average charge for the DRGs to which they were currently assigned (that is, the CC DRGs). We then computed the average charge for the DRGs to which the case would be classified if the diagnosis were treated as non-CC (that is, the non-CC DRGs). If the average charge for the cases in subset one, where the only CC was the diagnosis being considered for deletion, was approximately equal to or less than the average charge for the DRGs with the same diagnosis treated as a non-CC, then we considered this diagnosis for deletion from the list of CCs.

After we had prepared a list of possible CC deletions, we asked our medical staff to review each diagnosis on the list for clinical significance as a CC. In addition, we considered the code category of the diagnosis proposed to be deleted. If one or more codes in a three digit ICD-9-CM diagnosis group qualified for deletion, we reviewed any codes remaining within that group for possible deletion. In many cases, there were not enough cases with a particular diagnosis reported as the only CC to allow us to conduct an average charge analysis. However, if all or most of the codes in a particular code category were either already not CCs or were on our

suggested deletion list, we generally did not leave one code as a CC. This was particularly true when the only code that would remain on the list was an "Unspecified" or "Not elsewhere classified" subcategory. We believe that leaving only one of those codes on the CC list would create opportunities to use a nonspecific diagnosis code to qualify as a CC if other related diagnoses were not qualified CC diagnoses. Therefore, we did not have average charge data on every code we proposed to delete. When we deleted an entire category, we had data available on one or more of the codes and deleted the remaining codes on a clinical basis and to prevent misuse of the code.

In summary, we analyzed the CC diagnosis code by comparing average charges for the DRGs with only that specific CC to the average charges for the DRGs to which the case would be assigned with the CC and to the average charge for the DRGs with the diagnosis as a non-CC; we considered the inclusion or exclusion of related diagnoses; and we subjected the list of diagnoses to be deleted from the CC list to the review of physicians on the HCFA staff, as well as consulting physicians.

Comment: One commenter supported removal of diagnosis code 788.0 (Renal colic) from the CC list. The commenter stated that classifying renal colic as a CC provided opportunity to manipulate the urinary DRG assignments and, by removing this diagnosis from the list of CCs, we are reducing this possibility. Further, it was suggested that we also remove diagnosis codes 786.3 (Hemoptysis) and 599.7 (Hematuria) from the list.

Response: We are aware of the importance of maintaining as CCs only those diagnoses that truly result in increased resource use and length of stay when present with nonrelated principal diagnoses. We understand the attraction of coding CCs to attain assignment to the higher-weighted CC DRG. We attempt to give recognition to those diagnoses that meet the definition of a CC while keeping the list free of diagnoses that are not specific, are present in a majority of hospital stays, are easily miscoded, or do not contribute to higher resource use.

In the case of the other conditions mentioned by the commenter as candidates for removal from the CC list, hemoptysis and hematuria, we note that these codes were included in our analysis of existing CCs. Using the results of our analysis, both diagnosis codes 599.7 and 786.3 are overpaid in the DRGs where they classify as a CC. However, for both codes, especially for

786.3, removal as a CC would result in substantial underpayment for these cases. These diagnoses will remain as CCs, but we will re-evaluate them, as well as all the other diagnosis that remain on the CC list, as part of our DRG analysis for next year.

Comment: Commenters noted that new diagnosis code 535.00 (Acute gastritis without hemorrhage) was not identified as a CC in Table 6A of the proposed rule.

Response: Currently, the diagnosis code 535.0 (Acute gastritis) is considered to be a CC. Effective October 1, 1991, this diagnosis category is expanded by adding a fifth digit "0," without hemorrhage, or "1," with hemorrhage. We determined that acute gastritis without hemorrhage should not be considered a CC. This is consistent with the CC treatment of other diagnosis codes in this category. For example, acute gastrojejunal ulcer with hemorrhage (codes 534.00 and 534.01) is a CC whether or not an obstruction is present, but acute gastrojejunal ulcer without mention of hemorrhage or perforation (codes 534.30 and 534.31) is a CC only when an obstruction is present. We believe that the hemorrhage is the reason these codes should be considered CCs and not just the acute gastritis. We note that the other specified gastritis with hemorrhage (code 534.41) is considered a CC and that without hemorrhage (code 534.40) is not.

Comment: Several commenters questioned the removal of specific diagnoses from the CC list. Two commenters objected to the removal of diagnosis codes 571.1 (Acute alcoholic hepatitis) and 790.8 (Viremia). Several commenters stated their objection to the removal of diagnosis code 318.2 (Profound mental retardation) as a CC. These objections were based on the commenters' belief that these diagnoses increase resource consumption as expressed in increased length of stay, charges, or intensity of service.

Response: As discussed in detail in a previous response, in our evaluation of CCs, we analyzed separately the average charges for the DRG to which these CCs currently group for the cases with only the one CC, and for the DRGs to which the diagnosis would group if it was considered a non-CC. For cases in which each of the questioned diagnoses was the only CC, hospitals were significantly overpaid. We believe that removing these diagnoses from the CC list results in more equitable payment, with charges for the cases with the deleted CC approximately the average charge of the DRG to which the cases are classified when the diagnoses are

treated as non-CCs. Continuing to classify cases to DRGs with a CC assignment would cause substantial overpayment for those cases in the short run and, in the long run, would result in lowering the weight for these DRGs by decreasing the average charges.

We note that one of the commenters who questioned the deletion of diagnosis code 318.2 represents a children's hospital association. While we are aware of the fact that changes we make in the Medicare DRG system may have an impact on these hospitals with regard to other payment systems that use our DRGs, we remind the commenter that the prospective payment system, and the DRG classifications in particular, are based on Medicare data and are designed for the Medicare population, that is, the elderly and disabled. Therefore, changes and modifications we make to that system may not always be appropriate for a younger population, such as the one treated most often in children's hospitals.

9. Review of Procedure Codes in DRGs 468 and 477

Each year, we review cases assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis) in order to determine whether, in conjunction with certain principal diagnoses, there were certain procedures performed that are not currently included in the surgical hierarchy for the MDC in which the diagnosis falls. In FY 1989, this review resulted in the addition of DRG 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis) and DRG 477 (Non-Extensive OR Procedure Unrelated to Principal Diagnosis). For a detailed discussion of these changes, see the September 30, 1988 final rule (53 FR 38487).

Since DRG 468 is reserved for those cases in which none of the OR procedures is related to the principal diagnosis, it is intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRGs 476 and 477 are assigned to specific subsets of these cases. DRG 476 is currently assigned to those discharges in which one of the following prostatic procedures is performed and it is unrelated to the principal diagnosis:

- 60.0—Incision of prostate
- 60.12—Open biopsy of prostate
- 60.15—Biopsy of periprostatic tissue
- 60.18—Other diagnostic procedures on prostatic and periprostatic tissue
- 60.2—Transurethral prostatectomy
- 60.61—Local excision of lesion of prostate

- 60.69—Prostatectomy NEC
- 60.93—Repair of prostate
- 60.94—Control of (postoperative) hemorrhage of prostate
- 60.99—Other operations on prostate

DRG 477 is assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD-9-CM procedure codes for the procedures we consider nonextensive procedures if performed with an unrelated principal diagnosis was published in Table 6c in section IV of the addendum to the September 30, 1988 final rule (53 FR 38591). As a part of the September 4, 1990 final rule, we moved a large number of procedures from DRG 468 to 477. We listed the procedure codes in Table 6g in section IV of the addendum to that final rule (55 FR 36135).

We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. This year's review did not identify any changes that are necessary; therefore, we did not propose to move any procedures from DRGs 468 or 477 to one of the surgical DRGs.

However, because of an ICD-9-CM coding revision, we proposed to add a procedure to DRG 476. Effective October 1, 1991, procedure code 60.95 (Transurethral balloon dilation of the prostatic urethra) will be added to the ICD-9-CM. Since this is an OR procedure that is clinically similar to the other procedures that currently group to DRG 476 when they are performed on patients with an unrelated principal diagnosis, we proposed to add procedure code 60.95 to the list of DRG 476 prostatic procedures.

We also reviewed the list of OR procedures that produce DRG 468 assignments to ascertain if any of those procedures should be moved to the list of nonextensive procedures that produce DRG 477 assignments. We analyzed the charge and length of stay data for cases assigned to DRG 468 to identify those procedures that are associated with discharges that are more similar to the discharges that currently group to DRG 477 than to the discharges that group to DRG 468. Generally, we consider moving only those procedures for which we have an adequate number of discharges to analyze the data.

Based on our analysis, we proposed to add the following two procedures to the list of nonextensive procedures that group to DRG 477:

- 53.41 Repair of umbilical hernia with prosthesis
- 53.49 Other umbilical herniorrhaphy

These cases will group to DRG 477 instead of DRG 468 beginning with discharges on or after October 1, 1991.

We received no comments concerning our proposals for DRGs 476 and 477. Therefore, we are incorporating these proposals into the final DRG classification changes.

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

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

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

The Committee encourages participation in the above process by major health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for input into coding matters from representatives of recognized organizations in the coding fields, such as the American Medical Record Association (AMRA), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, and other members of

the public. After considering the opinions expressed at the public meetings, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on April 23, July 26, and December 7, 1990 and finalized the coding changes after consideration of comments received at the meetings and in writing in the 30 days following the December 7, 1990 meeting. The initial meeting for consideration of coding issues for resolution in FY 1992 and held on May 2, 1991 and a second meeting was held on August 1-2, 1991. Copies of the minutes of these meetings may be obtained by writing to the co-chairpersons representing NCHS and HCFA. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Ms. Sue Meads, R.R.A., Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, NCHS, Rm. 9-58, 6525 Belcrest Road, Hyattsville, Maryland 20782.

Questions and comments concerning the procedure codes should be addressed to: Ms. Patricia E. Brooks, Co-Chairperson, ICD-9-CM Coordination and Maintenance Committee, HCFA, Office of Coverage Policy, Rm. 401 East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

The ICD-9-CM code changes that have been approved will become effective October 1, 1991. The new ICD-9-CM codes are listed, along with their DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section IV of the addendum to this final rule.

Further, the Committee has approved the expansion of certain ICD-9-CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes or have been deleted are in Table 6c (Invalid Diagnosis Codes). Procedure codes that have been replaced by expanded codes or have been deleted are in Table 6d (Invalid Procedure Codes). These diagnosis and procedure codes will not be recognized by the GROUPE beginning with discharges occurring on or after October 1, 1991. The corresponding new expanded codes are included in Tables 6a and 6b. Revisions to diagnosis and procedure code titles are in Tables 6e (Revised Diagnosis Code Titles) and 6f (Revised Procedure Code Titles), which also include the DRG assignments for these revised codes.

We received several comments on the new ICD-9-CM codes and their DRG assignments.

Comment: One commenter disagreed with the proposed DRG assignments of three new diagnosis codes. The commenter stated that diagnosis code 670.00 (Major puerperal infection, unspecified as to episode of care or not applicable) should be assigned to DRG 469 (Principal Diagnosis Invalid as Discharge Diagnosis), not to DRGs 383 and 384 (Other Antepartum Diagnosis) as proposed. The commenter stated that all other pregnancy codes ending with a fifth digit of "0" (that is, unspecified as to episode of care or not applicable) group to DRG 469.

The commenter also disagreed with the proposed DRG assignment of diagnosis codes 670.02 (Major puerperal infection, delivered, with mention of postpartum complication) and 672.02 (Pyrexia of unknown origin during the puerperium, delivered, with mention of postpartum complication) to DRGs 370 and 371 (Cesarean Section), and 372, 373, 374, and 375 (Vaginal Delivery With and Without Complicating Diagnosis, With Sterilization and/or D.&C., or With Other OR Procedure, respectively). The commenter believes that these codes should not be assigned to DRG 373 (Vaginal Delivery Without Complicating Diagnoses). The commenter stated that in the DRG Definitions Manual published by 3M/HIS, these codes currently are considered complicating diagnoses and do not group to DRG 373.

Response: We agree with the commenter that diagnosis code 670.00 should be assigned to DRG 469, not to DRGs 383 and 384. We also agree that diagnosis code 670.02 as well as diagnosis code 672.02 should be assigned to DRGs 370, 371, 372, 374, and 375, and not to DRG 373. We did not propose this assignment; it was a typographical error in the Federal Register publication. We note that there was also a typographical error in that document concerning the proposed DRG assignment of new diagnosis code 204.01 (Acute lymphoid leukemia in remission). DRG 401 was erroneously included with the correct DRG assignments of code 204.01 to DRGs 400, 405, and 473.

Contrary to the commenter's assertion, not all pregnancy codes with a fifth digit of "0" are assigned to DRG 469. For example, the following "unspecified as to episode of care or not applicable" codes are assigned to DRG 379 (Threatened Abortion): 640.00 (Threatened abortion), 640.80 (Other specified hemorrhage in early pregnancy), and 640.90 (Unspecified hemorrhage in early pregnancy). In

addition, codes 641.30 (Antepartum hemorrhage associated with coagulation defects), 642.50 (Severe pre-eclampsia), 642.60 (Eclampsia), and 642.70 (Pre-eclampsia or eclampsia superimposed on pre-existing hypertension) are assigned to DRG 383 (Other Antepartum Diagnosis with Medical Complication) when present with other diagnosis codes as well as to DRG 469.

Comment: One commenter noted an error in one of the proposed assignments of new procedure code 51.23 (Laparoscopic cholecystectomy). The commenter pointed out that DRG 198 (Cholecystectomy without Common Duct Exploration (C.D.E.), without CC) is not in MCD 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms), as is listed in Table 6b of the proposed rule (56 FR 25263).

Another commenter requested that Medicare begin paying for laparoscopic cholecystectomies now that we have established a separate code for them. The commenter cited the advantages of this procedure over the traditional cholecystectomy, which uses a more invasive approach, such as reduction in the hospitalization period (from 5 to 7 days to 1 day or no inpatient stay), reduction in the recuperation period (from 5 to 6 weeks to 1 week to 10 days), and reduced pain and discomfort for the patient. The commenter also stated that approval of the procedure should result in cost savings to the Medicare program.

Response: There was a typographical error in the listing of MDC assignments of new procedure code 51.23 in Table 6b of the proposed rule. The commenter is correct in stating that DRG 198 is in MDC 7.

With regard to the coverage under Medicare of laparoscopic cholecystectomy, HCFA recently received an assessment for coverage of the laparoscopic cholecystectomy procedure from the Public Health Service (PHS). We are developing coverage instructions for the laparoscopic cholecystectomy procedure. In cases where the procedure is covered by Medicare during an inpatient hospital stay, we will make payment for it under the DRG system.

Comment: We received one comment on the proposed DRG assignments of the revised procedure codes. The commenter believes that DRGs 193 and 194 (Biliary Tract Procedure Except Only Cholecystectomy with or without C.D.E.) should be added to the DRG assignments for the revised procedure code 51.22 (Cholecystectomy), because the DRG Definitions Manual published by 3M/HIS lists DRGs 193 and 194 as current 51.22 assignments.

Response: Procedure code 51.21 (Partial cholecystectomy), not code 51.22, is currently assigned to DRGs 193 and 194. Procedure code 51.21 will become an invalid code effective October 1, 1991. Currently, procedure code 51.22 is entitled "Total cholecystectomy" and is assigned to DRGs 195 through 198, 400, 406, 407, 442, 443, and 486. Effective October 1, 1991, the title of procedure code 51.22 will be revised to "Cholecystectomy" and the DRG assignments will remain the same as prior to the code title revision.

Comment: One commenter stated that each year in the proposed rule some of the codes that will be included in the MCE edits are announced; for example, the "non-OR" status of procedure codes is indicated. However, other edits are not provided to the public. The commenter believes that, in order to ensure accurate data reporting, all changes that affect the DRG system should be stated in the proposed and final rules. The commenter also requested confirmation that new diagnosis codes 176.9 (Kaposi's sarcoma, unspecified) and 524.60 (Temporomandibular joint disorders, unspecified) will be included in the MCE as nonspecific principal diagnoses.

Response: As noted above in section III.B.1 of this preamble, the MCE is a claims processing tool used by the fiscal intermediaries to ensure that Medicare claims are processed and paid correctly. In general, the MCE identifies claims that may need further development before payment, such as those that present conflicting information (for example, a claim for a female that also includes surgery for the prostate), nonspecific or unacceptable principal diagnosis or nonspecific or noncovered procedures, or invalid codes. The information in the MCE is not needed by hospitals to ensure correct coding. If hospitals code claims with correct ICD-9-CM codes and according to coding guidelines and ensure that all the remaining information on the claim matches the patient's status, then the claims will generally not be rejected during the MCE edit and will be processed correctly and timely by the intermediary. We believe that the information that is published in the proposed and final prospective payment rules is adequate to inform the public of the changes we are making as well as allow them to develop their own version of the GROUPE program. Since the MCE is an internal HCFA processing device and has no implication for correctly coded cases, we do not believe providing a description of any MCE changes we might make is necessary.

The "Non-OR" information provided in Tables 6b, 6d, and 6f (for new, invalid, and revised procedure codes, respectively) is included in the proposed rule to inform the public that the procedure is a nonoperating room (non-OR) procedure. Typically, these procedures do not affect DRG assignment; thus, they do not have a DRG assignment listed. However, a few non-OR procedures do affect DRG assignment and are indicated by a footnote "Non-OR procedure that affects DRG assignment" in Tables 6b, 6d, and 6f. This information is not provided in reference to the MCE.

Regarding the commenter's request for verification of code assignment, new diagnosis codes 176.9 and 524.60 will be included in the edit for nonspecific principal diagnosis.

11. Expansion of Diagnosis and Procedure Reporting Fields on the UB-82 Form

In the May 9, 1990 proposed rule (55 FR 19459), in response to the PropAC recommendation, we announced our intention to expand to 10 the number of fields available for reporting diagnosis and procedure codes on the UB-82 billing form (the billing form used for Medicare discharges). We agreed with PropAC that this expansion was necessary to ensure complete medical information reporting and expressed our intention to implement a revised form that would allow the reporting of 10 codes in each field for discharges occurring on or after October 1, 1990. The current UB-82 form limits these fields to five diagnosis and three procedure codes.

Based upon comments we received in response to the May 9, 1990 proposal and our own analysis of the situation, we stated in the September 4, 1990 final rule (55 FR 36068) that we would delay implementation of an expansion of the UB-82 billing form to accept additional diagnosis and procedure codes until October 1, 1991. We also agreed to do more analysis on the number of codes necessary to optimize DRG refinement. Based upon our analysis of the FY 1990 MEDPAR file and data from the California Statewide Discharge Data Set, we announced in the June 3, 1991 proposed rule that we will expand the UB-82 billing form to include 9 diagnosis fields and 6 procedure code fields effective for discharges occurring on or after October 1, 1991. We estimated that this expansion will encompass approximately 95 percent of the diagnosis and procedure codes reported.

In the proposed rule, we stated that we will continue to work with the

National Uniform Bill Committee on revising the UB-82 to accommodate these expanded fields. Until the billing form is revised, hospitals are to use the "Remarks" section of the bill to report the additional codes. With the expanded fields, we believe that there will be adequate room for hospitals to completely code virtually all inpatient hospital discharges. As we noted in the proposed rule, we expect hospitals to fully code every case using the Uniform Hospital Discharge Data Set (UHDDS) definitions and instructions as well as the coding guidelines set forth in the *Coding Clinic for ICD-9-CM (Coding Clinic)*, published quarterly by the AHA for use by hospitals. *Coding Clinic* provides specific diagnosis and procedure information and guidelines that are helpful for determining proper coding.

Comment: The comments received regarding the UB-82 billing form and our intention to expand the available fields for reporting diagnosis and procedures from 5 to 9 and from 3 to 6, respectively, were almost unanimously supportive and favorable. The commenters agreed that it is necessary to expand the available reporting fields for both diagnosis and procedures to enable identification of additional information that will enhance our reporting and analytical capacity. However, many commenters expressed concern about the date of implementation of the changes. Their concerns included the need to allow time to prepare data forms and systems to accommodate this expansion and to allow a phase-in period for implementing claims processing revisions required by the change. Most commenters requested that we postpone implementation for 6 months to allow hospitals time to change their reporting systems, while several commenters requested that no expansion be implemented until after the UB-82 form is revised to accommodate the expansion.

Response: Last year, in response to our May 9, 1990 proposed rule (55 FR 19459), we received many similar comments requesting delay in the implementation of the expanded reporting fields, which we had originally intended to be effective October 1, 1990. In our September 4, 1990 final rule (55 FR 36068), we stated that we would delay implementation of an expansion of the UB-82 billing form to accept the additional diagnosis and procedure codes until October 1, 1991. Therefore, hospitals, intermediaries, and other interested parties have known for more than a year that this change was imminent. The National Uniform Billing

Committee (NUBC), of which HCFA is a member, has agreed to modify the UB-82 billing form to accommodate this request for additional data fields. The revised form should be available October 1, 1992.

However, we agree with the commenters that there may be a need for some delay in the expansion to allow hospitals time to revise their internal claims reporting systems. Although these hospitals were aware that a change was going to be made, it was not until publication of the proposed rule on June 3, 1991 that the exact number of diagnosis and procedure codes was known. In light of this fact, we have decided to allow those hospitals that are capable of reporting the expanded number of codes to begin reporting as of October 1, 1991; however, for those hospitals that have to make internal changes to accommodate the expansion, we will delay the requirement to expand coding until April 1, 1992. Effective with discharges occurring on or after April 1, 1992, we expect that all hospitals will be coding at the level of nine diagnosis and six procedure codes. The fiscal intermediaries will be prepared to accept the expanded nine diagnosis and six procedure codes effective October 1, 1991.

In response to those commenters who requested that we delay the expansion of the coding until the UB-82 form is revised, we note that currently only 10 percent of the inpatient hospital claims are submitted on that form. The vast majority of the inpatient hospital claims are submitted electronically. For those claims submitted on the form, we have stated that any codes that do not fit in the prescribed space may be entered in the "Remarks" section of the bill. The instructions that accompany the UB-82 already explain how to accomplish this procedure. While several commenters stated that this was either inadequate or risky because it would lead to commingling of the diagnosis and procedure codes in the "Remarks" section, we note that the instructions for the form require that any continuation in that field must be identified by reporting the field location of the continued data. Therefore, if a diagnosis field is being continued, the number of the diagnosis field on the UB-82 form is noted in "Remarks" followed by the additional codes. Similarly, reporting the additional procedures requires identification of the procedure field in "Remarks." This alone should be sufficient to distinguish diagnosis codes from procedure codes. In addition, procedure codes are accompanied by the date the procedure is performed. Again, we believe that any

overflow into "Remarks" should not cause problems. We note that, of the 10 percent of claims that are submitted using the UB-82 form, only a small percentage will contain more than the five diagnosis and three procedure code fields already provided.

HCFA appreciates that hospitals, whether their billing systems are electronic or paper driven, require implementation time to accommodate the required expansion of reported fields. We believe the 6-month delay in requiring that the expanded codes be reported is sufficient to prepare systems, as well as to educate hospital staff on these new requirements.

Comment: One commenter, while strongly supporting the proposal to increase the number of data fields for diagnosis and procedure codes for UB-82, requested information on whether HCFA's analysis of the number of fields necessary to accommodate hospital coding included a review of the number of diagnosis and procedure codes reported for sick infants. The question was raised due to concern that a sick neonatal population would require more than nine diagnosis and six procedure fields to accommodate all the necessary reporting.

Response: As noted in the proposed rule (56 FR 25188), in determining the number of fields needed for complete reporting of diagnoses and procedures, we used not only Medicare claims data but also data from a study completed by the California Patient Discharge Data, which included 3.5 million discharge records from the general population. While it is not known how many of these records represent "sick infants," we assume that the number of them included was proportional to their number in the hospital inpatient population.

Comment: One commenter asked whether the additional diagnoses and procedures would be used in the calculation of the DRG or if the additional codes would be used for informational purposes only without having an impact on DRG assignment.

Response: To the extent that the reported information in the expanded fields represents diagnoses that are valid CCs recognized in the GROUPE version in operation at the time of reporting or that the procedures reported are considered necessary to the classification of the case to a DRG, the information reported in the additional fields will be considered in assignment to a DRG. However, we believe that, in most cases, the current number of fields already adequately provides for these diagnoses and procedures. Our main

purpose in expanding the fields is to provide us with additional information that we need to allow us to base future DRG classification revisions on the most complete possible data analysis.

Comment: One commenter requested that HCFA restate its instructions on the proper use of the UB-82 form for reporting diagnoses and procedure codes. That is, even though the form is expanded to accommodate 9 diagnoses and 6 procedure codes, only those diagnoses and procedures that affect the treatment provided or the length of stay or both are to be reported.

Response: As we stated in the proposed rule (56 FR 25188), we expect hospitals to continue to code using the Uniform Hospital Discharge Data Set (UHDDS) definitions and instructions. We neither expect nor want hospitals to begin coding minor procedures or diagnoses that do not affect the hospital stay. The current UHDDS instructions provide for the coding of a principal diagnosis (the condition determined after study to be chiefly responsible for the admission to the hospital) and secondary diagnoses that are present on admission, develop during the stay, and affect the treatment received, the length of stay, or both. In addition, all significant procedures are to be reported. A significant procedure is one that is surgical in nature, carries a procedural or anesthetic risk or both, or requires specialized training to perform.

The Peer Review Organizations (PROs) will continue to review the diagnoses and procedures reported on the UB-82 as a part of their DRG validation review. PROs review the medical record to assure that the diagnostic and procedural information reported by the hospital and resulting in the DRG assignment by the intermediary matches the information in the medical record. This review includes verifying the accuracy of principal diagnosis and any secondary diagnoses as well as the major procedures performed.

Comment: Another comment raised the issue of the Medicare physician attestation requirement. Under the regulations at § 412.46(a), each diagnosis and each procedure on the bill must be attested to by the attending physician prior to submitting the claim. The commenter expressed concern that the increased number of diagnoses and procedures might cause a substantial delay in the hospital's billing process and asked if there was any possibility of revising or relaxing the attestation requirement. The commenter suggested that we consider requiring that the physician attest only to those diagnoses or procedures that affect the DRG assignment, while allowing additional

diagnoses and procedures to be reported without attestation.

Response: As provided in § 412.46(a), before a claim is submitted, the attending physician must attest to the principal diagnosis, secondary diagnoses, and names of major procedures performed. While expanding the number of fields to report diagnoses and procedures will increase the possible number of these items to which the physician must attest, we do not anticipate that this will incur a substantial increase in the time necessary to submit a claim. Although our primary objective in expanding these fields is to provide data for informational purposes, this additional information may serve in future DRG classification revisions. It is, therefore, necessary to ensure that the information on the claim is correct and reliable, even if the information is not essential to current DRG assignment. Hence, we are not recommending any modification to the physician attestation requirement, and the attending physician will continue to attest to all diagnoses and major procedures included on the claim.

12. Other Issues

Intractable epilepsy. Effective October 1, 1989, the diagnosis codes identifying epilepsy were modified by the addition of a fifth digit, which distinguished intractable from nonintractable epilepsy. (See Table 6A—New Diagnosis Codes, in section IV of the addendum to the September 1, 1989 final rule (54 FR 36547)). This modification added a fifth digit of "0" to specify "without mention of intractable epilepsy" and a fifth digit of "1" to identify intractable epilepsy cases to diagnosis codes 345.0, 345.1, and 345.4 through 345.9. Patients with a principal diagnosis of 345.00 through 345.11 and 345.40 through 345.91 are assigned to MDC 1 (Diseases and Disorders of the Nervous System). These cases group to DRG 1 (Craniotomy Age > 17 Except Trauma) or DRG 3 (Craniotomy Age 0-17) when surgery is performed and to DRG 24, 25, or 26 (Seizure and Headache) when there is no operating room procedure performed.

Effective October 1, 1989, we also added two new procedure codes to identify procedures typically performed in the diagnosis and treatment of intractable epilepsy patients. (See Table 6B—New Procedure Codes, in section IV of the addendum to the September 1, 1989 final rule (54 FR 36549)). These new codes are 89.10 (Intracarotid amobarbital test) and 89.19 (Video and radio-telemetered electroencephalographic monitoring).

In the September 1, 1989 final rule, at the time the new codes were announced, we stated that these codes would allow us to collect and evaluate data concerning resource requirements for patients with intractable epilepsy compared to patients with routine epilepsy and to determine whether any additional classification changes should be proposed once the FY 1990 data were available (54 FR 36461). Accordingly, we analyzed the FY 1990 MEDPAR data, comparing cases with intractable and nonintractable epilepsy with and without procedures 89.10 and 89.19. As a result of this analysis, we found that, while cases with intractable epilepsy assigned to DRGs 24, 25, and 26 incurred higher charges than those cases without intractable epilepsy, the differences are not significant enough to warrant any DRG classification changes at this time. Therefore, we did not propose to make any DRG classification changes concerning epilepsy.

We received several comments disagreeing with our decision not to make any change in classification for intractable epilepsy. The specific comments and our responses follow.

Comment: One commenter identified a mistake in the proposed rule in our reference to the ICD-9-CM diagnosis codes that distinguish intractable from nonintractable epilepsy. In that document, we stated that the fifth digit of 0 or 1 is required for all the codes ranging from 345.0 through 345.9. (See 56 FR 25188.) The commenter states that this is incorrect; only subcategories 345.0, 345.1, and 345.4 through 345.9 require the fifth digit.

Response: The commenter is correct. We erroneously identified 345.0 through 345.9 as the range of codes in which a fifth digit of "0" defines nonintractable epilepsy and a fifth digit of "1" defines intractable epilepsy. The correct codes are, as stated by the commenter, 345.0, 345.1, and 345.4 through 345.9. Neither 345.2 (Petit mal status) nor 345.3 (Grand mal status) may be appropriately assigned as either intractable or nonintractable epilepsy. These are status codes, while the other codes in this series are disease codes.

Comment: Several commenters disagreed with our decision not to modify the existing classification for epilepsy patients but to maintain DRGs 24, 25, and 26 (Seizure and Headache) without change. These commenters indicated that their experience is that intractable epilepsy patients incur significantly higher charges than nonintractable epilepsy patients. Some of the commenters recommended that we modify the classifications so that all

patients with intractable epilepsy would be classified under DRG 24 (Seizure and Headache with CC, Age >17), as the weight assigned to that DRG recognizes the severity and greater resource needs for these patients and should therefore provide a more appropriate level of payment. Another commenter detailed the differential costs for treatment of intractable and nonintractable epilepsy patients, stating that changes in the DRG system need to be made to enable hospitals to continue to treat these patients.

Response: Since publication of the proposed rule, we have continued our analysis of intractable and nonintractable epilepsy using the most current update of the FY 1990 MEDPAR file. Our further evaluation supports our prior analysis, that is, that intractable epilepsy cases do incur higher charges than nonintractable patients, but not significantly high enough to warrant reclassification of these cases.

We do not agree with the recommendation that all intractable epilepsy cases be classified as CC cases and, thus, be assigned to DRG 24. While it is the intent of the DRG logic to assign cases that incur greater resource consumption due to the presence of CCs to a higher-weighted DRG, it is not intended that all cases, including those without a CC, that incur resource consumption above the average be assigned to a higher-weighted DRG. The GROUPE system assigns cases by diagnosis, procedure, and age, with further classification in some cases determined by the presence or absence of select secondary diagnoses (CCs); the system is not designed to group cases by greater or lesser charges. To do so would establish a precedent that would undermine one of the basic tenets of the patient classification system. The purpose of the prospective payment system is not to pay for the costs of individual cases, but to pay an average, with some cases falling above and some below this average. To initiate a grouping that defies this principal, by establishing a group for only high cost cases, would defeat the objective of the prospective payment system to provide incentives for efficient care.

Comment: One commenter stated that our analysis was limited because we are unable to examine the resource requirements specific to the comprehensive evaluation for intractable epilepsy patients. This comment defines a comprehensive medical evaluation as involving video and electroencephalographic monitoring with surface and possibly sphenoidal electrodes, cognitive testing, and other

diagnostic procedures. The monitoring is stated to be the key diagnostic component of the comprehensive evaluation. There is concern that the existing coding system is not sufficient to distinguish the severity of patients nor the highly technical multidisciplinary treatment required for intractable epilepsy patients with comprehensive evaluation. The commenter hopes that HCFA will work with national epilepsy organizations in clarifying the ICD-9-CM codes, so that the comprehensive medical evaluations for intractable seizure patients can be coded.

Response: As we stated in the proposed rule (56 FR 25188), codes are now available that will identify specific procedures performed on epilepsy patients in addition to the codes that distinguish intractable from nonintractable epilepsy. Our analysis of the MEDPAR data included identification of cases with the use of these codes. To date, the differences found in cases reporting these procedure codes have been minimal. However, we have identified problems in the reporting of the procedure codes and in the need for specificity in coding the services performed in treating intractable epilepsy patients. HCFA's Medical Coding Policy staff has been, and continue to, work with the professional community to ensure correct, adequate coding for these cases.

b. Automatic Implantable Cardioverter Defibrillator (AICD). **Comment:** We received a large number of comments that recommended that AICD replacement cases be moved from DRG 120 (Other Circulatory System OR Procedures) and reassigned to a DRG that more accurately reflects the resources incurred during the replacement procedure, preferably a DRG with a weight of at least 3.7208. These comments were based on studies commissioned by the manufacturer of the AICD device, who contracted three studies on AICD replacements in the last 3 years. These studies concluded that the average standardized charges for AICD replacement cases have been consistently understated in the MEDPAR file. One commenter included a copy of an updated version of the study, based on FY 1990 MEDPAR data. This update states that—

- Hospitals purchasing the AICD device have improved their coding and billing, with 65 percent correctly coded and billed;
- 42 percent of AICD replacement cases were from hospitals that never purchased the device;

- Correctly coded cases have an average standardized charge of \$18,922;
- Miscoded cases have an average standardized charge of \$10,231; and
- All cases coded with AICD have an average standardized charge of \$15,925.

One commenter noted that the GROUPE logic assigned AICD cases to DRG 112 (Percutaneous Cardiovascular Procedures) when electrophysiology (EP) studies were performed, as these procedures take precedence over AICD replacements. The result is that these cases group to DRG 112, which has a slightly lower weight than DRG 120, and, therefore, receives a lower payment.

Response: In the September 4, 1990 final rule (55 FR 36023), we stated that, based on our analysis of the FY 1989 MEDPAR data, we believe that the classification of cases with replacement or insertion of AICD leads or pulse generator alone to DRG 120 is appropriate. Our analysis of FY 1990 MEDPAR data continues to support this decision. While the manufacturer's study analyzed charges for only AICD generator, implant, and replacement (procedure codes 37.96 (Implantation of automatic cardioverter/defibrillator pulse generator only) and 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only)), our analysis also included procedure codes, 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only) and 37.97 (Replacement of cardioverter/defibrillator lead(s) only). Examining these procedures, separately and in aggregate, indicates that, while the charges for AICD were above the average charge for DRG 120, this difference was well within the variation in charges above and below the average charge for that DRG, which was \$13,470 in FY 1990. The distribution of the 954 AICD cases in our FY 1990 MEDPAR file for DRG 120 indicate that the majority (91 percent) of cases received AICD generator replacements, with an average charge of \$15,925, which is above the manufacturer's threshold value of \$15,000.

We note that both coding and billed charges are being more accurately reported, although the manufacturer's study indicates that there is still much room for improvement. As we stated in the September 4, 1990 final rule (55 FR 36023), we furnished the information provided by the commenters about potential improper coding and billing to the PROs for their review. In addition, we have sent instructions to our fiscal intermediaries and carriers concerning AICD cases. In Transmittal No. 1525 (May 1991), we instructed intermediaries

to return to the hospital any claim with procedure codes 37.94, 37.95, 37.96, 37.97, and 37.98 for which total charges are less than \$17,000. The providers are to be instructed to review the procedure codes and total charges to be sure they are correct. We have also instructed carriers, which process the Medicare Part B claims, to deny charges under Part B for any defibrillator implant furnished in support of surgery during an inpatient hospital stay (Transmittal No. 1393, May 1991). These charges are to be included on the inpatient bill and not billed separately. We hope that these changes will assist in the improvement of the AICD data in MEDPAR file. Although we believe that AICD cases continue to be classified appropriately in DRG 120 based on the MEDPAR data, we intend to review these cases as a part of our DRG analysis and evaluation for FY 1993. As a part of that review, we will also address the problem cited by the final commenter concerning assignment of AICD cases with EP studies to DRG 112.

c. DRG 112 (Percutaneous Cardiovascular Procedures). *Comment:* We received one comment suggesting that DRG 112 be split into two separate DRGs based on the presence or absence of CCs. The commenter stated that using this criterion for differentiating discharges assigned to DRG 112 could result in preventing the systematic underpayment to hospitals serving a disproportionately large share of the complicated cases that are assigned to DRG 112 while at the same time preventing the overpayment to hospitals serving a disproportionately large share of the uncomplicated cases assigned to that DRG.

Response: Our analysis of DRG 112 cases with and without CC indicates that both the length of stay and charges are somewhat higher for those cases with a CC condition. However, we do not believe that the difference is significant enough to warrant a change in the structure of the DRG.

A review of each of the DRGs that are not split on the basis of CCs would most likely reveal the same findings as our DRG 112 analysis did. That is, cases with CCs tend to result in longer stays and higher charges. We do not, however, split a DRG on the basis of CCs unless the CC cases consistently have significantly higher charges. One measure of charge variation is the coefficient of variation, which indicates the degree of variance from the average in charges. The coefficient of variation is computed by dividing the standard deviation by the average charge. Currently, DRG 112 has a coefficient of

variation of approximately 70, which is not atypical for a DRG and would indicate that a CC split is not warranted.

As we have noted in several previous prospective payment final rules, the prospective payment system is not designed so that the payment received covers the full cost of every discharge. A hospital's payment may be greater than its costs for some cases or some DRGs, and less than its costs for other cases or other DRGs. While the Medicare prospective payment amount may not cover the complete cost of care for some cases that develop complications or involve more severe illnesses or multiple procedures, there are likely to be many cases in which the Medicare payment exceeds the cost of treating the patients. The excess payments received in these latter cases should offset the shortfall for higher cost cases. Thus, the prospective payment system is intended to provide an incentive for hospitals to manage their operations more efficiently by evaluating those areas in which increased efficiencies can be instituted without adversely affecting the quality of care and by treating a mix of patients so that payment in excess of cost on one case will offset the costs in excess of payment on another case.

d. *Liver transplants.* On April 12, 1991, we published, in the Federal Register (56 FR 15006), a final notice to provide Medicare coverage for liver transplants for adults for certain conditions. As a part of our FY 1991 prospective payment final rule, in anticipation of this final coverage notice, we established a separate DRG for liver transplants (DRG 480) effective for discharges occurring on or after October 1, 1990. Because the final notice provides for coverage of these procedures as early as March 8, 1990 under certain circumstances, we are clarifying in this document how payment will be made during the period prior to our establishment of the new DRG.

Although the proposed notice concerning coverage of liver transplants for adults, which was published on March 8, 1990 (55 FR 8545), proposed to classify these cases in a DRG with a weight of 21.0000, this weight was based on relatively old Medicare bill data (1984) and a sample of claims from three hospitals from 1983 and 1984. As was discussed in detail in the September 4, 1990 final rule (55 FR 36011) as well as the April 12, 1991 final coverage notice (56 FR 15009), we calculated a final weight for DRG 480 of 15.2645 based on 29 liver transplant cases in the FY 1989 MEDPAR file. This is the weight we intend to use to pay any covered liver transplant cases performed on or after

March 8, 1990 (the first possible date of coverage) and before October 1, 1990, the effective date of the September 4, 1990 final rule.

We considered classifying those transplants performed before October 1, 1990 to the DRGs to which the cases would have grouped prior to that date; that is, to DRGs 191 and 192 (Pancreas and Liver Shunt Procedures) if the principal diagnosis is classified in MDC 7 and to DRG 468 if the principal diagnosis groups to MDC 10 and no other surgical procedure related to that diagnosis is performed. However, classification of liver transplants to those DRGs was made prior to our coverage of those procedures for adults, and, thus, the relative weights of those DRGs do not reflect the high resource intensity of a liver transplant. Therefore, we believe that the equitable policy would be to pay those covered liver transplants performed for discharges before October 1, 1990 using the relative weight assigned to DRG 480 for FY 1991.

e. *Bone Marrow Transplants.* While the coverage guidelines for bone marrow transplants have not been changed, we wish to alert hospitals to a few changes in the diagnosis codes that affect classification of bone marrow transplant cases. Effective October 1, 1991, as set forth in Table 6A of section IV of the addendum to this final rule, a fifth digit has been added to the ICD-9-CM diagnosis codes for leukemia. Codes for leukemias "in remission" have a fifth digit of "1," and leukemias "without mention of remission" have a fifth digit of "0." Therefore, we will no longer use the V10.60-V10.69 codes to specify leukemias in remission. Instead, we will use the new five-digit leukemia codes that specify "in remission."

In addition, in the coverage guidelines for autologous bone marrow transplants (procedure code 41.01) and in the September 4, 1990 final rule (55 FR 36013), the following ICD-9-CM diagnosis codes were omitted from the list of codes for resistant non-Hodgkin's lymphomas:

- 200.00-200.08
- 200.10-200.18
- 200.20-200.28
- 200.80-200.88
- 202.00-202.08
- 202.90-202.98

These codes are added to the previously listed codes 202.80 through 202.88 for non-Hodgkin's lymphomas.

To summarize, bone marrow transplant cases will be assigned to DRG 481 (Bone Marrow Transplant) when the following criteria are met:

- Procedure code 41.01 (Autologous bone marrow transplant) is performed

and any one of the following is either a principal or secondary diagnosis:

—Acute leukemia, in remission (diagnosis codes 204.01, 205.01, 206.01, 207.01, and 208.01).

—Resistant non-Hodgkin's lymphomas (diagnosis codes 200.00–200.08, 200.10–200.18, 200.20–200.28, 200.80–200.88, 202.00–202.08, 202.80–202.88, and 202.90–202.98).

—Advanced Hodgkin's disease (diagnosis codes 201.00–201.08, 201.10–201.18, 201.20–201.28, 201.40–201.48, 201.50–201.58, 201.60–201.68, 201.70–201.78, 201.90–201.98).

—Recurrent or refractory neuroblastoma (diagnosis codes 140.0–199.1).

• Either procedure code 41.02 (Allogeneic bone marrow transplant with purging) or 41.03 (Allogeneic bone marrow transplant without purging) is performed and any one of the following is either a principal or secondary diagnosis:

—Leukemia or leukemia in remission (diagnosis codes 204.00–208.91)

—Aplastic anemia (diagnosis codes 284.0–284.9)

—Wiskott-Aldrich syndrome (diagnosis code 279.12)

—Severe combined immunodeficiency disease (SCID) (diagnosis code 279.2)

C. Recalibration of DRG Weights

One of the basic issues in recalibration is the choice of a data that allows us to construct relative DRG weights that most accurately reflect current relative resource use. Since FY 1986, the DRG weights have been based on charge data. The latest recalibration, which was published as a part of the FY 1991 prospective payment final rule, used hospital charge information from the FY 1989 MEDPAR file. For a discussion of the options we considered and the reasons we chose to use charge data beginning in FY 1986, we refer the reader to the rules published on June 10, 1985 (50 FR 24372) and September 3, 1985 (50 FR 35652).

We proposed to use the same basic methodology for the FY 1992 recalibration as we did for FY 1991. (See the September 4, 1990 final rule (55 FR 38033).) That is, we proposed to recalibrate the weights based on charge data for Medicare discharges. However, we proposed to use the most current charge information available, the FY 1990 MEDPAR file, rather than the FY 1989 MEDPAR file. The MEDPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights were constructed from FY 1990 MEDPAR data, received by

HCFA through December 1990, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The MEDPAR file at that time included data for approximately 9.8 million Medicare discharges. The MEDPAR file updated through June 1991 includes data for approximately 10.1 million discharges, and this is the file used to calculate the weights set forth in Table 5 of the addendum to this final rule.

The methodology used to calculate the DRG weights from the FY 1990 MEDPAR file is as follows:

- All the claims were regrouped using the revised DRG classifications discussed above in section III.B of this preamble.

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

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

- We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated.

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

- We established the weighting factor for heart transplants (DRG 103) in a manner consistent with the methodology for all other DRGs except that the heart transplant cases that were used to establish the weight were limited to those Medicare-approved heart transplant centers that have cases in the FY 1990 MEDPAR file. Similarly, we limited the liver transplant cases that were used to establish the weight for DRG 480 (Liver Transplant) to those hospitals that are established liver transplant centers.

- Acquisition costs for kidney, heart, and liver transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); and DRG 480 (Liver Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including

the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. In the FY 1989 MEDPAR data used to establish the FY 1991 weights, there were 35 DRGs that contained fewer than 10 cases. We proposed to use that same case threshold in recalibrating the DRG weights for FY 1992. In the FY 1991 recalibration, we computed the weight for the 35 low-volume DRGs by adjusting the original weights of these DRGs by the percent change in the weight of the average case in the remaining DRGs. We proposed to use this same methodology for the FY 1992 recalibration. Using the FY 1990 MEDPAR data set, there are 37 DRGs that contain fewer than 10 cases.

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

In developing the FY 1990 weights, we made an across-the-board 1.22 percent reduction to the weights after normalization to take into account increases in the average case weight attributable to reclassification and recalibration changes between FY 1986 and FY 1988 (54 FR 36469). Section 6003(b) of Public Law 101-239 enacted section 1886(d)(4)(C)(ii) of the Act to ratify the 1.22 percent reduction to the DRG weights but required in section 1886(d)(4)(C)(iii) of the Act that reclassification and recalibration changes in subsequent years (beginning with FY 1991) be made in a manner that assures that the aggregate payments are not greater or less than the aggregate payments that would have been made without the changes. Section 1886(d)(4)(C)(iv) of the Act requires that the Secretary include recommendations regarding any adjustments to the weights in his annual report to the Congress (required under section

1886(e)(3)(B) of the Act) on his initial estimate of his recommendation for the prospective payment update factor for the coming year.

We also interpret section 1886(d)(4)(C)(iii) of the Act to require that we ensure the FY 1992 reclassification and recalibration changes do not affect aggregate payments. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals. Therefore, as discussed in section II.A.4.b of the Addendum to this final rule, we are making a budget neutrality adjustment to assure the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

As discussed above in section III.B.2 of this preamble, one of the reclassification changes that we made in FY 1990 involved the implementation of the new five-digit codes for cases with a diagnosis of acute myocardial infarction (AMI). Consistent with our policy at the time, which predated the enactment of Public Law 101-239, we assigned the revised codes for nonacute AMIs to DRGs 132 and 133, which we believed were the appropriate DRGs for payment purposes. Because we were unable to identify which cases in the FY 1988 MEDPAR file would no longer be assigned to DRGs 121 and 122, we left all the AMI cases in those DRGs in recalibrating their weights. In addition, because we could not identify which cases would no longer be assigned to DRGs 121 and 122, we could not determine an appropriate adjustment to the DRG weights for DRGs 121 and 122 and DRGs 132 and 133 to reflect the new DRG assignment.

ProPAC, as a part of its March 1, 1991 report, recommended that a one-time adjustment be made during the FY 1992 DRG recalibration process to account for the reassignment of the nonacute AMI cases in FY 1990 (Recommendation 5). ProPAC believes that the reassignment of the cases before the change could be accounted for in the recalibration policy resulted in inappropriately low weights for acute AMIs assigned to DRGs 121 and 122 and nonacute AMIs assigned to DRGs 132 and 133. ProPAC also believes that this adjustment is necessary to prevent the underpayment for these cases from being carried forward into the future.

The type of adjustment ProPAC recommended is similar to the -1.22 percent adjustment that we made in FY 1990 to account for increases in the case-mix index attributable to DRG

reclassification changes. We believe that in amending section 1886(d)(4)(C)(ii) of the Act, Congress intended that no adjustment be made in the DRG weights to make allowances for the impact of previous reclassification changes. As we did for FY 1991, we have taken into account in our update recommendation for FY 1992 any effect previous DRG changes had on aggregate payments (See appendix B). We note that just as the AMI change may have inadvertently reduced aggregate payments, other changes may have increased payments. We believe that any adjustment should be for the net effect of all reclassification changes. Therefore, we did not adopt ProPAC's recommendation. We received one comment that supported a one-time adjustment to the DRG weights to account for the reassignment of nonacute AMI cases in FY 1990. In support of this adjustment, the commenter cited the adjustment HCFA made in FY 1990 to account for increases in the average case weight attributable to reclassification and recalibration changes between FY 1986 and FY 1988.

Response: As we noted in the proposed rule (56 FR 25190) and above, we believe that in enacting section 6003(b) of Public Law 101-239, which amended section 1886(d)(4)(C)(ii) of the Act to require that reclassification and recalibration changes in FY 1991 be made in a budget neutral manner, Congress intended that no further adjustments be made similar to the one we made in FY 1990. Therefore, we continue to believe that no special adjustment should be made for the AMI classification change in FY 1990. We note that ProPAC, in its comments submitted in response to the proposed rule, did not take issue with our decision not to make an adjustment to the DRG weights.

IV. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(2)(C)(ii) of the Act required, as part of the process of developing separate urban and rural standardized amounts for FY 1984, that we standardize the average cost per case of each hospital for differences in area wage levels. Sections 1886(d)(2)(H) and 1886(d)(3)(E) of the Act have required that the standardized urban and rural amounts be adjusted for area variations in hospital wage levels as part of the methodology for determining prospective payments to hospitals. To fulfill both of these requirements, we constructed an index that reflects average hospital wages in each urban

and rural area as a percentage of the national average hospital wage.

In determining prospective payments to hospitals in FY 1990, the wage index was based on wage data from cost reporting periods beginning in FY 1984. Section 6003(h)(6) of Public Law 101-239 amended section 1886(d)(3)(E) of the Act to require that wage indexes that are applied to the labor-related portion of the national average standardized amounts of the prospective payment system be updated not later than October 1, 1990, and, thereafter, updated annually beginning October 1, 1993. The September 4, 1990 final rule (55 FR 35990) set forth a revised hospital wage index that was based on a HCFA survey of hospital wage and salary data for all hospitals subject to the prospective payment system with cost reporting periods ending in calendar year 1988. Home office costs and fringe benefits associated with hospital and home office salaries were included in the updated wage index. Nonhospital costs were excluded from the wage index.

In the September 4, 1990 final rule (55 FR 36041), we implemented a 1-year phase-in of the updated wage index for FY 1991 to lessen the impact of the most significant changes in wage index values. We limited the percentage change in the wage index value to 8 percent plus 50 percent of the difference between the 8 percent threshold and the new wage index value.

Section 115(a) of Public Law 101-403 extended the use of the area wage index applicable to prospective payment system hospitals that was in effect on September 30, 1990 (that is, the wage index in use in FY 1990, which was based on 1984 hospital wage data) to discharges occurring on or after October 1, 1990 and before October 21, 1990. Section 4007(a)(3) of Public Law 101-508 further extended use of the FY 1990 wage index for prospective payment hospitals for discharges occurring on or after October 21, 1990 and before January 1, 1991. These changes were announced in the January 7, 1991 notice, *Legislative Changes Concerning Payment to Hospitals for Federal Fiscal Year 1991* (56 FR 562).

Section 4002(d)(1)(A) of Public Law 101-508 specified that a wage index based on 1988 hospital wage data would be effective for discharges occurring on or after January 1, 1991 and before October 1, 1993. Also, section 4002(d)(1)(B) of Public Law 101-508 specified that the Secretary must apply the wage index without regard to a previous survey of wages and wage-related costs. Therefore, in the January 7, 1991 final rule with comment period,

Mid-Year FY 1991 Changes to the Inpatient Hospital Prospective Payment System (56 FR 568), we revised the wage index to eliminate the 1-year transition period set forth in the September 4, 1990 final rule.

B. Revisions to the Hospital Wage Index for FY 1992

For discharges occurring in FY 1992, the wage index continues to be based solely on 1988 wage data. In addition, in determining the wage index for discharges occurring on or after October 1, 1991, we have incorporated all corrections of errors that have been identified in the survey wage data since the construction of the wage index implemented in the January 7, 1991 final rule. The final revised national average hourly wage is \$13.9752 compared to \$13.9602 used to establish the wage index values that were effective for discharges occurring on or after January 1, 1991. With the higher national average wage, the wage index values for areas for which there were no changes in the average hourly wage (through either wage corrections or geographic reclassifications) decreased 0.1 percent from the January 1 values.

The wage indexes are provided in Tables 4a through 4c in the addendum to this final rule.

C. Revisions to the Wage Index Based On Hospital Reclassifications

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, 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 resulted in a reduction of the wage index value for the affected MSA, or resulted in a reduction of the wage index value for the rural area from

which these data were now excluded, then the wage index values for those affected areas were determined as if section 1886(d)(8)(B) of the Act had not been enacted. In addition, the wage index value for hospitals located in rural counties that were deemed urban was 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 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, some county-specific wage index values were so low that some rural hospitals redesignated as urban hospitals received lower payments (even though they were paid the urban standardized amount) than they would have received if they had not been redesignated.

In order to address the adverse impact on certain redesignated hospitals that resulted from implementation of section 8403(a) of Public Law 100-647, Congress revised the methodology for applying the wage index to hospitals affected by section 1886(d)(8)(B) of the Act. This change was effective for discharges occurring on or after April 1, 1990. As amended by section 6003(h)(3) or Public Law 101-239, section 1886(d)(8)(C) of the Act made the application of the wage index to redesignated hospitals dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the MSA to which they have been redesignated. Consistent with the changes prescribed by section 6003(h)(3), prior to January 1, 1991 the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals reduced the MSA wage index value by one percentage point or less, the MSA wage index value was applied to the redesignated hospitals deemed to be a part of that MSA. The MSA wage index value was determined exclusive of the wage data for the redesignated hospitals.

- If including the wage data for the redesignated hospitals reduced the MSA wage index value by more than one

percentage point, the wage index was calculated separately for the MSA and for the hospitals deemed to be part of that MSA. In this case, the redesignated hospitals had 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 could not be less than the Statewide rural wage index. (As described below, this part of the methodology was subsequently revised by Pub. L. 101-508.)

- Rural areas whose wage index values would be reduced by excluding the data for redesignated hospitals had their wage index calculated as if no redesignation had occurred. Those rural areas whose wage index values increase as a result of excluding the wage data for the redesignated hospitals had their wage index calculated exclusive of the redesignated hospitals.

Section 4002(h) of Public Law 101-508 amended section 1886(d)(8)(C) of the Act effective for discharges occurring on or after January 1, 1991 by specifying that if including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than one percentage point, the hospitals that are redesignated are subject to the wage index value of the area that results from including the wage data of the redesignated hospitals in this calculation. However, under section 1886(d)(8)(C)(iii) of the Act, the wage index value for the redesignated hospitals cannot be less than the wage index value for the rural areas of the State in which the hospitals are located. We note that the other two steps for determining the wage index values for redesignated hospitals were unchanged by this provision.

Section 6003(h)(1) of Public Law 101-239 added section 1886(d)(10) to the Act (which was later amended by section 4002(h) of Pub. L. 101-508) to provide for the establishment of the Medicare Geographic Classification Review Board (MGCRB). The MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. The first hospital reclassifications based on decisions of the MGCRB will take effect October 1, 1991.

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that are redesignated as a result of the MGCRB decisions under section 1886(d)(10) of the Act. We note

that, except for those rural areas where reclassifications would reduce the rural wage index value, the wage index value for each area is computed exclusive of the data for hospitals that have been granted reclassification from the area for purposes of their wage index. As a result, there were several MSAs listed in Table 4a of the June 3, 1991 proposed rule that did not have a wage index value. This is because the hospitals in the original MSA were reclassified to another area and there were no other hospitals currently classified in those areas.

The revised wage index values effective for discharges occurring on or after October 1, 1991, are shown in Tables 4a, 4b, and 4c, of the addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. It should be noted that for some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one State are included in the group of redesignated hospitals, and one State or more has a higher Statewide rural wage index value than the wage index value otherwise applicable to the redesignated hospitals.

Revised Table Names

Table 4a—Wage Index for Urban Areas
Table 4b—Wage Index for Rural Areas
Table 4c—Wage Index for Redesignated Hospitals

The FY 1992 wage index values incorporate all reclassification decisions made by the MGCRB that will be effective for FY 1992. The wage index values published in this final rule are different from those proposed in the June 3, 1991 proposed rule as a result of additional decisions made by the MGCRB since the publication of the proposed rule as well as changes in decisions that resulted from hospital appeals, discretionary review by the Administrator, and withdrawals of reclassification requests. The resulting classification changes have affected not only the wage index values for specific geographic areas, but also whether redesignated hospitals receive the wage index value of the area to which they are redesignated or a combined wage index value that includes the data for both the hospitals already in the area and for all hospitals redesignated to the area. Further, the wage index values for the areas from which some hospitals are redesignated have also been affected.

Comment: Many commenters expressed concern about the reductions in the wage index values for urban areas that lost hospitals as a result of the reclassification of some hospitals from

those areas. Some commenters suggested that we apply the same protection to urban areas as section 1886(d)(8)(C)(ii) of the Act affords to rural areas, that is, to prevent a rural area from having its wage index value reduced as a result of geographic reclassifications.

Response: As described above, section 1886(d)(8)(C) of the Act (as amended by section 4004(h)(1)(A) of Public Law 101-508) sets forth an explicit methodology for determining the effect of reclassifications on the wage index values of various groups of hospitals. This provision provides certain "hold harmless" protections that apply to hospitals that are not reclassified. Rural hospitals that are not reclassified are protected under section 1886(d)(8)(C)(ii) of the Act, since the wage index value for any rural area cannot be reduced as a result of the reclassification of hospitals from that area. Hospitals located in an urban area to which other hospitals with lower wage costs are reclassified are also protected. Under section 1886(d)(8)(C)(i) of the Act, they continue to receive the wage index for the urban area computed excluding the wage data for the reclassified hospitals. However, hospitals located in an urban area from which other hospitals with higher wage costs are reclassified do not receive "hold harmless" protection. Their wage index values fall because there is no provision requiring that the higher wage costs of the reclassified hospitals be retained in the wage index calculation as if no reclassification occurred. The only statutory provision that may be interpreted to help some of these hospitals is section 1886(d)(8)(C)(iii) of the Act, since it provides that hospital reclassifications under sections 1886(d)(8)(B) or 1886(d)(10) of the Act may not result in the reduction of any county's wage index value below the wage index value for rural areas in the State in which the county is located.

In order to provide more than a partial remedy to this situation, we considered using the general exceptions authority under section 1886(d)(5)(I) of the Act to provide the same "hold harmless" protection that the statute affords to rural areas when hospitals are reclassified from those areas. That is, we considered providing that the wage index value for an urban area could not be reduced due to the reclassification of hospitals from that area. However, we do not believe this action would be appropriate.

The statute is very specific with respect to the treatment of the wage index values for geographic areas from which and to which hospitals have been

reclassified. Moreover, the statutory requirement of budget neutrality specifically applies only to reclassifications and wage index recomputations that occur as prescribed under the statute. If we were to create a new "hold harmless" rule, and to specify that the new rule would be treated for purposes of budget neutrality as if authorized under section 1886(d)(8)(C) of the Act, we would be making a significant change in the scheme constructed by Congress. This change would need to be adopted through rulemaking, and, even then, our authority might be challenged by hospitals concerned with the resulting further reduction in the urban standardized amounts. Furthermore, we are generally reluctant to rely on the exceptions authority for the purpose of rewriting the statute to supply what may have been left out through oversight or inadvertence. Therefore, even though the change may be warranted, we believe that it should be made through legislation.

Given all these considerations, and particularly the need for rulemaking, we believe it would be highly problematic to establish in this final rule a policy that would preclude wage index reductions for urban areas that lose hospitals through reclassification.

Comment: A number of commenters pointed out that section 1886(d)(8)(C)(iii) of the Act should be interpreted to apply to those urban areas whose wage index values were reduced below the Statewide rural wage index due to the reclassification of hospitals from those areas. Other commenters suggested that this provision be expanded to protect hospitals in urban areas whose wage index values were already below the Statewide rural wage index value and were further reduced because of the reclassification of hospitals from those areas. That is, for hospitals in these areas, the wage index values prior to reclassifications should be maintained at their pre-reclassification values.

Response: Section 1886(d)(8)(C)(iii) of the Act states that, "[t]he application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) may not result in the reduction of any county's wage index to a level below the wage index for the rural areas in the State in which the county is located." We originally interpreted this provision to mean that the reclassification of hospitals to an area could not result in that area's wage index value falling below the Statewide rural wage index value. However, we agree with the commenters that this

provision may also be interpreted to prevent the wage index value of an area from which hospitals are reclassified from falling below the Statewide rural wage index value. Accordingly, we are adopting this interpretation. In computing the wage index values published in Tables 4a, b, and c in section IV of the addendum to this final rule, we have applied the Statewide rural wage index value as a floor in cases where an urban area's wage index value is reduced below the Statewide rural wage index value as a result of reclassifications from that area. In addition, we are assigning the Statewide rural wage index values to the MSAs which lost all their hospitals through reclassification for purposes of paying any hospitals newly classified to those MSAs. We note that our change of interpretation has no significance with respect to prior hospital reclassifications since until Federal fiscal year 1992, only rural hospitals were reclassified (under section 1886(d)(8)(B) of the Act).

However, we do not agree with commenters that section 1886(d)(8)(C)(iii) of the Act can be interpreted to apply to hospitals in urban areas whose wage index values are already below the Statewide rural wage index prior to the reclassification of other hospitals from those areas. The language of section 1886(d)(8)(C)(iii) of the Act specifically precludes the reclassification of hospitals under sections 1886(d)(8)(B) and 1886(d)(10) of the Act from resulting in "the reduction of a county's wage index to a level below the wage index for rural areas in the State in which the county is located." The statute establishes a floor that applies when a hospital's wage index value falls below the Statewide rural wage index as result of hospital reclassifications. Thus, when the wage index value for an urban area was already below the rural wage index value prior to the hospital reclassifications, this provision would not apply.

Comment: Several commenters recommended that we reevaluate labor market area definitions in light of the significant number of reclassifications that have been approved. One commenter specifically requested that the District of Columbia's hospitals be treated as a separate labor market area rather than as part of the Washington, DC-MD-VA MSA.

Response: Any method of geographic classification will fail to be satisfactory to all hospitals. In the past, we have analyzed different labor market configurations and have been unable to identify an alternative labor market

definition that would result in a considerably more accurate system. We are continuing our analysis with respect to appropriate labor market area definitions. We understand that ProPAC is planning further research and analysis in this area, and we will be working with them to evaluate alternative methods for defining labor market areas. As we have not proposed changes to the labor market area definitions in this document, we will respond directly to the commenter representing the District of Columbia hospitals.

Comment: Two commenters pointed out that wage survey corrections released in a June 28, 1991 HCFA memorandum were not reflected in the June 3, 1991 proposed rule.

Response: The wage survey corrections reflected in the HCFA memorandum dated June 28, 1991, represent midyear corrections applicable to the FY 1992 wage index values. As such, these midyear wage index changes do not reflect the data corrections in the national average hourly wage. When we make midyear corrections to the wage index value for a specific area, we do not reflect the change in the national average, but only apply the change to the affected area. The correction is not incorporated into the national average until the beginning of the next fiscal year. The reason that the wage index values published in the proposed rule for these areas are somewhat lower than the wage index values listed in the correction memorandum is that the wage index published in the proposed rule incorporated those corrections both in the average hourly wage for the affected areas and the national average hourly wage. As a result of making these and a number of other corrections to the wage data in the proposed rule, the national average went up, thereby slightly decreasing the wage index value for all areas. Additional corrections incorporated into the wage index in this final rule have resulted in a further reduction in wage index values for areas whose average hourly wages remain unchanged.

D. Occupational Mix Adjustment

In its March 1, 1991 report, ProPAC recommended that the Secretary collect hospital wage data by occupation and evaluate the effect of adjusting the HCFA wage index for occupational mix (Recommendation 4). The HCFA wage index reflects variations in the cost of labor; that is, it accounts for variations in the mix of occupations as well as the price of labor. ProPAC believes that the wage index should account for only variations in price, which are beyond

the hospital's control and are not otherwise accounted for by other adjustments in the prospective payment system.

Last year, ProPAC studied the effect of adjusting the wage index for occupational mix and found that a wage index adjusted for occupational mix would redistribute funds from urban to rural hospitals. Within urban areas, the occupational mix adjustment would redistribute funds from large to small hospitals. Within rural areas, the occupational mix adjustment would increase the wage index values of all bed size groups. Section 4002(d) of Public Law 101-508 required that ProPAC examine available data to analyze the impact of variation in occupational mix on the computation of the wage data and include in its March 1, 1991 report recommendations regarding the desirability and feasibility of modifying the wage index for occupational mix. To fulfill this requirement, ProPAC studied 1988 California wage and hour data and concluded, as in the earlier study, that the occupational mix adjustment would increase the wage index values in rural areas and decrease the values in large urban areas. Although ProPAC did not formally measure the burden of hospital reporting, it concluded that the California experience indicated the cost would not be prohibitive.

In June 3, 1991 proposed rule (56 FR 25192), we explained why we did not act on ProPAC's recommendation that we collect the recommended occupational mix data and adopt an occupational mix adjustment in the wage index. In this regard, we have an ongoing research project with the Center for Health Economics Research to evaluate several topics related to the wage index, including the change in wages across areas in the 1982, 1984, and 1988 HCFA wage surveys, occupational mix, and alternative labor market areas.

Comment: ProPAC continues to support the development of an occupational mix adjustment to the hospital wage index. The Commission believes that our argument in the proposed rule that the data collection burdens would be large is incorrect, and cites the relative ease of occupational mix data collection in California as evidence. It further states that differences in skill mix are already accounted for in the other prospective payment system payment adjustments. In addition, ProPAC believes that the current wage index does not measure the cost of labor, but rather average labor expenditures per hour. Several other commenters oppose the collection

of occupational mix data at this time, citing the prohibitive costs of such data collection. The majority of these commenters expressed an additional concern about the redistribution of payments that would occur if an occupational mix adjustment were to be implemented, especially in conjunction with the elimination of separate standardized amounts for rural and other urban hospitals.

Response: We continue to believe that collection of occupational mix data would be premature. Contrary to the ProPAC's statement that the reporting burden would not be substantial, the California Association of Hospitals and Health Systems stated, in their comment on the same issue, that while the reporting burden is no longer extreme after 15 years of data collection, it is important to note that the system was very costly to implement, and the data were difficult to collect in the first years of the reporting system. In addition, our experience with the Medicare National Uniform Reporting Demonstration Project has reinforced our belief that occupational mix data collection would be costly and difficult.

As we stated in the September 4, 1990 final rule (55 FR 36037), the standardization process used to recalibrate the DRG relative weights is intended to remove the effects of area wage differences from the case mix measure, including the effects of occupational mix. Moreover, we are puzzled by ProPAC's belief that there is a distinction to be made between the cost of labor and average labor expenditures per hour. We continue to believe that the appropriate measure of the wage index is variation in the cost of labor, and that any occupational mix adjustment to the wage index must be examined in the context of other possible adjustments to labor market areas, and in the context of other changes to the prospective payment system, including, as stated by most of the commenters, the elimination of separate standardized amounts for hospitals located in rural and other urban areas.

V. Other Decisions and Changes to the Regulations

A. Add-On Payment for Blood Clotting Factor (§ 412.2)

Section 1886(a)(4) of the Act provides that prospective payment hospitals receive an additional payment for the costs of administering blood clotting factor to hemophiliacs who are hospital inpatients. This add-on payment is effective for blood clotting factor

furnished on or after June 19, 1990 and before December 19, 1991.

In the April 20, 1990 final rule with comment period (55 FR 15158), we established an add-on price for clotting factor based on the latest (1990) price listing available from the Drug Topics Red Book, the publication of pharmaceutical average wholesale prices. Due to high variation in the costs of the different types of blood clotting factor, we set three separate add-on amounts, one for each of the three basic types of clotting factor. Also, we discounted the average wholesale prices by 15 percent before calculating the median price.

The prices we established for FY 1991 for the three types of blood clotting factors are as follows:

	Per unit
Factor VIII	\$.64
Factor IX	.26
Other Hemophilia blood clotting factor	1.00

In the September 4, 1990 final rule, we stated that we were aware that changes in the clotting factor market might require re-evaluation of the add-on payment amount as part of our FY 1992 changes to the prospective payment system. In the June 3, 1991 proposed rule, based upon that re-evaluation, we proposed updated prices per unit of factor as follows:

	Per unit
Factor VIII	\$.72
Factor IX	.26
Other Hemophilia blood clotting factor	1.11

We proposed that these prices would be used to pay for blood clotting factor for discharges occurring on or after October 1, 1991 and before December 19, 1991, at which time the authority for a separate payment for blood clotting factor expires.

We also proposed to include a new blood clotting factor used in the treatment of hemophilia inpatients that was recently approved by the Food and Drug Administration in the "Other" category both for purposes of calculating the average payment for that class and for purposes of payment for the product. This product differs from other Factor IX products both in cost and efficacy. Because this new product does not contain the same proportion of thrombogenic agents, the risk of thrombosis to the patient is significantly reduced. Extensive research and resources were invested to produce this

safer product. Consequently, the price established in the Drug Topics Red Book more closely resembles that of those products we have classified as "Other." If this new factor were to be included in the factor IX category, the resulting average would inflate the payment to other factor IX products and would so lower the payment for the new product that the incentive to use it would be diminished.

We received two comments concerning payment for blood clotting factor.

Comment: One commenter was concerned about the expiration of the statutory authority for the hemophilia blood clotting factor add-on. Specifically, the commenter wanted to know how payment would be made for these patients after December 19, 1991.

Response: Section 6011(d) of Pub. L. 101-239, which amended section 1886(a)(4) of the Act to include a separate add-on payment for blood clotting factor provided to Medicare hospital inpatients with hemophilia, is effective for discharges occurring from June 19, 1990 through December 19, 1991. Unless Congress enacts additional legislation to continue the pass-through payment for the blood clotting factor administered to Medicare hemophilia inpatients, our statutory authority to make this payment will end December 19, 1991. After that date, we will discontinue the add-on and resume paying for these cases with only the usual DRG-based payment per case that is used for all other cases.

Comment: Another commenter disapproved the use of a 15 percent discount on the average wholesale price for each of the three blood clotting factor categories. This commenter believes that the discount is inappropriate for blood clotting factor because the small number of patients with hemophilia and the even smaller number who require the clotting factor is insufficient to motivate pharmaceutical companies to offer hospitals either volume or incentive discounts.

Response: As we stated in the proposed rule (56 FR 25193), we established the payment amounts for the three types of blood clotting factor by calculating the median price for each factor using the average wholesale price for the various products as set forth in the most recent Drug Topics Red Book. However, before calculating the median, we discounted the prices by 15 percent, based on the results of a review conducted by the Department's Office of the Inspector General ("Use of Average Wholesale Prices in Reimbursing Pharmacies Participating in Medicaid

and Medicare Prescription Drug Program;" Report No. A-06-89-00037, October 3, 1989).

In response to a similar comment, we noted in the September 4, 1990 final rule (55 FR 36002) that although the volume of hemophilia inpatients is not as large as that of a number of other hospital inpatient conditions requiring drugs, treatment of hemophilia inpatients with blood clotting factor is concentrated in a few hemophilia treatment centers. We continue to believe that the intent of Congress in including this pass-through payment in the Act was to protect from heavy losses those hospitals that treat a large volume of hemophilia inpatients and, thus, purchase substantial amounts of blood clotting factor. In response to this comment, we again contacted experts in the field to ensure that clotting factor is available to hospitals at or below the price we have set. These experts assure us that our established add-on, even with a 15 percent discount, is both adequate and equitable.

B. Retroactive Adjustments for Provisionally Excluded Rehabilitation Hospitals and Units (§§ 412.23, 412.30, and 412.130)

Since October 1, 1983, our regulations have allowed new rehabilitation hospitals and units to be excluded from the prospective payment system, and existing excluded rehabilitation units to be expanded by the addition of new beds, without requiring proof that the new facilities actually treated an inpatient population meeting the requirements of § 412.23(b)(2) (the "75 percent" rule). A new rehabilitation hospital or unit can be excluded, or an existing unit can add new beds, if the new or added facilities are otherwise qualified for exclusion and the hospital submits a written certification that it intends to use the facilities to treat an inpatient population that meets the 75 percent rule. The provisions allowing this are located at § 412.23(b)(8) (for new hospitals) and § 412.30 (for addition of new units and expansion of existing units).

We recognize that there may be cases in which a hospital or unit does not actually perform in accordance with its projections and, therefore, is not able to show actual compliance with the 75 percent rule in the first 12-month cost reporting period for which it is excluded from the prospective payment system. Such a facility would not be able to qualify for exclusion from the prospective payment system as a rehabilitation hospital or unit in its next cost reporting period. However, because our current regulations do not allow us to make any retroactive changes in the

status of a hospital or unit, the operator of the facility is able to benefit financially from the first year of exclusion even though the hospital or unit failed to meet the 75 percent rule. Although this policy is consistent with the prospective nature of the hospital payment system, we are concerned that it might have the unintended effect of rewarding poor planning and might, in fact, encourage operators of marginally qualified facilities to request exclusion and attempt to meet the 75 percent rule, since they are assured of at least 1 year of exclusion.

To remedy this situation, we proposed that hospitals or units that have been excluded based on certifications of compliance with the 75 percent rule would be allowed to retain payments made to them on the basis of the exclusion only if they actually meet the 75 percent rule in the first year for which they are excluded. As proposed, if a hospital or unit does not actually meet the 75 percent rule in its first year of exclusion, we would determine the amount of actual payment under the exclusion, compute what we would have paid for the facility's services to Medicare patients under the prospective payment system, and recover any difference in accordance with the rules on the recoupment of overpayments. (We would also, of course, make additional payment to the hospital in the event that the payment amount computed under the prospective payment system is greater.)

We proposed to revise both §§ 412.23 and 412.30 and add in a new § 412.130 to implement the changes concerning rehabilitation hospitals and units.

Comment: We received two comments concerning the retroactive adjustment for provisionally excluded rehabilitation facilities. One commenter was concerned about the administrative burden associated with making a retroactive change in the methodology under which a facility is paid. However, another commenter agreed with HCFA that a retroactive change is appropriate if a provisionally excluded facility does not, in fact, meet the criteria.

Response: We recognize the difficulties associated with a retroactive payment methodology change; however, we do not believe that the administrative burden warrants the hospital receiving a benefit to which it is not entitled. Moreover, other difficulties are created for both the hospital and HCFA when an excluded hospital is subsequently determined not to have met the criteria for exclusion in whole or in part. One problem is that the base period costs in these situations may not

be representative of the costs required to furnish services in compliance with the exclusion criteria, since fewer than 75 percent of the hospital's patients meet the requirements of § 412.23(b)(2). As a result, the target amount may be inadequate when the hospital does meet the qualifying criteria, and administratively burdensome adjustments may be required.

The alternative to retroactive denial would be not to allow a hospital provisional exclusion based on its projection that it would meet the requirements of § 412.23(b)(2). However, this would penalize those hospitals that do meet the criteria from the outset. We believe that retroactive denial of excluded status is a reasonable solution that will pay hospitals under the appropriate payment methodology and at the same time will not allow hospitals that do not meet the criteria to receive a benefit to which they are not entitled.

In § 412.130(a)(3), we have corrected a technical error in the June 3, 1991 proposed rule. As proposed, that section referred to an inpatient population that did not meet the requirements of § 412.30(b)(2). The correct reference, which is set forth in this final rule, is to § 412.23(b)(2). We have also made clarifying changes in § 412.30(b) to emphasize that the payment adjustment will be for the difference between payments actually made on a cost basis and what would have been payable under the prospective payment system for the same period.

C. Outlier Payments (§ 412.84)

On February 28, 1991, we published a proposed rule to establish a prospective payment system for inpatient hospital capital-related costs (56 FR 8476). In that document, we proposed modifying our outlier policy in order to take into account capital costs for unusually long length of stay or high-cost cases (56 FR 8486). As discussed in that proposed rule, we believe that it is appropriate to establish a unified outlier payment methodology for operating and capital costs. Thus, in the June 3, 1991 proposed rule on the prospective payment system for operating costs, we proposed to establish a single set of thresholds that would be used to identify outlier cases for both operating and capital payments. In the capital proposed rule, we stated that the percentage reduction for outliers in the capital standard payment rate would be the same as the aggregate percentage reduction in the operating standardized amounts. We proposed to accomplish this by setting a single outlier pool target of 5.1 percent and reducing the urban standardized

amount, the rural standardized amount, and the capital payment rate by a factor that recognizes actual outlier payments to each group. We proposed only one offset to the capital payment rate, rather than separate urban and rural offsets, because the capital standard payment rate does not vary based on urban or rural location.

In the February 28, 1991 capital prospective payment system proposed rule, we proposed that capital-related payment for day outliers be determined based on the same provisions now in effect for operating-related costs. That is, the prospective portion of the capital payment rate for a DRG would be adjusted by the geometric mean length of stay for that DRG in order to determine a per diem capital-related outlier payment. Payment for cost outliers would be determined based on a single threshold that incorporates both capital-related costs and operating-related costs and the same marginal cost factor. We believe that it would be inappropriate to make cost outlier payments for high capital cost cases or high operating cost cases in which total capital-related and operating-related costs are below the cost threshold.

We proposed to set the outlier thresholds and the standardized amount reduction factors based on the assumption that capital payments are made on 100 percent of the Federal payment rate, instead of payment under the special transition period provisions.

However, actual payments would be made only for the portion of capital payments that are based on the Federal rate. Thus, outlier payments would not be made on the hospital-specific portion of the payment to hospitals under the fully prospective methodology. Similarly, for hospitals paid under the hold-harmless methodology, outlier payments would be made only on the payment for new capital that is based on the Federal rate. This method of estimating outlier payments is similar to the method used when the prospective payment system first was introduced for operating costs (see the January 4, 1984 final rule (49 FR 261)). Under that method, the outlier pool was set at a certain percentage level of Federal payments, but actual outlier payments were less than that percentage of total operating payments to hospitals because of the transition from hospital-specific to Federal rates. In addition, since it is not possible to determine at this point what proportion of capital payments to hospitals will be paid on the Federal rate (this depends on FY 1992 capital costs, in part), we cannot reliably set the outlier thresholds in any other manner. A detailed example of the combined outlier payment determination methodology was set forth in the February 28, 1991 capital proposed rule (56 FR 8497).

In the June 3, 1991 proposed rule on the prospective payment system, we proposed to set the FY 1992 day outlier

threshold at the geometric mean length of stay for each DRG plus the lesser of 32 days or 3 standard deviations and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or \$43,000. Based on the more recent data, in this final rule, we are establishing the FY 1992 day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 32 days or 3.0 standard deviations, and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or \$44,000.

The FY 1992 outlier thresholds will essentially maintain the current outlier payment split with 40.1 percent of cases being paid using the cost outlier methodology and 59.9 percent using the day outlier methodology. Cases that meet the day outlier threshold but that are paid using the cost outlier methodology, because it yields the higher payment, constitute 13.8 percent of all cases. Our simulation of FY 1992 outlier payments based on FY 1990 MEDPAR data indicates that the percentage of outlier cases that qualify as day outliers is about 73.7 percent. The cases qualifying as day outliers are expected to receive 80.5 percent of outlier payments in FY 1992. An estimated 26.3 percent of outlier cases would be cost-only outlier cases, which are expected to receive about 19.6 percent of outlier payments. The following table illustrates this finding in greater detail:

Type of outlier	Percentage of outlier cases	Percentage of operating outlier payments	Percentage of capital outlier payments	Percentage of total outlier payments
Meets day threshold only.....	49.7	23.4	26.8	23.7
Meets day and cost thresholds, paid using day methodology.....	10.3	22.5	25.6	22.7
Meets day and cost thresholds, paid using cost methodology.....	13.8	34.5	29.4	34.1
Subtotal—All cases meeting day threshold.....	73.8	80.4	81.8	80.5
Meets cost threshold only.....	26.3	19.6	18.2	19.6
Total ¹	100.0	100.0	100.0	100.0

¹ Individual columns may not add to 100.0 due to rounding.

In the proposed rule, we stated that when we modeled the combined outlier payments, we found that using a common set of thresholds would result in a lower percentage of outlier payments for capital-related costs than for operating costs. We estimated the proposed thresholds result in outlier payments equal to 5.1 percent of operating DRG payments and 4.5 percent of capital payments based on the Federal rate. The capital payment outlier percentage is only slightly below the operating percentage for the final outlier thresholds. Based on these final thresholds, we estimate that outlier

payments will equal 5.1 percent of operating DRG payments and 5.0 percent of capital payments based on the Federal rate.

The outlier adjustment factors that will be applied to the standardized amounts and the capital Federal rate for FY 1992 are as follows:

Urban standardized amount	Rural standardized amount	Capital Federal rate
.944047	.979202	.949722

Table 8a in section IV of the addendum to this final rule contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 1991, these Statewide average ratios replace the ratios published in the September 4, 1990 final rule (55 FR 36162). Table 8b contains comparable Statewide average capital cost-to-charge ratios. These average ratios are used to calculate cost

outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.332 or greater than 1.252 and capital cost-to-charge ratios lower than 0.016 or greater than 0.252. This range represents 3 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. The cost-to-charge ratios in tables 8a and 8b will be applied to all hospital-specific cost-to-charge ratios based on cost report settlements occurring during FY 1992.

The final rule to establish a capital prospective payment system effective with cost reporting periods beginning on or after October 1, 1991 is published elsewhere in this issue of the Federal Register. The following is an example of how additional payment to a hospital paid using the fully prospective payment methodology under the capital prospective payment system will be determined for an outlier case in FY 1992.

Example: Hospital A is a 150 bed hospital located in the San Francisco, California MSA, which is a large urban area. Hospital A has a ratio of interns and residents to beds of 0.1; a ratio of interns and residents to days of 0.12; and a disproportionate patient percentage of 30.2 percent. Mr. Jones is admitted to Hospital A on October 1, 1991 and is discharged on November 30, 1991. The billed charges for Mr. Jones' stay are \$150,000. Mr. Jones is classified in DRG 286. Because Mr. Jones' 61-day stay exceeds the 41-day length of stay outlier threshold for DRG 286, Hospital A is eligible for payment for 20 outlier days in addition to the otherwise applicable prospective payment. The amount of Hospital A's outlier payment (excluding the usual Federal payments for operating and capital costs that apply for both outlier and nonoutlier cases, and the hospital-specific portion of the capital payment) is calculated as follows:

Day Outlier

Step 1: Computation of the Payment Rate for Operating Costs (excludes capital, indirect medical education (IME) and disproportionate share hospital (DSH) payments)

National Large Urban Standardized

Amounts:
Labor-Related.....\$2,526.80
Nonlabor-Related.....\$1,041.01
San Francisco MSA Wage Index.....1.4517
DRG 286 Relative Weight.....2.4320

DRG Relative Weight $\times$ [(Labor-Related National Large Urban Standardized Amount $\times$ San Francisco MSA Wage Index) + Nonlabor-Related National Large Urban Standardized Amount] = Federal Rate for Operating Costs

$2.4320 \times [(\$2,526.80 \times 1.4517) + \$1,041.01] = \$11,452.69$

Step 2: Computation of Federal Rate for Capital-Related Payments

Capital Federal Rate.....\$415.59
DRG 286 Relative Weight.....2.4320
Federal Portion of Capital Rate.....10% *
Geographic Adjustment Factor.....1.2908
Large Urban Add-on.....1.03

* If Hospital A is paid a hold harmless payment for old capital costs, the Federal portion (for new capital costs) will be the hospital-specific ratio of new to total capital costs.

DRG Relative Weight $\times$ Capital Federal Rate $\times$ Federal Rate Portion of Capital Payment $\times$ Geographic Adjustment Factor $\times$ Large Urban Add-on = Federal Rate for Capital Costs

$2.4320 \times \$415.59 \times 0.10 \times 1.2908 \times 1.03 = \134.38

Step 3: Computation of Day Outlier Payments

Geometric Mean Length of Stay for DRG 286.....9.5 days
Outlier Days (61 - 41).....20
Marginal Cost Factor.....60%

A. Operating Outlier Payment (excludes IME and DSH) =

Number of Outlier Days $\times$ (Operating Federal Payment/Geometric Mean Length of Stay for DRG 286) $\times$ Marginal Cost Factor

$20 \times (\$11,452.69 \div 9.5) \times 0.60 = \$14,466.56$

B. Capital Outlier Payment (excludes IME and DSH) =

Number of Outlier Days $\times$ (Capital Federal Payment/Geometric Mean Length of Stay for DRG 286) $\times$ Marginal Cost Factor

$20 \times (\$134.38 \div 9.5) \times 0.60 = \169.74

Step 4: Computation of Operating IME and DSH Adjustment For Day Outliers:

IME Adjustment Factor.....0.0744
Operating DSH Adjustment Factor.....0.1262

Operating Outlier Payment $\times$ (IME Adjustment Factor + DSH Adjustment Factor) = Operating Outlier Adjustment for IME and DSH

$\$14,466.56 \times (0.0744 + 0.1262) = \$2,901.99$

Step 5: Computation of Capital DSH and IME Adjustments for Day Outliers

Capital DSH Adjustment Factor.....0.0631
Capital IME Adjustment Factor.....0.0344
Capital Outlier Payment.....\$169.74

Capital Outlier Payment $\times$ (Capital IME Adjustment Factor + Capital DSH Adjustment Factor) = DSH Outlier Adjustment

$\$169.74 \times (0.0344 + 0.0631) = \16.55

Step 6: Total Day Outlier Payments

Regular Operating Outlier Payment \$14,466.56
Regular Capital Outlier Payment.....\$169.74
IME and DSH for Operating.....\$2,901.99

IME and DSH for Capital.....\$16.55
Total.....\$17,554.84

Cost Outlier

Step 1: Computation of Hospital A's Standardized Costs

Billed Charges.....\$150,000
Hospital A's Operating Cost-To-Charge Ratio.....0.72 *
Hospital A's Capital Cost-To-Charge Ratio.....0.06
IME Operating Adjustment Factor.....0.0744
DSH Operating Adjustment Factor.....0.1262
IME Capital Adjustment Factor.....0.0344
DSH Capital Adjustment Factor.....0.0631

* This is the same cost-to-charge ratio currently used to determine outlier payments using operating costs only. The capital cost-to-charge ratio, when added to the operating cost-to-charge ratio, will yield a total cost-to-charge ratio. (This occurs because the denominator in both cases is total charges. The charges are not divided into operating and capital charges.)

(Billed Charges $\times$ Operating Cost-to-Charge Ratio) / (1 + IME Adjustment Factor + Operating DSH Adjustment Factor) = Standardized Operating Costs
 $(\$150,000 \times 0.72) / (1 + 0.0744 + 0.1262) = \$89,955.02$

(Billed Charges $\times$ Capital Cost-to-Charge Ratio) / (1 + Capital IME Factor + Capital DSH Factor) = Standardized Capital Costs

$(\$150,000 \times 0.06) / (1 + 0.0344 + 0.0631) = \$8,200.46$

Step 2: Determination of Capital Cost Thresholds

Computation 1: Based on Federal Rate

A. Operating Federal Rate for DRG 286 = \$11,452.69

$2 \times \text{Federal Rate} = \$22,905.38$

B. Capital Federal Rate for DRG 286

Federal Rate $\times$ DRG 286 Relative Weight $\times$ San Francisco MSA Geographic Adjustment Factor $\times$ Large Urban Add-on = Capital Federal Rate

$\$415.59 \times 2.4320 \times 1.2908 \times 1.03 = \$1,343.77$

$2 \times \text{Federal Rate} = \$2,687.54$

Computation 2: Based on Adjusted Standard Cost Outlier Thresholds

Standard Cost Outlier Threshold.....\$44,000
Labor-Related Share, Operating.....0.7140
Nonlabor Share, Operating.....0.2860

Operating Portion of Cost Threshold

Operating Cost-to-Charge Ratio / (Operating Cost-to-Charge Ratio + Capital Cost to Charge Ratio) = Operating Cost Portion

$0.72 / (0.72 + 0.06) = 0.9231$

Capital Portion of Cost Threshold

Capital Cost-to-Charge Ratio/(Operating Cost-to-Charge Ratio + Capital Cost-to-Charge Ratio)=Capital Cost Portion

$$0.06/(0.72+0.06)=0.0769$$

A. Wage Index Adjusted Operating Cost Outlier Threshold=Operating cost portion as a share of total costs × [(Standard Cost Outlier Threshold × Labor-Related Share × San Francisco MSA Wage Index) + (Standard Cost Outlier Threshold × Nonlabor-Related Share)]

$$0.9231 \times [(\$44,000 \times .71 + 40 \times 1.4517) + (\$44,000 \times 0.2860)] = \$53,715.75$$

B. Capital Cost Outlier Threshold Adjusted by Geographic Adjustment Factor=Capital Standard Cost as a Share of Total Costs × Standard Cost Outlier Threshold × San Francisco MSA Geographic Adjustment Factor × Large Urban Add-on

$$0.0769 \times \$44,000 \times 1.2908 \times 1.03 = \$4,498.58$$

Computation 1 Result, Operating.....\$22,905.38
Computation 1 Result, Capital.....\$2,687.54
Threshold Using Computation 1=\$25,592.92
Computation 2 Result, Operating.....\$53,715.75
Computation 2 Result, Capital.....\$4,498.58
Threshold Using Computation 2=\$58,214.33

The applicable cost outlier threshold equals the results of Computation 2.

Step 3: Determination of Cost Outlier Payment

Marginal Cost Factor.....0.75

A. Operating Outlier Payment

Operating Outlier Cost=Standard Operating Costs—Operating Threshold
\$89,955.02—\$53,715.75=\$36,239.27
Operating Outlier Payment=Operating Outlier Cost × Marginal Cost Factor
\$36,239.27 × 0.75=\$27,179.45

B. Federal Portion of Capital Outlier Payment

Capital Outlier Cost=Standard Capital Costs—Capital Threshold
\$8,200.46—\$4,498.58=\$3,701.88
Capital Outlier Payment=Capital Outlier Cost × Marginal Cost Factor
\$3,701.88 × 0.75=\$2,776.41
Federal Portion of Capital Outlier Payment=Federal Portion of Capital Rate × Capital Outlier Payment
\$2,776.41 × 0.10=\$277.64

Step 4: Computation of Operating IME and DSH Adjustment for Cost Outliers

Operating Outlier Payment × (IME Adjustment Factor + Operating DSH Adjustment Factor)=Operating Cost Outlier Payment for IME and DSH
\$27,179.45 × (0.0744 + 0.1262)=\$5,452.20

Step 5: Computation of Capital IME and DSH Adjustments for Cost Outliers

Capital Outlier Payment × (Capital IME Adjustment Factor + Capital DSH Adjustment Factor)=Cost Outlier Payment for DSH

$$\$277.64 \times (0.0344 + 0.0631) = \$27.07$$

Step 6: Total Cost Outlier Payments

Operating.....\$27,179.45
Federal Portion of Capital.....\$277.64
IME and DSH for Operating.....\$5,452.20
IME and DSH for Capital.....\$27.07
Total.....\$32,936.36

Determination of Outlier Payment

Total Day Outlier Payment.....\$17,554.84
Total Cost Outlier Payment.....\$32,936.36

Hospital A receives the greater of the two payments, which is \$32,936.36, the cost outlier payment.

We received several comments on the proposed outlier policy, as follows.

Comment: Several commenters requested clarification regarding outlier payments for discharges that occur after October 1, 1991 but before a hospital starts receiving prospective payments for capital. Some of the commenters suggested that these cases be paid using the threshold developed for operating costs only because they assert that use of the combined threshold will result in underpayment of these outlier cases.

Response: These cases will receive only the operating portion of the outlier payment. In addition, the determination of the appropriate cost outlier threshold will be made based on the operating portion of the threshold only. We calculated the threshold by multiplying the fixed threshold for combined operating costs and capital costs by a reduction factor using the national operating cost-to-charge ratio, divided by the sum of the national operating cost-to-charge ratio and the national capital cost-to-charge ratio. In other words, the operating share will be determined in a manner similar to that used once a hospital starts receiving prospective payments for capital, but using the national average cost-to-charge ratios in order to maintain a common operating cost threshold across hospitals.

It is necessary to calculate the operating share of the standard cost threshold for these cases because, as the commenters noted, the unadjusted standard cost threshold reflects capital costs as well. If we did not use the apportionment methodology for these cases, the standard cost threshold would be inappropriately high. Given the combined cost threshold of \$44,000, and national cost-to-charge ratios of 0.6448 for operating costs and 0.0628 for

capital costs, the standard fixed operating cost threshold for outlier cases discharged on or after October 1, 1991 and before capital prospective payments begin will be \$40,100.

Since the day outlier threshold methodology is set by DRG (that is, whether the threshold is 3 standard deviations above the geometric mean length of stay for the DRG or the fixed number of days), and not by examining the particular experience of a given case, the threshold for cases not receiving capital prospective payments will be the same as for cases paid under the prospective payment system for capital. Therefore, there is no need to make any adjustment to day outlier payments other than setting the capital payments to 0.0 until the hospital is paid under the capital prospective payment system. The comparison of day outlier payment and cost outlier payment, necessary to determine which payment is applicable to the case, will be made based on actual payments, so that a hospital that will be paid the operating portion of the outlier payment only will receive for the case the higher of the day operating outlier payment or the cost operating outlier payment.

Comment: Some commenters urged that any funds set aside for outlier payments but not paid out be added to the Federal rate for the next fiscal year. Other commenters requested that we clarify what will happen if actual outlier payments differ from estimated outlier payments.

Response: We have responded to similar comments in the September 3, 1986 final rule (52 FR 31525), the September 1, 1987 final rule (52 FR 33048), the September 30, 1988 final rule (53 FR 38508), the September 1, 1989 final rule (54 FR 36500) and the September 4, 1990 final rule (55 FR 36077). The outlier reduction factor reflects our best estimate (using the proposed thresholds and marginal cost factors) of the amount of outlier payments that as a percentage of Federal payments will be made for outlier cases. There is no "outlier pool" in the sense of money dedicated solely for outlier payments that can be "replaced" in the Medicare budget if not fully spent on outlier payments. Similarly, we do not retroactively reduce the standardized amounts if we pay out more in outlier payments than we anticipate.

Comment: A commenter questions the method of using the Statewide average capital cost-to-charge ratio if a hospital's ratio is more than 3.0 standard deviations from the mean capital cost-to-charge ratio. The commenter believes

that one-time-only expenses may appropriately place the ratio outside the 3.0 standard deviation band, and that it will be inappropriate to replace these ratios if the hospital can support the capital costs involved.

Response: We agree with the commenter. Therefore, under this final rule, if a provider believes that its capital cost-to-charge ratio properly lies outside the three standard deviation band provided for in this final rule, the provider may apply to the fiscal intermediary for use of its cost-to-charge ratio. If the intermediary finds that there is sufficient evidence to support the hospital's cost-to-charge ratio, the intermediary will use the hospital's ratio rather than the Statewide average.

D. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, § 412.96 sets forth the criteria a hospital must meet in order to receive special treatment under the prospective payment system as a rural referral center (that is, payment is based on the other urban payment rate rather than the rural payment rate). One of the criteria under which a rural hospital may qualify as a referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two mandatory criteria (number of discharges and case-mix index) and at least one of three optional criteria (medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, a hospital is classified as a rural referral center if its—

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

1. Case-Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. In determining the proposed national and regional case-mix index values, we followed the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at

§ 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value included all urban hospitals nationwide and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.118).

The values in the proposed rule were based on discharges occurring during FY 1990 (October 1, 1989 through September 30, 1990) and included bills posted to HCFA's records through December 1990. Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1991, a hospital's case-mix index value for FY 1990 must be at least—

- 1.2567; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.118) calculated by HCFA for the census region in which the hospital is located. (See table set forth in the proposed rule at 56 FR 25196.)

Based on the latest data available (through June 1991), the final national case-mix index value is 1.2584 and the median case-mix values by region are as follows:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)...	1.1740
2. Middle Atlantic (PA, NJ, NY).....	1.1784
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	1.2620
4. East North Central (IL, IN, MI, OH, WI).....	1.1951
5. East South Central (AL, KY, MS, TN).....	1.2073
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	1.1834
7. West South Central (AR, LA, OK, TX).....	1.2589
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	1.2815
9. Pacific (AK, CA, HI, OR, WA).....	1.2798

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing the FY 1990 case-mix index values in table 3c in section IV of the addendum to this final rule. In keeping with our criteria on discharges, these case-mix index values are computed based on all Medicare patient discharges (including transfers) subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and

regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. However, we proposed to update the regional standards, which are based on discharges for urban hospitals during FY 1989 (that is, October 1, 1988 through September 30, 1989). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we proposed that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1991, a hospital's number of discharges for its cost reporting period that began during FY 1990 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located, (see table set forth in the proposed rule at 56 FR 25196.)

Based on the latest discharge data available, the final median numbers of discharges by census region are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)...	6,991
2. Middle Atlantic (PA, NJ, NY).....	8,250
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	6,690
4. East North Central (IL, IN, MI, OH, WI).....	8,138
5. East South Central (AL, KY, MS, TN).....	6,000
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	6,029
7. West South Central (AR, LA, OK, TX).....	4,767
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	7,414
9. Pacific (AK, CA, HI, OR, WA).....	5,103

We again note that to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1991, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1990 must have been at least 3,000.

Comment: One commenter suggested that the minimum number of discharges required for rural referral center status be lowered from 5,000 to 4,000 annually. The commenter believes that, with the shift to more outpatient services under the Medicare program, many hospitals cannot continue to meet the requirement for 5,000 discharges annually.

Response: Section 9302(d)(1) of Public Law 99-509 amended section 1886(d)(5)(C)(i) of the Act to provide that

the number of discharges criterion is set at 5,000 per year or, if fewer, the median number of discharges for urban hospitals in the region in which the hospital is located. Since the number of discharges criterion is established by statute, we do not have the authority to revise the criterion as the commenter requests.

In addition, we note that the regional standards reflect the actual experience of urban hospitals within the same census region as the hospitals seeking classification as rural referral centers, and a year-to-year comparison shows that over the last several years, these median numbers have actually increased. Only one region's median is currently below the 5,000 national standard. Since the rural referral center criteria at § 412.96(c) are designed to identify those rural hospitals that are comparable to their urban counterparts in terms of case-mix index values and numbers of discharges, we do not believe it would be appropriate to lower the national number of discharges as the commenter suggests.

E. Indirect Medical Education Costs (§ 412.105, formerly § 412.118)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education program receive an additional payment to reflect the higher indirect operating costs associated with graduate medical education. Each hospital's additional indirect medical education (IME) payment is determined by multiplying the hospital's total DRG revenue by the applicable IME adjustment factor. The regulations governing the calculation of this additional payment previously were set forth at § 412.118 but are being redesignated in this final rule as § 412.105. This change places these regulations in Subpart G—Special Treatment of Certain Facilities, which we believe is more appropriate than their former placement in Subpart H—Payments to Hospitals under the Prospective Payment System.

Section 4002(b)(3)(B) of Public Law 101-508 revised section 1886(d)(5)(B)(ii) of the Act to delete the scheduled increase in the IME adjustment factor from approximately 7.7 percent to 8.1 percent for every 10 percent increase in the hospital's resident-to-bed ratio for discharges occurring on or after October 1, 1995. The IME adjustment factor is an approximation because it is applied on a curvilinear or variable basis. That is, each absolute increment in a hospital's resident-to-bed ratio does not result in an equal proportional increase in costs. The deletion of the scheduled increase

in the adjustment factor was made as a conforming amendment to the repeal of the sunset provision for the disproportionate share adjustment. To implement this change, we proposed to delete both § 412.118(c)(2), which specifies a larger IME adjustment factor for discharges occurring on or after October 1, 1995, and § 412.118(d)(2), which sets forth the steps for calculating the IME adjustment factor for discharges occurring on or after October 1, 1995. We also corrected a typographical error in newly redesignated § 412.118(c). That paragraph currently states that the .405 factor applied to determine the amount of each hospital's adjustment is effective with discharges "on or after May 1, 1988"; however, as set forth in section 1886(d)(5)(B)(ii) of the Act, the correct effective date is "on or after May 1, 1986."

We received no comments on this issue and are making the changes as proposed.

F. Ceiling on Rate of Hospital Cost Increases (§ 413.40)

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248) added section 1886 of the Act to establish a ceiling on the allowable rate of increase for hospital inpatient operating costs. This ceiling still applies to hospitals and hospital distinct-parts units excluded from the prospective payment system. Under section 1886(d)(1)(B) of the Act, excluded hospital and hospital units include psychiatric, rehabilitation, cancer, children's, and 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 paid 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 inpatient costs per discharge for the hospital's next cost reporting period.

A hospital that has inpatient operating costs less than its target amount is paid its costs plus the lower of—

- 50 percent of the difference between the inpatient operating cost per discharge and the target amount; or
- 5 percent of the target amount.

For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1991, hospitals that have inpatient operating costs per discharge in excess of their target amount are to be paid no more than the target amount. However, section 4005(a) of Public Law 101-508 amended section 1886(b)(1)(B) of the Act to provide that hospitals with cost reporting periods beginning on or after October 1, 1991 are allowed 50 percent of the costs in excess of the target amount, but this additional payment is not to exceed 10 percent of the target amount (after any exceptions or adjustments are made to the target amount for the cost reporting period). We proposed to revise § 413.40(d)(3) to implement this provision.

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. In addition, section 6015 of Public Law 101-239 amended 1886(b)(4)(A) of the Act to provide that a hospital or excluded unit may be assigned a new base year and added section 1886(b)(4)(B) of the Act, which sets out criteria for consideration in establishing the assignment of a new base period.

To implement section 1886(b)(4)(A) of the Act, regulations at § 413.40 provide that HCFA may adjust a hospital's operating costs considered in establishing costs per case for purposes of determining the target amount, including both the periods subject to the limit and the hospital's base period, as follows:

- Section 413.40(g) provides for an exception to the target amount to take into account unusual costs due to extraordinary circumstances beyond the provider's control or distortions in costs caused by a change in case mix as a result of the addition or discontinuation of services.
- Section 413.40(h) provides for an adjustment to take into account factors such as a change in the inpatient services that a hospital provides that could result in a significant distortion in the operating costs of inpatient hospital services.

• Effective with cost reporting periods beginning on or after April 1, 1990, § 413.40(j) provides that a new base period will be assigned to address substantial and permanent changes in inpatient care services that are so broad in nature that the resulting cost distortion cannot be adequately addressed through the more targeted exceptions and adjustments available under § 413.400 (g) and (h).

The adjustments 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 the circumstances specified as creating the cost distortion, and are verified by the intermediary. (In addition to the provisions outlined above that implement section 1886(b)(4)(A) of the Act, § 413.40(i) provides for an adjustment to the target amount authorized by the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) as amended by the Family Support Act of 1988 (Pub. L. 100-485) and the Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101-234) to take into account cost distortions due to the temporary elimination of the day limitation on inpatient hospital services under catastrophic coverage.)

1. The Appeals Process (§ 413.40(e))

The general procedures for applying for an exemption or adjustment to the rate-of-increase limit are described in § 413.40(e). Section 413.40(e) requires that the hospital file its request with its fiscal intermediary no later than 180 days from the date on the notice of amount of program reimbursement (NPR) issued by the intermediary. (HCFA considers adjustment requests prior to the release of the NPR to help alleviate the financial strain a hospital might experience if it had to wait for the NPR before pursuing an adjustment.) The intermediary makes a recommendation on the hospital's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the hospital of HCFA's decision.

Section 4005(c)(1)(A) of Public Law 101-508 amended section 1816(f) of the Act to require that the performance standards and criteria for fiscal intermediaries include the ability to process a completed application for an adjustment to the target amount not later than 75 days after the application is filed, and, if the application is incomplete, to return it with proper instructions within 60 days. This provision should decrease substantially

the processing time applied by intermediaries before forwarding hospital applications to HCFA.

Section 4005(c)(1)(B) of Public Law 101-508 amended section 1886(b)(4)(A) of the Act by adding a requirement that the Secretary issue a decision on any request for an exemption, exception, or adjustment to the target amount not later than 180 days after receiving a completed application from the intermediary. Further, the provision requires that the Secretary issue a detailed explanation of the grounds on which the request was approved or denied. This statutory provision essentially codifies our current policy for processing rate-of-increase limit appeals. Under our current procedures, until we receive a hospital's completed application and any recommendation from the intermediary, the 180-day period does not begin to run. We do not count within the 180-day limitation the time required to secure the additional information needed to reach a decision on the request. Although there have been some instances in which appeals have not been processed within the 180-day period even though all necessary information has been submitted, most decisions that have taken more than 180 calendar days have involved delays because needed documentation was not included in the original request. Further, in issuing a decision, we provide an explanation of the basis for our decision. Nevertheless, to reflect the statutory requirements, we proposed to revise § 413.40(e) to state explicitly that HCFA's decision will be issued not later than 180 days after receiving a completed application with the intermediary's recommendation and that the decision will contain a detailed explanation of the grounds for the approval or denial.

An adjustment to the target amount is granted only if the hospital's costs are reasonable, the cost increase is attributable to significant changes in the provision of services or the type of patient served, and the effect of those changes on the hospital's costs is separately identified by the hospital and verified by the intermediary.

Some requests for an adjustment to the target amount do not contain sufficient justification and documentation to support a favorable decision. For example, a request for an adjustment may set out the circumstances that caused the cost distortion to occur but fail to quantify the effect of those circumstances on the hospital's costs. In other cases, the increased costs may be appropriately documented but the application does not

link the increases to changes in patient care services. Although we deny the request based on the information in the application, we also indicate a willingness to reconsider our decision if the hospital submits additional information. Since this has been an informal procedure, we have not established a time limit within which the hospital has to submit additional information. In some instances, we have received additional information several years after we issued our initial decision. We do not believe it is appropriate for the appeals process to be prolonged in this manner. Therefore, we proposed to formalize our reconsideration process by providing that HCFA's decision will be considered final unless a hospital submits additional information within 90 days of the date the intermediary notifies the hospital of HCFA's decision.

In processing applications for adjustments, we have identified situations where we do not believe it is necessary for HCFA to review the request. One example is an application for an adjustment to the target amount that is based on circumstances that are similar to those in an earlier cost reporting period for which HCFA has already issued a decision. Another example would involve circumstances for which our adjustment policy is well-established; that is, the type of circumstances that gave rise to the cost increases is generally accepted as a basis for adjustment, the evaluation of whether the circumstances actually occurred is relatively straightforward, and there is an established methodology for determining the amount of the exception. In these situations, we believe that direct review by HCFA of the hospital's request for an adjustment would unnecessarily delay commencement of the appeals process. To streamline the application review process in these situations, we proposed that HCFA may authorize the intermediary to make the final determination on a request for an adjustment under § 413.40(g). This authorization may be for specific hospitals or for specific circumstances. As proposed, the authorization for specific hospitals for subsequent cost reporting periods would be issued at the same time as the decision on the initial adjustment request. The authorization for specific circumstances would be issued through manual instructions and would be applicable only if one of those circumstances were the only basis for an adjustment request. If HCFA authorizes the intermediary to make the final determination, the decision would

be subject to the same rules as a decision issued by HCFA. The intermediary would be required to issue a decision that included a detailed explanation of the grounds for approval or disapproval within 180 days of receiving a completed application from the hospital. We also proposed that the decision would be subject to review under the administrative and judicial review provisions set forth in subpart R of 42 CFR part 405. However, it must be noted that a final NPR for the cost reporting period in question must be issued before a hospital can appeal a final determination of an adjustment request. This is because the amount by which operating costs actually exceed the rate-of-increase ceiling is not known until the final NPR is issued.

Comment: A commenter noted that the changes proposed in § 413.40(e) did not specify that the revisions apply to distinct-part units of hospitals that are excluded from the prospective payment systems as well as excluded hospitals. The commenter suggested that HCFA should make it clear that the changes apply to both excluded hospitals and units.

Response: We believe that § 413.40(a)(2)(ii) already explicitly identifies the types of providers subject to the ceiling on rate of hospital cost increases and to the provisions of § 413.40. Section 413.40(a)(2)(ii) states, "For cost reporting periods beginning on or after October 1, 1983, this section is applicable to hospitals excluded from the prospective payment system in accordance with § 412.23 of this chapter, subprovider psychiatric and rehabilitation units (distinct parts) excluded from the prospective payment system in accordance with §§ 412.25 through 412.32 of this chapter * * *." Therefore, we believe that the current regulation already makes it clear that the changes we are making in this final rule apply to excluded hospitals and units.

Comment: A commenter asserted that the language in proposed § 413.40(e)(2), " * * HCFA issues a decision (for an exemption, exception, or adjustment to the target amount) to the intermediary within 180 days from the date it receives the completed application and the intermediary's recommendation" is not in accordance with section 1886(b)(4)(A) of the Act, which requires the Secretary to issue a decision on any request for an exemption, exception, or adjustment to the target amount not later than 180 days after receiving a completed application from the intermediary.

Response: We do not agree that there is a substantive difference in the language, but we are revising

§ 413.40(e)(2) to reflect the suggested change since it more closely conforms to the statutory language.

Comment: One commenter suggested that § 413.40(e)(2) and (e)(3) explicitly require that the time limits that apply to the initial adjustment request also apply as time limits on the intermediary and HCFA action on reconsideration requests.

Response: We did not intend that the time limits in proposed § 413.40(e)(2) and (e)(3) only apply to the initial adjustment request submitted by the hospital. We are adding a new § 413.40(e)(6) to clarify that the 180-day limit applies to both an initial adjustment request and a request for reconsideration based on additional information.

Comment: Several commenters recommended that, in cases in which the intermediary is authorized to make the determination for a hospital's request for an adjustment, the hospital should be able to elect to treat the intermediary's decision as a final decision and, therefore, be able to appeal it directly to the Provider Reimbursement Review Board (PRRB), or, alternatively, to elect to request a reconsideration of the intermediary's decision from HCFA.

Response: Proposed § 413.40(e)(4) specifically stated that adjustment decisions made by the intermediary or HCFA are subject to review under subpart R of part 405, which contains the provisions for provider payment determinations and appeals. We are revising § 413.40(e)(4) to clarify that appeals may be filed only after the intermediary issues a final NPR.

With respect to a hospital's request to HCFA for a reconsideration of an intermediary's decision, we believe that this would defeat the purpose of authorizing the intermediary to make final adjustment determinations. If a hospital does not agree with the intermediary's determination and has additional information that may have a bearing on the decision, the intermediary is in the best position to evaluate that information since it made the initial decision. However, this would not preclude the intermediary from consulting with HCFA with regard to any aspects of the case.

Comment: One commenter suggested that proposed § 413.40(e)(4) be changed to require the intermediary to provide the hospital with a copy of HCFA's decision, including a detailed explanation of grounds for the decision in order to meet the requirements of section 1886(b)(4)(A) of the Act.

Response: We intend for the intermediary to furnish the hospital with

a complete explanation of HCFA's decision. To avoid any misunderstanding, we are changing § 413.40(e)(4) to clarify this.

Comment: Several commenters suggested lengthening the 90-day time period for hospitals to submit additional information to justify an adjustment request because there may be situations in which a hospital is dependent on outside resources (over which they have no control) for data gathering. The commenters want the longer time period to be in the form of either an exception to the 90-day time period or for HCFA to establish a 180-day time period.

Response: We recognize there may be unusual circumstances that cause the hospital to have difficulty in obtaining or developing the additional documentation to support a request for an adjustment within 90 days. However, we believe that providing a case-by-case exception to the 90-day limit would create a new administrative burden in deciding whether the delay is warranted. Therefore, we are adopting the suggestion to change the 90-day time period to a 180-day time period. We believe 180 days is more than adequate to obtain any additional documentation that is needed to support or justify an adjustment request. We are revising § 413.40(e)(4) accordingly.

2. Exceptions and Adjustments (§§ 413.40(g) and 413.40(h))

We have found that the separate provisions at §§ 413.40(g) and 413.40(h) for adjustments in the hospital's costs per case have resulted in confusion. One source of confusion has been the use of the term "exceptions" under § 413.40(g) and the term "adjustments" under § 413.40(h). There is no substantive difference between the two terms as they are applied under § 413.40 and the terms may be used interchangeably to describe the general procedure for adjusting a hospital's costs for purposes of determining the target amount.

To eliminate confusion on this point, we proposed to combine the provisions of § 413.40(g) and § 413.40(h). As a result of this change, a single provision, that is, § 413.40(g), would be used to describe the basis of adjustments to the target amount authorized under section 1886(b)(4)(A) of the Act that do not involve the assignment of a new base period. The term "exceptions" would no longer be used to describe these adjustments.

A second source of confusion has been the adjustment for change in case mix authorized under § 413.40(g)(3). Originally, § 413.40(g) applied to acute care hospitals that became subject to

the prospective payment system effective with cost reporting periods beginning on or after October 1, 1983, as well as hospitals that are currently excluded from the prospective payment system. Since case mix in acute care hospitals could be readily measured by the DRG classification system and relative weights, there was a straightforward method to document case-mix changes to justify an adjustment in the target amount under § 413.40(g)(3). This provision is generally no longer applicable since there is no good measurement of case mix in excluded hospitals. In fact, a major reason these hospitals are excluded from the prospective payment system is that the existing DRGs do not adequately differentiate among the patients served within each type of excluded hospital. As a result, target amount adjustments for the cost distortions resulting from a change in the type of patient treated have been made under § 413.40(h)(1) instead of § 413.40(g)(3). Also, under our current policy, any situation that would qualify for an adjustment under § 413.40(g)(3) would also qualify for an adjustment under § 413.40(h)(1) since it would involve a cost distortion that would make the cost reporting period subject to the ceiling not comparable with the base period. Therefore, we proposed to eliminate the specific adjustment for case mix described in § 413.40(g)(3). Hospitals would continue to qualify for an adjustment under current § 413.40(h)(1) for cost distortions attributable to a change in the type of patient treated. Since § 413.40(h) does not explicitly identify a change in the type of patient treated as a basis for an exception, we proposed to add this as an example of a situation that would warrant an adjustment.

In the proposed rule, we incorporated the remainder of § 413.40(g) with the contents of § 413.40(h) into a newly redesignated § 413.40(g) with editorial changes to eliminate duplication. (As a consequence, paragraphs (i) and (j) of § 413.40 are redesignated as paragraphs (h) and (i), respectively.)

Comment: Several commenters opposed the elimination of the provision formerly in § 413.40(g)(3) that permitted an adjustment due to change in case mix.

Response: The provision allowing an adjustment to the target amount for a change in case mix had specific criteria that had to be met. The criteria applied to situations in which a hospital added or discontinued services in a year after its base period and experienced a change in case mix as a result of the

addition or discontinuation of services that created a distortion in the target amount. The hospital had to submit data summarizing the case mix changes and the resulting changes in costs. The measurement of case-mix change was based on changes in the hospital's average DRG weight.

One of the main reasons certain types of hospitals and hospital distinct-part units are exempt from the prospective payment systems is because, in general, the current DRG classification system does not adequately differentiate among the patients these hospitals and units serve. Currently, there is no standard patient classification system that can be used to differentiate patients in excluded hospitals and units according to their resource requirements. Absent a standard measurement for determining case mix in these hospitals, we believe the case-mix change adjustment provision as implemented in § 413.40(g)(3) is not appropriate. We note, however, that providing for adjustments for distortions in the target amount based on changes in the "type of patient served" encompasses situations involving a change in case mix without restricting the measurement of patient resource requirements to a single standard measure (that is, DRG relative weights). Thus, the change in the regulation will not preclude a children's hospital, for example, from using DRG weights to substantiate that there has been a change in type of patients served.

Comment: One commenter expressed concern that the phrase "type of patient" in proposed § 413.40(g)(3)(iv), concerning adjustments to take into account increases in service intensity or length of stay attributable to changes in the type of patient served, is too limited to address changes in service intensity or an increase in Medicare's average length of stay. The commenter suggested that the phrase be expanded to "type of patient served and patient services, including changes in diagnostic mix and procedure mix, patient acuity, severity of illness, technology, medical practice, and patient care protocols."

Response: We disagree that the phrase "type of patient served" is too limited to address increases in service intensity or length of stay. The various factors identified in the commenter's suggestion relate to either increased service intensity or the type of patient being treated. The conditions under which an adjustment may be granted under § 413.40(g)(3)(iv) is not limited to the factors suggested by the commenter. We believe the phrase "type of patient" is appropriately broad to encompass various changes in service delivery and

is preferable to attempting to develop an inclusive list of factors that could cause distortion in the target amount.

Comment: A commenter stated that § 413.40(g) should clearly state that an adjustment for operating costs may be initiated by the intermediary or HCFA without a hospital's request, and that the documentation requirement in proposed § 413.40(g)(1) only applies to requests filed by hospitals.

Response: We are revising § 413.40(g)(3) to clarify those circumstances under which HCFA may initiate an adjustment to a hospital's rate-of-increase ceiling without the hospital's request. We are also clarifying § 413.40(g)(1) to reflect that the documentation requirement applies when the hospital requests an adjustment.

3. Adjustment for Significant Wage Increases (§ 413.40(g))

Until October 1, 1991, significant increases in wages since the base period were not recognized as a basis for an adjustment in the target amount under § 413.40(h). This is because wage increases were accounted for by the update factor only. One of the assumptions behind the rate-of-increase limit has been that if a hospital needed to increase costs in one area beyond the amount provided by the update factor, cost containment measures would be taken in other areas. However, as discussed below in section IV.F.5 of this preamble, Congress explicitly provided that increases in wages should be taken into consideration in determining whether to assign a new base period. Since wage increases are to be considered in the new base period determination, we proposed to provide a limited adjustment under newly redesignated § 413.40(g) for wage increases significantly in excess of the increase in the national average hourly wage accounted for by the update factor. We also proposed to establish a specific methodology for these adjustments so that the intermediary can make the determination on the adjustment request.

As proposed, to qualify for an adjustment, the excluded hospital or hospital unit must be located in a geographic area that is determined to have an average hourly wage that increased significantly more than the national average hourly wage over the period. We proposed to use the hospital wage index for prospective payment hospitals to determine the rate of increase in the average hourly wage in the labor market area. To be eligible, a given area must have had at least an 8

percent increase between its wage index value based on 1982 wage data and its wage index value based on 1988 wage data. If the hospital's base period begins in FY 1984 or later, the geographic area must have had at least an 8 percent increase between the wage index value based on 1984 data and the wage index value based on 1988 wage data. The latest applicable wage data would be used in all cases for this comparison. Further, we proposed that the comparison would be made without regard to any geographic reclassifications under sections 1886(d)(8) and (10) of the Act.

As proposed, the amount of the adjustment for wage increases would be determined by taking three factors into account between the base period and the period for which an adjustment is requested: the rate of increase in the hospital's average hourly wage; the rate of increase in the average hourly wage in the labor market area; and the rate of increase in the national average hourly wage for hospital workers. The adjustment would be limited to the amount by which the lower of the hospital's or the labor market area's rate of increase in average hourly wages significantly exceeds the national increase (that is, exceeds the national rate of increase by more than 8 percent). For purposes of computing the adjustment, the relative rate of increase in the average hourly wage for the labor market area would be assumed to have been the same over each of the years covered by the wage surveys. In addition, it would also be assumed to be applicable to subsequent years until more recent wage data become available to determine the actual rate of increase relative to the national average in the subsequent years.

To determine the rate of increase in the national hourly wage, we proposed to use the average hourly earnings (AHE) component of the wages and salaries portion of the market basket. This measure would be derived from the 1982-based market basket since the 1987-based market basket uses the employment cost index (ECI) for hospital workers as the price proxy for this component. Unlike the AHE, the ECI for hospital workers can be measured historically only back to 1986. In addition, the ECI does not adjust for skill-mix shifts and, therefore, measures only the change in wage rates per hour.

The average hourly earnings for hospital workers as measured by the market basket show the following increases:

1983=8.4 percent
1984=5.6 percent

1985=5.4 percent
1986=4.1 percent
1987=4.7 percent
1988=6.5 percent
1989=6.9 percent
1990=5.6 percent

We proposed to use the following methodology to determine if an adjustment for significant wage increases is appropriate:

Step 1: Compare the hospital's rate of increase in average hourly wages to the rate of increase in the labor market area. The hospital's rate of increase is calculated by dividing its average hourly wage in the year for which the adjustment is requested by its average hourly wage in the base year. The rate of increase in the labor market area is computed by multiplying the cumulative percentage increase in the AHE for hospital workers by the applicable percentage change in the wage index. The lower of the two rates of increase will be used in Step 3.

Step 2: Determine the threshold for the adjustment. The threshold is equal to the cumulative percentage increase in the AHE for hospital workers over the period in question multiplied by 1.08.

Step 3: Subtract the amount determined in Step 2 from the lower of the two amounts determined in Step 1. This result is the percentage increase that is considered significantly above the increase that is accounted by the update factor.

Step 4: Determine the proportion of the hospital's operating costs that is attributable to wages and fringe benefits. Adjust this proportion of the hospital's target amount to account for the wage increase by multiplying it by the percentage increase determined in Step 3. As is the case with other adjustments under proposed § 413.40(g), we proposed that the adjustment would be made only to the extent the hospital's costs are in excess of the target amount.

Since we were providing a specific methodology to be used to make the wage adjustment, we proposed to authorize the intermediary to make the determinations on these requests for an adjustment due to a significant wage increase.

Comment: Several commenters suggested that the proposed 8 percent threshold for a wage increase adjustment is too stringent. One commenter was critical of our proposal to limit the adjustment to hospitals located in those areas where the increase is significantly above the national average. That commenter argued that section 1886(b)(4)(B) of the Act requires that, in determining whether to assign a new base period,

the Secretary take into consideration only whether the increase in area wages exceeds the national average increase, and not whether the area increase in wages is significantly higher than the national average increase. Another commenter indicated that the individual hospital's wage increase should have no bearing on the amount of the adjustment because section 1886(b)(4)(B) of the Act uses only the comparison of the area wage increase to the national average as a factor in the new base period assignment. In contrast, other commenters suggested that the methodology for determining the adjustment should be based solely on a comparison of the increase in the hospital's own wages to the national average and should not take into consideration area wage increases.

Response: We continue to believe that it is appropriate to take into account comparisons of both the rate of increase in the hospital's own wages and in the average area wages to the national average in determining whether to make an adjustment in the target amount for wage increases. The comparison of the area wage increase to the national wage increase establishes whether there are atypical wage pressures in the labor market area that cause wage increases beyond the hospital's control. The comparison of the hospital's wage increase to the national average determines the extent to which the hospital's wage increase exceeds the increase in wages accounted for by the update factor. If the hospital's wage increase has been accounted for by the update factor, there is no basis for a wage adjustment.

As amended by section 4005(c)(2) of Public Law 101-508, section 1886(b)(4)(B) of the Act provides that the area wage comparison is one of several factors that the Secretary should take into consideration in assigning a new base period. The Conference Committee report accompanying section 4005(c)(2) of Public Law 101-508 indicated that the conferees did not intend that an above average increase in area wages would automatically result in assignment of a new base period (H.R. Rep. No. 964, 101st Cong. 2nd Sess. 704 [1990]).

Similarly, we do not believe it is appropriate for any wage increase that is in excess of the national average increase to result in an automatic adjustment to the target amount. The basic purpose of the rate of increase limitation is to hold hospitals to an annual rate of increase unless events beyond a hospital's control or extraordinary circumstances warrant an adjustment. One of the underlying

premises is that while a hospital may experience cost increases that are above average in some areas, there are other areas where its increases are less than average and, on average, the target rate of increase is appropriate. If we were to adjust for any wage increases that are above average, we would defeat the purpose of the rate of increase limit. To avoid doing so, we are limiting the adjustment to significant wage increases that are beyond the hospital's control. We believe these rates of increase are sufficiently high that it would be unreasonable to expect the hospital to offset the wage increases with cost containment measures in other areas.

We do not agree with the commenters that the 8 percent threshold is too stringent. The threshold applies to the relative rate of increase. In other words, if the national average hourly wage increases by 8 percent in a given year, we will consider it significant if the hospital's wages increased by 6.48 percent. We do not believe that this is an unreasonable threshold amount.

For purposes of determining whether a hospital is eligible for a wage adjustment, the labor market area in which the hospital is located must have had at least an 8 percent increase between the applicable area wage index values used in the comparison. If the hospital is located in a labor market area with significant wage increases, the adjustment will be based on the amount by which the lower of the hospital's or the labor market area's rate of increase exceeds the national rate of increase by more than 8 percent. We are providing, in table 9 of section IV of the addendum to this final rule, a listing of the labor market areas that have had wage increases in excess of 8 percent. Consistent with the proposed rule, we have determined the wage index based on 1988 wage data using the most current data available and without regard to geographic reclassifications under section 1886(d)(10) of the Act.

Following is an example of the determination of the wage index adjustment based on the 8 percent threshold:

Example: A rehabilitation hospital located in Boston, Massachusetts has a base period beginning January 1, 1984. The wage index value for Boston, Massachusetts based on 1984 wage data was 1.0813. The wage index value based on 1988 wage data is 1.1820. The rate of increase above the national average rate of increase equals $(1.1820 - 1.0813) / 1.0813$, or 9.31 percent. Since the additional rate of increase is more than 8 percent, the hospital may qualify for a wage adjustment. The 9.31 percent will be assumed to apply to each of the years between 1984 and 1988 and, until a new wage index is published, to 1989 and later.

The hospital is requesting an adjustment for its 1990 cost reporting period. Over this period, its average hourly wage increased from \$8.00 to \$12.63. The hospital's salaries, fringe benefits, and payments for contract labor and computer services constitute 75 percent of its operating costs. In FY 1990, its operating costs per case were \$8,000 and its target amount prior to adjustment was \$7,600.

Step 1:

a. Determine the hospital's rate of increase in average hourly wages:

$$\$12.63 - \$8.00 / \$8.00 = .578, \text{ or } 57.8 \text{ percent}$$

b. Determine the labor market area's rate of increase in average hourly wages by multiplying the national average increase by the rate at which the increase in average hourly wage in the Boston MSA exceeded the national rate of increase (9.31 percent):

$$1985 \quad 5.4 \times 1.0931 = 5.90$$

$$1986 \quad 4.1 \times 1.0931 = 4.48$$

$$1987 \quad 4.7 \times 1.0931 = 5.14$$

$$1988 \quad 6.5 \times 1.0931 = 7.11$$

$$1989 \quad 6.9 \times 1.0931 = 7.54$$

$$1990 \quad 5.6 \times 1.0931 = 6.12$$

$$(1.0590 \times 1.0448 \times 1.0514 \times 1.0711 \times 1.0754 \times 1.0612) = 1.422, \text{ or } 42.2 \text{ percent}$$

Since the rate of increase in the labor market area (42.2 percent) is less than the hospital's rate of increase (57.8 percent), the increase in the labor market area will be used in the rest of the calculations.

Step 2: Determine the adjustment threshold by increasing the rate of increase in the national hourly average wage by 8 percent.

$$5.4 \times 1.08 = 5.83$$

$$4.1 \times 1.08 = 4.43$$

$$4.7 \times 1.08 = 5.08$$

$$6.5 \times 1.08 = 7.02$$

$$6.9 \times 1.08 = 7.45$$

$$5.6 \times 1.08 = 6.05$$

$$(1.0583 \times 1.0443 \times 1.0508 \times 1.072 \times 1.0745 \times 1.0605) = 1.416, \text{ or } 41.6 \text{ percent}$$

Step 3: Determine the adjustment to the wage-related portion of the target amount by subtracting the amount determined in Step 2 from the amount determined in Step 1:

$$42.2 \text{ percent} - 41.6 \text{ percent} = 0.6 \text{ percent}$$

Step 4: Determine the adjusted target amount.

a. Determine the wage-related portion of target amount subject to adjustment.

$$\$7,600 \times .75 = \$5,700$$

b. Apply the adjustment determined in Step 2 to the wage-related portion of target amount.

$$\$5,700 \times 1.006 = \$5,734.20$$

c. Determine the adjusted target amount by adding the adjusted wage-related portion of the target amount to the nonwage-related portion.

$$\$5,734.20 + (\$7,600 \times .25) = \$7,634.20$$

Since \$7,634.20 is less than the hospital's operating costs per case, the full adjustment will be authorized.

Comment: One commenter questioned why the threshold would be the same for an increase measured over the 6-year period from 1982 to 1988 and an increase over the 4-year period from 1984 to 1988. In the commenter's view, the threshold should be smaller for measuring wage changes over 4 years

than for measuring wage changes over 6 years.

Response: The commenter may have misunderstood the basis of the comparison, which is relative rates of increase in the average hourly wage. If the national average increased 6 percent, the test is whether the rate of increase was 8 percent higher than the national average, that is, 6.48 percent (6×1.08). It is appropriate to have a single annual percentage threshold that is applied to the actual rates of increase in each year. The definition of a significant wage increase is based on annual rates of increase that are 8 percent higher than the national rate of increase for each year. For example, the national hourly wage increased 6.5 percent in 1988 and 6.9 percent in 1989, or 13.8 percent (1.065×1.069) over the 2-year period. In determining the cumulative threshold, 7.02 percent (6.5×1.08) would be used for 1988 and 7.452 percent for 1989, or 15.0 percent over the 2-year period. The cumulative threshold will increase as the comparison period lengthens.

Comment: Several commenters recommended that hospitals that do not qualify for a wage adjustment based on the established methodology should be able to demonstrate special circumstances that warrant a wage adjustment. One commenter stated that the adjustment for significant wage adjustments failed to address situations in which a hospital had below market wages in the base year or is at a competitive disadvantage with new hospitals that have a more recent base period and, therefore, higher wages in their target amount.

Response: A hospital that does not qualify for an adjustment based on significant wage increases may still request consideration of an adjustment to its target amount under § 413.40(g)(3) if there is a significant distortion in the hospital's costs between the base year and the current year. However, no adjustment will be given for increases in salaries for specific classes of employees, such as therapists, without the hospital documenting that its average hourly increase for all employees is significantly higher than the increase that is accounted for in the update factor. The rate of increase limit is based on average increases, and it would not be appropriate to make an adjustment for the salaries of some employee groups without taking into account wages for other groups that may have increased at a lower rate. Similarly, no adjustment will be given for increases occurring in a single year without consideration of the cumulative

increase in wages since the base period. The average wage increase may be higher than the national average in one year and less than the national average in another. An adjustment is warranted only if there is a distortion from the base period. Finally, no adjustment will be granted unless the hospital documents that the increases are beyond its control.

The issues raised by the commenter regarding hospitals that are at a competitive disadvantage because of low base year wages are inherent in a rate of increase limit on hospital-specific costs and are beyond the scope of the adjustment process. Instead, they are part of the broader issues of the rate of increase limits that we will be addressing in a report to Congress required by section 4005(b) of Public Law 101-508 concerning proposals for modifications in the payment methodology for hospitals that are excluded from the prospective payment system. The report is due to Congress by April 1, 1992.

Comment: A commenter argued that the area wage indexes should not be used in determining if there has been a significant increase in the area wages. This is because the 1982 and 1984 wage data include excluded hospitals, which do not have the same labor mix as acute care hospitals, whereas the 1988 wage data do not include these hospitals. The commenter is also concerned that the comparison may be distorted if the hospital's base year does not coincide with the year the wage survey was conducted.

Response: We use the hospital wage index data to determine whether the wage increases in the area are significantly above the national average because it is the best data available on wage increases across labor market areas. Although the 1988 wage data are an improvement over the 1982 and 1984 wage data, we do not agree with the commenter's conclusion that the earlier data are too inaccurate to use. If a hospital does not qualify for an adjustment based on the methodology we are adopting in this final rule, the hospital may still request an adjustment based on other data that demonstrate that the average increase in the hospital's wages and in the area wages since the hospital's base year are significantly above the national average. As indicated in response to an earlier comment, these data must cover all employee classes and cannot be limited to specific years or classes of employees.

Comment: Two commenters indicated that the wage increase adjustment should not be limited to direct wages and fringe benefits and that recognition

should be given to the costs incurred in contracting for the services of nurses and other health professionals. One of the commenters recommended that the adjustment should take into account all components that would be subject to the area wage adjustment under the prospective payment system.

Response: We agree with the commenter that the portion of the target amount that is adjusted for significant wage differences should include the components of cost that comprise the labor-related portion of the target amount as defined in the hospital market basket. This includes, in addition to the hospital's wage and fringe benefit costs, costs for contract labor (exclusive of payments for supplies and equipment), other professional fees, and payments for business and computer services and blood services. For excluded hospitals, the labor-related component constitutes, on average, 80.5 percent of costs. The actual portion of the target amount that will be adjusted for significant wage increases will be based on the hospital's own proportion of costs that are labor-related.

We do not agree with the commenters that the comparison of the hospital's rate of increase in average hourly wages should include contract labor. This is because the hospital wage index does not include contract labor and it would distort the comparison to include contract labor costs in the hospital's average hourly wage but not in the national average hourly wage. The assumption in excluding contract labor from all comparisons is that the effect of contract labor on the relative rates of increase in wage-related costs is the same across geographic areas. Excluding contract labor does not understate the comparison of either the area rate of increase or the hospital rate of increase with the national average rate of increase unless both the hospital's use of contract labor and the rate of increase in hourly contract labor costs is disproportionate to the national average. Hospitals that believe they are disadvantaged by the comparison may request an adjustment under § 413.40(g)(3).

Comment: One commenter complained that the wage increase adjustment does not correct for understatements of the target rate of increase updates prior to FY 1988.

Response: The wage adjustment is designed to correct for significant wage increases that have not been accounted for under the rate of increase limit established by law. It would be contrary to the purpose of the adjustment to use it to correct for reductions in the update factors that were made to account for

the rapid growth in prospective payments due to case-mix increases. (See the June 3, 1991 proposed rule (56 FR 25321).) The Secretary's recommendation for the FY 1992 update factor addresses the concern that a cumulative comparison of update factors and the hospital market basket indicates excluded hospitals with base periods beginning in FY 1983 through FY 1987 have been disadvantaged and warrant a higher update relative to other excluded hospitals.

4. Adjustment for Part B Services (§ 413.40(g); formerly § 413.40(h))

Current § 413.40(h)(1)(i) states that base period costs are to be adjusted to explicitly include services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period. The purpose of this provision was to take into account the requirement that the hospital furnish directly or under arrangements all nonphysician services furnished to inpatients effective October 1, 1983. With this requirement, outside suppliers were no longer permitted to bill directly under Part B for services they furnished to hospital inpatients.

Section 4003 of Public Law 101-508 amended section 1886(a)(4) of the Act by expanding the definition of inpatient hospital services to include diagnostic or other services that are related to the admission (as defined by the Secretary) that are provided by the hospital (or by an entity wholly owned or operated by the hospital) during the 3 days immediately preceding the date of the patient's admission. We are implementing this provision through program instructions and a separate Federal Register document.

To the extent a hospital furnishes services prior to admission that were not considered inpatient hospital services in the base period, there will be a cost distortion between the base period and the current cost reporting period. Current § 413.40(h)(1)(i) provides that the cost distortion would be corrected through an adjustment to the base period. We do not believe it is feasible for hospitals to reconstruct from base period billing information the cost of services that would be affected by section 4003 of Public Law 101-508. Therefore, we proposed in redesignated § 413.40(g)(3)(ii)(B) to delete the reference to the base period adjustment and authorize adjustment for Part B services to either the base period or the current period.

We received one comment, which supported the proposed change and,

thus, we are adopting § 413.40(g)(3)(ii)(B) as proposed.

5. Assignment of a New Base Period (§ 413.40(i); formerly § 413.40(j))

Section 1886(b)(4)(A) of the Act, as amended by section 6015(a) of Public Law 101-239, authorizes the Secretary to assign a new base period to a hospital if it is more representative of the reasonable and necessary costs of its inpatient services. Implementing regulations were published in the April 20, 1990 final rule with comment period (55 FR 15157) and the comments received on that rule were discussed in the September 4, 1990 final rule (55 FR 36003). Current § 413.40(j) (redesignated as § 413.40(i)) provides that the Secretary may assign a new base period if the hospital experiences a substantial and permanent change in patient care services that is so broad in nature that the resulting cost distortion cannot be adequately addressed through the more targeted adjustments available under current § 413.40 (g) and (h) (redesignated as § 413.40(g)). As is the case with adjustments, rebasing is authorized only if the hospital's operating costs per discharge are in excess of its target amount.

Section 4005(c)(2) of Public Law 101-508 added a new section 1886(b)(4)(B) of the Act to include factors that the Secretary must take into consideration in determining whether to assign a new base period. These factors are the following:

- Changes in applicable technologies and medical practices.
- Differences in the severity of illness among patients.
- Increases in wages and wage-related costs for hospitals in the area that exceed the national average increases.
- Such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

The Conference Committee report accompanying the legislation noted that the assignment of the new base period falls within the Secretary's discretionary authority to grant adjustments to the target amount. (See H.R. Rep. No. 964, 101st Cong., 2nd Sess. 704 (1990)). The conferees stated that although the Secretary was required to take into consideration certain factors in determining whether to assign a new base period, the Secretary may take into consideration other factors that might lead to a determination that a new base period is not warranted. Further, the conferees noted that they did not expect the increase in wage-related costs in the area to result in an automatic

assignment of the base period. The amendment is effective for cost reporting periods beginning on or after April 1, 1990.

We proposed to revise current § 413.40(j)(1) (redesignated as § 413.40(i)(1)) to include the factors specified in section 1886(b)(4)(B) of the Act in the determination of whether the hospital's costs are necessary and proper. We intend to take these factors into account in conjunction with the factors that are already identified in redesignated § 413.40(i)(1). The factors identified in redesignated § 413.40(i)(1) constitute other factors that we believe are appropriate in determining whether the cost increases warrant rebasing. We do not anticipate that any of the added factors in isolation would result in the assignment of a new base period since these factors in isolation can be accommodated through the adjustment provisions provided in redesignated § 413.40(g). However, we will consider the hospital's documentation of the changes in technology, medical practices, and patient severity and the impact of those changes on the hospital's costs as support of the requirement that a substantial and permanent change in furnishing patient care has been met. We also consider the hospital's demonstration that the wage increases in the area have exceeded the national average increase and have had a substantial impact on the hospital's costs in determining whether increases in the hospital's wage costs are necessary and proper.

The circumstances under which we will authorize the assignment of a new base period continue to be limited to those involving substantial and permanent changes in patient services that cannot be addressed by the more targeted adjustments provided for by redesignated § 413.40(g) as set forth above. To some extent, cost increases for new technologies and changes in medical practice patterns are offset by productivity improvements and are taken into account in the update factor. When the new technology or change in medical practice patterns results in the provision of a new service, it creates a cost distortion that will be a basis for an adjustment to the target amount under redesignated § 413.40(g). Similarly, cost increases that are attributable to changes in the patient population that result in increases in service intensity or length of stay are a basis for an adjustment. As explained above in section IV.F.3 of this preamble, we are establishing an adjustment under § 413.40(g) for significant wage increases.

We received no comments that specifically addressed the changes we proposed. We did receive several comments that suggested that we are interpreting section 1886(b)(4)(A) of the Act too restrictively. Since we did not propose to make any changes other than those required by section 4005(c)(2) of Public Law 101-508, we are not responding to those commenters in this final rule. We responded to similar comments in the September 4, 1990 final rule (55 FR 36003). However, we are responding to one commenter's suggestion that we expand the general adjustment authority to provide for the assignment of a new base period when the adjustment results in the full recognition of costs.

Comment: One commenter noted that the proposed assignment of a new base period for excluded hospitals and units would be limited to cases involving changes that cannot be addressed by the adjustment authority provided for by the proposed § 413.40(g). The commenter believes it would be helpful if the "general rule" under § 413.40(g)(1) stated that HCFA may assign a new base period if the adjustments described in paragraph § 413.40(g) do not result in the recognition of the reasonable and necessary costs of providing inpatient services.

Response: We disagree with the commenter. As we explained in the September 4, 1990 final rule (55 FR 36003), we do not believe that Congress intended us to implement this provision with broad and general criteria that would permit the widespread assignment of new base periods. Such action would have been inconsistent with the basic premise of the rate of increase limitation, which is to hold hospitals to the annual rate of increase except when events beyond a hospital's control or extraordinary circumstances warrant an adjustment. Therefore, to avoid substantially revamping the rate of increase limits methodology, we have limited the assignment of a new base period to hospitals that meet the specific conditions set forth under § 413.40(i).

For hospitals to qualify for an assignment of a new base period under this provision, the higher costs must result from substantial and permanent changes in furnishing patient care services. Thus, if the more limited adjustments do not result in full recognition of the reasonable and necessary costs of providing inpatient services, it does not necessarily follow that a new base period will be assigned. In this regard, we note that a hospital's costs may frequently exceed the target amount, even after adjustments, because

of generally higher rates of increase in costs relative to the rate of increase limit. However, this type of cost increase is not the kind that would qualify a hospital for an assignment of a new base period.

G. Direct Graduate Medical Education Payments (§ 413.86)

Section 1886(h)(5)(A) of the Act provides that "[t]he term 'approved medical residency training program' means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." On September 29, 1989, we published a final rule in the *Federal Register* (54 FR 40286) that added a new § 413.86, which included a new counting methodology for determining resident full-time equivalents (FTEs) for graduate medical education payment (GME) purposes. In § 413.86(b), we defined *Approved medical residency program* as a program that meets one of three criteria. Under the second criterion, the program "may count towards certification of the participant in a specialty or subspecialty listed in the Directory of Residency Training Programs published by the American Medical Association. In reviewing the second criterion, we have determined that the definition is not sufficiently broad in accordance with section 1886(h)(5)(A) of the Act. That is, the Directory of Residency Training Programs published by the American Medical Association is not the sole directory of specialties and subspecialties that are counted toward certification by a national organization. In addition, the American Board of Medical Specialties publishes a current directory of approved programs in its *Annual Report and Reference Handbook*. An approved program is one for which a member specialty board of the American Board of Medical Specialties may confer a general or subspecialty certificate. We received several comments supporting this change and, therefore, we are amending the third criterion of *Approved medical residency program* under § 413.86(b) to include programs that may count towards certification of the participant in a specialty or subspecialty listed in the *Annual Report and Reference Handbook* published by the American Board of Medical Specialties.

VI. Other ProPAC Recommendations

As required by law, we reviewed the March 1, 1991 report submitted by

ProPAC to Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our response to that recommendation, we have not repeated the recommendation and response in the discussion below. Recommendations 1 and 6 concerning the update factors are discussed in appendix B to this document. Recommendation 4 concerning incorporating the occupational mix data into the area wage index is discussed in section IV of this preamble. Recommendation 5 concerning adjusting payments for acute myocardial infarction (AMI) is discussed in section III.C of this preamble. The remaining recommendations on which we received comments are discussed below.

A. The Indirect Medical Education Adjustment (Recommendation 3)

Recommendation: The indirect medical education (IME) adjustment to PPS should be reduced from its current level of 7.7 percent to 7.0 percent for FY 1992. This reduction should be implemented in a budget-neutral fashion, with the anticipated decrease in IME payments returned to all hospitals through corresponding increases in the standardized payment amounts. Before recommending further reductions, ProPAC intends to examine the financial status of teaching hospitals to determine whether further reductions in the IME adjustment would produce deleterious effects on access to care for Medicare beneficiaries.

Response in the Proposed Rule: ProPAC's recommended reduction of 0.7 percentage points in the IME adjustment represents one-fifth of the difference between the current level of 7.7 percent (set forth at section 1886(d)(5)(B)(ii) of the Act) and 4.2 percent, which is ProPAC's most recent estimate of the effect of teaching activity on inpatient operating costs. That is, ProPAC estimates that for every 10 percent change in the resident-to-bed ratio, there is, on average, a 4.2 percent increase in Medicare inpatient operating costs per case.

The statistical model ProPAC used to generate the estimate of 4.2 percent is different from previous models in that it did not control for the effects on costs of a disproportionate share of low-income

patients. When controlling for these effects, ProPAC's estimate was 2.1 percent. The difference in the estimates is due to the overlap of hospitals receiving both the IME and the disproportionate share adjustments.

We agree that the IME adjustment should be reduced from its current level. The President's budget for FY 1992 proposes to reduce the adjustment over 5 years, starting at 4.4 percent during FY 1992, and gradually reducing it to 4.1 percent in FY 1993, 3.8 percent in FY 1994, 3.5 percent in FY 1995, and 3.2 percent in FY 1996. Because we believe payment levels to other hospitals are adequate, the money saved from reducing the adjustment should be retained as budget savings rather than redistributed among all hospitals, as proposed by ProPAC. Our proposal to lower the adjustment to 3.2 percent over a 5-year period is based on the results of the analysis ProPAC included in its March 1, 1990 report, which estimated a 3.2 percent effect of graduate medical education of higher operating costs. This estimate was attained by controlling for all payment variables, including disproportionate share payments. We believe it is appropriate to control for the effects of disproportionate share when estimating the effects of teaching. Not controlling for the effects of all of the payment variables distorts the results by loading the effects of the excluded variables onto the estimates of the other variables.

Continuing to pay IME at the current level, or reducing it to 7.0 percent as proposed by ProPAC, would result in payments exceeding all recent estimates of the indirect costs associated with graduate medical education. We strongly believe that payment for the added costs associated with graduate medical education should be based on the best estimate of the added costs incurred in treating Medicare patients and that payment in excess of this amount is an inappropriate expenditure of Medicare trust funds.

In addition, it must be noted that teaching hospitals continue to have much higher Medicare operating margins than nonteaching hospitals. In FY 1988, the most recent year for which complete data are available, major teaching hospitals (that is, those with resident-to-bed ratios greater than or equal to .25) had an average Medicare operating margin of 12.4 percent, while nonteaching hospitals had a Medicare operating margin of negative 1.7 percent. The national average Medicare operating margin was 2.2 percent, and minor teaching hospitals (that is, those with a resident-to-bed ratio of less than

.25) had an average Medicare operating margin of 3.7 percent.

ProPAC's reason for reducing the adjustment only to 7.0 percent in FY 1992 is that major teaching hospitals have had lower total operating margins (which are based on the facility's overall operations, not just Medicare patients) than other types of hospitals. These lower total operating margins are associated with the fact that major teaching hospitals tend to be faced with a broad array of social issues not directly related to Medicare patients, stemming largely from their location in urban areas and their role in providing services to low-income individuals. ProPAC's concern is that a reduction greater than 7.0 percent might impair the continued operation of these hospitals and, thus, the fulfillment of their special role in the health care system.

While we share ProPAC's view that teaching hospitals fulfill a unique health care role, we disagree with the conclusion that the IME adjustment should be decreased only marginally in order to help offset losses in other areas of the operations of teaching hospitals. First, teaching hospitals have successfully responded to the incentives of the prospective payment system in the past, and we believe that they will continue to do so. In addition, social problems that are not directly related to Medicare beneficiaries should be addressed through more targeted policies rather than through indirect subsidies in the form of higher Medicare payments to all teaching hospitals. In this regard, we note that in ProPAC's discussion of uncompensated care at the end of the recommendations section, ProPAC indicated that it found no relationship between the amount of uncompensated care a hospital provides and the IME payments it receives. (Specifically, ProPAC found that although the top 10 percent of prospective payment hospitals in terms of uncompensated care load provide 27 percent of all uncompensated care, these hospitals together receive the same proportion of total IME payments (9 percent) as do the prospective payment hospitals ranking in the bottom 10 percent of uncompensated care load, which provide only 1 percent of all uncompensated care.) The Secretary's Task Force on Health Care Reform is examining more appropriate ways to address some of these larger social issues.

The President's budget for FY 1992 also recommends that the measure of teaching intensity be changed, on a budget neutral basis, from a resident-to-bed ratio to a resident-to-average daily

census (or resident-to-day) ratio. This change is based on our belief that use of beds in the measurement of teaching intensity presents hospitals an opportunity to receive higher Medicare payments per case simply by taking unused beds out of service. It is highly unlikely that the closing of unused beds should increase the impact of teaching activities on operating costs.

Comment: We received two comments concerning our proposal that the IME adjustment should be reduced to a level below that recommended by ProPAC. ProPAC agreed with our position that health-related social problems that are not directly related to Medicare beneficiaries should be addressed through policies targeted directly at those problems. However, concern that a sharp reduction in the IME adjustment might adversely affect Medicare beneficiaries' access to high-quality health care by exacerbating the weak (non-Medicare) financial condition of major teaching hospitals led ProPAC to object to the reductions in the IME adjustment proposed in the President's FY 1992 budget. The second commenter stated that the proposed reduction in the IME adjustment factor does not address the limitations in the DRG system cited by Congress when discussing the need for such an adjustment in the original prospective payment system legislation. That is, the IME adjustment was included in the system in part to help account fully for factors such as the severity of illness of patients requiring specialized treatment provided by teaching hospitals, which Congress was unsure would be covered by the DRG system.

Response: As we stated in the proposed rule, we recognize the unique role fulfilled by teaching hospitals, especially major teaching hospitals, in maintaining a high-quality health care system. Nevertheless, Medicare payment-to-cost relationships for teaching hospitals are, on average, consistently above those of other hospital groups, while estimates (including those performed by ProPAC) of the effects of teaching on hospital costs are consistently well below the current adjustment and that proposed by ProPAC. Therefore, we believe the reductions to the IME adjustment proposed in the President's budget are very reasonable. Since the publication of the proposed rule, the FY 1989 Medicare cost data have become available. These data indicate that the Medicare operating margins for teaching hospitals during FY 1989 remain higher than those of nonteaching hospitals. In addition, we continue to believe that

teaching hospitals will respond successfully to the incentives of the prospective payment system as they have in the past and that the IME adjustment is an inappropriate and ineffective vehicle for addressing the problem of uncompensated care.

In response to the second commenter, we note that the IME adjustment was set at 11.59 percent when the prospective payment system was enacted, which was twice the estimated cost effect at that time. The cost estimate was doubled due to concern that teaching hospitals would be adversely affected by the change to prospective payment. As noted above, this has not been the case. In fact, Congress' doubts appeared to have been alleviated by 1986 when it enacted section 9104 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), which amended section 1886(d)(5)(B) of the Act to reduce the adjustment to a level equal to the estimate by the Congressional Budget Office of the actual effects of teaching on hospitals' costs per discharge.

As we noted in the September 4, 1990 final rule (55 FR 36066) in response to a similar comment, one of the reasons for the smaller estimate of the effects of teaching on hospital costs is the refinements we have made to the DRGs, so that they more closely reflect the variations in costs associated with differences in the severity of illness. Therefore, given the ongoing favorable performance of teaching hospitals under the prospective payment system, we do not think it is necessary to continue to pay teaching hospitals an IME adjustment beyond the estimated teaching cost effect on the hospital's operating costs per case.

Comment: In its comment, ProPAC also advised against changing the measure of teaching intensity from the resident-to-bed ratio to the resident-to-day (average daily census) ratio, as we proposed in the President's budget. ProPAC is concerned that such a change would reward hospitals with low occupancy rates and would result in lower payments to major teaching hospitals, which tend to have high occupancy rates. An example was given in which, if two hospitals with identical counts of residents and beds have different occupancy rates, the hospital with the lower occupancy rate would have the higher resident-to-day ratio. It was noted that many major teaching hospitals traditionally have high occupancy rates; thus, these hospitals would lose relative to other teaching hospitals if such a change were to be made.

Response: We do not disagree with the example given, but would note that the indirect operating costs stemming from teaching programs should be more closely related to the numerical relationship between residents and patients rather than the relationship between residents and beds. That is, one would expect the indirect medical education cost experiences of two hospitals with the same ratios of residents to average daily census but different ratios of residents to available beds to be more similar than a situation where this relationship is reversed. This expectation has been borne out by our analysis, which found that replacing available beds with average daily census is a better estimate of the effect of a teaching program on hospital costs as indicated by a smaller standard error (the variance of the coefficient) and a slightly larger t-statistic (an indicator of the significance of the independent variable as an estimator of the dependent variable) when the resident-to-day ratio is used to estimate the effect rather than the resident-to-bed ratio.

In addition, the administrative complexities that are involved with trying to identify and count available beds would be reduced by revising the denominator to occupied beds. The General Accounting Office recently released a report on the identified weaknesses in data used to calculate the IME adjustment. (A copy of this report, "Flawed Data Add Millions to Teaching Hospital Payments," GAO/IMTEC-91-31, June 1991, can be obtained by contacting the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20877 or by calling (202) 275-6421.) The study indicates that problems exist regarding the uniform application of our bed-counting policy. While the report does not include a recommendation to adopt average daily census, because we had already included that recommendation as a part of the FY 1992 budget proposal, it does refer to average daily census as a "verifiable" statistic compared to beds.

We are aware of the redistributive effects that would result among major teaching facilities with high occupancy rates and teaching hospitals with lower occupancy rates if the resident-to-day ratio were to be adopted. We do not believe, however, that this should obscure the need to refine the IME adjustment to approximate more accurately the costs hospitals incur as part of the teaching process. As stated in our previous response, the IME adjustment is neither the most appropriate nor the most effective

method for addressing non-Medicare related social health issues. We note that we are providing for an adjustment under the capital prospective payment system that is based on the effect of teaching activity on combined operating and capital costs. The specification of the adjustment formula is based on the resident-to-day ratio and will increase approximately 2.8 percentage points for each .10 increase in a hospital's resident-to-day ratio. For further information on this adjustment, see Section IV.E in this document.

Comment: After publication of the proposed rule, we receive many inquiries concerning the actual effects of the FY 1992 budget proposals to reduce the IME adjustment and to change the denominator to average daily census. Several individuals were concerned that we were proposing these changes effective October 1, 1991.

Response: We are not changing the level of the IME adjustment or the measure of teaching intensity as part of this final rule. Section 1886(d)(5)(B)(ii) of the Act specifies the level of the IME adjustment at 7.7 percent and the use of available beds in the adjustment formula. Thus, changing either policy would require Congressional action to amend the Act. The proposal discussed in the proposed rule are part of our recommendation for the President's FY 1992 budget. Absent any Congressional action, the IME adjustment for operating costs remains at 7.7 percent, and we will continue to use available beds rather than average daily census for calculating IME payments for operating costs under the prospective payment system.

B. Data Collection and Coding Requirements (Recommendation 9)

Recommendation: Uniform coding and billing requirements should be implemented for all providers of outpatient care. These requirements should apply to the hospital outpatient setting, physicians' offices, and free-standing ambulatory care providers. In addition, a mechanism for periodic collection of producer-specific cost data in free-standing settings (including physicians' offices and ambulatory surgery centers) should be implemented.

Response in the Proposed Rule: We agree in principle with ProPAC's recommendation. Both uniform coding and billing requirements and a systematic cost data collection mechanism are prerequisites for a prospective payment system that would be applicable across all outpatient settings. However, in practice, there are several problems involved in the implementation of this recommendation.

First, it should be understood that there are two categories of codes to which the recommendation applies, diagnosis coding and procedure coding. HCFA uses the ICD-9-CM coding system for reporting diagnoses and inpatient hospital procedures and the CPT-4 coding system for reporting ambulatory services. A major problem in implementing ProPAC's recommendation is the lack of standardization between the two coding systems, which are managed by separate entities.

As discussed in section III.B.10 of this preamble, HCFA plays a major role in the development of ICD-9-CM coding guidelines, since the ICD-9-CM system is controlled by two Federal agencies, NCHS and HCFA. We have made significant progress in standardizing the way in which ICD-9-CM codes are used. HCFA and the NCHS work closely with AHA and AMRA in developing the ICD-9-CM coding guidelines.

The CPT-4 coding system is owned and managed by the American Medical Association (AMA). Although HCFA participates as one of 12 voting members of the panel that creates CPT-4 codes, we have no control over either the creation of the codes or the AMA's coding guidelines. We are continuing to encourage the AMA to strive toward a more systematic coding system.

Another problem inherent in the use of the CPT-4 coding system is that it was designed specifically for reporting physician services. Ambulatory services provided by nonphysician practitioners, such as physical and occupational therapists, speech pathologists and audiologists, optometrists, and nurse practitioners are not always included in the CPT-4 system. The lack of a single coding system that is used by all providers of ambulatory services makes comparisons of services across all outpatient settings difficult. We recommend that the procedure coding system that we ultimately adopt be uniform and contain codes for all types of providers and practitioners to make possible standardized procedure coding and billing across all ambulatory settings.

With respect to ProPAC's recommendation regarding cost data collection, we agree that a more systematic and comprehensive method is needed for collecting nonhospital cost data for rate-setting purposes, and we have begun to examine the design of such a method. A data collection system should employ a sample from all outpatient settings and take into account surgical and medical specialty, volume of procedures, and case mix. Critical

elements of such a data collection system will be the definition of a unit of service that is comparable across all service sites and the universal use by both providers and fiscal intermediaries of a unique provider identification number. Verification of the data by audit is essential, as is the establishment of quality of care measurements to assure that the quality of service is reasonably comparable across care settings. Policies will also need to be developed to determine payment for services and procedures when there are insufficient cost data available to set payment rates.

In conclusion, we support ProPAC's recommendation regarding uniform coding requirements and the need for periodic cost data collection. We will continue to explore possible mechanisms for achieving these ends.

Comment: We received one comment supporting ProPAC's recommendation that we implement uniform coding and billing requirements for all providers of outpatient care. The commenter urged that the ICD-9-CM coding system be adopted as the sole reporting system.

Response: As noted in our response to the ProPAC recommendation in the June 3, 1991 proposed rule, we recognize the need for uniform coding and billing requirements and agree that HCFA will continue to evaluate that recommendation.

VII. Other Required Information

A. Paperwork Reduction Act

This final rule does not impose information collection requirements. However, completion of the UB-82 billing form (the billing form used for Medicare discharges), as discussed in section III.B.11 of this preamble, requires information collection that is subject to review by the Office of Management and Budget (OMB) under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501-3511). The current information collection requirements associated with the UB-82 billing form have been approved through April 30, 1992 under OMB number 0938-0279.

In this document, we are announcing changes to the UB-82 billing form that result in an increase in the number of fields for diagnosis and procedure codes that may be completed. The current UB-82 billing form limits these fields to five diagnosis and three procedure codes. We have decided to expand the UB-82 billing form to include nine diagnosis fields and six procedure code fields effective for discharges occurring on or after October 1, 1991. However, hospitals that need to make internal changes in their claims reporting

systems to accommodate the expansions will have until April 1, 1992 to begin expanded coding.

There are approximately 10 million Medicare inpatient hospital claims filed every year. Of that number, we estimate that approximately 86 percent of the claims are completed with the current five diagnosis codes and approximately 87 percent of the claims are completed with the current three procedure codes. Thus, we estimate that no more than 27 percent of the claims (if there is no overlap between these two sets) and possibly as few as 14 percent of the claims will require additional coding.

Because the prospective payment system requires the coding of the principal diagnosis and because the coding of certain secondary diagnoses results in assignment of the claim to a higher-weighted DRG, medical record technicians and coders should already be reviewing the entire medical record and collecting all diagnosis codes to maximize DRG payment. Also, because there is a hierarchy that assigns a surgical claim to a DRG based on the most resource-intensive procedure, the technicians and coders must also review the entire record and collect all procedures. Thus, we estimate that these expanded reporting fields should not result in any additional collection activities. However, they will result in a minimal amount of time necessary to record the additional codes; we estimate that this will be less than 1 minute per claim. We believe that this additional time will be more than offset by the time saved due to the fact that, for the vast majority of claims, the coders and technicians will no longer be required to make any decisions concerning which diagnoses and procedures to code to ensure correct DRG assignment because there will be adequate room to include all codes.

The information collection and recordkeeping requirements associated with the expanded reporting fields in the UB-82 billing form have been sent to OMB for review under 44 U.S.C. 3501-3511. We will publish a notice in the *Federal Register* when approval has been obtained.

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.

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

Subchapter B—Medicare Program

I. Part 412 is amended as follows:

A. The title of part 412 is revised to read as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395hh, and 1395ww).

C. The title of subpart B is revised to read as follows:

Subpart B—Hospital Services Subject to and Excluded from the Prospective Payment Systems for Operating Costs and Capital Costs.

1. In § 412.23, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; the introductory text of paragraph (b) is republished; and a new paragraph (b)(9) is added to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements:

* * * * *

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment system for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, HCFA adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130 of this part.

* * * * *

2. In § 412.30, a new paragraph (c) is added to read as follows:

§ 412.30 Exclusion of new distinct part rehabilitation units and expansion of units already excluded.

* * * * *

(c) *Retroactive adjustments for certain units.* For cost reporting periods beginning on or after October 1, 1991, if a hospital has a new rehabilitation unit excluded from the prospective payment system for a cost reporting period under paragraph (a) of this section or expands an existing rehabilitation unit under paragraph (b) of this section, but the

inpatient population actually treated in the new unit or the beds added to the existing unit during that cost reporting period does not meet the requirements in § 412.23(b)(2), HCFA adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130 of this part.

D. Subpart H is amended as follows:

Subpart H—Payments to Hospitals under the Prospective Payment System

1. Section 412.118 is redesignated as § 412.105; the heading of newly redesignated § 412.105 is revised; the undesignated introductory text and the introductory text of paragraph (a) are reprinted; paragraph (a)(2) is amended by revising the first sentence; paragraph (c) is revised; paragraph (d)(2) is removed; the introductory text of paragraph (d)(1) and paragraphs (d)(1)(i) through (d)(1)(iii) are redesignated as the introductory text of paragraph (d) and paragraphs (d)(1) through (d)(3), respectively; and paragraph (e) is revised to read as follows:

§ 412.105 Determination of indirect medical education adjustment under the prospective payment system for operating costs.

To determine the indirect medical education costs, HCFA uses the following procedures:

(a) *Basic data.* HCFA determines the following for each hospital:

(2) The hospital's total DRG revenue based on DRG-adjusted prospective payment rates for operating costs (for transition period payments, the Federal portion of the hospital's payment rates), including outlier payments determined under subpart F of this part but excluding additional payments made under the provisions of subpart G of this part. * * *

(c) *Measurement for teaching activity.* The factor representing the effect of teaching activity on inpatient operating costs equals .405 for discharges occurring on or after May 1, 1986. * * *

(e) *Determination of payment amount.* Each hospital's indirect medical education payment under the prospective payment system for operating costs is determined by multiplying the total DRG revenue, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section. * * *

2. A new § 412.130 is added to read as follows:

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and distinct part units.

(a) *Hospitals for which adjustment is made.* The intermediary makes the payment adjustment described in paragraph (b) of this section for the following hospitals:

(1) A hospital that was excluded from the prospective payment system as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that had a distinct part unit excluded from the prospective payment system as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during that period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(3) A hospital that added new beds to its existing distinct part rehabilitation unit for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.30(b) regarding the inpatient population the hospital planned to treat in these new beds during that cost reporting period, if the inpatient population actually treated in the new beds during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(b) *Adjustment of payment.* The intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(1) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds, and the amount that would have been paid under the prospective payment system for services furnished during that period.

(2) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment system.

E. In subpart L, § 412.273, paragraph (a) is revised and paragraph (b) is amended by adding the heading to read as follows:

Subpart L—The Medicare Geographic Classification Review Board

§ 412.273 Withdrawing an application.

(a) *Timing of a withdrawal.* A hospital, or group of hospitals, may withdraw an application only during the following time periods:

(1) At any time before the MGCRB issues a decision; or

(2) After the MGCRB issues a decision, provided that the request for withdrawal is received by the MGCRB within 45 days of publication of HCFA's annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application has been filed.

(b) *Written request only.*

* * *

II. Part 413 is amended as follows:

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

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

Authority: Sec. 1102, 1814(b), 1815, 1833(a) and (i), 1861(v), 1871, 1881, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a) and (i), 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. 1305ww (note)) and sec. 101(c) of Pub. L. 101-234 (42 U.S.C. 1305ww (note)).

B. In subpart C, § 413.40, paragraphs (c)(1)(ii) and (d)(3)(ii) are revised; new paragraph (d)(3)(iii) is added; paragraphs (e) and (g) are revised; paragraph (h) is removed; paragraphs (i) and (j) are redesignated as paragraphs (h) and (i), respectively; newly redesignated introductory text (i)(1)(i), newly redesignated paragraphs (i)(1)(i)(B), (i)(1)(i)(C), and (i)(1)(ii) are revised to read as follows:

Subpart C—Limits on Cost Reimbursement

§ 413.40 Ceiling on rate of hospital cost increases.

* * *

(c) *Procedure for establishing the ceiling (target amount)—* (1) *Costs subject to the ceiling.* * * *

(ii) For cost reporting periods beginning on or after October 1, 1982

and before October 1, 1983, these operating costs include operating costs of routine services (as described in § 413.53(b)), ancillary service operating costs, and special care unit operating costs. These operating costs exclude the costs of malpractice insurance, certain kidney acquisition costs, capital-related costs, the Medicare inpatient routine nursing salary cost differential, and costs a hospital allocates to approved medical education programs (nursing school or approved intern and resident programs) on its Medicare cost report.

(d) *Application of target amounts in determining reimbursement.* * * *

(3) *Inpatient operating costs are greater than the target amount.* * * *

(ii) For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1991, payment will be based on the hospital's target amount per case.

(iii) For cost reporting periods beginning on or after October 1, 1991, payment will be based on the lower of the hospital's—

(A) Target amount plus 50 percent of the allowable operating costs per case in excess of the target amount; or

(B) 110 percent of the target amount per case.

(e) *Hospital requests regarding applicability of the rate-of-increase ceiling—(1) Timing of application.* A hospital may request an exemption from, or adjustment to, the rate of cost increase ceiling imposed under this section. The hospital's request must be made to its fiscal intermediary no later than 180 days after the date on the intermediary's notice of amount of program reimbursement.

(2) *Intermediary recommendation.* Unless HCFA has authorized the intermediary to make the decision, the intermediary makes a recommendation on the hospital's request to HCFA, which makes the decision. HCFA issues a decision to the intermediary no later than 180 days after receipt of the completed application and the intermediary's recommendation.

(3) *Intermediary decision.* If HCFA has authorized the intermediary to make the decision, the intermediary issues a decision no later than 180 days after receipt of the completed application.

(4) *Notification and review.* The intermediary notifies the hospital of the decision, including a full explanation of the grounds for the decision. A decision issued under paragraph (e)(2) or (e)(3) of this section is considered final unless the hospital submits additional information no later than 180 days after

the date on the intermediary's notice of the decision. The final decision is subject to review under subpart R of part 405 of this chapter, provided the hospital has received a notice of amount of program reimbursement for the cost reporting period in question.

(5) *Extending time limit for PRRB review of NPR.* The time required to review the request is considered good cause for the granting of an extension of the time limit to apply for review of the notice of amount of program reimbursement by the Provider Reimbursement Review Board, as specified in § 405.1841(b) of this chapter.

(6) *Applicability.* The provisions in paragraphs (e)(1) through (e)(5) of this section apply to a hospital's initial request for an adjustment and to a request for a reconsideration of the original decision based on additional data.

(g) *Adjustments—(1) General rule.* HCFA must adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified below. When an adjustment is requested by the hospital, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary. HCFA may grant an adjustment requested by the hospital only if a hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(2) *Extraordinary circumstances.* HCFA may make an adjustment to take into account unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

(3) *Comparability of cost reporting periods—(i) Adjustment for distortion.* HCFA may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

(ii) *Factors.* The adjustments described in paragraph (g)(3)(i) of this section, include, but are not limited to, adjustments to take into account:

(A) FICA taxes (if the hospital did not incur costs for FICA taxes in its base period).

(B) Services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period.

(C) Malpractice insurance costs (if malpractice costs were not included in the base year operating costs).

(D) Increases in service intensity or length of stay attributable to changes in the type of patient served.

(E) A change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as an addition or discontinuation of services or treatment programs.

(F) The manipulation of discharges to increase reimbursement.

(iii) *Adjusting operating costs.* Without a formal request from a hospital, HCFA may adjust the amount of operating costs, determined under paragraph (c)(1) of this section, to take into account adjustments under paragraphs (g)(3)(ii) (A), (B), (E), and (F) of this section.

(4) *Significant wage increase—(i) Criteria.* HCFA may make an adjustment to take into account a significant increase in wages occurring between the base period and the cost reporting period subject to the ceiling if the increase in the average hourly wage for the geographic area in which the hospital is located (determined by reference to the wage index for prospective payment hospitals without regard to geographic reclassifications under sections 1886(d) (8) and (10) of the Act) meets one of the following criteria:

(A) The wage index value based on 1988 wage data is at least 8.0 percent higher than the wage index value based on 1982 wage data.

(B) If the hospital's base period begins in FY 1984 or later, the wage index value based on 1988 wage data is at least 8.0 percent higher than the wage index value based on 1984 wage data.

(ii) *Amount of the adjustment.* The adjustment for a significant wage increase equals the amount by which the lesser of the following calculations exceeds 105 percent of the increase in the national average hourly earnings for hospital workers:

(A) The rate of increase in the average hourly wage in the geographic area (determined by applying the applicable increase in the area wage index value to the rate of increase in the national average hourly earnings for hospital workers).

(B) The rate of increase in the hospital's average hourly wage.

(i) *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 inpatient services and all the following conditions apply:

(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. In making this determination, HCFA takes into consideration the following factors:

(1) Changes in the services provided by the hospital.

(2) Changes in applicable technologies and medical practices.

(3) Differences in the severity of illness among patients or types of patients served.

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

(ii) The revised ceiling is based on the necessary and proper costs incurred during the new base period.

(A) Increases in overhead costs (for example, administrative and general costs and housekeeping costs) are not taken into consideration unless the hospital documents that these increases result from substantial and permanent changes in furnishing patient care services.

(B) In determining whether wage increases are necessary and proper, HCFA takes into consideration whether increases in wages and wage-related costs for hospitals in the labor market area exceed the national average increase.

C. In subpart F, § 413.86, the introductory text of paragraph (b) is republished and the definition *Approved medical residency program* is amended by republishing the introductory text and revising (2) to read as follows:

Subpart F—Specific Categories of Costs

§ 413.86 Direct graduate medical education payments.

(b) *Definitions.* For purposes of this section, the following definitions apply:

Approved medical residency program means a program that meets one of the following criteria:

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, suite 805, Evanston, Illinois 60201.

(Catalog of Federal Domestic Assistance Programs No. 93.733, Medicare—Hospital Insurance; No. 93.744, Medicare—Supplementary Medicare Insurance)

Dated: August 23, 1991.

Gail R. Wilensky,
Administrator, Health Care Financing Administration.

Approved: August 23, 1991.

Louis W. Sullivan,
Secretary.

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

Addendum—Schedule of Standardized Amounts Effective with Discharges On or After October 1, 1991 and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1991

I. Summary and Background

In this addendum, we are making changes in the amounts and factors for determining prospective payment rates for Medicare inpatient hospital services. We are also setting forth new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals and hospital units excluded from the prospective payment system.

For discharges occurring on or after October 1, 1991, except for sole community hospitals, Medicare-dependent small rural hospitals, hospitals located in Puerto Rico, and hospitals subject to the regional floor, each hospital's payment per discharge under the prospective payment system will be comprised of 100 percent of the Federal national rate.

For cost reporting periods beginning on or after April 1, 1990, sole community hospitals and Medicare-dependent, small rural hospitals are paid based on

whichever of the following rates yields the greatest aggregate payment: The Federal national rate (subject to the regional floor), 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. Hospitals in Puerto Rico are paid on the basis of a rate per discharge composed of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act). Hospitals affected by the regional floor are paid on the basis of 85 percent of the Federal national rate and 15 percent of the Federal regional rate (section 1886(d)(1)(A)(iii) of the Act).

As discussed below in section II, we are making changes in the determination of the prospective payment rates. The changes, to be applied prospectively, will affect the calculation of the Federal rates. Section III sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the final rule are presented at the end of this addendum in section IV.

II. Changes to Prospective Payment Rates For Hospitals for FY 1992

The basic methodology for determining prospective payment rates is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below we discuss the manner in which we are changing some of the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 1991. As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and relative weights for discharges in FY 1992.

In summary, the standardized amounts set forth in Tables 1a, 1b, and 1c of section IV of this addendum were—

- Updated by 2.8 percent for urban hospitals (that is, the market basket percentage increase of 4.4 percent minus 1.6 percent); and 3.8 percent for rural hospitals (that is, the market basket percentage increase of 4.4 percent minus 0.6 percent);

- Adjusted by the revised urban and rural outlier adjustment factors;

- Adjusted to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act; and

• Adjusted to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act.

A. Calculation of Adjusted Standardized Amounts

1. *Standardization 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 September 1, 1983 interim final rule (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 requires 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 from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(C) and (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 the standardized amounts have already been adjusted for differences in case mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, no additional adjustments for these factors for fiscal year 1992 were made. That is, the standardization adjustments reflected in the fiscal year 1992 standardized amounts are the same as those reflected in the fiscal year 1991 standardized amounts.

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act require that, in making payments under the prospective

payment system, the Secretary adjust the proportion of payments that are wage-related (as estimated by the Secretary from time to time). Beginning with October 1, 1990, when the market basket was rebased, we have considered 71.40 percent of costs to be labor-related for purposes of the prospective payment system.

2. *Computing Urban and Rural Averages Within Geographic Areas.* In determining the prospective payment rates for fiscal year 1984, section 1886(d)(2)(D) of the Act required that the average standardized amounts be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. Under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge for fiscal year 1988 must be determined for hospitals located in urban and rural areas in Puerto Rico. Hospitals in Puerto Rico are paid a blend of 75 percent of the applicable Puerto Rico standardized amount and 25 percent of a national standardized payment amount.

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

Based on 1990 census population data published by the Bureau of the Census, the current 46 large urban areas continue to meet the criteria to be defined as large urban areas for fiscal year 1992. A list of those areas was set forth in the April 5, 1988 notice (at 53 FR 11138) concerning fiscal year 1988 legislative changes that affect payment to hospitals. In addition, these areas are identified by an asterisk in tables 4a and 4c. Effective with fiscal year 1992, the following additional large urban areas have been identified:

- Middlesex-Somerset-Hunterdon, NJ
- Orlando, FL
- Rochester, NY

Table 1a contains the three national standardized amounts that will continue to be applicable to most hospitals. Table 1b sets forth the 27 regional standardized amounts that will continue to be applicable for hospitals located in census areas subject to the regional floor. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national rural standardized amount, the national large urban standardized amount, and the national other urban standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is set forth in Table 1c. This table also includes the three standardized amounts that will be applicable to most hospitals in Puerto Rico.

The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts.

Although we stated in the proposed rule that the Office of Management and Budget (OMB) may announce new Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA) designations that are used in calculating standardized amounts, we note that OMB has made no such announcement. Therefore, the MSA and NECMA designations remain unchanged.

3. *Updating the Average Standardized Amounts.* In accordance with section 1886(d)(3)(A) of the Act, we will update the large urban, other urban, and rural average standardized amounts using the applicable percentage increases specified in section 1886(b)(3)(B)(i). Section 1886(b)(3)(B)(i)(VII) (as added by sections 4002(a) and (c) of Pub. L. 101-508) specifies the following update factors for the standardized amounts for fiscal year 1992:

- The market basket percentage increase of 4.4 minus 1.6 percentage points (that is, 2.8 percent) for hospitals located in urban areas.
- The market basket percentage increase of 4.4 minus 0.6 percentage points (that is, 3.8 percent) for hospitals located in rural areas.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecasted hospital market basket increase for fiscal year

1992, as reflected in the calculation above, is 4.4 percent.

Although the update factor for fiscal year 1992 is set by law, we were required by section 1886(e)(3)(B) of the Act to report to Congress no later than March 1, 1991 on our initial recommendation of update factors for fiscal year 1992 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we published the report to Congress as appendix C to the proposed rule. Our final recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as appendix B to this final rule.

Comment: Several commenters were concerned about the unexpectedly low market basket forecast. They indicated that the breakdown of the wages and salaries portion of the market basket does not effectively reflect changes in the salaries of hospital employees because only 30 percent of the price proxies used to measure this variable are directly related to wages and salaries within the hospital setting. One commenter suggested we adopt the price proxies used by ProPAC.

Response: At the time of the proposed rule, the market basket forecast, which was 3.8, was unusually low due to the severe downturn in the economy during the period. However, the market basket forecast has increased since the proposed rule was published, and the latest forecast for fiscal year 1992 is a market basket increase of 4.4 percent. Otherwise, HCFA proposed no changes to the market basket structure. The hospital market basket was rebased in fiscal year 1991, at which time we addressed the issue raised by the commenters. A complete discussion of the market basket construction and price proxies, and our responses to comments on these issues is included in the September 4, 1990 final rule (55 FR 36043).

4. Other Adjustments to the Average Standardized Amounts—*a. Reclassified Hospitals—Budget Neutrality Adjustment.* Section 1886(d)(8)(B) of the Act provides that certain rural hospitals are deemed urban effective with discharges occurring on or after October 1, 1988. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals beginning in fiscal year 1992 based on determinations by the Medicare Geographic Classification Review Board (MGCRCB). Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Section 1886(d)(8)(D) of the Act specifies two budget neutrality objectives that must be met. First, the fiscal year 1992 urban 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) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Second, the rural standardized amounts are to be adjusted to ensure that aggregate payments to rural hospitals not affected by these provisions neither increase nor decrease as a result of implementation of these provisions. The following adjustment factors, necessary to achieve the requisite budget neutrality constraints, were applied to the proposed standardized amounts:

Urban	Rural
.988778	.999765

The following adjustment factors were applied to the final standardized amounts:

Urban	Rural
.989149	.999766

The proposed adjustments factors reflected the results of all wage index and standardized amount reclassifications approved by the MGCRCB as of March 31, 1991. Approximately 500 cases were still pending before the MGCRCB as of that date. The final budget neutrality adjustment factors reflect the effects of all reclassifications decisions by the MGCRCB for fiscal year 1992, as well as any changes in these reclassification decisions based on the Administrator's review of the decisions.

Comment: Several commenters noted that their analyses indicated that the budget neutrality adjustment for the urban standardized amount appeared to be overstated in the proposed rule and they questioned whether it had been computed properly.

Response: In determining the budget neutrality adjustment in the proposed rule, a technical error was made that has been corrected in this final rule. If the error had not been made in computing the proposed budget neutrality factor, the factor would have been about .994 rather than .988778 in the proposal.

We have carefully reviewed our methodology for calculating the adjustment in the final rule, and we are confident that it is technically correct.

Comment: A number of commenters stated that the update to the standardized amounts for urban hospitals was unreasonable compared to that for rural hospitals, which receive a higher update as well as benefitting from the geographic reclassifications. In contrast, urban hospitals not only receive a lower general update, but also have their standardized amounts reduced through the budget neutrality adjustment required by section 1886(d)(8)(D) of the Act that funds the geographic reclassifications. One commenter suggested that the differential between the urban and rural updates should be capped at 50 percent and that the number of reclassifications be restricted to limit the amount of the offset against the urban rates needed to fund the reclassifications.

Response: The amount of the update to the standardized amounts for fiscal year 1992 applicable to urban and rural hospitals is mandated under section 1886(b)(3)(B)(i) (as amended by Pub. L. 101-508). Thus, we do not have the authority to modify the amount of the update for urban hospitals. Similarly, we do not have the authority to limit the number of geographic reclassifications for the purpose of reducing the budget neutrality adjustment necessary to fund the reclassifications. The reclassifications granted by the MGCRCB are based on guidelines adopted by regulation. When the reclassification guidelines were published in the *Federal Register* for public comment in our September 6, 1990 final rule with comment period (55 FR 36754), the only comments we received indicated that the guidelines were too stringent and would not allow all hospitals that merited geographic reclassification to qualify. None of the commenters stated that the guidelines might be too lenient. However, in light of the comments we have received in response to the June 3, 1991 proposed rule, we will reevaluate the MGCRCB guidelines and propose any changes that appear appropriate in a separate rulemaking document. The changes would apply to requests for reclassification that would be effective in fiscal year 1994. Finally, we note that 201 urban hospitals have benefited from the reclassification guidelines.

Comment: We received a number of comments suggesting that we cushion the financial impact of geographic reclassifications on urban hospitals through a blend of 50 percent of payments based on the reclassification

and 50 percent of payments based on what hospitals would have received in the absence of the reclassifications. One hospital association indicated that it would seek legislation to have this change adopted.

Response: While we share the commenters concern about the adverse impact geographic reclassifications will have on payments to urban hospitals, we do not believe we have authority to reduce payments to hospitals that have been reclassified. The statute clearly contemplates that geographic reclassifications granted by the MGCRB would be funded through a reduction in the urban standardized amounts. An administrative reduction in payments to reclassified hospitals would undermine this provision. We agree with the commenter that legislative action would be required to implement this change.

b. *Recalibration of DRG Weights and Updated Wage Index-Budget Neutrality Adjustment.* Section 1886(d)(4)(C)(iii) of the Act specifies that beginning in fiscal year 1991, the annual DRG reclassifications and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section III.C of the preamble to this final rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. While this adjustment is intended to ensure that recalibration does not affect total payments to hospitals, our analysis indicates that the normalization adjustment does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals.

Section 1886(d)(3)(E) of the Act specifies that the hospital wage index must be updated based on new survey data no later than October 1, 1990 and on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the DRG reclassification changes and recalibration of the relative weights be budget neutral and the requirement in section 1886(d)(E) of the Act that the updated wage index be implemented in a budget neutral manner, we compared aggregate payments using the FY 1991 relative weights and the wage index effective January 1, 1991 to aggregate payments using the proposed FY 1992 relative weights and wage index. This

was the same methodology used for the FY 1991 recalibration. (See discussion in September 4, 1990 final rule (55 FR 36073).) Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 1.000018. We applied this budget neutrality adjustment factor to the standardized amounts.

The budget neutrality adjustment factor that was applied to the final standardized amounts is .999757.

In addition, we are continuing to apply the same adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1991, in order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the DRG weights and updated wage index. (See discussion in September 4, 1990 final rule (55 FR 36073).)

c. *Retroactive Budget Neutrality Adjustment to Reflect FY 1991 Midyear Wage Index Corrections.* In the September 4, 1990 final rule (55 FR 36042), we set forth under § 412.63(1) our policy for making midyear corrections in the wage index and applying those corrections on a prospective basis effective with discharges occurring after the date the corrections are made. As described in that rule, when midyear corrections are made under the provisions of § 412.63(1), the correction in the wage index value for the affected area is effective prospectively from the date the revision is made; however, both the corresponding prospective adjustment to the wage index values for all other wage areas (to reflect the effect of the corrected data on the national average hourly wage), and the budget neutrality adjustment to the standardized amounts required by section 1886(d)(3)(E) (to account for the effect on payments of the midyear corrections), are not made until the beginning of the next fiscal year.

To account for the effect that midyear corrections in the wage index for FY 1991 had on program payments for that year, we computed a retroactive budget neutrality adjustment factor of .999676 in the proposed rule. This adjustment was computed by comparing FY 1991 aggregate payments before the wage data corrections were made with aggregate payments after the revised wage index values were implemented. Based on the additional revised wage values that have been implemented since the proposed rule was issued, the final budget neutral adjustment factor is .999570. This adjustment has been applied to the FY 1992 standardized amounts.

d. *Outliers.* Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act requires that the urban and rural standardized amounts be separately reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments for hospitals located in urban areas and those located in rural areas. Section 1886(d)(9)(B)(iv) of the Act requires that the urban and rural standardized amounts be reduced by the proportion of estimated total payments made to hospitals in Puerto Rico attributable to estimated outlier payments.

Consequently, instead of a uniform reduction factor applying equally to all the standardized amounts, there are two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Furthermore, sections 1886(d)(5)(A)(iv) and 1886(d)(9)(D)(i) of the Act direct that outlier payments for operating costs in any year may not be less than 5 percent nor more than 6 percent of total payments projected to be made based on the prospective payment rates for operating costs.

In the September 4, 1990 final rule, we set the outlier thresholds so as to result in estimated outlier payments equal to 5.1 percent of total prospective payments. We also set the same outlier thresholds and offsets for the Puerto Rico prospective payment standardized amounts as we had for hospitals located outside Puerto Rico. For FY 1991, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 29 days or 3.0 standard deviations. The cost outlier threshold is the greater of 2.0 times the prospective payment rate for the DRG or \$35,000. In implementing the changes required by Public Law 101-508 in the January 7, 1991 final rule with comment period, we determined that maintaining the FY 1991 thresholds would result in estimated outlier payments equal to 5.2 percent of total prospective payments. Accordingly, we revised the adjustment factors to reflect the higher outlier payments. The outlier adjustments for FY 1991 that were effective for discharges on or after January 1, 1991 were .944078 for the urban rates and .977448 for the rural rates.

As discussed in section IV.C of this document, we proposed to establish outlier thresholds that would be applicable to both operating costs and

capital-related costs. The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1992 were as follows:

Urban standardized amount	Rural standardized amount	Capital federal rate
.944309	.979808	.954854

The final outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1992 are as follows:

Urban standardized amount	Rural standardized amount	Capital federal rate
.944047	.979202	.949722

We proposed to continue to set the outlier thresholds so as to result in estimated outlier payments equal to 5.1 percent of total prospective payments for operating costs. The model that we use to determine the outlier thresholds necessary to target our desired outlier payments for FY 1992 uses FY 1990 charges. We proposed to adjust that model to take into account the effect of expanded Medicare coverage for inpatient hospital services during the first quarter of FY 1990 that resulted from the enactment of the Catastrophic Coverage Act of 1988 (Pub. L. 100-360). These catastrophic coverage provisions were effective with discharges occurring on or after January 1, 1989 (the second quarter of FY 1989) and were repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101-234) effective for discharges occurring on or after January 1, 1990.

We determine the outlier thresholds and establish the outlier adjustment factor based on the covered days and charges reflected in the billing data. The FY 1990 billing data that we used to determine the FY 1992 outlier payments contain 3 months of data for discharges occurring while the catastrophic legislation was in effect (data from discharges occurring on or after October 1, 1989 and before December 31, 1989) and 9 months of data for discharges occurring after the catastrophic legislation was repealed (data from discharges occurring on or after January 1, 1990 and before October 1, 1990). For discharges occurring on or after October 1, 1989 through December 31, 1989, we are not able to identify the additional days (and charges) covered under the catastrophic legislation that are no longer covered after its repeal. If we include the additional inpatient days

attributable to catastrophic coverage in the model used to estimate outlier payments, we will overestimate the FY 1992 outlier payments. Since we are not able to isolate the catastrophic-covered days and charges from other covered days and charges, we have developed an adjustment to the outlier model to account for the catastrophic-covered days reflected in the billing data. The adjustment is based on a comparative analysis of outlier payments modeled on covered days and charges and on total days and charges using post-catastrophic billing data and billing data for the period the catastrophic legislation was in effect.

We proposed to adjust the model used to develop the outlier thresholds by calculating an adjustment to the 5.1 percent outlier payment target solely for purposes of estimating the thresholds. By adjusting the payment target, we eliminate the impact that the changes in coverage that occurred in FY 1990 would have had on the computation of the outlier thresholds. To accomplish this, we calculated, for each quarter in FY 1990, the ratio of outlier payments based on covered days and covered charges to payments based on total days and total charges. We arrived at the adjustment by comparing the ratio for the first quarter (in which catastrophic days and charges occurred) to the succeeding quarters (in which postcatastrophic days and charges occurred). The result was a proposed adjustment factor of .9966. Based on more complete FY 1990 MEDPAR data, the final adjustment factor is .9995. Based on this analysis, we estimate that outlier payments will be 99.95 percent of the amounts estimated based on FY 1990 covered days and charges. To account for this, we multiplied the outlier payments estimated by the model by .9995 before determining the outlier adjustment factors that are applied to the standardized amounts and the capital Federal rate.

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

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

for hospitals located in the 50 States, the District of Columbia, and Puerto Rico.

1. *Adjustment for Area Wage Levels.* Sections 1886(d)(2)(H) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section IV of the preamble to this final rule, we discuss certain revisions we are making to the wage index. This index is set forth in tables 4a through 4c of this addendum.

2. *Adjustment for Cost of Living in Alaska and Hawaii.* Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages above. For FY 1992, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii will be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Table of Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska—All areas.....	1.25
Hawaii:	
Oahu.....	1.225
Kauai.....	1.175
Maui.....	1.20
Molokai.....	1.20
Lanai.....	1.20
Hawaii.....	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section III of the preamble to this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that are intended to reflect the resource utilization of cases in each DRG relative to Medicare cases or other DRGs.

Table 5 of section IV of this addendum contains the weighting factors that we will use for discharges occurring in FY 1992. These factors have been recalculated as explained in section III.C of the preamble.

D. Calculation of Prospective Payment Rates for FY 1992

General Formula for Calculation of Prospective Payment Rates for FY 1992:

Prospective payment rate for all hospitals located outside Puerto Rico except sole community hospitals and Medicare-dependent, small rural hospitals.	=	Federal rate.
Prospective payment rate for sole community hospitals and Medicare-hospitals and Medicare-dependent, small rural hospitals (for cost reporting periods beginning on or after April 1, 1990).	=	Whichever of the rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the FY 1982 hospital-specific rate, or 100 percent of the FY 1987 hospital-specific rate.
Prospective payment rate for Puerto Rico.....	=	75 percent of the Puerto Rico rate + 25 percent of a discharge-weighted average of the large urban, other urban, and rural national rates.

1. *Federal Rate.* For discharges occurring on or after October 1, 1991 and before October 1, 1992, except for sole community hospitals, Medicare-dependent, small rural hospitals, hospitals located in Puerto Rico, and hospitals subject to the regional floor, the hospital's rate is comprised exclusively of the Federal national rate. Section 1886(d)(1)(A)(iii) of the Act provides that the Federal rate is comprised of 100 percent of the Federal national rate except for those hospitals located in census regions that have a regional rate that is higher than the national rate. This provision, which was due to expire effective with discharges occurring on or after October 1, 1990, was extended by section 115(b)(1) of Public Law 101-403 and section 4002(e) of Public Law 101-508 to discharges occurring before October 1, 1993. The Federal rate for hospitals located in census regions that have a regional rate that is higher than the national rate equals 85 percent of the Federal national rate plus 15 percent of the Federal regional rate. For discharges occurring on or after October 1, 1991, rural hospitals in regions I, II, III, and IV and urban and large urban hospitals in I, IV, and VI are affected by the regional floor.

The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and designation of the hospital as large urban, other urban, or rural (see Tables 1a and 1b, section IV of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located (see Tables 4a, 4b, and 4c, section IV of this addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted if appropriate under Step 3).

Step 5—Multiply the final amount from Step 4 by the weighting factor corresponding to the appropriate DRG (see Table 5, section IV of this addendum).

2. *Hospital-Specific Rate (Applicable Only to Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals).* Section 1886(d)(5)(D)(i) of the Act provides that for cost reporting periods beginning on or after April 1, 1990, sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate (subject to the regional floor), 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. Under section 1886(d)(5)(G) of the Act, Medicare-dependent small rural hospitals are eligible for special payment under the prospective payment system and, effective for cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993, are paid based on the same formula applicable to sole community hospitals.

Hospital-specific rates have been determined for each of these hospitals based on both the FY 1982 cost per discharge and the FY 1987 cost per discharge. For a more detailed discussion of the calculation of the FY 1982 hospital-specific rate and the FY 1987 hospital-specific rate, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); and the September 4, 1990 final rule (55 FR 35994).

a. *Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 1992 Cost Reporting Periods.* For cost reporting periods beginning on or after October 1, 1991, we are increasing the hospital-specific rates by 4.4 percent (the hospital market basket percentage increase) for hospitals located in all areas. Sections 1886(b)(3)(C)(ii) and (b)(3)(D)(ii) of the Act (as amended by section 4002(c)(2)(A)(ii) of Public Law 101-508) provide that the update factor applicable to the hospital-specific rates for sole community and Medicare-dependent, small rural hospitals equals

the update factor provided under section 1886(b)(3)(B)(ii) of the Act, which, for cost reporting periods beginning in FY 1992, is the market basket rate of increase.

b. *Calculation of Hospital-Specific Rate.* For sole community hospital and Medicare-dependent, small rural hospital cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992, the applicable hospital-specific rate will be calculated by multiplying a hospital's hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 4.4 percent). In addition, the hospital-specific rate will be adjusted by the budget neutrality adjustment factor (that is, .999757) as discussed in section II.A.4.b of this addendum. This resulting rate will be used in determining under which rate a sole community or Medicare-dependent, small rural hospital is paid for its cost reporting period beginning on or after October 1, 1991, based on the formula set forth above.

3. *General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1991 and Before October 1, 1992—*a. *Puerto Rico Rate.* The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban, other urban, or rural designation of the hospital (see Table 1c, section IV of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index (see Tables 4a and 4b, section IV of the addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 75 percent.

Step 5—Multiply the amount from Step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section IV of the addendum).

b. *National Rate.* The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section IV of the addendum) by the appropriate wage index.

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 25 percent.

Step 4—Multiply the amount from Step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section IV of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience, trended forward by the applicable update factors. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

As discussed in section IV.F of the preamble, effective with cost reporting periods beginning on or after October 1, 1991, a hospital that has inpatient operating costs per discharge in excess

of its target amount will be paid its target amount plus 50 percent of its costs in excess of the target amount. Total payments may not exceed 110 percent of the target amount. However, a hospital that has inpatient operating costs less than its target amount will 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 cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992, section 1886(b)(3)(B)(ii) of the Act provides that the applicable percentage increase is the market basket percentage increase. In order to determine a hospital's target amount for its cost reporting period beginning in FY 1992, the hospital's target amount for its reporting period that began in FY 1991 is increased by the market basket percentage increase for FY 1992. The most recent forecasted market basket increase for FY 1992 for hospitals and units excluded from the prospective payment system is 4.7 percent. Therefore, the applicable percentage increase is also 4.7 percent.

IV. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of tables 1a, 1b, 1c, 3c, 4a, 4b, and 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 3c, 4a, 4b, 4c, 5, 6a, 6b, 6c, 6d,

6e, 6f, 6g, 6h, 6i, 7A, 7B, 8a, 8b, and 9 are presented below. The tables presented below are as follows:

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

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

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

Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1990.

Table 4a—Wage Index for Urban Areas.

Table 4b—Wage Index for Rural Areas.

Table 4c—Wage Index for Hospitals That Are Reclassified.

Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Length of Stay Outlier Cutoff Points Used in the Prospective Payment System.

Table 6a—New Diagnosis Codes.

Table 6b—New Procedure Codes.

Table 6c—Invalid Diagnosis Codes.

Table 6d—Invalid Procedure Codes.

Table 6e—Revised Diagnosis Code Titles.

Table 6f—Revised Procedure Code Titles.

Table 6g—Additions to the CC Exclusions List.

Table 6h—Deletions to the CC Exclusions List.

Table 6i—New HIV-Related Conditions Necessary for Assignment to MDC 25.

Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 90 MEDPAR Update 06/91 GROUPE V8.0.

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 90 MEDPAR Update 06/91 GROUPE V9.0.

Table 8a—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted).

Table 8b—Statewide Average Capital Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted).

Table 9—Percentage Difference in Wage Indexes for Areas that Qualify for a Wage Index Exception for Excluded Hospitals and Units.

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
2,526.80	1,041.01	2,486.80	1,024.54	2,534.26	816.50

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).....	2,653.55	1,087.04	2,611.53	1,069.82	2,809.71	969.01
2. Middle Atlantic (PA, NJ, NY).....	2,383.96	1,029.84	2,346.23	1,013.54	2,690.86	916.04
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV).....	2,544.81	950.43	2,504.52	935.39	2,572.34	794.33
4. East North Central (IL, IN, MI, OH, WI).....	2,684.15	1,124.51	2,641.65	1,106.71	2,604.84	882.84
5. East South Central (AL, KY, MS, TN).....	2,442.31	860.59	2,403.64	846.98	2,549.45	740.73
6. West North Central (IA, KS, MN, MO, NB, ND, SD).....	2,545.53	1,024.63	2,505.23	1,008.40	2,477.88	791.36
7. West South Central (AR, LA, OK, TX).....	2,530.88	943.99	2,490.81	929.05	2,376.39	727.78
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY).....	2,441.40	1,011.14	2,402.75	995.13	2,403.17	837.03

TABLE 1b.—REGIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR—Continued

	Large urban		Other urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
9. Pacific (AK, CA, HI, OR, WA).....	2,374.81	1,155.02	2,337.21	1,136.73	2,337.28	942.97

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

	Large urban		Other urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Puerto Rico.....	2,272.59	472.64	2,236.61	465.16	1,727.42	372.39
National.....	2,514.14	978.22				

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TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PAGE 1 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.2935	010062	01.0023	010128	00.8732	030010	01.3717	030083	01.3701
010004	00.9749	010064	01.5068	010129	01.0306	030011	01.2948	030084	01.0513
010005	01.1605	010065	01.2011	010130	01.0276	030012	01.1948	030085	01.2994
010006	01.3040	010066	00.9162	010131	01.2555	030013	01.1935	030086	01.2678
010007	01.1369	010068	01.1751	010134	00.8776	030014	01.4259	030087	01.4496
010008	01.0568	010069	01.1279	010136	00.9732	030016	01.1746	030088	01.2790
010009	01.0549	010072	01.1804	010137	01.3160	030017	01.3567	030089	01.2199
010010	01.0976	010073	00.9596	010138	00.9784	030018	01.5545	030091	00.8823
010011	01.3788	010078	01.1912	010139	01.4298	030019	01.2075	030092	01.3930
010012	01.2734	010079	01.1768	010143	01.1526	030022	01.3051	030093	01.2841
010015	01.1369	010080	00.9804	010144	01.3690	030023	01.2050	030094	01.3103
010016	01.1430	010081	01.7266	010145	01.2421	030024	01.5210	030098	00.6389
010018	00.8944	010083	01.1236	010146	01.1338	030025	01.1563	030099	01.2260
010019	01.1920	010084	01.2971	010148	00.9381	030027	01.0501	040001	01.0129
010020	01.0938	010085	01.3102	010149	01.3676	030030	01.6132	040002	01.1699
010021	01.3043	010086	00.9883	010150	00.9698	030033	01.4063	040003	01.0175
010022	01.0016	010087	01.3386	010152	01.2642	030034	01.1406	040004	01.2756
010023	01.2947	010089	01.0366	010153	01.9047	030035	01.1845	040005	01.0349
010024	01.2387	010090	01.4847	010155	01.0301	030036	01.2900	040006	01.7706
010025	01.2264	010091	01.0044	010158	00.5329	030037	01.7239	040007	01.4926
010027	00.9056	010092	01.3111	020001	01.5033	030038	01.4499	040008	01.0749
010028	01.1262	010094	01.2481	020002	01.0827	030040	01.0017	040010	01.1228
010029	01.4336	010095	01.1082	020004	01.1676	030041	00.8996	040011	00.8919
010031	01.2461	010096	00.9348	020005	00.9646	030043	01.1312	040013	01.0092
010032	00.8599	010097	01.0532	020006	01.0167	030044	01.0982	040014	01.1202
010033	01.8597	010098	01.0522	020007	01.2222	030046	01.0077	040015	01.0309
010034	01.0668	010099	01.0341	020008	00.9314	030047	00.9379	040016	01.3783
010035	01.1593	010100	01.2322	020009	00.8278	030049	00.9426	040017	01.2420
010036	01.1448	010101	01.0180	020010	00.9078	030051	01.1159	040018	01.1189
010038	01.1991	010102	00.9200	020011	00.8563	030054	00.8988	040019	01.1837
010039	01.5641	010103	01.4694	020012	01.2750	030055	01.2092	040020	01.4371
010040	01.2264	010104	01.5315	020013	00.8902	030057	01.1831	040021	01.2209
010043	00.9929	010108	01.1182	020014	01.0487	030059	01.3527	040022	01.6199
010044	01.0176	010109	01.1121	020017	01.3687	030060	01.0770	040024	00.9549
010045	01.0610	010110	00.9080	020018	00.9205	030061	01.4047	040025	01.0371
010046	01.2724	010112	01.1392	020019	00.9478	030062	01.2824	040026	01.3489
010047	00.8856	010113	01.5206	020020	00.8835	030064	01.4504	040027	01.2489
010049	01.1428	010114	01.2068	020021	00.8732	030065	01.4348	040028	00.9645
010050	00.9415	010115	00.9153	020024	01.0086	030067	01.0530	040029	01.1018
010051	00.9934	010117	01.0275	020025	00.7465	030068	01.0042	040030	00.9110
010052	01.0149	010118	01.1902	020026	01.2853	030069	01.2308	040031	00.9077
010053	01.0150	010119	01.3135	020027	00.9946	030071	01.0145	040032	00.9648
010054	01.1426	010120	00.9459	030001	01.3487	030072	00.8905	040033	00.9133
010055	01.3306	010121	01.0879	030002	01.6734	030073	01.1298	040035	00.9168
010056	01.3090	010122	00.9526	030003	01.3652	030074	01.1864	040036	01.1904
010057	01.0598	010123	01.2208	030004	00.9592	030075	00.9029	040037	01.0403
010058	01.0024	010124	01.2468	030005	01.4600	030076	00.9900	040039	01.0738
010059	01.0189	010125	01.0159	030007	01.3264	030078	01.0035	040040	01.0051
010060	00.9684	010126	01.0661	030008	01.7527	030079	00.7516	040041	01.1532
010061	00.9892	010127	01.5004	030009	01.2047	030080	01.4734	040042	01.2628

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

[illegible]

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX
050274 01.0414	050351 01.4203	050434 01.0797	050517 01.3778	050591 01.1861
050276 01.1146	050352 01.2453	050435 01.1655	050522 01.3377	050592 01.3319
050277 01.3198	050353 01.5817	050436 01.0786	050523 01.2286	050593 01.2824
050278 01.3115	050355 00.9115	050438 01.4249	050526 01.2468	050594 01.9373
050279 01.2703	050357 01.7070	050440 01.2862	050527 01.3364	050597 01.2809
050280 01.4014	050359 01.0780	050441 01.6536	050528 01.2251	050598 01.3208
050281 01.2956	050360 01.3919	050442 01.2073	050530 01.3038	050599 01.5335
050282 01.2957	050363 01.3437	050443 00.9647	050531 01.1105	050601 01.2764
050283 01.3048	050366 01.3528	050444 01.1998	050534 01.3919	050603 01.3960
050286 00.9609	050367 01.2485	050446 00.9429	050535 01.3369	050604 01.2927
050289 01.5766	050369 01.3467	050447 01.1368	050537 01.2444	050607 01.2628
050290 01.4397	050373 01.2037	050448 01.0191	050539 01.3085	050608 01.1901
050291 01.1849	050376 01.2527	050449 01.1845	050541 01.4081	050609 01.3425
050292 01.1623	050377 01.0600	050450 00.8738	050542 01.1054	050613 01.0621
050293 00.9420	050378 01.2023	050451 00.9845	050543 01.1472	050615 01.5339
050295 01.2928	050379 01.2143	050454 01.6180	050544 01.4127	050618 01.2949
050296 01.1852	050380 01.5764	050455 01.7497	050545 00.8814	050619 01.3654
050298 01.2673	050381 01.2588	050456 01.3151	050546 00.8479	050622 01.2499
050299 01.2249	050382 01.2958	050457 01.6652	050547 00.9994	050623 01.2545
050300 01.3254	050385 01.2248	050458 00.9362	050549 01.6536	050624 01.1890
050301 01.2188	050387 01.0223	050459 01.3663	050550 01.2500	050625 01.4662
050302 01.2814	050388 00.8693	050464 01.7972	050551 01.3000	050630 01.1954
050305 01.3803	050390 01.2215	050467 01.2530	050552 01.1376	050633 01.1970
050307 01.4742	050391 01.3561	050468 01.4547	050557 01.4227	050635 01.2245
050308 01.5510	050392 00.8513	050469 01.0534	050559 01.3123	050636 01.2854
050309 01.2560	050393 01.4610	050470 01.1721	050560 01.2818	050637 01.2759
050310 01.1624	050394 01.4738	050471 01.7385	050561 01.0760	050638 01.0407
050312 01.7479	050396 01.4814	050476 01.2806	050564 01.2761	050641 01.1544
050313 01.1906	050397 00.8823	050477 01.3594	050565 01.2106	050643 00.8252
050315 01.2761	050401 01.2495	050478 00.9862	050566 00.9377	050644 00.9951
050317 01.2820	050404 01.0868	050481 01.5434	050567 01.4983	050649 01.3181
050319 01.3291	050406 01.0376	050482 00.9971	050568 01.3242	050650 01.0897
050320 01.1842	050407 01.1527	050483 01.3748	050569 01.1744	050651 01.2906
050324 01.7681	050410 01.1017	050485 01.6082	050570 01.6243	050655 00.5668
050325 01.2333	050411 01.2007	050486 01.4679	050571 01.3239	050660 01.1291
050327 01.5761	050414 01.2802	050488 01.1753	050573 01.5456	050661 00.8842
050328 01.3253	050417 01.1468	050489 01.1628	050575 01.2618	050662 01.1541
050329 01.2795	050418 01.2759	050491 01.4837	050577 01.2928	050663 01.0948
050331 01.2903	050419 01.2017	050492 01.2597	050578 01.3215	050665 00.5929
050333 01.0155	050420 01.3941	050494 01.0673	050579 01.3759	050666 00.8420
050334 01.4318	050421 01.3081	050496 01.6775	050580 01.2531	050667 01.1426
050335 01.2849	050423 01.0534	050497 00.9029	050581 01.3129	050668 01.1137
050336 01.2794	050424 01.7370	050498 01.1389	050583 01.6606	050669 01.1085
050337 01.2675	050425 01.2444	050502 01.6726	050584 01.2731	050670 01.1774
050342 01.4165	050426 01.3925	050503 01.4001	050585 01.3085	050671 01.1158
050343 01.0760	050427 00.9215	050506 01.4485	050586 01.3338	050672 00.6666
050345 01.3277	050430 00.9401	050510 01.2548	050587 01.1856	050674 01.1357
050348 01.5880	050431 01.1894	050512 01.2166	050588 01.2739	050675 01.5462
050349 01.0349	050432 01.5031	050515 01.3401	050589 01.3342	050676 00.9538
050350 01.3772	050433 01.0084	050516 01.3111	050590 01.2671	

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C. HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050677	01.2585	060043	00.9207	070015	01.2443	100012	01.3927	100070	01.3132
050678	01.1801	060044	01.1244	070016	01.2898	100014	01.2615	100071	01.3484
050679	01.3815	060046	01.2537	070017	01.3858	100015	01.3108	100072	01.1952
050680	01.2043	060047	00.8761	070018	01.2840	100016	01.0483	100073	01.7376
050682	00.7724	060049	00.9874	070019	01.1517	100017	01.6963	100074	01.2884
050684	01.2171	060050	01.0805	070020	01.3500	100018	01.2885	100075	01.6516
050685	01.1262	060052	01.0215	070021	01.2086	100019	01.4768	100076	01.3017
050686	01.1700	060053	00.9750	070022	01.6190	100020	01.3179	100077	01.2705
050687	01.1043	060054	01.2046	070023	01.2009	100021	01.3307	100078	01.1325
050688	01.0801	060056	00.9478	070024	01.2016	100022	01.4637	100079	01.1841
050689	01.4765	060057	01.0695	070025	01.5944	100023	01.2918	100080	01.5236
050690	01.1930	060058	00.8323	070026	01.1610	100024	01.1779	100081	01.1641
050691	00.9118	060060	01.0293	070027	01.2144	100025	01.4856	100082	01.3542
050695	01.1209	060062	00.9543	070028	01.4242	100026	01.3782	100083	01.3344
060001	01.4393	060063	01.2211	070029	01.2512	100027	00.9103	100084	01.3333
060003	01.1837	060064	01.3180	070030	01.2559	100028	01.3181	100085	01.3113
060004	01.0020	060065	01.3281	070031	01.3123	100029	01.3842	100086	01.3223
060005	01.6943	060066	00.9437	070033	01.2993	100030	01.1022	100087	01.6229
060006	01.1314	060068	01.1756	070034	01.2595	100032	01.3774	100088	01.3724
060007	01.1850	060070	01.0355	070035	01.3283	100033	01.3993	100089	01.2331
060008	01.0814	060071	01.1246	070036	01.2641	100034	01.4908	100090	01.2828
060009	01.3108	060072	00.9454	070038	00.5272	100035	01.4208	100092	01.2527
060010	01.5044	060073	01.0535	080001	01.5353	100038	01.5022	100093	01.4417
060011	01.0989	060074	00.9238	080002	01.1690	100039	01.5583	100098	01.0597
060012	01.3553	060075	01.2106	080003	01.2153	100040	01.5629	100099	01.2187
060013	01.1899	060076	01.2992	080004	01.2558	100042	01.1902	100100	01.1737
060014	01.5086	060085	01.0267	080005	01.2643	100043	01.3580	100102	01.1600
060015	01.3673	060087	01.4305	080006	01.1402	100044	01.3385	100103	00.9821
060016	01.0912	060088	01.0496	080007	01.1768	100045	01.3418	100105	01.2764
060017	01.2262	060090	00.8500	080001	01.4195	100046	01.3014	100106	01.0121
060018	01.1232	060093	00.8704	090002	01.3020	100047	01.3454	100107	01.2499
060020	01.4736	060096	01.1144	090003	01.3876	100048	00.9442	100108	01.0004
060022	01.4466	060100	01.3359	090004	01.5413	100049	01.3383	100109	01.1904
060023	01.4767	060101	01.9030	090005	01.2577	100050	01.1382	100110	01.3963
060024	01.5338	060102	01.2883	090006	01.2744	100051	01.1315	100112	00.9884
060026	01.3542	060103	01.2026	090007	01.1694	100052	01.3076	100113	01.7198
060027	01.2944	070001	01.7510	090008	01.3009	100053	01.1452	100114	01.3981
060028	01.3480	070002	01.7403	090009	01.2572	100054	01.3874	100117	01.3076
060029	00.9380	070003	01.1549	090010	01.0598	100055	01.3317	100118	01.2589
060030	01.3256	070004	01.1412	090011	01.7018	100056	01.4856	100121	01.2063
060031	01.3894	070005	01.2722	090018	00.5215	100057	01.3271	100122	01.3397
060032	01.3510	070006	01.2474	100001	01.3137	100059	01.4301	100124	01.2978
060033	01.1073	070007	01.3392	100002	01.3537	100060	01.6711	100125	01.0828
060034	01.2654	070008	01.2357	100004	01.0661	100061	01.4064	100126	01.4383
060036	01.2180	070009	01.2480	100005	00.9586	100062	01.5427	100127	01.4370
060037	00.9677	070010	01.4457	100006	01.5621	100063	01.2099	100128	02.2884
060038	01.1267	070011	01.1920	100007	01.8750	100065	01.3047	100129	01.4465
060039	00.9426	070012	01.2400	100008	01.5983	100067	01.4184	100130	01.1214
060041	01.1971	070013	01.3125	100009	01.4024	100068	01.4282	100131	01.3030
060042	00.9849	070014	01.1252	100010	01.3162	100069	01.3950	100132	01.3355

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100134	01.0114	100203	01.0985	100264	01.2774	110041	01.0990	110103	00.9433
100135	01.4773	100204	01.5276	100265	01.2134	110042	01.0857	110104	01.1266
100137	01.1807	100206	01.3681	100266	01.3054	110043	01.4979	110105	01.1693
100138	01.0344	100207	01.3495	100267	01.2434	110044	01.0881	110107	01.5312
100139	01.0186	100208	01.4368	100268	01.3018	110045	00.9739	110108	00.8226
100140	01.1306	100209	01.5300	100269	01.2825	110046	01.2081	110109	01.0210
100142	01.0626	100210	01.5742	100270	00.8947	110048	01.0781	110111	01.0299
100143	01.0879	100211	01.2444	100271	01.4572	110049	01.0892	110112	00.9518
100144	01.1719	100212	01.5095	100273	01.1475	110050	01.1065	110113	01.0048
100145	01.2871	100213	01.5398	100275	01.2510	110051	00.9487	110114	01.1532
100146	01.0820	100217	01.1391	100276	01.3086	110052	00.8795	110115	01.5368
100147	01.0858	100218	00.8897	100277	01.0237	110054	01.2077	110117	01.0588
100149	01.2577	100219	01.3948	100278	00.5667	110055	00.9192	110118	00.9041
100150	01.3678	100220	01.6984	100898	00.5215	110056	00.9298	110120	01.0225
100151	01.7240	100221	01.5038	110001	01.2155	110059	01.1856	110121	01.0165
100152	01.2244	100222	01.2878	110002	01.2001	110061	00.9359	110122	01.2998
100154	01.4550	100223	01.3890	110003	01.2373	110062	00.9021	110123	01.0124
100156	01.0783	100224	01.2465	110004	01.2073	110063	01.0593	110124	01.0859
100157	01.4351	100225	01.3868	110005	01.2823	110064	01.1944	110125	01.1193
100159	00.9776	100226	01.3069	110006	01.2598	110065	01.0443	110127	00.9337
100160	01.1534	100227	01.0534	110007	01.3535	110066	01.2141	110128	01.0466
100161	01.4621	100228	01.1882	110008	01.1368	110069	01.1624	110129	01.4687
100162	01.2805	100229	01.5098	110009	01.1583	110070	00.9276	110130	01.0070
100164	00.9682	100230	01.2441	110010	01.8448	110071	01.0572	110131	01.1237
100165	01.0336	100231	01.5110	110011	01.1175	110072	00.9916	110132	01.1021
100166	01.4245	100232	01.2547	110013	01.0432	110073	01.3340	110133	00.9150
100167	01.2825	100234	01.2194	110014	01.1532	110074	01.2703	110134	00.8959
100168	01.2673	100235	01.4012	110015	01.1328	110075	01.1944	110135	01.1151
100169	01.7404	100236	01.3328	110016	01.1518	110076	01.2987	110136	01.1528
100170	01.3255	100237	02.0581	110017	00.9498	110077	01.0287	110140	00.8941
100172	01.3777	100238	01.3576	110018	01.1229	110078	01.4767	110141	00.9089
100173	01.4704	100239	01.3587	110020	01.0985	110079	01.1563	110142	01.0870
100174	01.5002	100240	00.7920	110023	01.1721	110080	01.0234	110143	01.2133
100175	01.0962	100241	01.0463	110024	01.3487	110082	01.8734	110144	01.2990
100176	01.9082	100242	01.2865	110025	01.1954	110083	01.4330	110146	00.9494
100177	01.3108	100243	01.2979	110026	01.1412	110085	01.1066	110149	00.9681
100179	01.6234	100244	01.3653	110027	01.0847	110086	01.1218	110150	01.1911
100180	01.3748	100246	01.3083	110028	01.4508	110087	01.2298	110151	01.0090
100181	01.2812	100248	01.6223	110029	01.2956	110088	00.9399	110152	01.0126
100183	01.3119	100249	01.2905	110030	01.1990	110089	01.1009	110153	01.0102
100185	01.1493	100252	01.2517	110031	01.2196	110091	01.2660	110154	00.9765
100186	01.3960	100253	01.3740	110032	01.0862	110092	01.0294	110155	01.0643
100187	01.2310	100254	01.5148	110033	01.3528	110093	00.9686	110156	00.9536
100189	01.3219	100255	01.3766	110034	01.3959	110094	00.9860	110157	01.1743
100191	01.3124	100256	01.5699	110035	01.3165	110095	01.2795	110161	01.1686
100194	01.2249	100258	01.7050	110036	01.5698	110096	01.1276	110162	00.8615
100195	01.4910	100259	01.4288	110037	01.1650	110097	01.1011	110163	01.2793
100196	01.2273	100260	01.2886	110038	01.2681	110098	01.0585	110164	01.3070
100199	01.2626	100262	01.3174	110039	01.2678	110100	01.0977	110165	01.1446
100200	01.3140	100263	01.4042	110040	00.9522	110101	01.0157	110166	01.3934

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
110168	01.4828	120027	01.1672	140008	01.3754	140069	01.1043	140129	01.0200
110169	00.7331	130001	00.9874	140010	01.3398	140070	01.2550	140130	01.1337
110171	01.3210	130002	01.3569	140011	01.0892	140071	01.0785	140131	01.4672
110172	01.0988	130003	01.3006	140012	01.2611	140072	01.1278	140132	01.3303
110174	00.8739	130005	01.3547	140013	01.2985	140073	01.3662	140133	01.1801
110175	00.8807	130006	01.5963	140014	01.0736	140074	01.0373	140134	01.0410
110176	01.1301	130007	01.4995	140015	01.1676	140075	01.2271	140135	01.1037
110177	01.3862	130008	00.8426	140016	01.0055	140076	01.7005	140136	01.0771
110178	01.1665	130009	01.0100	140017	01.1342	140077	01.1100	140137	01.0657
110179	01.1115	130010	00.9267	140018	01.3210	140078	01.2316	140138	00.9841
110181	00.9558	130011	01.2438	140019	00.9101	140079	01.2616	140139	01.0431
110183	01.1940	130012	00.9953	140020	01.0882	140080	01.1953	140140	01.0168
110184	01.1803	130013	01.2303	140021	01.1010	140081	01.0295	140141	01.0791
110185	01.0405	130014	01.3111	140022	01.3349	140082	01.5091	140142	01.4572
110186	01.2294	130015	00.9753	140023	01.4884	140083	01.2227	140143	01.3495
110187	01.0298	130016	00.9080	140024	01.0228	140084	01.5229	140144	01.0866
110188	01.3177	130017	00.9415	140025	01.2071	140085	01.2753	140145	01.1240
110189	01.0419	130018	01.1020	140026	01.148	140086	01.2172	140146	01.2450
110190	01.1226	130019	00.9477	140027	01.0621	140087	01.2643	140147	01.0449
110191	01.1850	130020	01.0214	140028	01.1516	140088	00.9114	140148	01.1678
110192	01.2833	130021	00.9903	140029	01.2085	140089	00.9997	140149	00.9460
110193	01.1623	130022	01.2743	140030	01.0819	140090	01.1955	140150	00.8593
110194	00.9092	130023	00.9941	140031	01.1420	140091	01.2127	140151	01.4299
110195	01.1768	130024	01.1124	140032	01.6230	140092	01.3257	140152	01.0191
110196	01.2933	130025	00.9071	140033	01.2771	140093	01.2172	140153	01.2863
110197	01.5791	130026	01.2251	140034	01.0535	140094	01.1546	140154	01.2021
110198	01.1743	130027	01.1608	140035	01.2584	140095	01.2533	140155	01.2127
110200	01.7321	130028	01.0214	140036	01.6230	140096	01.1791	140156	01.2876
110201	01.2824	130029	01.0214	140037	01.0535	140097	01.4700	140157	01.2819
110202	01.1574	130030	00.9903	140038	01.0535	140098	01.5179	140158	01.2872
110203	01.0058	130031	00.9941	140039	01.0402	140099	00.9863	140159	01.1240
110205	00.9135	130032	00.9071	140040	01.1596	140100	01.3642	140160	01.3461
110206	00.5215	130033	00.9754	140041	01.2447	140101	01.1973	140161	01.3663
120001	01.5791	130034	01.2251	140042	01.2760	140102	01.1350	140162	00.9637
120002	01.1743	130035	01.1608	140043	01.1651	140103	01.4346	140163	01.1514
120003	01.1098	130036	01.2251	140044	01.6324	140104	01.2795	140164	01.0612
120004	01.2937	130037	01.1608	140045	01.2505	140105	01.0862	140165	01.3077
120005	01.1315	130038	01.0392	140046	01.2505	140106	01.0862	140166	
120006	01.1914	130039	00.8867	140047	01.2505	140107	01.0862	140167	
120007	01.5362	130040	00.9647	140048	01.2505	140108	01.0862	140168	
120008	00.8663	130041	01.0392	140049	01.2505	140109	01.0862	140169	
120009	00.8663	130042	01.0392	140050	01.2505	140110	01.0862	140170	
120010	01.5577	130043	00.8867	140051	01.2505	140111	01.0862	140171	
120011	01.3415	130044	00.8867	140052	01.2505	140112	01.0862	140172	
120012	00.9640	130045	01.0033	140053	01.2505	140113	01.0862	140173	
120014	01.2333	130046	01.0106	140054	01.2505	140114	01.0862	140174	
120015	00.8779	130047	01.1821	140055	01.2505	140115	01.0862	140175	
120016	00.9983	130048	01.0234	140056	01.2505	140116	01.0862	140176	
120018	00.8382	130049	00.9287	140057	01.2505	140117	01.0862	140177	
120019	01.1285	130050	00.9229	140058	01.2505	140118	01.0862	140178	
120021	00.8883	130051	01.0234	140059	01.2505	140119	01.0862	140179	
120022	01.5282	130052	00.9287	140060	01.2505	140120	01.0862	140180	
120026	01.3897	130053	00.9332	140061	01.2505	140121	01.0862	140181	
		130054	00.9229	140062	01.2505	140122	01.0862	140182	
		130055	01.2602	140063	01.2505	140123	01.0862	140183	
		130056	01.2602	140064	01.2505	140124	01.0862	140184	
		130057	01.2602	140065	01.2505	140125	01.0862	140185	
		130058	01.2602	140066	01.2505	140126	01.0862	140186	
		130059	01.2602	140067	01.2505	140127	01.0862	140187	
		130060	01.2602	140068	01.2505	140128	01.0862	140188	
		130061	01.2602	140069	01.2505	140129	01.0862	140189	
		130062	01.2602	140070	01.2505	140130	01.0862	140190	
		130063	01.2602	140071	01.2505	140131	01.0862	140191	
		130064	01.2602	140072	01.2505	140132	01.0862		
		130065	01.2602	140073	01.2505	140133	01.0862		
		130066	01.2602	140074	01.2505	140134	01.0862		
		130067	01.2602	140075	01.2505	140135	01.0862		
		130068	01.2602	140076	01.2505	140136	01.0862		
		130069	01.2602	140077	01.2505	140137	01.0862		
		130070	01.2602	140078	01.2505	140138	01.0862		
		130071	01.2602	140079	01.2505	140139	01.0862		
		130072	01.2602	140080	01.2505	140140	01.0862		
		130073	01.2602	140081	01.2505	140141	01.0862		
		130074	01.2602	140082	01.2505	140142	01.0862		
		130075	01.2602	140083	01.2505	140143	01.0862		
		130076	01.2602	140084	01.2505	140144	01.0862		
		130077	01.2602	140085	01.2505	140145	01.0862		
		130078	01.2602	140086	01.2505	140146	01.0862		
		130079	01.2602	140087	01.2505	140147	01.0862		
		130080	01.2602	140088	01.2505	140148	01.0862		
		130081	01.2602	140089	01.2505	140149	01.0862		
		130082	01.2602	140090	01.2505	140150	01.0862		
		130083	01.2602	140091	01.2505	140151	01.0862		
		130084	01.2602	140092	01.2505	140152	01.0862		
		130085	01.2602	140093	01.2505	140153	01.0862		
		130086	01.2602	140094	01.2505	140154	01.0862		
		130087	01.2602	140095	01.2505	140155	01.0862		
		130088	01.2602	140096	01.2505	140156	01.0862		
		130089	01.2602	140097	01.2505	140157	01.0862		
		130090	01.2602	140098	01.2505	140158	01.0862		
		130091	01.2602	140099	01.2505	140159	01.0862		
		130092	01.2602	140100	01.2505	140160	01.0862		
		130093	01.2602	140101	01.2505	140161	01.0862		
		130094	01.2602	140102	01.2505	140162	01.0862		
		130095	01.2602	140103	01.2505	140163	01.0862		
		130096	01.2602	140104	01.2505	140164	01.0862		
		130097	01.2602	140105	01.2505	140165	01.0862		
		130098	01.2602	140106	01.2505	140166	01.0862		
		130099	01.2602	140107	01.2505	140167	01.0862		
		130100	01.2602	140108	01.2505	140168	01.0862		
		130101	01.2602	140109	01.2505	140169	01.0862		
		130102	01.2602	140110	01.2505	140170	01.0862		
		130103	01.2602	140111	01.2505	140171	01.0862		
		130104	01.2602	140112	01.2505	140172	01.0862		
		130105	01.2602	140113	01.2505	140173	01.0862		
		130106	01.2602	140114	01.2505	140174	01.0862		
		130107	01.2602	140115	01.2505	140175	01.0862		
		130108	01.2602	140116	01.2505	140176	01.0862		
		130109	01.2602	140117	01.2505	140177	01.0862		
		130110	01.2602	140118	01.2505	140178	01.0862		
		130111	01.2602	140119	01.2505	140179	01.0862		
		130112	01.2602	140120	01.2505	140180	01.0862		
		130113	01.2602	140121	01.2505	140181	01.0862		
		130114	01.2602	140122	01.2505	140182	01.0862		
		130115	01.2602	140123	01.2505	140183	01.0862		
		130116	01.2602	140124	01.2505	140184	01.0862		
		130117	01.2602	140125	01.2505	140185	01.0862		
		130118							

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

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PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX
140192 01.0859	140288 01.5400	150045 01.1195	150102 01.0709	160033 01.3181
140193 00.9576	140289 01.2711	150046 01.1293	150103 01.1212	160034 01.0236
140197 01.3111	140290 01.3594	150047 01.5152	150104 01.1112	160035 01.0279
140199 01.0320	140291 01.2527	150048 01.1990	150105 01.1911	160036 01.0954
140200 01.4610	140292 01.2049	150049 01.0859	150106 01.0284	160037 01.0759
140202 01.1962	140293 00.8927	150050 01.1331	150109 01.2781	160039 00.9786
140203 01.1377	140294 01.0635	150051 01.2151	150110 00.9094	160040 01.2240
140204 00.9516	140295 00.8926	150052 01.0323	150111 01.1275	160041 01.0891
140205 00.9827	140297 01.4532	150053 01.0722	150112 01.1448	160043 00.9802
140206 01.1578	140299 00.9976	150054 01.0789	150113 01.1566	160044 01.2637
140207 01.2471	150001 01.1112	150056 01.6227	150114 01.0771	160045 01.5178
140208 01.4297	150002 01.3101	150057 02.2445	150115 01.2127	160046 01.0214
140209 01.4889	150003 01.5169	150058 01.4479	150122 01.1083	160047 01.3440
140210 01.0507	150004 01.2701	150059 01.1527	150123 00.9718	160048 01.0124
140211 01.1453	150005 01.2198	150060 01.1310	150124 01.1433	160049 00.8693
140212 01.2877	150006 01.2371	150061 01.1711	150125 01.3685	160050 01.0905
140213 01.2113	150007 01.2027	150062 01.0343	150126 01.5502	160051 01.1853
140215 01.0814	150008 01.3129	150063 01.1614	150127 01.2110	160052 01.0718
140217 01.2055	150009 01.2881	150064 01.0549	150128 01.1601	160054 00.9896
140218 00.9538	150010 01.2025	150065 01.1002	150129 01.2696	160055 00.9317
140220 01.1176	150011 01.1523	150066 01.1265	150130 01.1329	160056 01.0362
140223 01.4447	150012 01.5300	150067 01.0885	150132 01.3474	160057 01.3450
140224 01.2748	150013 01.0484	150069 01.2375	150133 01.2196	160058 01.5550
140226 00.7740	150014 01.2800	150070 01.0915	150134 01.2095	160059 01.1941
140228 01.5121	150015 01.2108	150071 01.1730	150135 00.8233	160060 01.0443
140229 00.9699	150017 01.5586	150072 01.2430	150136 01.0686	160061 01.0022
140230 00.9497	150018 01.1878	150073 01.0447	160001 01.1783	160062 00.9786
140231 01.2758	150019 01.2462	150074 01.4078	160002 01.1808	160063 01.1448
140232 01.0356	150020 01.1087	150075 01.2519	160003 01.0418	160064 01.1492
140233 01.5610	150021 01.5847	150076 01.0179	160005 01.1207	160065 01.1249
140234 01.1624	150022 01.1309	150077 01.1493	160007 01.0336	160066 01.0467
140236 01.0097	150023 01.3773	150078 01.0613	160008 01.0650	160067 01.2122
140239 01.4890	150024 01.2130	150079 01.1142	160009 01.1008	160068 01.1084
140240 01.2739	150025 01.4703	150082 01.3651	160012 01.1488	160069 01.3452
140242 01.4046	150026 01.1467	150084 01.6187	160013 01.2262	160070 01.0174
140245 01.0350	150027 01.0116	150085 00.9353	160014 01.0193	160071 01.0718
140246 01.0111	150029 01.1929	150086 01.1853	160016 01.2604	160072 01.1037
140250 01.2235	150030 01.1848	150088 01.1689	160018 00.9619	160073 00.9143
140251 01.2778	150031 01.1086	150089 01.2909	160020 01.0693	160074 01.0579
140252 01.2879	150032 01.6492	150090 01.2789	160021 01.1197	160075 01.0479
140253 01.3990	150033 01.5190	150091 01.2018	160023 01.0865	160076 00.9613
140258 01.2988	150034 01.3086	150092 01.1141	160025 01.7147	160077 01.0846
140271 01.0433	150035 01.3340	150094 01.0471	160026 01.0704	160079 01.2978
140273 01.1245	150036 01.0290	150095 01.0497	160027 01.1019	160080 01.1204
140275 01.1899	150037 01.1660	150096 01.0352	160028 01.2445	160081 01.1209
140276 01.9184	150038 01.2725	150097 01.1038	160029 01.3207	160082 01.6128
140280 01.1921	150039 01.0795	150098 00.9879	160030 01.2363	160083 01.4812
140281 01.4551	150042 01.2201	150099 01.3693	160031 01.0867	160085 00.9504
140285 01.2334	150043 01.0852	150100 01.5118	160032 01.0016	160086 00.9504
140286 01.1081	150044 01.2210	150101 01.1027		160088 01.0316

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160089	01.2068	160153	01.5143	170057	01.0244	170116	01.1432	180013	01.3273	180013	01.3273	180013	01.3273	180013	01.3273
160090	01.0705	160898	00.5215	170058	01.0473	170117	00.9845	180014	01.5063	180014	01.5063	180014	01.5063	180014	01.5063
160091	01.1851	170001	01.1868	170060	01.0065	170119	01.0046	180015	01.1280	180015	01.1280	180015	01.1280	180015	01.1280
160092	01.0036	170003	01.1837	170061	01.0317	170120	01.1929	180016	01.2336	180016	01.2336	180016	01.2336	180016	01.2336
160093	00.9518	170004	01.1328	170062	00.9286	170121	00.8500	180017	01.2633	180017	01.2633	180017	01.2633	180017	01.2633
160094	01.1067	170006	01.1750	170063	00.8559	170122	01.8134	180018	01.2041	180018	01.2041	180018	01.2041	180018	01.2041
160095	01.1259	170007	01.2084	170064	01.1227	170123	01.5824	180019	01.1861	180019	01.1861	180019	01.1861	180019	01.1861
160097	01.1767	170008	01.0539	170066	00.9789	170124	01.0180	180020	01.0200	180020	01.0200	180020	01.0200	180020	01.0200
160098	01.0210	170009	01.1682	170067	00.9705	170125	00.9974	180021	00.9631	180021	00.9631	180021	00.9631	180021	00.9631
160099	01.0731	170010	01.1460	170068	01.1334	170126	00.9974	180022	00.8627	180022	00.8627	180022	00.8627	180022	00.8627
160101	01.1766	170011	01.3185	170069	00.8930	170128	00.9692	180023	00.8522	180023	00.8522	180023	00.8522	180023	00.8522
160102	01.2696	170012	01.4115	170070	00.9459	170131	01.0840	180025	01.0931	180025	01.0931	180025	01.0931	180025	01.0931
160103	00.9491	170013	01.2629	170072	00.9088	170133	01.2408	180026	00.9947	180026	00.9947	180026	00.9947	180026	00.9947
160104	01.1011	170014	01.0522	170073	01.2139	170134	00.9946	180027	01.1338	180027	01.1338	180027	01.1338	180027	01.1338
160106	01.0538	170015	01.0468	170074	01.1234	170137	01.1592	180028	00.9853	180028	00.9853	180028	00.9853	180028	00.9853
160107	01.0909	170016	01.5472	170075	00.8375	170139	00.9539	180029	01.2607	180029	01.2607	180029	01.2607	180029	01.2607
160108	01.2133	170017	01.1560	170076	01.1513	170140	01.0254	180030	01.1209	180030	01.1209	180030	01.1209	180030	01.1209
160109	01.0529	170018	01.0715	170077	01.0334	170142	01.2088	180031	01.0005	180031	01.0005	180031	01.0005	180031	01.0005
160110	01.4746	170019	01.2601	170078	00.9589	170143	01.1248	180032	00.8156	180032	00.8156	180032	00.8156	180032	00.8156
160111	01.0625	170020	01.2330	170080	00.9763	170144	01.4314	180033	01.0038	180033	01.0038	180033	01.0038	180033	01.0038
160112	01.2497	170021	00.9317	170081	01.0956	170145	01.1783	180034	01.4080	180034	01.4080	180034	01.4080	180034	01.4080
160113	00.9749	170022	01.2234	170082	00.9558	170146	01.2988	180035	01.0724	180035	01.0724	180035	01.0724	180035	01.0724
160114	01.0035	170023	01.3017	170084	01.0251	170147	01.1518	180036	01.3145	180036	01.3145	180036	01.3145	180036	01.3145
160115	01.0758	170024	01.1911	170085	00.9705	170148	01.2960	180037	01.2412	180037	01.2412	180037	01.2412	180037	01.2412
160116	01.1191	170025	01.1704	170086	01.5737	170150	01.1346	180038	01.8027	180038	01.8027	180038	01.8027	180038	01.8027
160117	01.2871	170026	01.0706	170087	01.3900	170151	01.0339	180040	01.0967	180040	01.0967	180040	01.0967	180040	01.0967
160118	01.0810	170027	01.1684	170088	01.0062	170152	01.0145	180041	01.0681	180041	01.0681	180041	01.0681	180041	01.0681
160119	00.8733	170030	01.0118	170089	00.9872	170159	00.9831	180042	01.0107	180042	01.0107	180042	01.0107	180042	01.0107
160120	00.9932	170031	00.9115	170090	00.9901	170160	00.9652	180043	01.1113	180043	01.1113	180043	01.1113	180043	01.1113
160122	01.1227	170032	01.0450	170092	00.8458	170164	01.0782	180044	01.1718	180044	01.1718	180044	01.1718	180044	01.1718
160123	01.0746	170033	01.2217	170093	00.9972	170166	01.0151	180045	01.0059	180045	01.0059	180045	01.0059	180045	01.0059
160124	01.1649	170034	01.0273	170094	01.0202	170168	00.8945	180046	01.1697	180046	01.1697	180046	01.1697	180046	01.1697
160126	01.0521	170035	00.9183	170095	01.1532	170170	01.0033	180047	01.3456	180047	01.3456	180047	01.3456	180047	01.3456
160129	01.1444	170036	00.8410	170097	00.8902	170171	01.2057	180048	01.2965	180048	01.2965	180048	01.2965	180048	01.2965
160130	01.0823	170037	01.1080	170098	00.9994	170172	01.0099	180049	01.1924	180049	01.1924	180049	01.1924	180049	01.1924
160131	01.1761	170038	00.9399	170099	01.2287	170173	01.0505	180050	01.0055	180050	01.0055	180050	01.0055	180050	01.0055
160132	00.9380	170039	01.0629	170100	00.7725	170174	00.8644	180051	01.0459	180051	01.0459	180051	01.0459	180051	01.0459
160133	01.1367	170040	01.3994	170101	01.1072	170175	01.2609	180052	00.9351	180052	00.9351	180052	00.9351	180052	00.9351
160134	00.9359	170041	00.9622	170102	01.0015	170176	01.4563	180053	00.9352	180053	00.9352	180053	00.9352	180053	00.9352
160135	00.9594	170043	01.0014	170103	01.1662	170178	01.1340	180054	00.9352	180054	00.9352	180054	00.9352	180054	00.9352
160138	00.9748	170044	01.2126	170104	01.3946	170179	01.1340	180055	00.9352	180055	00.9352	180055	00.9352	180055	00.9352
160140	01.0478	170045	01.0577	170105	01.0033	180001	01.1340	180056	00.9352	180056	00.9352	180056	00.9352	180056	00.9352
160141	00.9133	170049	01.2663	170106	00.8811	180004	01.1448	180058	00.9352	180058	00.9352	180058	00.9352	180058	00.9352
160142	01.1090	170050	00.9605	170108	00.8874	180005	01.0243	180059	00.9352	180059	00.9352	180059	00.9352	180059	00.9352
160143	01.1017	170051	00.9930	170109	01.0153	180006	00.8757	180060	00.9352	180060	00.9352	180060	00.9352	180060	00.9352
160145	01.0290	170052	01.0677	170110	00.9783	180007	01.3732	180062	00.9042	180062	00.9042	180062	00.9042	180062	00.9042
160146	01.2819	170053	00.9049	170112	01.1063	180009	01.1208	180063	01.0496	180063	01.0496	180063	01.0496	180063	01.0496
160147	01.2403	170054	01.1539	170113	01.1175	180010	01.6858	180064	01.0749	180064	01.0749	180064	01.0749	180064	01.0749
160151	01.1144	170055	01.0492	170114	01.0338	180011	01.1601	180065	00.9492	180065	00.9492	180065	00.9492	180065	00.9492
160152	01.0673	170056	00.9713	170115	01.1185	180012	01.2419	180066	01.0986	180066	01.0986	180066	01.0986	180066	01.0986

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180069	01.1358	190005	01.2162	190088	01.2051	190164	01.1061	200019	01.2317	200019	01.2317
180070	00.9917	190006	01.1056	190089	01.1084	190165	01.0183	200020	01.0396	200020	01.0396
180072	01.0318	190007	01.0565	190090	01.2219	190166	01.0622	200021	01.1767	200021	01.1767
180075	00.9644	190008	01.4199	190092	01.2672	190167	01.3180	200023	00.8746	200023	00.8746
180078	01.0223	190009	01.1715	190095	01.0556	190170	00.9774	200024	01.1645	200024	01.1645
180079	00.9959	190010	00.9735	190098	01.2760	190173	01.3783	200025	01.1384	200025	01.1384
180080	01.1793	190011	01.0558	190099	01.2388	190175	01.1713	200026	01.0264	200026	01.0264
180081	01.3524	190012	00.9915	190102	01.4353	190176	01.4281	200027	01.0969	200027	01.0969
180085	01.2325	190013	01.1964	190103	00.9679	190177	01.4337	200028	01.0014	200028	01.0014
180087	01.0094	190014	00.9450	190106	01.1603	190178	01.0070	200031	01.2094	200031	01.2094
180088	01.5530	190015	01.2025	190109	01.0613	190182	01.0719	200032	01.2598	200032	01.2598
180092	01.1237	190017	01.1927	190110	00.9755	190183	01.0169	200033	01.6799	200033	01.6799
180093	01.3492	190018	01.4271	190111	01.4682	190184	00.9569	200034	01.1942	200034	01.1942
180094	00.9688	190019	01.2995	190112	01.2995	190185	01.1778	200037	01.1580	200037	01.1580
180095	01.0049	190020	01.1410	190113	01.2221	190186	00.9273	200038	01.0708	200038	01.0708
180099	00.9538	190023	00.9288	190114	00.9551	190187	00.6314	200039	01.2654	200039	01.2654
180101	01.2321	190025	01.1788	190115	01.2777	190188	00.8035	200040	01.0708	200040	01.0708
180102	01.3563	190026	01.2734	190116	01.1953	190189	01.2160	200041	01.1822	200041	01.1822
180103	01.6834	190027	01.3791	190118	01.0137	190190	01.0119	200043	00.7760	200043	00.7760
180104	01.3989	190029	01.2139	190119	00.9131	190191	01.1334	200044	01.1506	200044	01.1506
180105	00.9288	190033	00.9588	190120	00.8827	190193	01.2085	200050	01.1108	200050	01.1108
180106	00.8576	190034	01.2232	190122	01.2147	190194	01.1794	200051	00.9515	200051	00.9515
180108	00.9513	190035	01.4083	190124	01.3278	190196	00.9773	200052	01.0713	200052	01.0713
180115	01.0111	190036	01.5873	190125	01.2882	190197	01.1500	200055	01.0473	200055	01.0473
180116	01.2443	190037	01.0117	190127	01.3897	190198	01.1196	200062	00.9789	200062	00.9789
180117	01.2501	190039	01.3822	190128	00.8691	190199	01.1628	200063	01.2221	200063	01.2221
180118	00.9949	190040	01.3065	190130	00.9872	190200	01.4972	200066	01.2386	200066	01.2386
180120	00.9255	190041	01.5037	190131	01.2656	190201	01.2672	210001	01.2826	210001	01.2826
180121	01.0812	190043	01.0486	190132	01.1456	190202	01.2673	210002	01.6951	210002	01.6951
180122	00.9705	190044	01.0801	190133	01.0117	190203	01.5931	210003	01.1512	210003	01.1512
180123	01.3447	190045	01.2515	190134	01.0478	190204	01.3774	210004	01.2569	210004	01.2569
180124	01.2170	190046	01.4023	190135	01.3186	190205	01.3155	210005	01.2280	210005	01.2280
180125	00.9950	190047	01.1357	190136	00.9516	190206	01.3962	210006	01.0802	210006	01.0802
180126	01.0130	190048	01.0629	190138	00.8006	190207	01.2938	210007	01.4025	210007	01.4025
180127	01.1338	190049	01.0220	190140	00.9790	190208	00.8430	210008	01.2099	210008	01.2099
180128	01.0903	190050	01.1082	190142	00.9349	190211	00.8697	210009	01.4130	210009	01.4130
180129	01.1679	190053	01.0073	190144	01.1597	190212	00.8862	210010	01.1817	210010	01.1817
180130	01.3558	190054	01.3179	190145	00.9383	200001	01.3042	210011	01.2957	210011	01.2957
180132	01.2967	190059	00.9516	190146	01.4967	200002	01.0410	210012	01.3000	210012	01.3000
180133	01.2012	190060	01.2533	190147	00.9877	200003	00.9552	210013	01.2814	210013	01.2814
180134	01.1294	190064	01.3983	190148	00.9219	200006	01.1336	210015	01.2217	210015	01.2217
180136	01.2705	190065	01.4041	190149	00.9946	200007	00.9938	210016	01.6333	210016	01.6333
180137	01.7286	190071	00.9748	190151	01.1060	200008	01.1895	210017	01.1277	210017	01.1277
180138	01.1985	190075	01.3874	190152	01.3729	200009	01.6329	210018	01.2823	210018	01.2823
180139	00.9341	190077	00.9066	190155	01.0643	200012	01.1256	210019	01.2790	210019	01.2790
180898	00.5215	190078	01.1592	190156	00.8483	200013	01.1590	210021	01.1989	210021	01.1989
190001	00.9029	190079	01.2490	190158	01.3040	200015	01.2765	210022	01.2308	210022	01.2308
190002	01.5033	190081	00.8854	190160	01.1017	200016	01.0227	210023	01.2227	210023	01.2227
190003	01.3284	190083	00.8819	190161	00.9445	200017	01.2907	210024	01.2526	210024	01.2526
190004	01.1451	190086	01.2305	190162	01.1326	200018	01.0896	210025	01.2054	210025	01.2054

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
210026	01.2944	220031	01.6844	220099	01.1167	230024	01.4743	230096	01.0786
210027	01.1968	220033	01.1631	220100	01.2307	230027	01.1426	230097	01.3176
210028	00.9995	220034	01.1939	220101	01.3116	230029	01.4445	230098	01.4035
210029	01.2587	220035	01.1789	220102	00.6121	230030	01.1756	230099	01.1520
210030	01.0183	220036	01.4868	220104	01.1877	230031	01.3395	230100	01.1363
210031	01.6683	220038	01.2065	220105	01.1528	230032	01.7240	230101	01.0858
210032	01.1443	220040	01.2819	220106	01.1176	230034	01.1668	230103	01.0141
210033	01.1397	220041	01.1641	220107	01.1171	230035	01.0997	230104	01.4278
210034	01.1716	220042	01.1385	220108	01.1558	230036	01.2561	230105	01.5334
210035	01.1114	220045	01.2070	220110	01.8992	230037	01.0963	230106	01.1037
210036	01.1607	220046	01.1641	220111	01.1751	230038	01.4941	230107	01.0410
210037	01.1942	220048	01.1717	220114	01.0683	230039	01.2856	230108	01.1091
210038	01.3143	220049	01.1331	220115	01.3499	230040	01.2401	230110	01.2520
210039	01.1520	220050	01.0123	220116	01.7249	230041	01.1225	230111	00.9648
210040	01.2763	220051	01.1785	220117	00.9729	230042	01.1019	230113	00.9620
210043	01.1683	220052	01.2129	220118	01.8438	230043	00.8935	230114	00.8012
210044	01.2030	220053	01.2249	220119	01.3003	230046	01.6376	230115	00.8566
210045	00.9918	220055	01.1740	220120	00.9870	230047	01.2093	230116	00.9402
210046	01.1099	220057	01.2186	220123	00.9066	230051	00.9701	230117	01.7713
210048	01.1103	220058	01.0310	220126	01.2531	230053	01.3618	230118	01.2287
210049	01.1116	220060	01.0842	220128	01.1221	230054	01.5645	230119	01.1594
210051	01.2363	220062	00.5593	220129	01.0709	230055	01.0857	230120	01.0217
210054	01.2273	220063	01.1374	220131	01.1297	230056	01.0077	230121	01.1821
210055	01.1849	220064	01.1982	220133	00.7297	230058	01.1086	230122	01.3368
210056	01.3572	220065	01.1431	220135	01.1006	230059	01.4186	230124	01.0594
210057	01.1639	220066	01.3035	220153	00.9267	230060	01.1385	230125	01.4337
210058	01.7246	220067	01.1980	220154	00.8998	230062	01.0551	230128	01.3352
210059	01.2855	220068	00.6405	220156	01.1928	230063	01.2214	230129	01.9042
220001	01.1548	220070	01.1619	220162	01.2286	230065	01.3111	230130	01.5278
220002	01.3331	220071	01.7669	220163	01.9398	230066	01.2506	230132	01.3398
220003	01.0133	220073	01.2086	220171	01.4376	230068	01.2751	230133	01.1139
220004	01.3534	220074	01.0877	220173	00.5510	230069	01.1542	230134	01.1000
220006	01.2113	220075	00.7532	220175	00.9517	230070	01.2951	230135	01.2207
220008	01.2061	220076	01.1931	220188	00.5215	230071	00.6868	230137	01.0878
220010	01.1631	220077	01.6090	230001	01.2527	230072	01.1956	230138	00.8856
220011	01.2577	220079	01.1196	230002	01.2198	230075	01.2758	230140	01.1583
220012	01.1940	220080	01.1509	230003	01.1336	230076	01.1384	230141	01.4967
220015	01.2020	220081	00.9835	230004	01.6150	230077	02.0109	230142	01.2451
220016	01.1593	220082	01.1946	230005	01.1671	230078	01.1951	230143	01.2782
220017	01.2503	220083	01.1831	230006	01.0859	230080	01.2546	230144	01.1834
220019	01.0829	220084	01.2009	230007	01.0984	230081	01.1689	230145	01.1422
220020	01.0978	220086	01.5494	230012	00.8536	230082	01.0770	230146	01.1596
220021	01.1760	220088	01.5302	230013	01.2862	230085	01.2008	230147	01.2888
220023	01.2129	220089	01.2371	230014	00.9884	230086	01.0015	230149	01.1048
220024	01.1767	220090	01.2282	230015	01.2854	230087	01.0762	230150	01.6669
220025	01.0603	220092	01.2002	230017	01.5272	230089	01.3222	230151	01.3878
220026	01.2355	220094	01.1703	230019	01.5333	230090	01.0978	230153	01.0942
220028	01.3318	220095	01.1790	230020	01.4836	230092	01.2127	230154	01.0856
220029	01.1244	220097	01.0505	230021	01.4110	230093	01.1299	230155	01.0174
220030	01.0430	220098	01.1431	230022	01.2428	230095	01.0782	230156	01.5773

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230241	01.1267	230247	01.4158	240047	00.9847	240107	00.9847	240169	00.9684
230244	01.3001	240048	01.2901	240048	01.2901	240108	00.9927	240170	01.0944
230253	01.1097	240049	01.6036	240049	01.6036	240109	01.1309	240171	01.1072
230254	01.2457	240050	01.0070	240050	01.0070	240110	01.0735	240172	01.1642
230257	00.9041	240051	00.9148	240051	00.9148	240111	01.0501	240173	01.0421
230259	01.0750	240052	01.1844	240052	01.0482	240112	01.0482	240175	00.8395
230264	01.1695	240053	01.4126	240053	01.0151	240114	01.0151	240176	01.0238
230266	01.3096	240056	01.3311	240056	01.4183	240115	01.4183	240179	01.0242
230269	01.2518	240057	01.7407	240057	00.9767	240116	00.9767	240180	00.9706
230270	01.2394	240058	01.0119	240058	01.1127	240117	01.1127	240183	01.1343
230273	01.3835	240059	01.0993	240059	00.8818	240119	00.8818	240184	01.0406
230275	00.9082	240061	01.5161	240061	00.9451	240121	00.9451	240187	01.1355
230276	00.8372	240063	01.4256	240063	01.0896	240122	01.0896	240192	00.9313
230277	01.2277	240064	01.2053	240064	01.0475	240124	01.0475	240193	00.9385
230278	00.7969	240065	01.0304	240065	01.0665	240124	01.0665	240196	01.3160
240001	01.5482	240066	01.2953	240066	01.0128	240125	01.0128	240200	00.9852
240002	01.6185	240069	01.2498	240069	01.0374	240127	01.0374	240201	00.9893
240003	01.2507	240071	01.1309	240071	01.1552	240128	01.1552	240205	00.8632
240004	01.4148	240072	00.9839	240072	00.9618	240129	00.9618	240206	00.8518
240005	01.0221	240073	01.0533	240073	00.9940	240130	00.9940	240207	01.2253
240006	01.1353	240074	00.8762	240074	01.2339	240132	01.2339	240210	01.2616
240007	01.0730	240075	01.2117	240075	01.1397	240133	01.1397	240211	00.9945
240008	01.1108	240076	01.0498	240076	00.9961	240134	00.9961	250001	01.3740
240009	01.0754	240077	00.9954	240077	00.9048	240135	00.9048	250002	00.7995
240010	01.8258	240078	01.3542	240078	00.9057	240136	00.9057	250003	00.9090
240011	01.0543	240079	01.1489	240079	01.2079	240137	01.2079	250004	01.3648
240013	01.1877	240080	01.3512	240080	00.8660	240138	00.8660	250005	00.9721
240014	01.1273	240082	01.1381	240082	01.0291	240139	01.0291	250006	01.0557
240016	01.3267	240083	01.2070	240083	00.8456	240140	00.8456	250007	01.1200
240017	01.1806	240084	01.2276	240084	01.0499	240141	01.0499	250008	00.9474
240018	01.2511	240085	00.9075	240085	01.0371	240142	01.0371	250009	01.1005
240019	01.3703	240086	01.0711	240086	01.0445	240143	01.0445	250010	01.0641
240020	01.1894	240087	01.0920	240087	00.9567	240144	00.9567	250012	00.9409
240021	00.9936	240088	01.3934	240088	00.9580	240145	00.9580	250015	01.0641
240022	01.0799	240089	01.0633	240089	00.9374	240146	00.9374	250016	00.8447
240023	01.0560	240090	01.0714	240090	00.9319	240148	00.9319	250017	01.0056
240025	01.1921	240091	00.9894	240091	00.9647	240149	00.9647	250018	01.0215
240027	01.0888	240093	01.3408	240093	00.9363	240152	00.9363	250019	01.2192
240028	01.0983	240094	01.0541	240094	01.0388	240153	01.0388	250020	01.0179
240029	01.1825	240096	00.9971	240096	01.0315	240154	01.0315	250021	00.9731
240030	01.3065	240097	01.1043	240097	01.0522	240155	01.0522	250023	00.8273
240031	00.9099	240098	00.9825	240098	01.1059	240156	01.1059	250024	01.0239
240036	01.4236	240099	01.0859	240099	01.0479	240157	01.0479	250025	01.0225
240037	01.0709	240100	01.3106	240100	01.0245	240158	01.0245	250027	00.9658
240038	01.4277	240101	01.2310	240101	00.9670	240160	00.9670	250029	00.8607
240040	01.2253	240102	00.9007	240102	00.9368	240161	00.9368	250030	00.9210
240041	01.2056	240103	01.1304	240103	01.0779	240162	01.0779	250031	01.1635
240043	01.1141	240104	01.2372	240104	00.9784	240163	00.9784	250032	01.1215
240044	01.1574	240105	00.9249	240105	01.1080	240166	01.1080	250033	00.9996
240045	01.0639	240106	01.2886	240106	00.8474	240167	00.8474	250034	01.4205

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
250035	00.8593	250099	01.2575	260019	00.9829	260082	01.1783	260172	01.0305	260173	01.1871	260175	01.1244
250036	00.9725	250100	01.1442	260020	01.4874	260085	01.4173	260176	01.2906	260177	01.2792	260178	01.4145
250037	00.8975	250101	00.8892	260021	01.2663	260088	01.0012	260179	01.4478	260180	01.4841	260182	01.0434
250038	00.9120	250102	01.3709	260022	01.3458	260089	01.1225	260183	01.3295	260185	01.1519	260188	01.1603
250039	01.0010	250104	01.2858	260023	01.2130	260090	01.3740	260189	01.0279	260190	01.1379	260191	01.2489
250040	01.1763	250105	00.9268	260024	01.1093	260091	01.5088	260193	01.2063	260195	01.1052	260197	01.2113
250042	01.1801	250107	00.8881	260025	01.2248	260092	01.1458	260198	01.4063	260200	01.1774	260202	01.2818
250043	00.8696	250109	01.0068	260026	01.0104	260094	01.0555	260203	01.2306	260206	00.9022	260207	00.9200
250044	01.0855	250112	00.9457	260027	01.5048	260095	01.3295	260208	00.9142	260209	00.9997	260211	01.1149
250045	01.1542	250113	00.9566	260028	01.0723	260096	01.3884	260212	01.3496	260213	01.2272	260214	01.5045
250046	01.0238	250117	01.0769	260030	01.0870	260097	01.1812	260216	00.9556	260217	01.2246	260219	00.9097
250047	00.9188	250119	00.9600	260031	01.3178	260098	01.1822	260220	01.1128	260221	01.1128	260223	01.2656
250048	01.3198	250120	01.0699	260032	01.5469	260102	01.0380	260224	01.0996	260226	00.9605	260227	01.0033
250049	00.9497	250122	01.1892	260033	01.2631	260103	01.3205	260228	01.0758	260229	01.0778	260230	00.9596
250050	01.0643	250123	01.1250	260034	01.0212	260104	01.5723	260231	00.8844	260232	01.1395	260233	00.9136
250051	00.9188	250124	00.8704	260035	01.0583	260105	01.7960	260235	00.9605	260236	00.9605	260237	00.9257
250057	01.1239	250125	01.1686	260036	01.0843	260107	01.2734	260238	01.0758	260239	01.0778	260240	01.0276
250058	01.1021	250126	01.0200	260037	01.1736	260108	01.6360	260241	01.1128	260242	01.1128	260243	01.1128
250059	01.0200	250127	00.8593	260038	01.3546	260109	01.0184	260244	01.2410	260245	01.2410	260246	01.2410
250060	00.8052	250128	01.0150	260039	01.4407	260110	01.5002	260247	01.2188	260248	01.2188	260249	01.2188
250061	00.9614	250129	01.0949	260040	01.4407	260111	01.5002	260250	01.2188	260251	01.2188	260252	01.2188
250062	01.0571	250131	00.9039	260041	00.8982	260112	01.3426	260253	01.2188	260254	01.2188	260255	01.2188
250063	00.8514	250132	00.9181	260042	01.2439	260113	01.1922	260256	01.2188	260257	01.2188	260258	01.2188
250065	00.9596	250134	00.9914	260043	01.2997	260114	01.1384	260259	01.2188	260260	01.2188	260261	01.2188
250066	00.8853	250136	00.8685	260044	01.3175	260115	01.1823	260262	01.2188	260263	01.2188	260264	01.2188
250067	01.0037	250137	00.9220	260045	00.9634	260116	01.1823	260265	01.2188	260266	01.2188	260267	01.2188
250068	00.8525	250138	01.1530	260046	01.0729	260117	01.1998	260268	01.2188	260269	01.2188	260270	01.2188
250069	01.1837	250139	00.9011	260047	01.2997	260118	01.1823	260271	01.2188	260272	01.2188	260273	01.2188
250071	00.9373	250140	00.8162	260048	01.3175	260119	01.1823	260274	01.2188	260275	01.2188	260276	01.2188
250072	01.1306	250141	01.3098	260049	00.9634	260120	01.1998	260277	01.2188	260278	01.2188	260279	01.2188
250073	00.9881	250142	00.8685	260050	01.0729	260121	01.1998	260280	01.2188	260281	01.2188	260282	01.2188
250076	00.9818	250143	00.9128	260051	01.2361	260122	01.1458	260283	01.2188	260284	01.2188	260285	01.2188
250077	00.8807	250144	01.3098	260052	01.1458	260123	00.9822	260286	01.2188	260287	01.2188	260288	01.2188
250078	01.3631	250145	00.8685	260053	01.0992	260124	00.9822	260289	01.2188	260290	01.2188	260291	01.2188
250079	00.8171	250146	01.3147	260054	01.3017	260125	00.9822	260292	01.2188	260293	01.2188	260294	01.2188
250081	01.1687	250147	00.5215	260055	01.1407	260126	01.1458	260295	01.2188	260296	01.2188	260297	01.2188
250082	01.2022	250148	01.5180	260056	01.1883	260127	01.1458	260298	01.2188	260299	01.2188	260300	01.2188
250083	00.9329	250149	01.0025	260057	01.1883	260128	01.1458	260301	01.2188	260302	01.2188	260303	01.2188
250084	01.2016	250150	01.0489	260058	01.0016	260129	01.1458	260304	01.2188	260305	01.2188	260306	01.2188
250085	00.9807	250151	01.2671	260059	01.0016	260130	01.1458	260307	01.2188	260308	01.2188	260309	01.2188
250086	00.9554	250152	01.1918	260060	01.1407	260131	01.1458	260310	01.2188	260311	01.2188	260312	01.2188
250088	01.0298	250153	01.2912	260061	01.1239	260132	01.1458	260313	01.2188	260314	01.2188	260315	01.2188
250089	00.9595	250154	01.2072	260062	01.2438	260133	01.1458	260316	01.2188	260317	01.2188	260318	01.2188
250091	00.9573	250155	01.5032	260063	01.0780	260134	01.1458	260319	01.2188	260320	01.2188	260321	01.2188
250093	01.1717	250156	01.0071	260064	01.4900	260135	01.1458	260322	01.2188	260323	01.2188	260324	01.2188
250094	01.1842	250157	01.0982	260065	01.4916	260136	01.1458	260325	01.2188	260326	01.2188	260327	01.2188
250095	01.0966	250158	01.5675	260066	00.9916	260137	01.1458	260328	01.2188	260329	01.2188	260330	01.2188
250096	01.1118	250159	01.0618	260067	00.8592	260138	01.1458	260331	01.2188	260332	01.2188	260333	01.2188
250097	01.1824	250160	01.1045	260068	01.7348	260139	01.1458	260334	01.2188	260335	01.2188	260336	01.2188
250098	00.9057	250161	01.2541	260069	01.0517	260140	01.1458	260337	01.2188	260338	01.2188	260339	01.2188
		250162	00.9704	260070	00.9574	260141	01.1458	260340	01.2188	260341	01.2188	260342	01.2188
				260071	00.9574	260142	01.1458	260343	01.2188	260344	01.2188	260345	01.2188
				260072	01.0982	260143	01.1458	260346	01.2188	260347	01.2188	260348	01.2188
				260073	01.1993	260144	01.1458	260349	01.2188	260350	01.2188	260351	01.2188
				260074	01.3942	260145	01.1458	260352	01.2188	260353	01.2188	260354	01.2188
				260075	01.1004	260146	01.1458	260355	01.2188	260356	01.2188	260357	01.2188
				260076	01.0254	260147	01.1458	260358	01.2188	260359	01.2188	260360	01.2188
				260077	01.0891	260148	01.1458	260361	01.2188	260362	01.2188	260363	01.2188
				260078	01.4061	260149	01.1458	260364	01.2188	260365	01.2188	260366	01.2188
				260079	01.4061	260150	01.1458	260367	01.2188	260368	01.2188	260369	01.2188
				260080	01.4061	260151	01.1458	260370	01.2188	260371	01.2188	260372	01.2188
				260081	01.4061	260152	01.1458	260373	01.2188	260374	01.2188	260375	01.2188
				260082	01.4061	260153	01.1458	260376	01.2188	260377	01.2188	260378	01.2188
				260083	01.4061	260154	01.1458	260379	01.2188	260380	01.2188	260381	01.2188
				260084	01.4061	260155	01.1458	260382	01.2188	260383	01.2188	260384	01.2188
				260085	01.4061	260156	01.1458	260385	01.2188	260386	01.2188	260387	01.2188
				260086	01.4061	260157	01.1458	260388	01.2188	260389	01.2188	260390	01.2188
				260087	01.4061	260158	01.1458	260391	01.2188	260392	01.2188	260393	01.2188
				260088	01.4061	260159	01.1458	260394	01.2188	260395	01.2188	260396	01.2188
				260089	01.4061	260160	01.1458	260397	01.2188	260398	01.2188	260399	01.2188
				260090	01.4061	260161	01.1458	260400	01.2188	260401	01.2188	260402	01.2188
				260091	01.4061	260162	01.1458	260403	01.2188	260404	01.2188	260405	01.2188
				260092	01.4061	260163	01.1458	260406	01.2188	260407	01.2188	260408	01.2188
				260093	01.4061	260164	01.1458	260409	01.2188	260410	01.2188	260411	01.2188
				260094	01.4061	260165	01.1458	260412	01.2188	260413	01.2188	260414	01.2188
				260095	01.4061	260166	01.1458	260415	01.2188	260416	01.2188	260417	01.2188
				260096	01.4061	260167	01.1458	260418	01.2188	260419	01.2188	260420	01.2188
				260097	01.4061	260168	01.1458						

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
 : CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
310084	01.1652	320053	00.9668	330043	01.2590	330116	01.0043	330191	01.2471
310085	01.2163	320055	00.8669	330044	01.2244	330118	01.5220	330193	01.4391
310086	01.1767	320057	01.0438	330045	01.2361	330119	01.4122	330194	01.6219
310087	01.1757	320058	00.7941	330046	01.4693	330121	01.1306	330195	01.6538
310088	01.2074	320059	00.9998	330047	01.2670	330122	01.2372	330196	01.3720
310090	01.1937	320060	00.9254	330048	01.2353	330125	01.7045	330197	01.0348
310091	01.2273	320061	01.1767	330049	01.2870	330126	01.2096	330198	01.2594
310092	01.2468	320062	00.8494	330053	01.0710	330127	01.2049	330199	01.2256
310093	01.0942	320063	01.2052	330055	01.2525	330128	01.2686	330201	01.4722
310096	01.7036	320065	01.1648	330056	01.2457	330132	01.1209	330202	01.1862
310105	01.0958	320067	00.8926	330057	01.5400	330133	01.3065	330203	01.3887
310108	01.2179	320068	00.9191	330058	01.3357	330135	01.2540	330204	01.2247
310110	01.1815	320069	01.1160	330059	01.4639	330136	01.2466	330205	01.1266
310111	01.2343	320070	00.9330	330061	01.3208	330140	01.5845	330206	01.1606
310112	01.1488	320074	01.0323	330062	01.1396	330141	01.2021	330208	01.1796
310113	01.2482	320076	01.1265	330064	01.3288	330142	01.2584	330211	01.2191
310115	01.1594	320079	01.0575	330065	01.2142	330144	01.0245	330212	01.1812
310116	01.2289	330001	01.1614	330066	01.2226	330148	01.0243	330213	01.1333
310118	01.2072	330002	01.4612	330067	01.2323	330151	01.1189	330214	01.6444
310119	01.2890	330003	01.2696	330072	01.2768	330152	01.3771	330215	01.2007
310120	01.0565	330004	01.2410	330073	01.1888	330153	01.3344	330218	01.2112
310121	01.0342	330005	01.5556	330074	01.2333	330154	01.3623	330219	01.4717
320001	01.3719	330006	01.3553	330075	01.0821	330155	01.1615	330221	01.2858
320002	01.2338	330007	01.2399	330078	01.3583	330157	01.2561	330222	01.2207
320003	01.2373	330008	01.1434	330079	01.1630	330158	01.2760	330223	01.1160
320004	01.1789	330009	01.2235	330080	01.2751	330159	01.3289	330224	01.2773
320005	01.2745	330010	01.2053	330082	01.2165	330160	01.3785	330225	01.2369
320006	01.1726	330011	01.1707	330084	01.0036	330161	01.1239	330226	01.2611
320009	01.2597	330012	01.5851	330085	01.3555	330162	01.2313	330229	01.2361
320010	01.2795	330013	01.8581	330086	01.2067	330163	01.1486	330230	01.4484
320011	01.0206	330014	01.3108	330088	01.2071	330164	01.3632	330231	01.1479
320012	00.9770	330015	01.3794	330090	01.6344	330166	00.9738	330232	01.2319
320013	01.0513	330016	01.0352	330091	01.3183	330167	01.4261	330233	01.4974
320014	00.9306	330019	01.2514	330092	00.9795	330168	01.0485	330234	01.7909
320016	01.1018	330020	01.0436	330094	01.2339	330171	01.2546	330235	01.1973
320017	01.0814	330022	01.0077	330095	01.2339	330174	00.8075	330236	01.3073
320018	01.2095	330023	01.2409	330096	01.1478	330175	00.8075	330238	01.1395
320019	01.3876	330024	01.6141	330097	01.2254	330176	01.0637	330239	01.1374
320021	01.6276	330025	01.1314	330100	00.6812	330177	00.8885	330240	01.1411
320022	01.2071	330027	01.3910	330101	01.6185	330179	01.0883	330241	01.5912
320023	01.0509	330028	01.2682	330102	01.2365	330180	00.9181	330242	01.3435
320030	01.0876	330029	01.1449	330103	01.1603	330181	01.2498	330244	01.0424
320031	00.9343	330030	01.1434	330104	01.3741	330182	01.2487	330245	01.4242
320032	00.9449	330033	01.2718	330106	01.5394	330183	02.1356	330246	01.1461
320033	01.0900	330034	01.2685	330107	01.2704	330184	01.3819	330247	00.6033
320035	01.0572	330036	01.2729	330108	01.2914	330185	01.2821	330249	01.2225
320037	01.2227	330037	01.1108	330110	01.0013	330186	01.1798	330250	01.2499
320038	01.1331	330038	01.0942	330111	01.1111	330188	01.1511	330252	00.9262
320046	00.9847	330039	00.9062	330114	01.0160	330189	01.1440	330254	01.0330
320048	01.3318	330041	01.4421	330115	01.1825		00.7955	330258	01.3407

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360001	01.1843	360057	00.9216	360113	01.2398	360170	01.0585	370017	01.0030
360002	01.1340	360058	01.0969	360114	01.1038	360172	01.2959	370018	01.1954
360003	01.4175	360059	01.3582	360115	01.1837	360174	01.1317	370019	01.0557
360006	01.6145	360061	00.9928	360116	01.0580	360175	01.1564	370020	01.2895
360007	01.1101	360062	01.4253	360118	01.2342	360176	01.1740	370021	00.8997
360008	01.1850	360063	01.0751	360119	01.1028	360177	01.1221	370022	01.2449
360009	01.2288	360064	01.4153	360120	01.0236	360178	01.1547	370023	01.1959
360010	01.1816	360065	01.2180	360121	01.1157	360179	01.2670	370025	01.2481
360011	01.2553	360066	01.2256	360122	01.2991	360180	01.8911	370026	01.2813
360012	01.3186	360067	01.2526	360123	01.1589	360184	00.7221	370028	01.5052
360013	01.0685	360068	01.3480	360124	01.1446	360185	01.1900	370029	01.2157
360014	01.1460	360069	01.0309	360125	01.1122	360186	01.0872	370030	01.2777
360015	01.3996	360070	01.2556	360126	01.1652	360187	01.3309	370032	01.3066
360016	01.3779	360071	01.1770	360127	00.9850	360188	01.0142	370033	01.2018
360017	01.6510	360072	01.2376	360128	01.0575	360189	01.1240	370034	01.1388
360018	01.3039	360074	01.2810	360129	01.0520	360192	01.1764	370035	01.4016
360019	01.1750	360075	01.3936	360130	01.1168	360193	01.2103	370036	01.1271
360020	01.2270	360076	01.2232	360131	01.2552	360194	01.1039	370037	01.4804
360021	01.2199	360077	01.3663	360132	01.1832	360195	01.1597	370038	00.9587
360024	01.2117	360078	01.2304	360133	01.3765	360197	01.0795	370039	01.2464
360025	01.1806	360079	01.5531	360134	01.4701	360200	01.1918	370040	01.0781
360026	01.1297	360080	01.1903	360135	01.1178	360203	01.1262	370041	00.9869
360027	01.4689	360081	01.2315	360136	01.0587	360204	01.2058	370042	00.8745
360028	01.2187	360082	01.3104	360137	01.4458	360210	01.1636	370043	00.9922
360029	01.0680	360083	01.2116	360139	01.0390	360211	01.0911	370045	01.0607
360030	01.1533	360084	01.4254	360140	01.0559	360212	01.4256	370046	01.0869
360031	01.1807	360085	01.6088	360141	01.3384	360213	01.0641	370047	01.1846
360032	01.1394	360086	01.2884	360142	01.0518	360218	01.2894	370048	01.1243
360034	01.0849	360087	01.2962	360143	01.1676	360230	01.2999	370049	01.2230
360035	01.4039	360088	01.1707	360144	01.2669	360231	01.0812	370050	00.8754
360036	01.1596	360089	01.0689	360145	01.4777	360232	01.0749	370051	01.1172
360037	01.7089	360090	01.1950	360147	01.2242	360234	01.2263	370054	01.2693
360038	01.4241	360091	01.3436	360148	01.1559	360236	01.1347	370056	01.3592
360039	01.1930	360092	01.1421	360149	01.0901	360238	00.9775	370057	01.1000
360040	01.2069	360093	01.1288	360150	01.2498	360239	01.1933	370059	01.3518
360041	01.2038	360094	01.1831	360151	01.2485	360240	00.7381	370060	00.9801
360042	01.1214	360095	01.2556	360152	01.4375	360241	00.6750	370063	01.0442
360044	01.0673	360096	01.0962	360153	01.1845	370001	01.6757	370064	00.9205
360045	01.3852	360098	01.2967	360154	01.0272	370002	01.2055	370065	01.1210
360046	01.0644	360099	01.0825	360155	01.1659	370004	01.0500	370069	01.0073
360047	01.0637	360100	01.2577	360156	01.1321	370005	00.9597	370071	00.9541
360048	01.6182	360101	01.5092	360159	01.1631	370006	01.2367	370072	00.9488
360049	01.2409	360102	01.2202	360161	01.2472	370007	01.1425	370075	01.1130
360050	01.2505	360103	01.2732	360162	01.1847	370008	01.2110	370077	01.2598
360051	01.4032	360104	00.9095	360163	01.6079	370011	00.9300	370078	01.4249
360052	01.5080	360106	01.2120	360164	01.0800	370012	00.9230	370079	00.8449
360053	01.2263	360107	01.0632	360165	01.0459	370013	01.3400	370080	00.9427
360054	01.2672	360108	01.0738	360166	01.0237	370014	01.1914	370082	00.9867
360055	01.1693	360109	01.0424	360168	00.8680	370015	01.0944	370083	01.0004
360056	01.2619	360112	01.4851	360169	01.0335	370016	01.2709	370084	00.8864

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370085	00.8982	370173	01.0793	380048	00.9964	390018	01.2191
370086	01.0937	370174	00.9278	380050	01.3307	390019	01.0899
370089	01.2867	370175	01.2318	380051	01.3662	390021	01.0635
370091	01.4884	370177	00.9368	380052	01.1965	390022	01.2418
370092	01.0639	370178	00.9991	380055	01.1698	390023	01.1187
370093	01.5002	370179	00.9780	380056	01.0076	390024	00.7880
370094	01.2215	370180	01.0504	380059	00.9135	390025	00.8008
370095	00.9467	370182	01.0116	380060	01.3242	390026	01.3170
370097	01.2667	370183	01.1389	380061	01.5228	390027	01.6102
370099	01.1392	370184	01.0247	380062	00.8853	390028	01.6791
370100	01.0248	370186	00.9679	380063	01.2350	390029	01.5365
370103	00.9635	370189	00.9542	380064	01.2682	390030	01.1493
370105	01.8545	370189	00.5215	380065	01.0978	390031	01.1307
370106	01.2997	380001	01.3566	380066	01.0937	390032	01.2223
370107	01.0583	380002	01.2041	380068	01.0937	390033	00.8795
370108	00.9455	380003	01.1706	380069	01.1209	390035	01.3217
370110	00.9756	380004	01.7608	380070	01.0266	390036	01.2332
370112	00.9664	380005	01.1507	380071	01.2256	390037	01.2233
370113	01.1060	380006	01.2401	380072	00.9411	390039	01.0778
370114	01.5081	380007	01.7340	380075	01.3649	390040	00.9543
370117	01.1330	380008	01.0515	380078	01.1761	390041	01.1706
370121	00.2905	380009	01.1922	380081	01.1387	390042	01.1918
370123	01.1112	380010	01.1351	380082	01.3048	390043	01.1019
370125	00.9685	380011	01.1327	380083	01.1349	390044	01.4617
370126	01.1630	380013	01.1703	380084	01.4256	390045	01.2513
370131	00.9743	380014	01.2713	380087	01.0636	390046	01.3778
370133	01.1045	380017	01.7236	380088	00.9572	390047	01.4479
370138	01.1116	380018	01.8508	380089	01.3010	390048	01.1484
370139	00.9648	380019	01.1687	380090	01.3389	390049	01.4484
370140	00.9896	380020	01.3642	380091	01.1771	390050	01.8058
370141	01.4118	380021	01.3057	380094	01.0532	390051	01.9918
370144	01.0439	380022	01.1924	380096	00.9214	390052	01.1219
370146	00.9485	380023	01.3289	380098	00.5283	390054	01.1642
370148	01.3109	380024	01.3020	390001	01.2251	390055	01.5791
370149	01.1985	380025	01.2589	390002	01.1987	390056	01.1203
370153	01.1013	380026	01.3429	390003	01.1558	390057	01.2876
370154	00.9775	380027	01.2556	390004	01.2601	390058	01.2882
370156	01.0571	380029	01.0887	390005	01.1258	390059	01.3250
370157	00.9735	380030	00.8109	390006	01.5996	390060	01.1968
370158	01.0367	380031	00.9698	390007	01.1820	390061	01.2771
370159	01.1324	380033	01.5886	390008	01.0981	390062	01.1544
370161	01.0516	380035	01.3015	390009	01.4155	390063	01.5355
370163	00.8783	380036	01.0507	390010	01.1109	390064	01.3502
370165	01.0736	380037	01.3354	390011	01.1717	390065	01.2533
370166	01.0858	380038	01.2434	390012	01.2277	390066	01.2918
370169	01.0086	380039	01.3782	390013	01.1999	390067	01.4853
370170	00.9769	380040	01.2683	390014	00.6305	390068	01.2615
370171	00.9867	380042	01.1460	390015	01.1230	390069	01.2267
370172	00.8904	380045	01.1257	390016	01.1608	390070	01.1973
		380047	01.5454	390017	01.0446	390071	01.0946

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390132	01.0524	390191	01.0882	390265	01.2134	400103	01.4205	420030	01.1519
390133	01.3367	390192	01.1024	390266	01.1372	400104	01.1988	420031	01.0055
390135	01.2378	390193	01.2393	390267	01.2181	400105	01.2736	420032	00.8964
390136	01.2083	390194	01.0891	390268	01.1883	400106	01.0474	420033	01.1834
390137	01.1823	390195	01.4855	390270	01.2887	400109	01.3932	420035	00.8397
390138	01.2729	390196	01.2482	390272	00.5595	400110	01.2232	420036	01.2609
390139	01.4315	390197	01.2737	390275	00.5834	400111	01.1910	420037	01.2746
390142	01.8403	390198	01.2195	390277	01.4314	400112	01.2351	420038	01.0884
390143	00.9101	390199	01.2797	390278	00.7828	400113	01.1823	420039	01.1086
390145	01.1930	390200	01.0154	390288	00.5300	400114	01.0307	420040	01.2287
390146	01.1808	390201	01.2856	400002	01.1119	400115	01.0519	420042	01.0886
390147	01.1968	390203	01.2634	400003	01.2883	400116	01.0815	420043	01.1328
390148	01.1262	390204	01.2392	400004	01.1161	400117	01.1486	420044	01.2040
390149	01.2343	390205	01.2307	400005	01.1473	400118	01.1952	420048	01.0562
390150	01.2052	390206	01.2982	400006	01.0462	400120	01.2939	420049	01.0694
390151	01.2709	390209	01.0004	400008	01.1784	410001	01.2710	420051	01.4450
390152	01.0035	390211	01.1558	400007	01.0846	410002	01.1741	420053	01.1327
390153	01.1708	390213	00.9977	400008	01.1050	410004	01.3330	420054	01.1000
390154	01.1187	390215	01.2015	400009	00.9774	410005	01.2821	420055	01.0381
390155	01.2805	390217	01.1327	400010	01.0300	410006	01.2042	420056	01.1087
390156	01.3503	390219	01.2135	400011	01.0615	410007	01.4839	420057	01.0795
390157	01.1572	390220	01.1853	400012	00.9881	410008	01.1450	420059	01.0685
390158	01.2269	390222	01.2212	400013	00.9176	410009	01.2776	420061	01.2562
390159	01.2135	390223	01.5055	400014	01.3554	410010	00.9279	420062	01.1626
390160	01.1779	390224	00.9834	400015	01.1382	410011	01.1799	420064	01.1213
390161	01.0914	390225	01.2649	400016	01.2651	410012	01.5348	420065	01.2515
390162	01.2404	390226	01.4983	400017	01.0622	410013	01.1841	420066	01.0216
390163	01.1510	390228	01.2193	400018	01.2240	410016	00.9134	420067	01.1023
390164	01.6490	390229	01.3862	400019	01.1483	410018	00.5215	420068	01.1627
390165	01.0831	390231	01.3023	400021	01.2824	420002	01.3053	420069	01.0179
390166	01.1491	390232	01.0953	400022	01.2855	420003	00.9367	420070	01.2346
390167	01.2293	390233	01.2527	400024	01.0267	420004	01.7892	420071	01.2691
390168	01.1205	390235	01.2904	400026	00.9546	420005	01.0716	420072	00.9865
390169	01.2387	390237	01.7731	400027	01.0615	420006	01.3312	420073	01.3332
390170	01.5595	390238	01.1599	400028	01.0310	420007	01.4377	420074	00.9097
390171	01.1166	390239	01.4684	400029	01.0307	420009	01.2773	420075	01.0719
390172	01.1709	390240	00.9673	400031	01.0296	420010	01.0745	420076	01.0945
390173	01.1254	390242	01.2223	400032	01.1660	420011	01.0768	420078	01.5238
390174	01.4840	390244	00.8910	400037	00.8608	420014	01.1091	420079	01.5101
390176	01.1659	390245	01.2547	400038	00.9581	420015	01.1973	420080	01.1427
390178	01.3462	390246	01.2061	400044	01.1486	420016	01.1219	420081	00.5862
390179	01.2457	390247	01.1015	400048	01.1546	420018	01.5425	420082	01.3059
390180	01.2837	390249	01.0511	400061	01.7838	420019	01.1587	420083	01.1880
390181	01.0887	390252	00.7808	400079	01.1509	420020	01.1505	420084	00.7840
390183	01.1013	390256	01.5788	400087	01.2200	420022	01.0748	420085	01.2190
390184	01.2067	390258	01.1986	400088	00.7537	420023	01.2448	420086	01.2909
390185	01.1763	390260	01.1865	400089	01.0902	420026	01.7710	420087	01.3610
390186	01.0733	390261	01.7383	400094	00.9455	420027	01.2151	420088	01.1426
390187	01.1222	390262	01.6675	400098	01.2401	420028	01.0289	420089	01.2464
390189	01.1162	390263	01.5019	400102	01.1424	420029	01.8168	420898	00.6005

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
420899	00.5215	430079	00.9712	440053	01.1607	440141	00.8998	450005	01.0185
430004	01.1487	430080	00.9747	440054	00.9622	440142	00.9712	450007	01.2814
430005	01.2754	430081	01.0600	440056	00.9679	440143	00.9836	450008	01.2270
430007	01.1525	430082	00.9169	440057	00.9755	440144	01.1930	450010	01.2234
430008	01.1917	430083	00.8012	440058	01.1863	440145	01.0159	450011	01.5515
430009	01.1582	430084	00.9252	440059	01.0823	440146	01.1775	450014	01.0830
430010	01.0974	430085	00.9740	440060	01.1409	440147	00.8651	450015	01.3682
430011	01.2295	430086	00.8276	440061	01.1038	440148	01.0610	450016	01.6574
430012	01.2529	430087	00.9725	440063	01.3006	440149	01.1416	450018	01.5573
430013	01.1525	430088	00.9775	440064	00.9559	440150	01.2835	450020	01.1257
430014	01.2399	440001	01.0144	440065	01.0729	440151	01.1378	450021	01.6202
430015	01.0418	440002	01.4206	440067	01.1428	440152	01.4736	450023	01.4171
430016	01.6323	440003	01.1511	440068	01.1556	440153	00.9515	450024	01.2581
430017	01.0838	440006	01.3726	440069	01.1499	440154	00.7258	450025	01.4163
430018	00.9402	440007	01.0072	440070	00.9123	440156	01.3737	450027	01.1587
430022	00.9433	440008	01.0314	440071	01.3179	440157	01.0574	450028	01.3312
430023	00.9196	440009	01.0336	440072	01.2801	440159	01.1451	450029	01.1934
430024	01.0435	440010	00.9468	440073	01.2937	440160	01.0381	450031	01.1755
430025	00.9433	440011	01.2294	440074	00.9233	440161	01.5490	450032	01.1302
430026	00.8974	440012	01.2253	440078	00.9747	440162	01.1063	450033	01.5659
430027	01.6207	440014	00.9386	440079	00.8571	440166	01.2174	450034	01.5100
430028	01.0533	440015	01.4856	440081	01.1410	440167	01.1345	450035	01.4647
430029	00.9052	440016	00.9727	440082	01.7672	440168	01.0206	450037	01.4550
430031	00.9825	440017	01.3692	440083	01.2392	440170	01.2771	450039	01.0991
430033	01.0071	440018	01.2549	440084	01.0731	440173	01.3812	450040	01.5658
430034	01.1347	440019	01.5075	440087	00.9892	440174	00.9077	450041	00.9865
430036	01.0667	440020	01.1798	440090	01.0361	440175	01.1066	450042	01.5442
430037	00.9311	440022	01.0855	440091	01.4213	440176	01.1665	450043	01.4031
430038	01.0546	440023	00.9670	440095	01.0187	440177	00.9336	450044	01.4357
430039	01.0040	440024	01.0968	440100	01.0877	440178	01.2247	450046	01.4307
430040	00.9556	440025	01.0874	440102	01.0398	440180	01.0782	450047	01.1029
430041	00.9885	440026	01.1539	440103	01.2786	440181	00.9722	450048	01.1534
430042	00.9930	440029	01.2052	440104	01.4320	440182	00.9926	450050	01.1495
430043	01.2050	440030	01.0218	440105	01.1585	440183	01.3964	450051	01.5952
430044	00.8716	440031	01.0563	440109	01.0352	440184	01.0958	450052	01.0493
430047	01.2049	440032	00.9829	440110	01.1023	440185	01.1160	450053	01.1789
430048	01.1064	440033	01.1334	440111	01.1476	440186	01.0594	450054	01.5203
430049	00.9281	440034	01.3188	440114	01.1055	440187	01.0215	450055	01.1004
430051	01.0041	440035	01.1629	440115	01.0846	440189	01.4179	450056	01.4844
430054	00.9212	440038	00.9230	440120	01.4354	440192	00.9584	450057	01.1821
430056	00.8127	440039	01.5636	440121	01.1569	440193	01.1395	450058	01.4503
430057	00.8979	440040	00.9474	440125	01.3643	440194	01.2111	450059	01.2708
430060	00.8734	440041	00.8907	440128	01.0155	440196	01.0300	450060	01.2122
430062	00.8964	440046	01.0284	440130	01.1335	440197	01.2568	450063	00.9314
430064	01.0347	440047	00.9531	440131	01.1058	440200	01.0781	450064	01.4381
430065	00.9298	440048	01.5372	440132	00.9706	440203	01.0461	450065	01.0949
430066	00.9806	440049	01.5977	440133	01.4879	440205	00.9663	450068	01.5340
430073	01.0611	440050	01.1163	440135	01.2083	440898	00.5283	450070	01.1527
430076	00.9843	440051	00.9085	440136	01.2903	450002	01.3495	450072	01.2050
430077	01.3706	440052	01.0789	440137	01.1039	450004	01.0615	450073	01.0546

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450074	01.1186	450147	01.2868	450221	01.0217	450330	01.1308	450451	01.1126
450076	01.1547	450148	01.3410	450222	01.5402	450331	00.8664	450457	01.5197
450077	00.9270	450149	01.3673	450224	01.0594	450334	01.0323	450480	01.0419
450078	01.0171	450150	00.9492	450229	01.4117	450337	01.1400	450482	01.3979
450079	01.4449	450151	01.0758	450231	01.5377	450340	01.2802	450484	00.9144
450080	01.2360	450152	01.3823	450233	01.0612	450341	00.9581	450485	01.1376
450081	01.1793	450153	01.4344	450234	00.8724	450346	01.3075	450487	01.0187
450082	01.0147	450154	01.2088	450235	01.0874	450347	01.2477	450489	01.2399
450083	01.4638	450155	01.1456	450236	01.1667	450348	00.9786	450492	01.0158
450085	01.0476	450157	00.9999	450237	01.4679	450349	01.2092	450493	01.1152
450087	01.2886	450160	00.8848	450239	01.1424	450351	01.2866	450495	01.1286
450090	01.1848	450162	01.5013	450241	00.8939	450352	01.2917	450497	00.9588
450092	01.2117	450163	01.1975	450243	01.0217	450353	01.1592	450498	01.4291
450094	01.3121	450164	00.9058	450246	01.0138	450355	00.8949	450499	01.0006
450096	01.4170	450165	00.9528	450249	00.8847	450358	01.8388	450488	01.1070
450097	01.3378	450166	00.9857	450250	00.8847	450362	00.9933	450489	01.0345
450098	01.1587	450169	00.8740	450253	01.1206	450365	00.9313	450492	00.8598
450099	01.1367	450170	01.1631	450256	01.0260	450366	01.6560	450497	01.1287
450101	01.3517	450175	01.2664	450258	01.0772	450369	01.1771	450488	00.9958
450102	01.5531	450176	01.2554	450259	01.2949	450370	01.1927	450508	01.4797
450104	01.2704	450177	01.0953	450264	00.8579	450371	01.1580	450514	01.1034
450107	01.4067	450178	01.0315	450268	01.1699	450372	01.3177	450517	00.9618
450108	01.0174	450179	00.9999	450289	00.9290	450373	01.1644	450518	01.2599
450109	00.9681	450181	00.9561	450290	01.1092	450374	00.8368	450523	01.4419
450110	01.2139	450183	01.1893	450291	01.1234	450376	01.4616	450530	01.3081
450111	01.2101	450184	01.3892	450292	01.1748	450378	01.3336	450534	01.0313
450112	01.2129	450185	01.1092	450293	01.0067	450379	01.5227	450535	01.2811
450113	01.1869	450187	01.2322	450296	01.1232	450381	00.9079	450537	01.3080
450115	01.1110	450188	00.9603	450297	00.9435	450388	01.5551	450538	01.1784
450118	01.4464	450190	01.2463	450280	01.2632	450389	01.2698	450539	01.3123
450119	01.2339	450191	01.0933	450283	01.0802	450393	01.2580	450544	01.2811
450121	01.3110	450192	01.0688	450286	01.0702	450394	01.1733	450545	01.3148
450123	01.0543	450193	02.1113	450288	01.1735	450395	01.0790	450546	01.3348
450124	01.4544	450194	01.1329	450289	01.2936	450399	01.1265	450547	00.8631
450126	01.1784	450195	01.4029	450292	01.2067	450400	01.1420	450550	01.1323
450127	00.9178	450196	01.1841	450293	00.9751	450403	01.2351	450551	01.1024
450128	01.2324	450197	01.2129	450296	01.1720	450410	01.0975	450557	01.0389
450130	01.3791	450200	01.2371	450297	01.0198	450411	01.0487	450558	01.7982
450131	01.1592	450201	01.0007	450299	01.4171	450417	01.0149	450559	00.9039
450132	01.4889	450203	01.2022	450303	00.9093	450418	01.3823	450561	01.4441
450133	01.4083	450207	01.2221	450306	01.0442	450419	01.2953	450563	01.1968
450135	01.5305	450208	01.2260	450307	01.1085	450422	00.7786	450565	01.2049
450137	01.2395	450209	01.2475	450309	01.0429	450423	01.4069	450570	00.9896
450140	00.9825	450210	01.0270	450315	01.2633	450424	01.2113	450571	01.4360
450141	01.0682	450211	01.2804	450320	01.2989	450428	00.9946	450573	01.0719
450142	01.3447	450213	01.3585	450321	00.9249	450431	01.4418	450574	01.1084
450143	01.0136	450214	01.3235	450322	00.8769	450438	01.0727	450575	00.9276
450144	01.1624	450217	00.8293	450324	01.5419	450446	00.8425	450578	01.0053
450145	01.0480	450218	00.9643	450325	01.2957	450447	01.2990	450580	01.1607
450146	01.0811	450219	01.1501	450327	01.0501	450450	01.0704	450583	00.9928

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASL MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450584	01.2852	450669	01.3467	450743	01.3445	450033	00.8510
450586	01.1308	450670	01.1914	450744	00.9510	450035	00.8976
450587	01.1558	450672	01.5102	450745	00.7559	450036	00.9342
450590	00.9591	450673	00.9177	450746	00.9560	450037	00.9668
450591	01.1552	450674	00.8529	450747	01.1701	450039	00.9627
450596	01.1872	450675	01.2571	450749	01.0462	450041	01.2026
450597	01.0856	450677	01.2532	450750	00.9573	450042	01.3542
450600	00.9375	450678	01.4288	450751	01.1611	450043	01.2311
450603	00.7851	450681	01.5297	450753	01.1258	450044	01.2005
450604	01.2221	450682	01.2623	450754	00.8965	450046	00.9775
450605	01.2820	450683	01.2919	450755	00.9660	450047	01.6773
450607	00.8885	450684	01.3653	450757	00.9426	450048	00.5300
450609	00.9927	450685	01.3362	450758	01.5637	450049	01.1339
450610	01.3362	450686	01.3335	450759	00.9913	450050	01.8109
450614	01.0097	450688	01.1845	450760	01.2560	450051	01.1891
450615	00.9626	450690	01.2748	450761	00.8614	450055	01.2102
450617	01.2828	450691	01.4154	450763	01.0985	450056	01.1879
450620	01.1242	450694	01.1199	450764	01.7831	450058	01.1639
450623	01.1304	450696	01.0789	450765	01.0274	450059	01.0035
450626	00.9627	450697	01.4300	450766	01.4640	450061	01.1937
450628	00.9868	450698	00.8446	450767	00.9183	450062	01.2816
450630	01.5996	450700	00.8897	450768	01.1837	450063	01.0920
450631	01.6227	450702	01.2562	450769	01.5510	450065	01.1976
450632	00.9605	450703	01.2781	450770	01.4222	450066	01.0923
450633	01.5058	450704	01.2402	450771	01.5807	450068	01.2815
450634	01.2495	450705	00.8119	450772	01.2815	450069	00.9332
450637	01.1767	450706	01.2459	450773	01.3371	450070	01.2285
450638	01.4513	450709	01.2060	450774	01.2323	450072	01.1207
450639	01.5250	450711	01.5302	450775	01.2577	450073	01.1272
450641	00.8941	450712	00.8316	450776	01.7371	450074	01.0604
450643	01.1876	450713	01.2340	450777	01.9546	450075	00.8214
450644	01.7821	450715	01.3548	450778	01.2515	450076	01.3060
450646	01.3489	450716	01.1744	450779	01.3383	450077	01.1545
450647	01.9701	450717	01.2869	450780	01.0099	450078	01.4040
450648	01.1290	450718	01.1145	450781	01.2417	450079	01.1839
450649	01.0034	450719	01.2291	450782	01.9088	450080	01.8021
450651	01.6675	450723	01.2775	450783	01.2061	450081	01.1147
450652	00.9088	450724	01.2258	450784	00.9298	450082	01.5788
450653	01.2315	450725	00.9363	450785	00.9811	450083	01.2488
450654	00.9446	450726	00.8831	450786	00.9811	450084	01.2321
450656	01.2561	450727	01.0116	450787	01.0179	450085	01.0474
450658	01.0353	450728	00.8652	450788	01.3764	450086	01.1407
450659	01.3570	450729	00.8672	450789	00.9712	450087	01.1407
450660	01.4869	450730	01.3773	450790	01.0932	450088	01.5033
450661	01.2460	450732	01.1311	450791	00.9891	450089	01.3629
450662	01.2623	450733	01.3573	450792	00.8826	450090	01.2606
450665	00.9836	450734	01.1291	450793	00.8672	450091	01.1405
450666	01.1961	450735	00.8623	450794	00.8672	450092	01.1198
450667	01.0609	450737	00.5859	450795	00.3252	450093	01.0754
450668	01.4438	450742	01.2861	450796	00.9706	450094	01.3392
				450797	01.0509	450095	01.3392
				450798	00.9562	450096	01.1828
				450799	00.9562	450097	01.1466
				450800	00.9562	450098	01.3141

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.

: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
490099	00.9354	500028	00.9645	500092	01.1820	510026	01.0041	520012	00.9339
490100	01.2672	500029	00.9239	500093	01.1292	510027	01.2297	520013	01.2711
490101	01.0861	500030	01.3000	500094	00.9380	510028	01.0686	520014	01.1729
490104	00.8678	500031	01.2273	500096	00.9972	510029	01.2367	520015	01.1947
490105	00.7994	500033	01.2670	500097	01.0126	510030	01.1399	520016	01.0219
490106	00.7966	500034	00.9970	500098	00.8968	510031	01.2358	520017	01.1721
490107	01.1576	500035	01.4890	500101	00.9378	510033	01.2052	520018	01.0090
490108	00.8737	500036	01.2374	500102	00.9040	510035	01.1087	520019	01.2373
490109	00.8314	500037	01.2233	500104	01.2328	510036	01.1726	520020	01.3666
490110	01.1069	500039	01.2863	500106	00.9047	510038	01.0558	520021	01.1701
490111	01.1347	500041	01.2006	500107	01.1194	510039	01.2805	520024	01.0224
490112	01.4449	500042	01.2610	500108	01.6175	510040	01.0589	520025	01.1129
490113	01.1950	500043	01.2463	500110	01.2217	510043	01.0202	520026	01.0168
490114	01.0148	500044	01.9311	500114	00.9746	510046	01.2762	520027	01.1542
490115	01.1629	500045	01.2282	500118	01.1337	510047	01.1256	520028	01.2752
490116	01.1171	500048	00.9254	500119	01.2586	510048	01.1469	520029	00.9103
490117	01.0422	500049	01.2375	500122	01.2289	510050	01.2258	520030	01.4772
490118	01.6472	500050	01.3042	500123	01.0284	510053	01.0100	520031	01.1205
490119	01.3101	500051	01.6904	500124	01.3035	510055	01.1685	520032	01.1313
490120	01.3004	500052	01.2317	500125	00.9310	510058	01.1849	520033	01.1921
490122	01.1786	500053	01.2321	500127	00.9979	510059	01.1707	520034	01.1494
490123	01.0920	500054	01.7829	500129	01.6437	510060	01.1635	520035	01.2378
490124	01.2689	500055	00.9945	500132	00.8520	510061	01.1314	520037	01.5700
490126	01.1629	500057	01.2109	500134	00.5607	510062	01.1687	520038	01.2282
490127	01.0602	500058	01.2513	500135	01.1385	510063	01.0728	520039	01.0202
490129	00.6657	500059	01.1245	500137	00.8214	510065	01.0024	520040	01.3816
490130	01.1839	500060	01.1771	500138	02.2450	510066	01.0965	520041	01.1030
490131	00.9150	500061	01.0186	500139	01.3118	510067	01.2201	520042	01.0295
490898	00.5215	500062	01.0294	500140	00.8633	510068	01.1559	520044	01.3762
500001	01.2990	500064	01.5362	500141	01.3017	510070	01.1494	520045	01.6324
500002	01.4058	500065	01.1539	500898	00.5215	510071	01.3324	520047	00.9810
500003	01.3962	500068	01.0434	510001	01.4873	510072	01.0653	520048	01.2632
500005	01.6901	500069	01.0413	510002	01.2975	510076	00.9870	520049	01.7522
500007	01.2829	500071	01.3166	510004	00.9436	510077	01.1299	520051	01.8092
500008	01.9049	500072	01.2108	510005	00.9864	510080	00.9566	520053	01.0707
500009	01.3644	500073	01.0363	510006	01.2274	510081	01.0584	520054	01.2167
500010	00.5654	500074	01.1138	510007	01.3039	510082	00.9641	520056	01.2894
500011	01.2440	500075	01.2317	510008	01.1683	510084	01.0079	520057	01.1355
500012	01.5193	500076	01.2354	510009	01.0985	510085	01.2593	520058	01.1471
500014	01.6294	500077	01.2439	510012	01.0609	510086	01.1204	520059	01.2540
500015	01.3351	500078	01.2905	510013	01.1563	510087	00.8158	520060	01.2179
500016	01.3221	500079	01.2052	510014	00.7564	520002	01.2923	520062	01.2087
500017	01.2530	500080	01.0329	510015	01.0086	520003	01.1099	520063	01.1944
500019	01.1905	500084	00.9835	510016	01.0046	520004	01.2205	520064	01.4509
500021	01.2680	500085	01.0223	510018	01.1252	520006	01.0353	520066	01.2425
500023	01.1097	500086	01.3187	510020	01.1782	520007	01.1214	520068	01.0224
500024	01.3094	500087	01.1146	510022	01.5668	520008	01.2090	520069	01.2687
500025	01.9292	500088	01.3246	510023	01.0104	520009	01.3479	520070	01.2352
500026	01.2841	500089	00.9775	510024	01.2953	520010	01.1029	520071	01.1358
500027	01.5704	500090	00.8224	510025	01.0351	520011	01.1262	520074	01.1232

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1990

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PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX	PROVIDER CASE MIX
520075 01.3198	520141 01.1260	530032 01.1734	
520076 01.1901	520142 00.9348		
520077 01.0079	520144 00.9335		
520078 01.3261	520145 01.0058		
520081 01.1944	520146 01.1188		
520082 01.2561	520148 01.1325		
520083 01.5211	520149 01.1489		
520084 01.0592	520151 01.0788		
520087 01.5003	520152 01.1308		
520088 01.1779	520153 01.1186		
520089 01.3410	520154 01.1219		
520090 01.1179	520156 01.0667		
520091 01.2734	520157 01.0420		
520092 01.1338	520159 00.9259		
520094 01.1787	520160 01.7379		
520095 01.2529	520161 01.1193		
520096 01.3269	520170 01.2105		
520097 01.2223	520171 00.9805		
520098 01.6124	520173 01.0750		
520100 01.2314	520174 01.3999		
520101 01.1339	520176 00.8372		
520102 01.2592	520177 01.4274		
520103 01.2908	520178 01.1361		
520104 00.9899	520180 00.6320		
520105 01.0055	530001 01.2636		
520107 01.2743	530002 01.2255		
520109 01.0969	530003 00.9574		
520110 01.0188	530004 00.9913		
520111 01.1077	530005 01.0433		
520112 01.0813	530006 01.1403		
520113 01.2024	530007 01.0516		
520114 01.1250	530008 01.0608		
520115 01.3174	530009 00.9081		
520116 01.1489	530010 01.1564		
520117 01.0413	530011 01.1563		
520118 00.8402	530012 01.6076		
520120 01.0382	530014 01.0988		
520121 01.0102	530015 01.0510		
520122 01.0140	530016 01.0895		
520123 00.9790	530017 01.0214		
520124 01.0810	530018 01.1367		
520130 01.0017	530019 00.9768		
520131 01.1107	530022 01.0858		
520132 01.2144	530023 00.8713		
520134 01.1485	530024 00.9498		
520135 00.9904	530025 01.1823		
520136 01.4282	530026 01.0155		
520138 01.7102	530027 00.9336		
520139 01.2337	530029 00.9260		
520140 01.3431	530031 01.0226		

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1991

BILLING CODE 4210-03-C

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX	0.9437
Taylor, TX	
Aguadilla, PR	.4572
Aguada, PR	
Aguadilla, PR	
Isabella, PR	
Moca, PR	
Akron, OH	.9016
Portage, OH	
Summit, OH	
Albany, GA	.8057
Dougherty, GA	
Lee, GA	
Albany-Schenectady-Troy, NY	.8931
Albany, NY	
Greene, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Albuquerque, NM	1.0133
Bernalillo, NM	
Alexandria, LA	.8283
Rapides, LA	
Allentown-Bethlehem-Easton, PA-NJ	.9265
Warren, NJ	
Carbon, PA	
Lehigh, PA	
Northampton, PA	
Altoona, PA	.9247
Blair, PA	
Amarillo, TX	.8747
Potter, TX	
Randall, TX	
*Anaheim-Santa Ana, CA	1.2021
Orange, CA	
Anchorage, AK	1.4189
Anchorage, AD	
Anderson, IN	1.0122
Madison, IN	
Anderson, SC	.7265
Anderson, SC	
Ann Arbor, MI	1.1394
Washtenaw, MI	
Anniston, AL	.7938
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	.9229
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Arecibo, PR	.3957
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
Quebradillas, PR	
Asheville, NC	.8747
Buncombe, NC	
Athens, GA	.8216
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
*Atlanta, GA	.9604
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	1.0516
Atlantic, NJ	
Cape May, NJ	
Augusta, GA-SC	.9409
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	.9208
Kane, IL	
Kendall, IL	
Austin, TX	.9608
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.0878
Kern, CA	
*Baltimore, MD	1.0165
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	.9072
Penobscot, ME	
Baton Rouge, LA	.9097
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	.9107
Calhoun, MI	
Beaumont-Port Arthur, TX	.9612
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0174
Beaver, PA	
Bellingham, WA	1.0506
Whatcom, WA	
Benton Harbor, MI	.7713
Berrien, MI	
*Bergen-Passaic, NJ	1.0305
Bergen, NJ	
Passaic, NJ	
Billings, MT	.9333
Yellowstone, MT	
Biloxi-Gulfport, MS	.8069
Hancock, MS	
Harrison, MS	
Binghamton, NY	.9268
Broome, NY	
Tioga, NY	
Birmingham, AL	.8777
Blount, AL	
Jefferson, AL	
Saint Clair, AL	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Shelby, AL	
Walker, AL	
Bismarck, ND	.8851
Burleigh, ND	
Morton, ND	
Bloomington, IN	.7848
Monroe, IN	
Bloomington-Normal, IL	.8666
McClean, IL	
Boise City, ID	1.0120
Ada, ID	
*Boston-Lawrence-Salem-Lowell-	
Brockton, MA	1.1820
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	1.0158
Boulder, CO	
Bradenton, FL	.8828
Manatee, FL	
Brazoria, TX	.8805
Brazoria, TX	
Bremerton, WA	1.0375
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.2043
Fairfield, CT	
Brownsville-Harlingen, TX	.8609
Cameron, TX	
Bryan-College Station, TX	.9497
Brazos, TX	
Buffalo, NY	.8916
Erie, NY	
Burlington, NC	.7888
Alamance, NC	
Burlington, VT	.9366
Chittenden, VT	
Grand Isle, VT	
Caguas, PR	.4592
Caguas, PR	
Gurabo, PR	
San Lorenz, PR	
Agua Buenas, PR	
Cayey, PR	
Cidra, PR	
Canton, OH	.8461
Carroll, OH	
Stark, OH	
Casper, WY	.8899
Natrona, WY	
Cedar Rapids, IA	.7534
Linn, IA	
Champaign-Urbana-Rantoul, IL	.8757
Champaign, IL	
Charleston, SC	.8339
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	.9701
Kanawha, WV	
Putnam, WV	
*Charlotte-Gastonia-Rock Hill, NC-SC	.9495
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	.9624

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	.9206
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	.7915
Laramie, WY	
*Chicago, IL	1.0527
Cook, IL	
Du Page, IL	
McHenry, IL	
Chico, CA	1.1062
Butte, CA	
*Cincinnati, OH-KY-IN	.9830
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	.7326
Christian, KY	
Montgomery, TN	
*Cleveland, OH	1.0748
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	.9825
El Paso, CO	
Columbia, MO	.9515
Boone, MO	
Columbia, SC	.8948
Lexington, SC	
Richland, SC	
Columbus, GA-AL	.7577
Russell, AL	
Chattanooga, GA	
Muscogee, GA	
*Columbus, OH	.9682
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	.8602
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	.8195
Allegany, MD	
Mineral, WV	
*Dallas, TX	.9447
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	.7513
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	.8478
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	.9100

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	.8951
Volusia, FL	
Decatur, AL	.7493
Lawrence, AL	
Morgen, AL	
Decatur, IL	.8293
Macon, IL	
*Denver, CO	1.0767
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	.9179
Dallas, IA	
Polk, IA	
Warren, IA	
*Detroit, MI	1.0837
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	.7576
Dale, AL	
Houston, AL	
Dubuque, IA	.8382
Dubuque, IA	
Duluth, MN-WI	.9526
St. Louis, MN	
Douglas, WI	
Eau Claire, WI	.8495
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	.8722
El Paso, TX	
Elkhart-Goshen, IN	.8589
Elkhart, IN	
Elmira, NY	.8818
Chemung, NY	
Enid, OK	.8920
Garfield, OK	
Erie, PA	.9164
Erie, PA	
Eugene-Springfield, OR	1.0174
Lane, OR	
Evansville, IN-KY	.9284
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	.9715
Clay, MN	
Cass, ND	
Fayetteville, NC	.8303
Cumberland, NC	
Fayetteville-Springdale, AR	.7997
Washington, AR	
Flint, MI	1.1554
Genesee, MI	
Florence, AL	.7724
Colbert, AL	
Lauderdale, AL	
Florence, SC	.8436
Florence, SC	
Fort Collins-Loveland, CO	1.0247
Larimer, CO	
*Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0383

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Broward, FL	
Fort Myers-Cape Coral, FL	.9808
Lee, FL	
Fort Pierce, FL	1.1051
Martin, FL	
St. Lucie, FL	
Fort Smith, AR-OK	.7939
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	.8949
Okaloosa, FL	
Fort Wayne, IN	.8910
Allen, IN	
De Kalb, IN	
Whitley, IN	
*Fort Worth-Arlington, TX	.9498
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.0747
Fresno, CA	
Gadsden, AL	.8206
Etowah, AL	
Gainesville, FL	.8806
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	.9459
Galveston, TX	
Gary-Hammond, IN	.9485
Lake, IN	
Porter, IN	
Glens Falls, NY	.9239
Warren, NY	
Washington, NY	
Grand Forks, ND	.9586
Grand Forks, ND	
Grand Rapids, MI	.9892
Kent, MI	
Ottawa, MI	
Great Falls, MT	1.0001
Cascade, MT	
Greoley, CO	.9368
Weld, CO	
Green Bay, WI	.9594
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	.9173
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	.8911
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	.9166
Washington, MD	
Hamilton-Middletown, OH	.8461
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	.9928
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
*Hartford-Middletown-New Britain-Bristol, CT	1.1927
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	.8809

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1591
Honolulu, HI	
Houma-Thibodaux, LA	.7184
Lafourche, LA	
Terrebonne, LA	
*Houston, TX	.9788
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	.9446
Boyd, KY	
Carter, KY	
Greenup, KY	
Lasrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	.8843
Madison, AL	
*Indianapolis, IN	.9609
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	.9536
Johnson, IA	
Jackson, MI	.8833
Jackson, MI	
Jackson, MS	.7740
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	.7969
Madison, TN	
Jacksonville, FL	.9059
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	.7161
Onslow, NC	
Jamestown-Dunkirk, NY	.7069
Chatauqua, NY	
Janesville-Beloit, WI	.8453
Rock, WI	
Jersey City, NJ	1.0536
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN-VA	.8676
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	.8861
Cambria, PA	
Somerset, PA	
Joliet, IL	1.0518
Grundy, IL	
Will, IL	
Joplin, MO	.7888
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.1720

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Kalamazoo, MI	
Kankakee, IL	.8496
Kankakee, IL	
*Kansas City, KS-MO	.9597
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	.8863
Kenosha, WI	
Killeen-Temple, TX	1.1305
Bell, TX	
Coryell, TX	
Knoxville, TN	.8700
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	.9444
Howard, IN	
Tipton, IN	
LaCrosse, WI	.8964
LaCrosse, WI	
Lafayette, LA	.8234
Lafayette, LA	
St. Martin, LA	
Lafayette, In.	.8440
Tippicanoe, IN	
Lake Charles, LA	.8382
Calcasieu, LA	
Lake County, IL	.9417
Lake, IL	
Lakeland-Winter Haven, FL	.7665
Polk, FL	
Lancaster, PA	.9266
Lancaster, PA	
Lansing-East Lansing, MI	1.0232
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	.7284
Webb, TX	
Las Cruces, NM	.7916
Dona Ana, NM	
Las Vegas, NV	1.0641
Clark, NV	
Lawrence, KS	.8945
Douglas, KS	
Lawton, OK	.8396
Comanche, OK	
Lewiston-Auburn, ME	.9065
Androscoggin, ME	
Lexington-Fayette, KY	.8454
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	.8070
Allen, OH	
Auglaize, OH	
Lincoln, NE	.8964
Lancaster, NE	
Little Rock-North Little Rock, AR	.8428

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	.8699
Gregg, TX	
Harrison, TX	
Lorain-Elyria, OH	.8919
Lorain, OH	
* Los Angeles-Long Beach, CA	1.2366
Los Angeles, CA	
Louisville, KY-IN	.9100
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	.8798
Lubbock, TX	
Lynchburg, VA	.8551
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	.8812
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0320
Dane, WI	
Manchester-Nashua, NH	1.0139
Hillsborough, NH	
Merrimack, NH	
Mansfield, OH	.8400
Richland, OH	
Mayaguez, PR	.4776
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
San German, PR	
McAllen-Edinburg-Mission, TX	.7722
Hidalgo, TX	
Medford, OR	1.0054
Jackson, OR	
Melbourne-Titusville, FL	.9208
Brevard, FL	
Memphis, TN-AR-MS	.9068
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Merced, CA	1.0321
Merced, CA	
* Miami-Hialeah, FL	1.0198
Dade, FL	
* Middlesex-Somerset-Hunterdon, NJ	1.0410
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.0386
Midland, TX	
* Milwaukee, WI	.9728
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
* Minneapolis-St. Paul, MN-WI	1.0828

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	.8327
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.1593
Stanislaus, CA	
Monmouth-Ocean, NJ	.9909
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	.7871
Ouachita, LA	
Montgomery, AL	.7745
Autauga, AL	
Elmore, AL	
Montgomery, AL	
Muncie, IN	.8075
Delaware, IN	
Muskegon, MI	.9491
Muskegon, MI	
Naples, FL	1.0333
Collier, FL	
Nashville, TN	.9406
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford, TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
*Nassau-Suffolk, NY	1.2650
Nassau, NY	
Suffolk, NY	
New Bedford-Fall River-Attleboro, MA	1.1723
Bristol, MA	
New Haven-Waterbury-Meriden, CT	1.2106
New Haven, CT	
New London-Norwich, CT	1.1582
New London, CT	
*New Orleans, LA	.8909
Jefferson, LA	
Orleans, LA	
St. Bernard, LA	
St. Charles, LA	
St. John The Baptist, LA	
St. Tammany, LA	
*New York, NY	1.3479
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
*Newark, NJ	1.1242
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	.7567
Niagara, NY	
*Norfolk-Virginia Beach-Newport News, VA	.8523

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg, City, VA	
York, VA	
*Oakland, CA	1.4532
Alameda, CA	
Contra Costa, CA	
Ocala, FL	.8622
Marion, FL	
Odessa, TX	1.0849
Ector, TX	
Oklahoma City, OK	.9153
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	1.1012
Thurston, WA	
Omaha, NE-IA	.8997
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	.9205
Orange, NY	
*Orlando, FL	.9629
Orange, FL	
Osceola, FL	
Seminole, FL	
*Owensboro, KY	.8158
Daviess, KY	
Oxnard-Ventura, CA	1.2091
Ventura, CA	
Panama City, FL	.8640
Bay, FL	
Parkersburg-Marietta, WV-OH	.8547
Washington, OH	
Wood, WV	
Pascagoula, MS	.8763
Jackson, MS	
Pensacola, FL	.8631
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	.8717
Peoria, IL	
Tazewell, IL	
Woodford, IL	
*Philadelphia, PA-NJ	1.0962
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
*Phoenix, AZ	1.0438
Maricopa, AZ	
Pine Bluff, AR	.7879
Jefferson, AR	
*Pittsburgh, PA	1.0137

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	1.0792
Berkshire, MA	
Ponce, PR	.4606
Juana Diaz, PR	
Ponce, PR	
Portland, ME	.9300
Cumberland, ME	
Sagadahoc, ME	
York, ME	
*Portland, OR	1.1583
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	1.0115
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	1.0456
Dutchess, NY	
*Providence-Pawtucket-Woonsocket, RI	1.0657
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
Provo-Orem, UT	1.0239
Utah, UT	
Pueblo, CO	.8730
Pueblo, CO	
Racine, WI	.8453
Racine, WI	
Raleigh-Durham, NC	.9474
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	.8408
Pennington, SD	
Reading, PA	.9098
Berks, PA	
Redding, CA	1.0559
Shasta, CA	
Reno, NV	1.1628
Washoe, NV	
Richland-Kennewick, WA	.9410
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	.9426
Charles City Co., VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
*Riverside-San Bernardino, CA	1.1091
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	.8292
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.1039

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Olmsted, MN	
*Rochester, NY	.9719
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	.9291
Boone, IL	
Winnebago, IL	
*Sacramento, CA	1.2244
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
Saginaw-Bay City-Midland, MI	1.0461
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	.8927
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	.9422
Buchanan, MO	
*St. Louis, MO-IL	.9397
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0455
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.3052
Monterey, CA	
*Salt Lake City-Ogden, UT	.9941
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	.8147
Tom Green, TX	
*San Antonio, TX	.8450
Bexar, TX	
Comal, TX	
Guadalupe, TX	
*San Diego, CA	1.1945
San Diego, CA	
*San Francisco, CA	1.4517
Marin, CA	
San Francisco, CA	
San Mateo, CA	
*San Jose, CA	1.4661
Santa Clara, CA	
*San Juan, PR	.4991
Barcelona, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Corozal, PR	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Lugaillo, PR	
Manati, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Troje Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1779
Santa Barbara, CA	
Santa Cruz, CA	1.1829
Santa Cruz, CA	
Santa Fe, NM	.9170
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.2968
Sonoma, CA	
Sarasota, FL	.9790
Sarasota, FL	
Savannah, GA	.8335
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	.8923
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
*Seattle, WA	1.0881
King, WA	
Snodhomish, WA	
Sharon, PA	.9180
Mercer, PA	
Sheboygan, WI	.8880
Sheboygan, WI	
Sherman-Denison, TX	.9097
Grayson, TX	
Shreveport, LA	.9308
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	.8511
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	.8841
Minnehaha, SD	
South Bend-Mishawaka, IN	1.0076
St. Joseph, IN	
Spokane, WA	1.0701
Spokane, WA	
Springfield, IL	.9304
Menard, IL	
Sangamon, IL	
Springfield, MO	.8089
Christian, MO	
Greene, MO	
Springfield, MA	.9632
Hampden, MA	
Hampshire, MA	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
State College, PA	.9910
Centre, PA	
Steubenville-Weirton, OH-WV	.8720
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1623
San Joaquin, CA	
Syracuse, NY	.9570
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	.9877
Pierce, WA	
Tallahassee, FL	.9229
Gadsden, FL	
Leon, FL	
*Tampa-St. Petersburg-Clearwater, FL	.9196
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	.8766
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	.8050
Miller, AR	
Bowie, TX	
Toledo, OH	.9002
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	.9311
Shawnee, KS	
Trenton, NJ	1.0216
Mercer, NJ	
Tucson, AZ	.9628
Pima, AZ	
Tulsa, OK	.8540
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	.8529
Tuscaloosa, AL	
Tyler, TX	.9847
Smith, TX	
Utica-Rome, NY	.8162
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.2929
Napa, CA	
Solano, CA	
Vancouver, WA	1.0722
Clark, WA	
Victoria, TX	.9002
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	.9768
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.0402
Tulare, CA	
Waco, TX	.7822
McLennan, TX	
*Washington, DC-MD-VA	1.0951
District of Columbia, DC	

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

[Areas that qualify as large urban areas are designated with an asterisk]

Urban area (constituent counties or county equivalents)	Wage index
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	.8650
Black Hawk, IA	
Bremers, IA	
Wausau, WI	.9757
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	1.0087
Palm Beach, FL	
Wheeling, WV-OH	.8098
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	.9818
Butler, KS	
Harvey, KS	
Sedgwick, KS	
Wichita Falls, TX	.8179
Wichita, TX	
Williamsport, PA	.8872
Lycorning, PA	
Wilmington, DE-NJ-MD	1.0879
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	.8720
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	1.0740
Worcester, MA	
Yakima, WA	1.0120
Yakima, WA	
York, PA	.8981
Adams, PA	
York, PA	
Youngstown-Warren, OH	.9875
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	1.0176
Sutter, CA	
Yuba, CA	
Yuma, AZ	.8893
Yuma, AZ	

TABLE 4b.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7127
Alaska	1.3529
Arizona	.8604
Arkansas	.6973
California	1.0151
Colorado	.8416
Connecticut	1.1916
Delaware	.8580
Florida	.8738
Georgia	.7770

TABLE 4b.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Hawaii	.9627
Idaho	.8961
Illinois	.7707
Indiana	.7807
Iowa	.7534
Kansas	.7454
Kentucky	.7800
Louisiana	.7391
Maine	.8362
Maryland	.8069
Massachusetts	1.1723
Michigan	.8822
Minnesota	.8316
Mississippi	.6963
Missouri	.7218
Montana	.8262
Nebraska	.7001
Nevada	.9711
New Hampshire	.9555
New Jersey *	
New Mexico	.8325
New York	.8409
North Carolina	.7888
North Dakota	.7726
Ohio	.8461
Oklahoma	.7407
Oregon	.9615
Pennsylvania	.8621
Puerto Rico	.4337
Rhode Island *	
South Carolina	.7657
South Dakota	.7175
Tennessee	.7347
Texas	.7596
Utah	.9052
Vermont	.9617
Virginia	.7822
Washington	.9644
West Virginia	.8501
Wisconsin	.8453
Wyoming	.8465

* All counties within the State are classified urban.

TABLE 4c.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to . . .	Wage index
Abilene, TX	0.9437
Akron, OH	.9016
Albany, GA	.7600
Albany-Schenectady-Troy, NY	.8931
Albany-Schenectady-Troy, NY (Vermont Hospitals)	.9617
Albuquerque, NM	.9951
Alexandria, LA	.8283
Allentown-Bethlehem-Easton, PA-NJ	.9265
Altoona, PA	.9247
Amarillo, TX	.8747
Anaheim-Santa Ana, CA	1.1901
Anchorage, AK	1.4028
Ann Arbor, MI	1.1073
Appleton-Oshkosh-Neenah, WI	.9002
Asheville, NC	.8492
Atlanta, GA	.9604
Augusta, GA-SC	.9409
Aurora-Elgin, IL	.8979
Baltimore, MD	1.0165
Bangor, ME	.9072
Baton Rouge, LA	.9097
Battle Creek, MI	.9107
Beaver County, PA	.9679
Benton Harbor, MI	.7713
Benton Harbor, MI (Michigan Hospitals)	.8822

TABLE 4c.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to . . .	Wage index
Billings, MT	.9098
Biloxi-Gulfport, MS	.7917
Binghamton, NY	.8952
Birmingham, AL	.8777
Bismarck, ND	.8851
Bloomington, IN	.7848
Boise City, ID	1.0120
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1661
Boston-Lawrence-Salem-Lowell-Brockton, MA (Massachusetts Hospitals)	1.1723
Bremerton, WA	1.0375
Buffalo, NY	.8797
Burlington, VT	.9025
Burlington, VT (Vermont Hospitals)	.9617
Caguas, PR	.4592
Canton, OH	.8461
Casper, WY	.8899
Charleston, SC	.8178
Charleston, WV	.9547
Charlotte-Gastonia-Rock Hill, NC-SC	.9325
Charlottesville, VA	.9382
Chattanooga, TN-GA	.9010
Cheyenne, WY	.7729
Chicago, IL	1.0527
Chico, CA	1.1062
Cincinnati, OH-KY-IN	.9830
Cleveland, OH	1.0484
Columbia, MO	.9272
Columbia, SC	.8756
Columbus, GA-AL	.7577
Columbus, OH	.9528
Corpus Christi, TX	.8602
Dallas, TX	.9447
Davenport-Rock Island-Moline, IA-IL	.8350
Dayton-Springfield, OH	.9100
Daytona Beach, FL	.8951
Denver, CO	1.0767
Des Moines, IA	.9051
Detroit, MI	1.0837
Dothan, AL	.7576
Dubuque, IA	.8128
Dubuque, IA (Wisconsin Hospitals)	.8453
Duluth, MN-WI	.9526
Eau Claire, WI	.8495
Elkhart-Goshen, IN	.8589
Elmira, NY	.8699
Enid, OK	.8418
Erie, PA	.9164
Eugene-Springfield, OR	1.0174
Evansville, IN-KY	.9284
Fargo-Moorhead, ND-MN	.9325
Fayetteville, NC	.7888
Fayetteville-Springdale, AR	.7997
Flint, MI	1.1347
Florence, AL	.7724
Florence, SC	.8436
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0383
Fort Myers-Cape Coral, FL	.9808
Fort Pierce, FL	1.0313
Fort Walton Beach, FL	.8949
Fort Wayne, IN	.8672
Fort Worth-Arlington, TX	.9498
Fresno, CA	1.0633
Galveston-Texas City, TX	.9459
Gary-Hammond, IN	.8927
Grand Forks, ND	.9216
Grand Rapids, MI	.9892
Great Falls, MT	.9330
Greeley, CO	.9366
Green Bay, WI	.9340
Greensboro-Winston-Salem-High Point, NC	.8912
Greenville-Spartanburg, SC	.8766
Hagerstown, MD	.8766
Hamilton-Middletown, OH	.8229

TABLE 4C.—WAGE INDEX FOR HOSPITALS
THAT ARE RECLASSIFIED—Continued

Area reclassified to . . .	Wage index
Harrisburg-Lebanon-Carlisle, PA	.9438
Hartford-Middletown-New Britain-Bristol, CT	1.1825
Hickory, NC	.8592
Honolulu, HI	1.1591
Houston, TX	.9788
Huntington-Ashland, WV-KY-OH	.9263
Huntsville, AL	.8488
Indianapolis, IN	.9609
Iowa City, IA	.9336
Jackson, MI	.8833
Jackson, MS	.7740
Jackson, TN	.7969
Jacksonville, FL	.9059
Johnson City-Kingsport-Bristol, TN-VA	.8676
Joliet, IL	1.0221
Joplin, MO	.7888
Kalamazoo, MI	1.1251
Kansas City, KS-MO	.9597
Knoxville, TN	.8700
Kokomo, IN	.8922
LaCrosse, WI	.8784
Lafayette, LA	.8234
Lafayette, IN	.8440
Lake Charles, LA	.8382
Lancaster, PA	.9266
Lansing-East Lansing, MI	1.0120
Las Vegas, NV	1.0641
Lawton, OK	.8284
Lewiston-Auburn, ME	.9065
Lexington-Fayette, KY	.8331
Lincoln, NE	.8469
Little Rock-North Little Rock, AR	.8264
Longview-Marshall, TX	.8699
Lorain-Elyria, OH	.8919
Los Angeles-Long Beach, CA	1.2366
Louisville, KY-IN	.8977
Lubbock, TX	.8798
Lynchburg, VA	.8397
Macon-Warner Robins, GA	.8625
Madison, WI	1.0024
Manchester-Nashua, NH	1.0139
Mansfield, OH	.8461
Medford, OR	.9893
Memphis, TN-AR-MS	.8889
Midland, TX	1.0386
Milwaukee, WI	.9594
Minneapolis-St. Paul, MN-WI	1.0828
Mobile, AL	.8327
Modesto, CA	1.1593
Monroe, LA	.7763
Montgomery, AL	.7745
Muncie, IN	.8075
Muskegon, MI	.9491
Nashville, TN	.9406
New London-Norwich, CT	1.1273
New Orleans, LA	.8909
New York, NY	1.3479

TABLE 4C.—WAGE INDEX FOR HOSPITALS
THAT ARE RECLASSIFIED—Continued

Area reclassified to . . .	Wage index
Newark, NJ	1.1242
Norfolk-Virginia Beach-Newport News, VA	.8523
Oakland, CA	1.4532
Odessa, TX	1.0849
Oklahoma City, OK	.9153
Olympia, WA	1.0400
Omaha, NE-IA	.8997
Orange County, NY	.9205
Orlando, FL	.9629
Owensboro, KY	.8158
Parkersburg-Marietta, WV-OH	.8547
Peoria, IL	.8717
Philadelphia, PA-NJ	1.0853
Phoenix, AZ	1.0438
Pine Bluff, AR	.7765
Pittsburgh, PA	1.0137
Portland, ME	.9143
Portland, OR	1.1583
Portsmouth-Dover-Rochester, NH	1.0011
Poughkeepsie, NY	.9973
Providence-Pawtucket-Woonsocket, RI	1.0657
Providence-Pawtucket-Woonsocket, RI (Massachusetts Hospitals)	1.1723
Provo-Orem, UT	1.0239
Raleigh-Durham, NC	.9229
Rapid City, SD	.8291
Reading, PA	.8734
Redding, CA	1.0415
Reno, NV	1.1448
Roanoke, VA	.8292
Rochester, NY	.9594
Rockford, IL	.9060
Sacramento, CA	1.2244
Saginaw-Bay City-Midland, MI	1.0154
St. Cloud, MN	.8927
St. Louis, MO-IL	.9397
Salem, OR	1.0243
Salinas-Seaside-Monterey, CA	1.2910
San Angelo, TX	.8147
San Antonio, TX	.8450
San Diego, CA	1.1945
San Francisco, CA	1.4404
San Jose, CA	1.4549
San Juan, PR	.4991
Santa Barbara-Santa Maria-Lompoc, CA	1.1598
Santa FE, NM	.9170
Santa Rosa-Petaluma, CA	1.2668
Sarasota, FL	.9593
Scranton-Wilkes Barre, PA	.8923
Seattle, WA	1.0729
Sharon, PA	.9094
Sheboygan, WI	.8679
Shreveport, LA	.9308
Sioux City, IA-NE	.8331
Sioux Falls, SD	.8841
South Bend-Mishawaka, IN	.9695
Springfield, IL	.9202
Springfield, MO	.7966

TABLE 4C.—WAGE INDEX FOR HOSPITALS
THAT ARE RECLASSIFIED—Continued

Area reclassified to . . .	Wage index
State College, PA	.9337
Steubenville-Weirton, OH-WV. (Ohio Hospitals)	.8461
Steubenville-Weirton, OH-WV. (West Virginia Hospitals)	.8501
Syracuse, NY	.9405
Tacoma, WA	.9877
Tallahassee, FL	.8861
Tampa-St. Petersburg-Clearwater, FL	.9196
Terre Haute, IN	.8659
Texarkana, TX-Texarkana, AR	.8050
Toledo, OH	.9002
Topeka, KS	.9311
Tucson, AZ	.9628
Tulsa, OK	.8540
Tuscaloosa, AL	.8294
Tyler, TX	.9369
Vancouver, WA	1.0112
Victoria, TX	.9002
Waco, TX	.7822
Washington, DC-MD-VA	1.0951
Waterloo-Cedar Falls, IA	.8650
Wausau, WI	.9155
West Palm Beach-Boca Raton-Delray Beach, FL	1.0087
Wichita, KS	.9596
Wichita Falls, TX	.8179
Williamsport, PA	.8715
Wilmington, NC	.8720
Yakima, WA	.9995
Youngstown-Warren, OH	.9532
Rural California	1.0151
Rural Georgia	.7770
Rural Illinois	.7707
Rural Indiana	.7807
Rural Iowa	.7534
Rural Kansas	.7454
Rural Kentucky	.7800
Rural Louisiana	.7391
Rural Michigan	.8822
Rural Minnesota	.8316
Rural Missouri	.7218
Rural Nevada	.9388
Rural New Hampshire	.9555
Rural North Carolina	.7888
Rural Ohio	.8461
Rural Oklahoma	.7407
Rural Pennsylvania	.8621
Rural South Dakota	.7175
Rural Utah	.9052
Rural Washington	.9452
Rural West Virginia	.8501
Rural Wisconsin	.8453
Rural Wyoming	.8296

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TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	01	SURG	3.3637	12.2	44
2	01	SURG	3.3233	11.3	43
3	01	SURG *	2.8830	12.7	45
4	01	SURG	2.4577	9.9	42
5	01	SURG	1.5241	5.5	35
6	01	SURG	.4868	1.9	17
7	01	SURG	2.7185	11.6	44
8	01	SURG	.7730	3.0	35
9	01	MED	1.2933	7.1	39
10	01	MED	1.2834	7.7	40
11	01	MED	.7545	4.4	36
12	01	MED	.9372	6.9	39
13	01	MED	.8524	6.7	39
14	01	MED	1.2173	7.2	39
15	01	MED	.8524	4.1	33
16	01	MED	1.0824	6.6	39
17	01	MED	.6331	4.4	36
18	01	MED	.8971	5.9	38
19	01	MED	.5735	3.9	36
20	01	MED	1.9348	8.5	40
21	01	MED	1.4685	7.5	39
22	01	MED	.7190	4.4	35
23	01	MED	.8715	4.4	38
24	01	MED	.9792	5.3	37
25	01	MED	.5252	3.5	28
26	01	MED	.8281	3.4	31
27	01	MED	1.3566	4.3	36
28	01	MED	1.2371	5.9	38
29	01	MED	.5525	3.2	35
30	01	MED *	.3496	2.0	17
31	01	MED	.7139	4.3	36
32	01	MED	.4145	2.6	25
33	01	MED *	.2427	1.6	9
34	01	MED	1.1524	5.9	38
35	01	MED	.5648	3.7	38

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG	RETINAL PROCEDURES	.6434	2.1	12
37	02	SURG	ORBITAL PROCEDURES	.7951	2.9	35
38	02	SURG	PRIMARY IRIS PROCEDURES	.3532	2.1	16
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.4732	1.5	8
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.5101	2.0	23
41	02	SURG	* EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3613	1.6	7
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6162	2.1	15
43	02	MED	HYPERHMA	.3579	3.6	25
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6119	5.5	36
45	02	MED	NEUROLOGICAL EYE DISORDERS	.5938	3.5	30
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.6709	4.1	36
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.3923	2.7	31
48	02	MED	* OTHER DISORDERS OF THE EYE AGE 0-17	.3969	2.9	30
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	2.2790	7.0	39
50	03	SURG	SIALOADENECTOMY	.6625	2.2	14
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.5871	2.0	18
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7451	2.4	22
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	.6590	1.9	20
54	03	SURG	* SINUS & MASTOID PROCEDURES AGE 0-17	.6806	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.5134	1.6	14
56	03	SURG	RHINOPLASTY	.5444	1.8	15
57	03	SURG	T&A PROC. EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8501	3.4	35
58	03	SURG	* T&A PROC. EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3060	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.4071	1.5	10
60	03	SURG	* TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2584	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	.8065	2.5	35
62	03	SURG	* MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3052	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.0595	3.8	36
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1190	5.2	37
65	03	MED	DYSEQUILIBRIUM	.4727	3.3	23
66	03	MED	EPISTAXIS	.4606	3.3	24
67	03	MED	EPIGLOTTITIS	.8708	4.2	32
68	03	MED	OTITIS MEDIA & URI AGE >17 WITH CC	.7277	5.0	33
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5156	3.9	23
70	03	MED	OTITIS MEDIA & URI AGE 0-17	.5295	3.2	32

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED			
72	03	MED	.8197	4.8	37
73	03	MED	.5741	3.4	35
74	03	MED	.7500	4.1	36
75	04	MED	.3386	2.1	20
76	04	MED	3.0063	11.5	44
77	04	MED			
78	04	MED	2.3804	10.6	43
79	04	MED	1.0289	4.5	36
80	04	MED	1.4273	8.7	41
81	04	MED	1.7813	9.2	41
82	04	MED	1.0066	6.7	39
83	04	MED			
84	04	MED	1.0899	6.1	38
85	04	MED	1.2453	6.7	39
86	04	MED	.9806	6.2	38
87	04	MED	.4920	3.7	32
88	04	MED	1.1643	6.8	39
89	04	MED			
90	04	MED	.6834	4.3	36
91	04	MED	1.3851	6.0	38
92	04	MED	.9942	5.9	38
93	04	MED	1.1658	7.1	39
94	04	MED	.7282	5.4	30
95	04	MED			
96	04	MED	.7846	4.2	36
97	04	MED	1.1997	6.9	39
98	04	MED	.8028	5.2	37
99	04	MED	1.2472	7.1	39
100	04	MED	.6108	4.4	35
101	04	MED			
102	04	MED	.9457	5.9	35
103	05	MED	.6450	4.6	26
104	05	MED	.8262	5.5	37
105	05	MED	.7962	4.1	36
			.4983	2.6	18
			.9232	5.1	37
			.5272	3.3	30
			14.0323	25.2	57
			8.2575	18.1	50
			6.1581	12.7	45

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG			
107	05	SURG	5.4470	13.6	46
108	05	SURG	4.9616	11.3	43
109	05	SURG	5.9800	12.7	45
110	05	SURG	.0000	0	0
		MAJOR CARDIOVASCULAR PROCEDURES WITH CC	4.2703	10.3	42
111	05	SURG			
112	05	SURG	2.3980	7.5	40
113	05	SURG	2.0163	4.8	37
114	05	SURG	2.6925	14.3	46
115	05	SURG	1.5499	9.0	41
		PERM CARDIAC PACEMAKER IMPLANT W/AMI, HEART FAILURE OR SHOCK	3.6795	11.9	44
116	05	SURG			
117	05	SURG	2.4973	5.7	38
118	05	SURG	1.2743	3.7	36
119	05	SURG	1.6957	2.8	35
120	05	SURG	.9379	3.5	36
		OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0736	7.4	39
121	05	MED			
122	05	MED	1.6210	8.2	40
123	05	MED	1.1667	6.0	38
124	05	MED	1.3920	3.0	35
125	05	MED	1.1973	4.2	36
		CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	.7387	2.2	22
126	05	MED			
127	05	MED	2.8874	16.3	48
128	05	MED	1.0070	8.0	38
129	05	MED	.7906	7.4	33
130	05	MED	1.2551	2.4	34
		PERIPHERAL VASCULAR DISORDERS WITH CC	.9118	6.1	38
131	05	MED			
132	05	MED	.5882	4.5	37
133	05	MED	.7312	4.0	36
134	05	MED	.5342	3.0	26
135	05	MED	.5653	3.9	30
		CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 WITH CC	.8770	4.9	37
136	05	MED			
137	05	MED	.5434	3.2	27
138	05	MED	.6239	3.3	35
139	05	MED	.8211	4.5	36
140	05	MED	.5149	3.1	23
		CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	.6226	3.7	25

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED			
142	05	MED	.6950	4.3	35
143	05	MED	.5006	3.1	22
144	05	MED	.5118	2.7	18
145	05	MED	1.0888	5.2	37
			.6454	3.4	34
146	06	SURG	2.5777	12.4	44
147	06	SURG	1.6301	9.0	34
148	06	SURG	3.1804	13.5	46
149	06	SURG	1.5443	8.9	29
150	06	SURG	2.5069	11.4	43
151	06	SURG	1.2042	6.7	39
152	06	SURG	1.7255	8.7	41
153	06	SURG	1.0534	6.7	28
154	06	SURG	4.1746	14.3	46
155	06	SURG	1.5472	7.7	40
156	06	SURG	.8281	6.0	38
157	06	SURG	.9372	4.6	37
158	06	SURG	.4909	2.5	18
159	06	SURG	1.0701	4.9	37
160	06	SURG	.6156	2.9	20
161	06	SURG	.7382	3.2	34
162	06	SURG	.4476	1.8	11
163	06	SURG	.6612	4.0	33
164	06	SURG	2.1733	9.8	42
165	06	SURG	1.2562	6.9	25
166	06	SURG	1.2931	6.1	35
167	06	SURG	.7597	4.0	15
168	03	SURG	1.0601	3.8	36
169	03	SURG	.5406	2.0	17
170	06	SURG	2.7582	11.1	43
171	06	SURG	1.1303	5.3	37
172	06	MED	1.2549	7.0	39
173	06	MED	.6218	3.6	36
174	06	MED	.9735	5.5	37
175	06	MED	.5723	3.8	23

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED	1.0235	5.9	38
177	06	MED	.7840	5.1	32
178	06	MED	.5656	3.8	22
179	06	MED	1.1141	7.1	39
180	06	MED	.9216	5.8	38
181	06	MED	.4988	3.8	26
182	06	MED	.7599	4.9	37
183	06	MED	.5198	3.5	25
184	06	MED	.5125	2.7	18
185	03	MED	.7766	4.3	36
186	03	MED	.4062	2.9	23
187	03	MED	.5094	2.3	26
188	06	MED	.9846	5.2	37
189	06	MED	.4697	2.8	30
190	06	MED	.7555	4.2	36
191	07	SURG	4.4412	15.5	48
192	07	SURG	1.7379	8.5	41
193	07	SURG	3.0275	14.0	46
194	07	SURG	1.6189	8.8	41
195	07	SURG	2.2099	10.6	43
196	07	SURG	1.3547	7.6	28
197	07	SURG	1.6872	7.8	40
198	07	SURG	.9076	4.5	25
199	07	SURG	2.4049	11.9	44
200	07	SURG	2.7960	9.4	41
201	07	SURG	2.3034	8.8	41
202	07	MED	1.2231	7.2	39
203	07	MED	1.1784	6.8	39
204	07	MED	1.0870	6.1	38
205	07	MED	1.2402	6.7	39
206	07	MED	.6029	3.7	36
207	07	MED	.9732	5.5	37
208	07	MED	.5532	3.3	26
209	08	SURG	2.3795	10.1	36
210	08	SURG	1.9386	11.4	43

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.3747	9.0	36
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	.9139	4.0	36
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7471	9.4	41
214	08	SURG	BACK & NECK PROCEDURES WITH CC	1.8748	8.9	41
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.1156	5.8	33
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.0321	10.1	42
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCULOSKELETAL & CONN TISS DIS	3.1641	14.1	46
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 WITH CC	1.4112	7.2	39
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	.8977	4.6	29
220	08	SURG	* LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	.9130	5.3	37
221	08	SURG	KNEE PROCEDURES WITH CC	1.8350	7.7	40
222	08	SURG	KNEE PROCEDURES W/O CC	.9721	3.9	36
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	.8044	3.3	25
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	.6306	2.5	15
225	08	SURG	FOOT PROCEDURES	.7825	3.3	35
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3613	6.1	38
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6791	2.9	25
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	.8015	2.6	28
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5403	1.9	16
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.9278	4.1	36
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	1.0817	4.0	36
232	08	SURG	ARTHROSCOPY	1.2448	4.0	36
233	08	SURG	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC WITH CC	1.9873	9.0	41
234	08	SURG	OTHER MUSCULOSKELETAL SYS & CONN TISS O.R. PROC W/O CC	1.0365	4.6	37
235	08	MED	FRACTURES OF FEMUR	1.0974	7.4	39
236	08	MED	FRACTURES OF HIP & PELVIS	.8428	6.6	39
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5583	4.4	36
238	08	MED	OSTEOMYELITIS	1.5884	10.6	43
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0269	7.5	40
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.1486	7.1	39
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5704	4.5	36
242	08	MED	SEPTIC ARTHRITIS	1.2558	8.2	40
243	08	MED	MEDICAL BACK PROBLEMS	.6672	5.0	37
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7665	5.4	37
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5434	4.0	36

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TABLE 5

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED			
247	08	MED	.5872	4.4	36
248	08	MED	.5445	3.6	36
249	08	MED	.6673	4.6	37
250	08	MED	.7156	4.3	36
251	08	MED	.7021	4.5	37
252	08	MED	.4291	2.5	24
253	08	MED	.3454	1.8	15
254	08	MED	.7885	5.8	38
255	08	MED	.4238	3.5	35
256	08	MED	.4582	2.9	35
257	09	MED	.6409	3.8	36
258	09	SURG	.9024	4.6	24
259	09	SURG	.7057	3.6	15
260	09	SURG	.9073	4.0	36
261	09	SURG	.5720	2.4	14
262	09	SURG	.6749	2.2	15
263	09	SURG	.4944	1.9	18
264	09	SURG	2.6866	15.2	47
265	09	SURG	1.2982	8.6	41
266	09	SURG	1.3860	6.1	38
267	09	SURG	.6814	3.0	35
268	09	SURG	.5922	2.7	35
269	09	SURG	.7194	2.5	34
270	09	SURG	1.6600	8.1	40
271	09	SURG	.6551	2.9	35
272	09	MED	1.2480	8.8	41
273	09	MED	1.0789	7.4	39
274	09	MED	.6575	5.4	37
275	09	MED	1.1312	6.6	39
276	09	MED	.5870	3.3	35
277	09	MED	.5731	3.7	36
278	09	MED	.9198	7.0	39
279	09	MED	.6129	5.3	30
280	09	MED	.7278	4.2	24
			.6639	4.6	37

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4167	3.1	30
282	09	MED	* TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.3383	2.2	19
283	09	MED	MINOR SKIN DISORDERS WITH CC	.7350	5.2	37
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4410	3.6	34
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	2.7210	15.1	47
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.4320	9.5	41
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.2533	13.4	45
288	10	SURG	O.R. PROCEDURES FOR OBESITY	1.8810	6.9	39
289	10	SURG	PARATHYROID PROCEDURES	1.0079	4.0	36
290	10	SURG	THYROID PROCEDURES	.7491	2.8	17
291	10	SURG	THYROGLOSSAL PROCEDURES	.4416	1.7	8
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.8387	12.1	44
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1528	5.5	37
294	10	MED	DIABETES AGE >35	.7516	5.8	38
295	10	MED	DIABETES AGE 0-35	.7400	4.4	36
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.9378	6.0	38
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5303	4.0	31
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.5396	2.7	30
299	10	MED	INBORN ERRORS OF METABOLISM	.8598	4.8	37
300	10	MED	ENDOCRINE DISORDERS WITH CC	1.1191	6.9	39
301	10	MED	ENDOCRINE DISORDERS W/O CC	.5923	4.1	36
302	11	SURG	KIDNEY TRANSPLANT	3.8891	13.9	46
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6645	11.5	43
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.3986	10.1	42
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1821	5.3	37
306	11	SURG	PROSTATECTOMY WITH CC	1.2922	6.9	39
307	11	SURG	PROSTATECTOMY W/O CC	.7100	4.0	23
308	11	SURG	MINOR BLADDER PROCEDURES WITH CC	1.4341	6.4	38
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.7375	3.2	31
310	11	SURG	TRANSURETHRAL PROCEDURES WITH CC	.8792	3.9	36
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5182	2.3	16
312	11	SURG	URETHRAL PROCEDURES, AGE >17 WITH CC	.8174	3.8	36
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.4607	2.1	17
314	11	SURG	* URETHRAL PROCEDURES, AGE 0-17	.4271	2.3	26
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.1027	7.0	39

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED	1.2814	6.3	38
317	11	MED	.4825	2.5	33
318	11	MED	1.0908	6.0	38
319	11	MED	.5455	2.6	32
320	11	MED	1.0002	6.7	39
321	11	MED	.6346	4.9	28
322	11	MED	.6334	4.6	35
323	11	MED	.7422	3.0	32
324	11	MED	.3898	2.1	14
325	11	MED	.6673	4.3	36
326	11	MED	.4219	2.9	25
327	11	MED	.5444	3.1	32
328	11	MED	.6143	3.6	36
329	11	MED	.3978	2.0	18
330	11	MED	.2754	1.6	9
331	11	MED	.9566	5.3	37
332	11	MED	.5340	3.0	35
333	11	MED	.9094	4.8	37
334	12	SURG	1.7509	8.9	32
335	12	SURG	1.3574	7.4	21
336	12	SURG	.9005	5.0	26
337	12	SURG	.6163	3.7	13
338	12	SURG	.7776	2.9	35
339	12	SURG	.6382	2.5	35
340	12	SURG	.4283	2.4	13
341	12	SURG	.9615	3.3	25
342	12	SURG	.5955	2.5	35
343	12	SURG	.3742	1.7	6
344	12	SURG	1.0492	4.4	36
345	12	SURG	.7263	3.3	35
346	12	MED	.9609	5.8	38
347	12	MED	.5016	2.7	35
348	12	MED	.6709	3.9	36
349	12	MED	.4049	2.3	20
350	12	MED	.6731	4.9	28

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
351	MED	* STERILIZATION, MALE	.3293	1.3	5
352	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5838	3.3	35
353	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	2.0590	10.1	42
354	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.3909	7.2	33
355	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.8562	5.0	13
356	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7076	4.1	17
357	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.2167	10.2	42
358	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.1104	6.0	23
359	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.7823	4.6	12
360	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.7757	4.1	30
361	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.8512	3.3	35
362	SURG	* ENDOSCOPIC TUBAL INTERRUPTION	.4921	1.4	5
363	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6440	3.1	28
364	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.5295	2.5	28
365	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.6878	7.4	39
366	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.1681	6.6	39
367	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.4953	2.9	35
368	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.9233	6.0	38
369	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5274	3.2	35
370	SURG	CESAREAN SECTION W CC	1.0237	5.8	37
371	SURG	CESAREAN SECTION W/O CC	.6456	4.1	11
372	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5235	3.3	30
373	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3169	2.1	8
374	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.5045	2.5	9
375	SURG	* VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6735	4.4	29
376	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3764	2.5	23
377	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.0278	3.1	35
378	MED	ECTOPIC PREGNANCY	.7532	3.9	14
379	MED	THREATENED ABORTION	.2892	2.1	16
380	MED	ABORTION W/O D&C	.2720	1.4	9
381	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.3827	1.6	11
382	MED	FALSE LABOR	.1251	1.2	5
383	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3934	3.3	31
384	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3027	2.2	21
385	MED	* NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2084	1.8	34

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			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
386	15	MED	3.6039	17.9	50
387	15	MED	1.8046	13.3	45
388	15	MED	1.1431	8.6	41
389	15	MED	1.3846	6.1	38
390	15	MED	.8422	4.1	36
391	15	MED	.2191	3.1	11
392	16	SURG	3.2912	11.6	44
393	16	SURG	1.5022	9.1	41
394	16	SURG	1.5719	5.7	38
395	16	MED	.7679	4.6	37
396	16	MED	.5246	2.4	34
397	16	MED	1.2128	5.5	37
398	16	MED	1.2080	6.6	39
399	16	MED	.6661	4.0	36
400	17	SURG	2.5985	9.5	41
401	17	SURG	2.2510	10.3	42
402	17	SURG	.8701	3.6	36
403	17	MED	1.6125	8.1	40
404	17	MED	.7282	3.9	36
405	17	MED	1.0281	4.9	37
406	17	SURG	2.6566	10.9	43
407	17	SURG	1.1519	5.3	37
408	17	SURG	1.1046	4.3	36
409	17	MED	1.0094	6.4	38
410	17	MED	.5540	2.8	19
411	17	MED	.4569	2.6	33
412	17	MED	.4216	2.1	21
413	17	MED	1.3299	7.5	40
414	17	MED	.7231	4.3	36
415	18	SURG	3.6042	14.9	47
416	18	MED	1.5308	7.5	40
417	18	MED	1.0315	5.1	37
418	18	MED	.9585	6.5	39
419	18	MED	.9548	5.8	38
420	18	MED	.6484	4.5	30

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED	.6667	4.4	32
422	18	MED	.5916	4.0	33
423	18	MED	1.6240	8.2	40
424	19	SURG	2.3695	12.6	45
425	19	MED	.7113	4.7	37
VIRAL ILLNESS AGE >17					
VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17					
OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES					
O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS					
ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION					
426	19	MED	.6241	5.5	37
427	19	MED	.6028	5.2	37
428	19	MED	.7831	6.6	39
429	19	MED	.9342	7.6	40
430	19	MED	.9074	8.8	41
DEPRESSIVE NEUROSES					
NEUROSES EXCEPT DEPRESSIVE					
DISORDERS OF PERSONALITY & IMPULSE CONTROL					
ORGANIC DISTURBANCES & MENTAL RETARDATION					
PSYCHOSES					
431	19	MED	.7355	6.1	38
432	19	MED	.6960	4.3	36
433	20	MED	.3754	3.1	35
434	20	MED	.7689	5.6	38
435	20	MED	.5141	4.7	37
CHILDHOOD MENTAL DISORDERS					
OTHER MENTAL DISORDER DIAGNOSES					
ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA					
ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC					
ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC					
436	20	MED	1.0782	16.4	48
437	20	MED	1.1775	15.1	47
438			.0000	.0	0
439	21	SURG	1.5267	6.5	38
440	21	SURG	1.8492	8.4	40
SKIN GRAFTS FOR INJURIES					
WOUND DEBRIDEMENTS FOR INJURIES					
441	21	SURG	.6872	2.4	27
442	21	SURG	1.9377	6.2	38
443	21	SURG	.7595	2.7	32
444	21	MED	.7566	5.2	37
445	21	MED	.4911	3.6	30
TRAUMATIC INJURY AGE > 17 W/O CC					
446	21	MED	.4738	2.4	22
447	21	MED	.4776	2.6	24
448	21	MED	.3428	2.9	17
449	21	MED	.7867	4.2	36
450	21	MED	.4428	2.5	25
POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC					
POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC					
451	21	MED	.5126	2.1	17
452	21	MED	.8184	4.2	36
453	21	MED	.4177	2.8	25
454	21	MED	.9096	4.4	36
455	21	MED	.4187	2.5	25
OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC					

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22	MED	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	5.6	38
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	2.0198	35
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	1.6731	35
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	3.9835	48
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.9637	43
				1.0435	38
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	2.5	34
462	23	MED	REHABILITATION	1.8346	46
463	23	MED	SIGNS & SYMPTOMS W CC	7.297	37
464	23	MED	SIGNS & SYMPTOMS W/O CC	4.495	28
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	1.9	19
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	2.6	35
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	2.5	35
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	13.3	45
469			** PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0	0
470			** UNGROUPABLE	.0000	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	13.3	45
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	13.9563	55
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.3381	42
474	04		NO LONGER VALID	.0000	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6094	42
476			PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	14.3	46
477			NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.4338	38
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2177	39
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.3259	36
480			LIVER TRANSPLANT	22.8213	69
481			BONE MARROW TRANSPLANT	15.2890	70
482			TRACHEOSTOMY W MOUTH, LARYNX OR PHARYNX DISORDER	3.1795	45
483			TRACHEOSTOMY EXCEPT FOR MOUTH, LARYNX OR PHARYNX DISORDER	14.1506	72
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.2599	46
485	24	SURG	LIMB REATTACH., HIP AND FEMUR PROCS FOR MULTI SIGN TRAUMA	3.0632	46
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	11.1	43
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.8218	40
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.3106	49
489	25	MED	HIV W MAJOR RELATED CONDITION	1.9790	42
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1904	37

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.

** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.

NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.

NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

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

			RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
491 08 SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - UPPER EXTREMITY		1.5633	5.8	33
492 17 MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS		2.5737	8.3	40

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
 ** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
 NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
 NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

BILLING CODE 4120-03-C

TABLE 6a.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
070.20	Viral hepatitis B with hepatic coma, without mention of hepatitis delta.....	Y	07	205, 206
070.21	Viral hepatitis B with hepatic coma, with hepatitis delta.....	Y	07	205, 206
070.30	Viral hepatitis B without mention of hepatic coma, without mention of hepatitis delta.....	Y	07	205, 206
070.31	Viral hepatitis B without mention of hepatic coma, with hepatitis delta.....	Y	07	205, 206
070.41	Hepatitis C with hepatic coma.....	Y	07	205, 206
070.42	Hepatitis delta without mention of active hepatitis B disease with hepatic coma.....	Y	07	205, 206
070.43	Hepatitis E with hepatic coma.....	Y	07	205, 206
070.49	Other specified viral hepatitis with hepatic coma.....	Y	07	205, 206
070.51	Hepatitis C without mention of hepatic coma.....	Y	07	205, 206
070.52	Hepatitis delta without mention of active hepatitis B disease, without mention of hepatic coma.....	Y	07	205, 206
070.53	Hepatitis E without mention of hepatic coma.....	Y	07	205, 206
070.59	Other specified viral hepatitis without mention of hepatic coma.....	Y	07	205, 206
176.0	Kaposi's sarcoma, skin.....	N	09	283, 284
176.1	Kaposi's sarcoma, soft tissue.....	N	09	283, 284
176.2	Kaposi's sarcoma, palate.....	N	03	64
176.3	Kaposi's sarcoma, gastrointestinal sites.....	Y	06	172, 173
176.4	Kaposi's sarcoma, lung.....	Y	04	82
176.5	Kaposi's sarcoma, lymph nodes.....	Y	17	400, 401, 402, 403, 404
176.8	Kaposi's sarcoma, other specified sites.....	N	09	283, 284
176.9	Kaposi's sarcoma, unspecified.....	N	09	283, 284
203.00	Multiple myeloma without mention of remission.....	Y	17	400, 401, 402, 403, 404
203.01	Multiple myeloma in remission.....	Y	17	400, 401, 402, 403, 404
203.10	Plasma cell leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
203.11	Plasma cell leukemia in remission.....	Y	17	400, 401, 402, 403, 404
203.80	Other immunoproliferative neoplasms without mention of remission.....	Y	17	400, 401, 402, 403, 404
203.81	Other immunoproliferative neoplasms in remission.....	Y	17	400, 401, 402, 403, 404
204.00	Acute lymphoid leukemia without mention of remission.....	Y	17	400, 405, 473
204.01	Acute lymphoid leukemia in remission.....	Y	17	400, 405, 473
204.10	Chronic lymphoid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
204.11	Chronic lymphoid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
204.20	Subacute lymphoid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
204.21	Subacute lymphoid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
204.80	Other lymphoid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
204.81	Other lymphoid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
204.90	Unspecified lymphoid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
204.91	Unspecified lymphoid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
205.00	Acute myeloid leukemia without mention of remission.....	Y	17	400, 405, 473
205.01	Acute myeloid leukemia in remission.....	Y	17	400, 405, 473
205.10	Chronic myeloid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
205.11	Chronic myeloid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
205.20	Subacute myeloid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
205.21	Subacute myeloid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
205.30	Myeloid sarcoma without mention of remission.....	Y	17	400, 401, 402, 403, 404
205.31	Myeloid sarcoma in remission.....	Y	17	400, 401, 402, 403, 404
205.80	Other myeloid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
205.81	Other myeloid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
205.90	Unspecified myeloid leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
205.91	Unspecified myeloid leukemia in remission.....	Y	17	400, 401, 402, 403, 404
206.00	Acute monocytic leukemia without mention of remission.....	Y	17	400, 405, 473
206.01	Acute monocytic leukemia in remission.....	Y	17	400, 405, 473
206.10	Chronic monocytic leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
206.11	Chronic monocytic leukemia in remission.....	Y	17	400, 401, 402, 403, 404

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
206.20	Subacute monocytic leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
206.21	Subacute monocytic leukemia in remission.....	Y	17	400, 401, 402, 403, 404
206.80	Other monocytic leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
206.81	Other monocytic leukemia in remission.....	Y	17	400, 401, 402, 403, 404
206.90	Unspecified monocytic leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
206.91	Unspecified monocytic leukemia in remission.....	Y	17	400, 401, 402, 403, 404
207.00	Acute erythremia and erythroleukemia without mention of remission.....	Y	17	400, 405, 473
207.01	Acute erythremia and erythroleukemia in remission.....	Y	17	400, 405, 473
207.10	Chronic erythremia without mention of remission.....	Y	17	400, 401, 402, 403, 404
207.11	Chronic erythremia in remission.....	Y	17	400, 401, 402, 403, 404
207.20	Megakaryocytic leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
207.21	Megakaryocytic leukemia in remission.....	Y	17	400, 401, 402, 403, 404
207.80	Other specified leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
207.81	Other specified leukemia in remission.....	Y	17	400, 401, 402, 403, 404
208.00	Acute leukemia of unspecified cell type without mention of remission.....	Y	17	400, 405, 473
208.01	Acute leukemia of unspecified cell type in remission.....	Y	17	400, 405, 473
208.10	Chronic leukemia of unspecified cell type without mention of remission.....	Y	17	400, 401, 402, 403, 404
208.11	Chronic leukemia of unspecified cell type in remission.....	Y	17	400, 401, 402, 403, 404
208.20	Subacute leukemia of unspecified cell type without mention of remission.....	Y	17	400, 401, 402, 403, 404
208.21	Subacute leukemia of unspecified cell type in remission.....	Y	17	400, 401, 402, 403, 404
208.80	Other leukemia of unspecified cell type without mention of remission.....	Y	17	400, 401, 402, 403, 404
208.81	Other leukemia of unspecified cell type in remission.....	Y	17	400, 401, 402, 403, 404
208.90	Unspecified leukemia without mention of remission.....	Y	17	400, 401, 402, 403, 404
208.91	Unspecified leukemia in remission.....	Y	17	400, 401, 402, 403, 404
491.20	Obstructive chronic bronchitis, without mention of acute exacerbation.....	Y	04	88
491.21	Obstructive chronic bronchitis, with acute exacerbation.....	Y	04	88
524.60	Temporomandibular joint disorders, unspecified.....	N	03	185, 186, 187
524.61	Adhesions and ankylosis (bony or fibrous).....	N	03	185, 186, 187
524.62	Arthralgia of temporomandibular joint.....	N	03	185, 186, 187
524.63	Articular disc disorder (reducing or non-reducing).....	N	03	185, 186, 187
524.69	Other specified temporomandibular joint disorders.....	N	03	185, 186, 187
535.00	Acute gastritis, without mention of hemorrhage.....	N	06	182, 183, 184
535.01	Acute gastritis, with hemorrhage.....	Y	06	174, 175
535.10	Atrophic gastritis, without mention of hemorrhage.....	N	06	182, 183, 184
535.11	Atrophic gastritis, with hemorrhage.....	Y	06	174, 175
535.20	Gastric mucosal hypertrophy, without mention of hemorrhage.....	N	06	182, 183, 184
535.21	Gastric mucosal hypertrophy, with hemorrhage.....	Y	06	174, 175
535.30	Alcoholic gastritis, without mention of hemorrhage.....	N	06	182, 183, 184
535.31	Alcoholic gastritis, with hemorrhage.....	Y	06	174, 175
535.40	Other specified gastritis, without mention of hemorrhage.....	N	06	182, 183, 184
535.41	Other specified gastritis, with hemorrhage.....	Y	06	174, 175
535.50	Unspecified gastritis and gastroduodenitis, without mention of hemorrhage.....	N	06	182, 183, 184
535.51	Unspecified gastritis and gastroduodenitis, with hemorrhage.....	Y	06	174, 175
535.60	Duodenitis, without mention of hemorrhage.....	N	06	182, 183, 184
535.61	Duodenitis, with hemorrhage.....	Y	06	174, 175
537.83	Angiodysplasia of stomach and duodenum with hemorrhage.....	Y	06	174, 175
562.02	Diverticulosis of small intestine with hemorrhage.....	Y	06	174, 175
562.03	Diverticulitis of small intestine with hemorrhage.....	Y	06	174, 175
562.12	Diverticulosis of colon with hemorrhage.....	Y	06	174, 175
562.13	Diverticulitis of colon with hemorrhage.....	Y	06	174, 175
569.85	Angiodysplasia of intestine with hemorrhage.....	Y	06	174, 175
645.00	Prolonged pregnancy, unspecified as to episode of care or not applicable ¹	N	14	469
645.01	Prolonged pregnancy, delivered, with or without mention of antepartum condition ¹	N	14	370, 371, 372, 373, 374, 375
645.03	Prolonged pregnancy, antepartum condition or complication ¹	N	14	383, 384
657.00	Polyhydramnios, unspecified as to episode of care or not applicable ¹	N	14	469
657.01	Polyhydramnios, delivered, with or without mention of antepartum condition ¹	N	14	370, 371, 372, 373, 374, 375
657.03	Polyhydramnios, antepartum condition or complication ¹	N	14	383, 384

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
670.00	Major puerperal infection, unspecified as to episode of care or not applicable ¹	Y	14	469
670.02	Major puerperal infection, delivered, with mention of postpartum complication ¹	Y	14	370, 371, 372, 374, 375
670.04	Major puerperal infection, postpartum condition or complication ¹	Y	14	376, 377
672.00	Pyrexia of unknown origin during the puerperium, unspecified as to episode of care or not applicable ¹	N	14	469
672.02	Pyrexia of unknown origin during the puerperium, delivered, with mention of postpartum complication ¹	N	14	370, 371, 372, 374, 375
672.04	Pyrexia of unknown origin during the puerperium, postpartum condition or complication ¹	N	14	376, 377
702.0	Actinic keratosis	N	09	283, 284
702.1	Seborrheic keratosis	N	09	283, 284
702.8	Other specified dermatoses	N	09	283, 284
760.75	Cocaine affecting fetus via placenta or breast milk	N	15	390

¹ Note: Code categories 645, 657, 670, and 672 will now officially use "0" as the fourth-digit. The GROUPE currently requires that these codes have a fifth-digit for subclassification, however, now ICD-9-CM also requires it.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
29.31	Cricopharyngeal myotomy	Y	03	63
29.32	Pharyngeal diverticulectomy	Y	06	154, 155, 156
29.33	Pharyngectomy (partial)	Y	03	63
29.39	Other excision or destruction of lesion or tissue of pharynx	Y	06	154, 155, 156
39.28	Extracranial-intracranial (EC-IC) vascular bypass	Y	03	63
51.23	Laparoscopic cholecystectomy	Y	06	154, 155, 156
60.95	Transurethral balloon dilation of the prostatic urethra	Y	01	1, 2, 3
78.24	Limb shortening procedures, carpals and metacarpals	Y	21	442, 443
78.28	Limb shortening procedures, tarsals and metatarsals	Y	24	486
89.50	Ambulatory cardiac monitoring	N	07	195, 196, 197, 198
96.70	Continuous mechanical ventilation of unspecified duration	1	17	400, 401, 402, 403, 404
96.71	Continuous mechanical ventilation for less than 96 consecutive hours	1	21	442, 443
96.72	Continuous mechanical ventilation for 96 consecutive hours or more	1	24	486

¹ Non-OR procedure that affects DRG assignment.

TABLE 6C.—INVALID DIAGNOSIS CODES ¹

Diagnosis code	Description	CC	MDC	DRG
070.2	Viral hepatitis B with hepatic coma	Y	07	205, 206
070.3	Viral hepatitis B without mention of hepatic coma	Y	07	205, 206
070.4	Other specified viral hepatitis with hepatic coma	Y	07	205, 206
070.5	Other specified viral hepatitis without mention of hepatic coma	Y	07	205, 206
203.0	Multiple myeloma	Y	17	400, 401, 402, 403, 404
203.1	Plasma cell leukemia	Y	17	400, 401, 402, 403, 404
203.8	Other immunoproliferative neoplasms	Y	17	400, 401, 402, 403, 404
204.0	Acute lymphoid leukemia	Y	17	400, 401, 402, 403, 404
204.1	Chronic lymphoid leukemia	Y	17	400, 401, 402, 403, 404
204.2	Subacute lymphoid leukemia	Y	17	400, 401, 402, 403, 404
204.8	Other lymphoid leukemia	Y	17	400, 401, 402, 403, 404
204.9	Unspecified lymphoid leukemia	Y	17	400, 401, 402, 403, 404
205.0	Acute myeloid leukemia	Y	17	400, 401, 402, 403, 404
205.1	Chronic myeloid leukemia	Y	17	400, 401, 402, 403, 404
205.2	Subacute myeloid leukemia	Y	17	400, 401, 402, 403, 404
205.3	Myeloid sarcoma	Y	17	400, 401, 402, 403, 404
205.8	Other myeloid leukemia	Y	17	400, 401, 402, 403, 404
205.9	Unspecified myeloid leukemia	Y	17	400, 401, 402, 403, 404
206.0	Acute monocytic leukemia	Y	17	400, 401, 402, 403, 404
206.1	Chronic monocytic leukemia	Y	17	400, 401, 402, 403, 404
206.2	Subacute monocytic leukemia	Y	17	400, 401, 402, 403, 404
206.8	Other monocytic leukemia	Y	17	400, 401, 402, 403, 404

TABLE 6C—INVALID DIAGNOSIS CODES ¹—Continued

Diagnosis code	Description	CC	MDC	DRG
206.9	Unspecified monocytic leukemia	Y	17	400, 401, 402, 403, 404
207.0	Acute erythremia and erythroleukemia	Y	17	400, 405, 473
207.1	Chronic erythremia	Y	17	400, 401, 402, 403, 404
207.2	Megakaryocytic leukemia	Y	17	400, 401, 402, 403, 404
207.8	Other specified leukemia	Y	17	400, 401, 402, 403, 404
208.0	Acute leukemia of unspecified cell type	Y	17	400, 405, 473
208.1	Chronic leukemia of unspecified cell type	Y	17	400, 401, 402, 403, 404
208.2	Subacute leukemia of unspecified cell type	Y	17	400, 401, 402, 403, 404
208.8	Other leukemia of unspecified cell type	Y	17	400, 401, 402, 403, 404
208.9	Unspecified leukemia	Y	17	400, 401, 402, 403, 404
491.2	Obstructive chronic bronchitis	Y	04	88
524.6	Temporomandibular joint disorders	N	03	185, 186, 187
535.0	Acute gastritis	Y	06	182, 183, 184
535.1	Atrophic gastritis	N	06	182, 183, 184
535.2	Gastric mucosal hypertrophy	N	06	182, 183, 184
535.3	Alcoholic gastritis	N	06	182, 183, 184
535.4	Other specified gastritis	N	06	182, 183, 184
535.5	Unspecified gastritis and gastroduodenitis	N	06	182, 183, 184
535.6	Duodenitis	N	06	182, 183, 184
702	Other dermatoses	N	09	283, 284

¹ See Table 6a for new diagnosis codes (4 or 5 digits) that will be considered valid by the FY 1992 GROUPE.

TABLE 6D—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
13.61	Discission of primary membranous cataract	Y	02	39
13.62	Excision of primary membranous cataract	Y	02	39
13.63	Mechanical fragmentation of primary membranous cataract	Y	02	39
29.3	Excision or destruction of lesion or tissue of pharynx. ¹	Y	03	63
			06	154, 155, 156
36.00	Removal of coronary artery obstruction, not otherwise specified.	Y	05	110, 111
51.21	Partial cholecystectomy	Y	07	193, 194
			21	442, 443
			24	486
78.31	Other change in bone length, scapula, clavicle, and thorax [ribs and sternum].	Y	04	76, 77
			08	233, 234
			21	442, 443
			24	486
93.92	Other mechanical ventilation	(²)	04	475

¹ See Table 6b for new procedure codes (4 digits) that will be considered valid by the FY 1992 GROUPE.

² Non-OR procedure code that affects DRG assignment.

TABLE 6E—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
411.81	Coronary occlusion without myocardial infarction	Y	05	124, 140
537.82	Angiodysplasia of stomach and duodenum (without mention of hemorrhage).	N	06	182, 183, 184
562.00	Diverticulosis of small intestine (without mention of hemorrhage).	N	06	182, 183, 184
562.01	Diverticulitis of small intestine (without mention of hemorrhage).	N	06	182, 183, 184
562.10	Diverticulosis of colon (without mention of hemorrhage).	N	06	182, 183, 184
562.11	Diverticulitis of colon (without mention of hemorrhage).	N	06	182, 183, 184
569.84	Angiodysplasia of intestine (without mention of hemorrhage).	N	06	188, 189, 190
578.1	Blood in stool	Y	06	174, 175

TABLE 6F—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
36.09	Other removal of coronary artery obstruction	Y	05	112
46.85	Dilation of intestine	N		
51.22	Cholecystectomy	Y	07	195, 196, 197, 198
			17	400, 406, 407
			21	442, 443
			24	486
60.94	Control of (postoperative) hemorrhage of prostate	Y	12	344, 345
			21	442, 443

TABLE 6F—REVISED PROCEDURE CODE TITLES—Continued

Procedure code	Description	OR	MDC	DRG
78.10	Application of external fixation device, unspecified site	Y	24 08 21 24	486 233, 234 442, 443 486
78.11	Application of external fixation device, scapula, clavicle, and thorax (ribs and sternum)	Y	04	76, 77
78.12	Application of external fixation device, humerus	Y	08 21 24	233, 234 442, 443 486
78.13	Application of external fixation device, radius and ulna	Y	08 21 24	218, 219, 220 442, 443 486
78.14	Application of external fixation device, carpals and metacarpals	Y	08 21 24	223, 224 442, 443 486
78.15	Application of external fixation device, femur	Y	08 21 24	228, 229 441 486
78.16	Application of external fixation device, patella	Y	08 21 24	210, 211, 212 442, 443 485
78.17	Application of external fixation device, tibia and fibula	Y	08 21 24	221, 222 442, 443 486
78.18	Application of external fixation device, tarsals and metatarsals	Y	08 21 24	218, 219, 220 442, 443 486
78.19	Application of external fixation device, other	Y	8 21 24	225 442, 443 486
78.20	Limb shortening procedures, unspecified site	Y	08 21 24	233, 234 442, 443 486
78.22	Limb shortening procedures, humerus	Y	08 21 24	218, 219, 220 442, 443 486
78.23	Limb shortening procedures, radius and ulna	Y	08 21 24	223, 224 442, 443 486
78.25	Limb shortening procedures, femur	Y	08 21 24	210, 211, 212 442, 443 485
78.27	Limb shortening procedures, tibia and fibula	Y	08 21 24	218, 219, 220 442, 443 486
78.29	Limb shortening procedures, other	Y	08 21 24	233, 234 442, 443 486
78.30	Limb lengthening procedures, unspecified site	Y	08 21 24	233, 234 442, 443 486
78.32	Limb lengthening procedures, humerus	Y	08 21 24	218, 219, 220 442, 443 486
78.33	Limb lengthening procedures, radius and ulna	Y	08 21 24	223, 224 442, 443 486
78.34	Limb lengthening procedures, carpals and metacarpals	Y	08 21 24	228, 229 441 486
78.35	Limb lengthening procedures, femur	Y	08 21 24	210, 211, 212 442, 443 485
78.37	Limb lengthening procedures, tibia and fibula	Y	08 21 24	218, 219, 220 442, 443 486
78.38	Limb lengthening procedures, tarsals and metatarsals	Y	8 21 24	225 442, 443 486
78.39	Limb lengthening procedures, other	Y	08 21 24	233, 234 442, 443 486
92.24	Teleradiotherapy using photons	N		

Table 6g - Additions to the CC Exclusions List

CCs that are added to the list are in Table 6g-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*01580	07052	07049	*07043	07049	07030	6960	1540
6960	07053	07051	07020	07051	07031	*1398	1541
*01581	07059	07052	07021	07052	07041	07020	1542
6960	*0701	07053	07030	07053	07042	07021	1543
*01582	07020	07059	07031	07059	07043	07030	1548
6960	07021	0706	07041	0706	07049	07031	1550
*01583	07030	0709	07042	0709	07051	07041	1551
6960	07031	7800	07043	7800	07052	07042	1552
*01584	07041	*07031	07049	*07053	07053	07043	1560
6960	07042	07020	07051	07020	07059	07049	1561
*01585	07043	07021	07052	07021	*07889	07051	1562
6960	07049	07030	07053	07030	07020	07052	1568
*01586	07051	07031	07059	07031	07021	07053	1569
6960	07052	07041	0706	07041	07030	07059	1570
*01590	07053	07042	0709	07042	07031	*1628	1571
6960	07059	07043	7800	07043	07041	1764	1572
*01591	*07020	07049	*07049	07049	07042	*1629	1573
6960	07020	07051	07020	07051	07043	1764	1574
*01592	07021	07052	07021	07052	07049	*1658	1578
6960	07030	07053	07030	07053	07051	1764	1579
*01593	07031	07059	07031	07059	07052	*1659	*1764
6960	07041	0706	07041	0706	07053	1764	1622
*01594	07042	0709	07042	0709	07059	*1763	1623
6960	07043	7800	07043	7800	*0798	1500	1624
*01595	07049	*07041	07049	*07059	07020	1501	1625
6960	07051	07020	07051	07020	07021	1502	1628
*01596	07052	07021	07052	07021	07030	1503	1629
6960	07053	07030	07053	07030	07031	1504	1764
*01790	07059	07031	07059	07031	07041	1505	*1765
6960	0706	07041	0706	07041	07042	1508	1765
*01791	0709	07042	0709	07042	07043	1509	1960
6960	7800	07043	7800	07043	07049	1510	1961
*01792	*07021	07049	*07051	07049	07051	1511	1962
6960	07020	07051	07020	07051	07052	1512	1963
*01793	07021	07052	07021	07052	07053	1513	1965
6960	07030	07053	07030	07053	07059	1514	1966
*01794	07031	07059	07031	07059	*0799	1515	1968
6960	07041	0706	07041	0706	07020	1516	1969
*01795	07042	0709	07042	0709	07021	1518	*1958
6960	07043	7800	07043	7800	07030	1519	1764
*01796	07049	*07042	07049	*0706	07031	1520	1765
6960	07051	07020	07051	07020	07041	1521	*1960
*03682	07052	07021	07052	07021	07042	1522	1765
6960	07053	07030	07053	07030	07043	1523	*1961
*05671	07059	07031	07059	07031	07049	1528	1765
6960	0706	07041	0706	07041	07051	1529	*1962
*0700	0709	07042	0709	07042	07052	1530	1765
07020	7800	07043	7800	07043	07053	1531	*1963
07021	*07030	07049	*07052	07049	07059	1532	1765
07030	07020	07051	07020	07051	*09850	1533	*1965
07031	07021	07052	07021	07052	6960	1534	1765
07041	07030	07053	07030	07053	*09851	1535	*1966
07042	07031	07059	07031	07059	6960	1536	1765
07043	07041	0706	07041	*0709	*09859	1537	*1968
07049	07042	0709	07042	07020	6960	1538	1765
07051	07043	7800	07043	07021	*09889	1539	*1969

1765	20810	20801	20800	20781	20780	20721	20720
*1990	20811	20810	20801	20800	20781	20780	20721
1764	20820	20811	20810	20801	20800	20781	20780
1765	20821	20820	20811	20810	20801	20800	20781
*1991	20880	20821	20820	20811	20810	20801	20800
1764	20881	20880	20821	20820	20811	20810	20801
1765	20890	20881	20880	20821	20820	20811	20810
*20300	20891	20890	20881	20880	20821	20820	20811
20300	*20301	20891	20890	20881	20880	20821	20820
20301	20300	*20310	20891	20890	20881	20880	20821
20310	20301	20300	*20311	20891	20890	20881	20880
20311	20310	20301	20300	*20380	20891	20890	20881
20380	20311	20310	20301	20300	*20381	20891	20890
20381	20380	20311	20310	20301	20300	*20400	20891
20400	20381	20380	20311	20310	20301	20300	*20401
20401	20400	20381	20380	20311	20310	20301	20300
20410	20401	20400	20381	20380	20311	20310	20301
20411	20410	20401	20400	20381	20380	20311	20310
20420	20411	20410	20401	20400	20381	20380	20311
20421	20420	20411	20410	20401	20400	20381	20380
20480	20421	20420	20411	20410	20401	20400	20381
20481	20480	20421	20420	20411	20410	20401	20400
20490	20481	20480	20421	20420	20411	20410	20401
20491	20490	20481	20480	20421	20420	20411	20410
20500	20491	20490	20481	20480	20421	20420	20411
20501	20500	20491	20490	20481	20480	20421	20420
20510	20501	20500	20491	20490	20481	20480	20421
20511	20510	20501	20500	20491	20490	20481	20480
20520	20511	20510	20501	20500	20491	20490	20481
20521	20520	20511	20510	20501	20500	20491	20490
20530	20521	20520	20511	20510	20501	20500	20491
20531	20530	20521	20520	20511	20510	20501	20500
20580	20531	20530	20521	20520	20511	20510	20501
20581	20580	20531	20530	20521	20520	20511	20510
20590	20581	20580	20531	20530	20521	20520	20511
20591	20590	20581	20580	20531	20530	20521	20520
20600	20591	20590	20581	20580	20531	20530	20521
20601	20600	20591	20590	20581	20580	20531	20530
20610	20601	20600	20591	20590	20581	20580	20531
20611	20610	20601	20600	20591	20590	20581	20580
20620	20611	20610	20601	20600	20591	20590	20581
20621	20620	20611	20610	20601	20600	20591	20590
20680	20621	20620	20611	20610	20601	20600	20591
20681	20680	20621	20620	20611	20610	20601	20600
20690	20681	20680	20621	20620	20611	20610	20601
20691	20690	20681	20680	20621	20620	20611	20610
20700	20691	20690	20681	20680	20621	20620	20611
20701	20700	20691	20690	20681	20680	20621	20620
20710	20701	20700	20691	20690	20681	20680	20621
20711	20710	20701	20700	20691	20690	20681	20680
20720	20711	20710	20701	20700	20691	20690	20681
20721	20720	20711	20710	20701	20700	20691	20690
20780	20721	20720	20711	20710	20701	20700	20691
20781	20780	20721	20720	20711	20710	20701	20700
20800	20781	20780	20721	20720	20711	20710	20701
20801	20800	20781	20780	20721	20720	20711	20710

20711	20710	20701	20700	20691	20690	20681	20680
20720	20711	20710	20701	20700	20691	20690	20681
20721	20720	20711	20710	20701	20700	20691	20690
20780	20721	20720	20711	20710	20701	20700	20691
20781	20780	20721	20720	20711	20710	20701	20700
20800	20781	20780	20721	20720	20711	20710	20701
20801	20800	20781	20780	20721	20720	20711	20710
20810	20801	20800	20781	20780	20721	20720	20711
20811	20810	20801	20800	20781	20780	20721	20720
20820	20811	20810	20801	20800	20781	20780	20721
20821	20820	20811	20810	20801	20800	20781	20780
20880	20821	20820	20811	20810	20801	20800	20781
20881	20880	20821	20820	20811	20810	20801	20800
20890	20881	20880	20821	20820	20811	20810	20801
20891	20890	20881	20880	20821	20820	20811	20810
*20410	20891	20890	20881	20880	20821	20820	20811
20300	*20411	20891	20890	20881	20880	20821	20820
20301	20300	*20420	20891	20890	20881	20880	20821
20310	20301	20300	*20421	20891	20890	20881	20880
20311	20310	20301	20300	*20480	20891	20890	20881
20380	20311	20310	20301	20300	*20481	20891	20890
20381	20380	20311	20310	20301	20300	*20490	20891
20400	20381	20380	20311	20310	20301	20300	*20491
20401	20400	20381	20380	20311	20310	20301	20300
20410	20401	20400	20381	20380	20311	20310	20301
20411	20410	20401	20400	20381	20380	20311	20310
20420	20411	20410	20401	20400	20381	20380	20311
20421	20420	20411	20410	20401	20400	20381	20380
20480	20421	20420	20411	20410	20401	20400	20381
20481	20480	20421	20420	20411	20410	20401	20400
20490	20481	20480	20421	20420	20411	20410	20401
20491	20490	20481	20480	20421	20420	20411	20410
20500	20491	20490	20481	20480	20421	20420	20411
20501	20500	20491	20490	20481	20480	20421	20420
20510	20501	20500	20491	20490	20481	20480	20421
20511	20510	20501	20500	20491	20490	20481	20480
20520	20511	20510	20501	20500	20491	20490	20481
20521	20520	20511	20510	20501	20500	20491	20490
20530	20521	20520	20511	20510	20501	20500	20491
20531	20530	20521	20520	20511	20510	20501	20500
20580	20531	20530	20521	20520	20511	20510	20501
20581	20580	20531	20530	20521	20520	20511	20510
20590	20581	20580	20531	20530	20521	20520	20511
20591	20590	20581	20580	20531	20530	20521	20520
20600	20591	20590	20581	20580	20531	20530	20521
20601	20600	20591	20590	20581	20580	20531	20530
20610	20601	20600	20591	20590	20581	20580	20531
20611	20610	20601	20600	20591	20590	20581	20580
20620	20611	20610	20601	20600	20591	20590	20581
20621	20620	20611	20610	20601	20600	20591	20590
20680	20621	20620	20611	20610	20601	20600	20591
20681	20680	20621	20620	20611	20610	20601	20600
20690	20681	20680	20621	20620	20611	20610	20601
20691	20690	20681	20680	20621	20620	20611	20610
20700	20691	20690	20681	20680	20621	20620	20611
20701	20700	20691	20690	20681	20680	20621	20620

20621	20620	20611	20610	20601	20600	20591	20590
20680	20621	20620	20611	20610	20601	20600	20591
20681	20680	20621	20620	20611	20610	20601	20600
20690	20681	20680	20621	20620	20611	20610	20601
20691	20690	20681	20680	20621	20620	20611	20610
20700	20691	20690	20681	20680	20621	20620	20611
20701	20700	20691	20690	20681	20680	20621	20620
20710	20701	20700	20691	20690	20681	20680	20621
20711	20710	20701	20700	20691	20690	20681	20680
20720	20711	20710	20701	20700	20691	20690	20681
20721	20720	20711	20710	20701	20700	20691	20690
20780	20721	20720	20711	20710	20701	20700	20691
20781	20780	20721	20720	20711	20710	20701	20700
20800	20781	20780	20721	20720	20711	20710	20701
20801	20800	20781	20780	20721	20720	20711	20710
20810	20801	20800	20781	20780	20721	20720	20711
20811	20810	20801	20800	20781	20780	20721	20720
20820	20811	20810	20801	20800	20781	20780	20721
20821	20820	20811	20810	20801	20800	20781	20780
20880	20821	20820	20811	20810	20801	20800	20781
20881	20880	20821	20820	20811	20810	20801	20800
20890	20881	20880	20821	20820	20811	20810	20801
20891	20890	20881	20880	20821	20820	20811	20810
*20500	20891	20890	20881	20880	20821	20820	20811
20300	*20501	20891	20890	20881	20880	20821	20820
20301	20300	*20510	20891	20890	20881	20880	20821
20310	20301	20300	*20511	20891	20890	20881	20880
20311	20310	20301	20300	*20520	20891	20890	20881
20380	20311	20310	20301	20300	*20521	20891	20890
20381	20380	20311	20310	20301	20300	*20530	20891
20400	20381	20380	20311	20310	20301	20300	*20531
20401	20400	20381	20380	20311	20310	20301	20300
20410	20401	20400	20381	20380	20311	20310	20301
20411	20410	20401	20400	20381	20380	20311	20310
20420	20411	20410	20401	20400	20381	20380	20311
20421	20420	20411	20410	20401	20400	20381	20380
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20481	20480	20421	20420	20411	20410	20401	20400
20490	20481	20480	20421	20420	20411	20410	20401
20491	20490	20481	20480	20421	20420	20411	20410
20500	20491	20490	20481	20480	20421	20420	20411
20501	20500	20491	20490	20481	20480	20421	20420
20510	20501	20500	20491	20490	20481	20480	20421
20511	20510	20501	20500	20491	20490	20481	20480
20520	20511	20510	20501	20500	20491	20490	20481
20521	20520	20511	20510	20501	20500	20491	20490
20530	20521	20520	20511	20510	20501	20500	20491
20531	20530	20521	20520	20511	20510	20501	20500
20580	20531	20530	20521	20520	20511	20510	20501
20581	20580	20531	20530	20521	20520	20511	20510
20590	20581	20580	20531	20530	20521	20520	20511
20591	20590	20581	20580	20531	20530	20521	20520
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20601	20600	20591	20590	20581	20580	20531	20530
20610	20601	20600	20591	20590	20581	20580	20531
20611	20610	20601	20600	20591	20590	20581	20580

20581	20580	20531	20530	20521	20520	20511	20510
20590	20581	20580	20531	20530	20521	20520	20511
20591	20590	20581	20580	20531	20530	20521	20520
20600	20591	20590	20581	20580	20531	20530	20521
20601	20600	20591	20590	20581	20580	20531	20530
20610	20601	20600	20591	20590	20581	20580	20531
20611	20610	20601	20600	20591	20590	20581	20580
20620	20611	20610	20601	20600	20591	20590	20581
20621	20620	20611	20610	20601	20600	20591	20590
20680	20621	20620	20611	20610	20601	20600	20591
20681	20680	20621	20620	20611	20610	20601	20600
20690	20681	20680	20621	20620	20611	20610	20601
20691	20690	20681	20680	20621	20620	20611	20610
20700	20691	20690	20681	20680	20621	20620	20611
20701	20700	20691	20690	20681	20680	20621	20620
20710	20701	20700	20691	20690	20681	20680	20621
20711	20710	20701	20700	20691	20690	20681	20680
20720	20711	20710	20701	20700	20691	20690	20681
20721	20720	20711	20710	20701	20700	20691	20690
20780	20721	20720	20711	20710	20701	20700	20691
20781	20780	20721	20720	20711	20710	20701	20700
20800	20781	20780	20721	20720	20711	20710	20701
20801	20800	20781	20780	20721	20720	20711	20710
20810	20801	20800	20781	20780	20721	20720	20711
20811	20810	20801	20800	20781	20780	20721	20720
20820	20811	20810	20801	20800	20781	20780	20721
20821	20820	20811	20810	20801	20800	20781	20780
20880	20821	20820	20811	20810	20801	20800	20781
20881	20880	20821	20820	20811	20810	20801	20800
20890	20881	20880	20821	20820	20811	20810	20801
20891	20890	20881	20880	20821	20820	20811	20810
*20580	20891	20890	20881	20880	20821	20820	20811
20300	*20581	20891	20890	20881	20880	20821	20820
20301	20300	*20590	20891	20890	20881	20880	20821
20310	20301	20300	*20591	20891	20890	20881	20880
20311	20310	20301	20300	*20600	20891	20890	20881
20380	20311	20310	20301	20300	*20601	20891	20890
20381	20380	20311	20310	20301	20300	*20610	20891
20400	20381	20380	20311	20310	20301	20300	*20611
20401	20400	20381	20380	20311	20310	20301	20300
20410	20401	20400	20381	20380	20311	20310	20301
20411	20410	20401	20400	20381	20380	20311	20310
20420	20411	20410	20401	20400	20381	20380	20311
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[illegible]

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53441	53271	53111	53491	53320	53150	53551	53351
53450	53291	53120	53501	53321	53151	53561	53360
53451	53300	53121	53511	53331	53160	53783	53361
53460	53301	53131	53521	53340	53161	56202	53371
53461	53310	53140	53531	53341	53171	56203	53391
53471	53311	53141	53541	53350	53191	56212	53400
53491	53320	53150	53551	53351	53200	56213	53401
53501	53321	53151	53561	53360	53201	5693	53410
53511	53331	53160	53783	53361	53210	56985	53411
53521	53340	53161	56202	53371	53211	5780	53420
53531	53341	53171	56203	53391	53220	5781	53421
53541	53350	53191	56212	53400	53221	5789	53431
53551	53351	53200	56213	53401	53231	9981	53440
53561	53360	53201	5693	53410	53240	*53551	53441
53783	53361	53210	56985	53411	53241	4560	53450
56202	53371	53211	5780	53420	53250	5307	53451
56203	53391	53220	5781	53421	53251	53100	53460
56212	53400	53221	5789	53431	53260	53101	53461
56213	53401	53231	9981	53440	53261	53110	53471
5693	53410	53240	*53531	53441	53271	53111	53491
56985	53411	53241	4560	53450	53291	53120	53501
5780	53420	53250	5307	53451	53300	53121	53511
5781	53421	53251	53100	53460	53301	53131	53521
5789	53431	53260	53101	53461	53310	53140	53531
9981	53440	53261	53110	53471	53311	53141	53541
*53511	53441	53271	53111	53491	53320	53150	53551
4560	53450	53291	53120	53501	53321	53151	53561
5307	53451	53300	53121	53511	53331	53160	53783
53100	53460	53301	53131	53521	53340	53161	56202
53101	53461	53310	53140	53531	53341	53171	56203
53110	53471	53311	53141	53541	53350	53191	56212
53111	53491	53320	53150	53551	53351	53200	56213

5693	53410	53240	*56202	53441	53271	53111	53491
56985	53411	53241	4560	53450	53291	53120	53501
5780	53420	53250	5307	53451	53300	53121	53511
5781	53421	53251	53100	53460	53301	53131	53521
5789	53431	53260	53101	53461	53310	53140	53531
9981	53440	53261	53110	53471	53311	53141	53541
*53561	53441	53271	53111	53491	53320	53150	53551
4560	53450	53291	53120	53501	53321	53151	53561
5307	53451	53300	53121	53511	53331	53160	53783
53100	53460	53301	53131	53521	53340	53161	56202
53101	53461	53310	53140	53531	53341	53171	56203
53110	53471	53311	53141	53541	53350	53191	56212
53111	53491	53320	53150	53551	53351	53200	56213
53120	53501	53321	53151	53561	53360	53201	5693
53121	53511	53331	53160	53783	53361	53210	56985
53131	53521	53340	53161	56202	53371	53211	5780
53140	53531	53341	53171	56203	53391	53220	5781
53141	53541	53350	53191	56212	53400	53221	5789
53150	53551	53351	53200	56213	53401	53231	9981
53151	53561	53360	53201	5693	53410	53240	*56213
53160	53783	53361	53210	56985	53411	53241	4560
53161	56202	53371	53211	5780	53420	53250	5307
53171	56203	53391	53220	5781	53421	53251	53100
53191	56212	53400	53221	5789	53431	53260	53101
53200	56213	53401	53231	9981	53440	53261	53110
53201	5693	53410	53240	*56203	53441	53271	53111
53210	56985	53411	53241	4560	53450	53291	53120
53211	5780	53420	53250	5307	53451	53300	53121
53220	5781	53421	53251	53100	53460	53301	53131
53221	5789	53431	53260	53101	53461	53310	53140
53231	9981	53440	53261	53110	53471	53311	53141
53240	*53783	53441	53271	53111	53491	53320	53150
53241	4560	53450	53291	53120	53501	53321	53151
53250	5307	53451	53300	53121	53511	53331	53160
53251	53100	53460	53301	53131	53521	53340	53161
53260	53101	53461	53310	53140	53531	53341	53171
53261	53110	53471	53311	53141	53541	53350	53191
53271	53111	53491	53320	53150	53551	53351	53200
53291	53120	53501	53321	53151	53561	53360	53201
53300	53121	53511	53331	53160	53783	53361	53210
53301	53131	53521	53340	53161	56202	53371	53211
53310	53140	53531	53341	53171	56203	53391	53220
53311	53141	53541	53350	53191	56212	53400	53221
53320	53150	53551	53351	53200	56213	53401	53231
53321	53151	53561	53360	53201	5693	53410	53240
53331	53160	53783	53361	53210	56985	53411	53241
53340	53161	56202	53371	53211	5780	53420	53250
53341	53171	56203	53391	53220	5781	53421	53251
53350	53191	56212	53400	53221	5789	53431	53260
53351	53200	56213	53401	53231	9981	53440	53261
53360	53201	5693	53410	53240	*56212	53441	53271
53361	53210	56985	53411	53241	4560	53450	53291
53371	53211	5780	53420	53250	5307	53451	53300
53391	53220	5781	53421	53251	53100	53460	53301
53400	53221	5789	53431	53260	53101	53461	53310
53401	53231	9981	53440	53261	53110	53471	53311

53320	56213	53431	53501	6960	6960	6960	6960
53321	56985	53440	53511	*71121	*71149	*71177	*71215
53331	*56985	53441	53521	6960	6960	6960	6960
53340	4560	53450	53531	*71122	*71150	*71178	*71216
53341	5307	53451	53541	6960	6960	6960	6960
53350	53100	53460	53551	*71123	*71151	*71179	*71217
53351	53101	53461	53561	6960	6960	6960	6960
53360	53110	53471	53783	*71124	*71152	*71180	*71218
53361	53111	53491	56202	6960	6960	6960	6960
53371	53120	53501	56203	*71125	*71153	*71181	*71219
53391	53121	53511	56212	6960	6960	6960	6960
53400	53131	53521	56213	*71126	*71154	*71182	*71220
53401	53140	53531	56985	6960	6960	6960	6960
53410	53141	53541	*6960	*71127	*71155	*71183	*71221
53411	53150	53551	6960	6960	6960	6960	6960
53420	53151	53561	*71100	*71128	*71156	*71184	*71222
53421	53160	53783	6960	6960	6960	6960	6960
53431	53161	56202	*71101	*71129	*71157	*71185	*71223
53440	53171	56203	6960	6960	6960	6960	6960
53441	53191	56212	*71102	*71130	*71158	*71186	*71224
53450	53200	56213	6960	6960	6960	6960	6960
53451	53201	5693	*71103	*71131	*71159	*71187	*71225
53460	53210	56985	6960	6960	6960	6960	6960
53461	53211	5780	*71104	*71132	*71160	*71188	*71226
53471	53220	5781	6960	6960	6960	6960	6960
53491	53221	5789	*71105	*71133	*71161	*71189	*71227
53501	53231	9981	6960	6960	6960	6960	6960
53511	53240	*5780	*71106	*71134	*71162	*71190	*71228
53521	53241	53501	6960	6960	6960	6960	6960
53531	53250	53511	*71107	*71135	*71163	*71191	*71229
53541	53251	53521	6960	6960	6960	6960	6960
53551	53260	53531	*71108	*71136	*71164	*71192	*71230
53561	53261	53541	6960	6960	6960	6960	6960
53783	53271	53551	*71109	*71137	*71165	*71193	*71231
56202	53291	53561	6960	6960	6960	6960	6960
56203	53300	53783	*71110	*71138	*71166	*71194	*71232
56212	53301	56202	6960	6960	6960	6960	6960
56213	53310	56203	*71111	*71139	*71167	*71195	*71233
5693	53311	56212	6960	6960	6960	6960	6960
56985	53320	56213	*71112	*71140	*71168	*71196	*71234
5780	53321	56985	6960	6960	6960	6960	6960
5781	53331	*5781	*71113	*71141	*71169	*71197	*71235
5789	53340	53501	6960	6960	6960	6960	6960
9981	53341	53511	*71114	*71142	*71170	*71198	*71236
*5693	53350	53521	6960	6960	6960	6960	6960
53501	53351	53531	*71115	*71143	*71171	*71199	*71237
53511	53360	53541	6960	6960	6960	6960	6960
53521	53361	53551	*71116	*71144	*71172	*71210	*71238
53531	53371	53561	6960	6960	6960	6960	6960
53541	53391	53783	*71117	*71145	*71173	*71211	*71239
53551	53400	56202	6960	6960	6960	6960	6960
53561	53401	56203	*71118	*71146	*71174	*71212	*71280
53783	53410	56212	6960	6960	6960	6960	6960
56202	53411	56213	*71119	*71147	*71175	*71213	*71281
56203	53420	56985	6960	6960	6960	6960	6960
56212	53421	*5789	*71120	*71148	*71176	*71214	*71282

6960	6960	6960	6960	6960	6960	6960	6960
*71283	*71509	*71595	*71624	*71652	*71691	*71918	*71946
6960	6960	6960	6960	6960	6960	6960	6960
*71284	*71510	*71596	*71625	*71653	*71692	*71919	*71947
6960	6960	6960	6960	6960	6960	6960	6960
*71285	*71518	*71597	*71626	*71654	*71693	*71920	*71948
6960	6960	6960	6960	6960	6960	6960	6960
*71286	*71520	*71598	*71627	*71655	*71694	*71921	*71949
6960	6960	6960	6960	6960	6960	6960	6960
*71287	*71521	*71600	*71628	*71656	*71695	*71922	*71950
6960	6960	6960	6960	6960	6960	6960	6960
*71288	*71522	*71601	*71629	*71657	*71696	*71923	*71951
6960	6960	6960	6960	6960	6960	6960	6960
*71289	*71523	*71602	*71630	*71658	*71697	*71924	*71952
6960	6960	6960	6960	6960	6960	6960	6960
*71290	*71524	*71603	*71631	*71659	*71698	*71925	*71953
6960	6960	6960	6960	6960	6960	6960	6960
*71291	*71525	*71604	*71632	*71660	*71699	*71926	*71954
6960	6960	6960	6960	6960	6960	6960	6960
*71292	*71526	*71605	*71633	*71661	*71800	*71927	*71955
6960	6960	6960	6960	6960	6960	6960	6960
*71293	*71527	*71606	*71634	*71662	*71801	*71928	*71956
6960	6960	6960	6960	6960	6960	6960	6960
*71294	*71528	*71607	*71635	*71663	*71802	*71929	*71957
6960	6960	6960	6960	6960	6960	6960	6960
*71295	*71530	*71608	*71636	*71664	*71803	*71930	*71958
6960	6960	6960	6960	6960	6960	6960	6960
*71296	*71531	*71609	*71637	*71665	*71804	*71931	*71959
6960	6960	6960	6960	6960	6960	6960	6960
*71297	*71532	*71610	*71638	*71666	*71805	*71932	*71960
6960	6960	6960	6960	6960	6960	6960	6960
*71298	*71533	*71611	*71639	*71667	*71807	*71933	*71961
6960	6960	6960	6960	6960	6960	6960	6960
*71299	*71534	*71612	*71640	*71668	*71808	*71934	*71962
6960	6960	6960	6960	6960	6960	6960	6960
*7130	*71535	*71613	*71641	*71680	*71900	*71935	*71963
6960	6960	6960	6960	6960	6960	6960	6960
*7131	*71536	*71614	*71642	*71681	*71901	*71936	*71964
6960	6960	6960	6960	6960	6960	6960	6960
*7132	*71537	*71615	*71643	*71682	*71902	*71937	*71965
6960	6960	6960	6960	6960	6960	6960	6960
*7133	*71538	*71616	*71644	*71683	*71903	*71938	*71966
6960	6960	6960	6960	6960	6960	6960	6960
*7134	*71580	*71617	*71645	*71684	*71904	*71939	*71967
6960	6960	6960	6960	6960	6960	6960	6960
*7135	*71589	*71618	*71646	*71685	*71905	*71940	*71968
6960	6960	6960	6960	6960	6960	6960	6960
*7136	*71590	*71619	*71647	*71686	*71906	*71941	*71969
6960	6960	6960	6960	6960	6960	6960	6960
*7137	*71591	*71620	*71648	*71687	*71907	*71942	*71970
6960	6960	6960	6960	6960	6960	6960	6960
*7138	*71592	*71621	*71649	*71688	*71908	*71943	*71975
6960	6960	6960	6960	6960	6960	6960	6960
*7140	*71593	*71622	*71650	*71689	*71909	*71944	*71976
6960	6960	6960	6960	6960	6960	6960	6960
*71500	*71594	*71623	*71651	*71690	*71910	*71945	*71977

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Table 6h - Deletions to the CC Exclusions List

CCs that are deleted from the list are in Table 6h-Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*01100	*01111	*01122	*01133	*01144	*01155	*01166	*01180
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01101	*01112	*01123	*01134	*01145	*01156	*01170	*01181
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01102	*01113	*01124	*01135	*01146	*01160	*01171	*01182
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01103	*01114	*01125	*01136	*01150	*01161	*01172	*01183
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01104	*01115	*01126	*01140	*01151	*01162	*01173	*01184
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01105	*01116	*01130	*01141	*01152	*01163	*01174	*01185
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01106	*01120	*01131	*01142	*01153	*01164	*01175	*01186
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505
*01110	*01121	*01132	*01143	*01154	*01165	*01176	*01190
500	500	500	500	500	500	500	500
501	501	501	501	501	501	501	501
502	502	502	502	502	502	502	502
503	503	503	503	503	503	503	503
504	504	504	504	504	504	504	504
505	505	505	505	505	505	505	505

*01191	*01202	*01213	*01284	*01795	0704	501	6198
500	500	500	500	500	0705	502	*1363
501	501	501	501	501	0706	503	500
502	502	502	502	502	0709	504	501
503	503	503	503	503	7800	505	502
504	504	504	504	504	*0704	*11515	503
505	505	505	505	505	0702	500	504
*01192	*01203	*01214	*01285	*01796	0703	501	505
500	500	500	500	500	0704	502	*1398
501	501	501	501	501	0705	503	0702
502	502	502	502	502	0706	504	0703
503	503	503	503	503	0709	505	0704
504	504	504	504	504	7800	*11595	0705
505	505	505	505	505	*0705	500	*2030
*01193	*01204	*01215	*01286	*0212	0702	501	2030
500	500	500	500	500	0703	502	2031
501	501	501	501	501	0704	503	2038
502	502	502	502	502	0705	504	2040
503	503	503	503	503	0706	505	2041
504	504	504	504	504	0709	*1221	2042
505	505	505	505	505	7800	500	2048
*01194	*01205	*01216	*01790	*0310	*0706	501	2049
500	500	500	500	500	0702	502	2050
501	501	501	501	501	0703	503	2051
502	502	502	502	502	0704	504	2052
503	503	503	503	503	0705	505	2053
504	504	504	504	504	*0709	*1304	2058
505	505	505	505	505	0702	500	2059
*01195	*01206	*01280	*01791	*0391	0703	501	2060
500	500	500	500	500	0704	502	2061
501	501	501	501	501	0705	503	2062
502	502	502	502	502	*07889	504	2068
503	503	503	503	503	0702	505	2069
504	504	504	504	504	0703	*13100	2070
505	505	505	505	505	0704	6071	2071
*01196	*01210	*01281	*01792	*0700	0705	6072	2072
500	500	500	500	0702	*0798	6073	2078
501	501	501	501	0703	0702	6190	2080
502	502	502	502	0704	0703	6191	2081
503	503	503	503	0705	0704	6192	2082
504	504	504	504	*0701	0705	6198	2088
505	505	505	505	0702	*0799	*1318	2089
*01200	*01211	*01282	*01793	0703	0702	6071	*2031
500	500	500	500	0704	0703	6072	2030
501	501	501	501	0705	0704	6073	2031
502	502	502	502	*0702	0705	6190	2038
503	503	503	503	0702	*1122	6191	2040
504	504	504	504	0703	6071	6192	2041
505	505	505	505	0704	6072	6198	2042
*01201	*01212	*01283	*01794	0705	6073	*1319	2048
500	500	500	500	0706	6190	6071	2049
501	501	501	501	0709	6191	6072	2050
502	502	502	502	7800	6192	6073	2051
503	503	503	503	*0703	6198	6190	2052
504	504	504	504	0702	*11505	6191	2053
505	505	505	505	0703	500	6192	2058

2059	2053	2051	2049	2042	2040	2031	*2061
2060	2058	2052	2050	2048	2041	2038	2030
2061	2059	2053	2051	2049	2042	2040	2031
2062	2060	2058	2052	2050	2048	2041	2038
2068	2061	2059	2053	2051	2049	2042	2040
2069	2062	2060	2058	2052	2050	2048	2041
2070	2068	2061	2059	2053	2051	2049	2042
2071	2069	2062	2060	2058	2052	2050	2048
2072	2070	2068	2061	2059	2053	2051	2049
2078	2071	2069	2062	2060	2058	2052	2050
2080	2072	2070	2068	2061	2059	2053	2051
2081	2078	2071	2069	2062	2060	2058	2052
2082	2080	2072	2070	2068	2061	2059	2053
2088	2081	2078	2071	2069	2062	2060	2058
2089	2082	2080	2072	2070	2068	2061	2059
*2038	2088	2081	2078	2071	2069	2062	2060
2030	2089	2082	2080	2072	2070	2068	2061
2031	*2041	2088	2081	2078	2071	2069	2062
2038	2030	2089	2082	2080	2072	2070	2068
2040	2031	*2048	2088	2081	2078	2071	2069
2041	2038	2030	2089	2082	2080	2072	2070
2042	2040	2031	*2050	2088	2081	2078	2071
2048	2041	2038	2030	2089	2082	2080	2072
2049	2042	2040	2031	*2052	2088	2081	2078
2050	2048	2041	2038	2030	2089	2082	2080
2051	2049	2042	2040	2031	*2058	2088	2081
2052	2050	2048	2041	2038	2030	2089	2082
2053	2051	2049	2042	2040	2031	*2060	2088
2058	2052	2050	2048	2041	2038	2030	2089
2059	2053	2051	2049	2042	2040	2031	*2062
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2062	2060	2058	2052	2050	2048	2041	2038
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2069	2062	2060	2058	2052	2050	2048	2041
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2089	2082	2080	2072	2070	2068	2061	2059
*2040	2088	2081	2078	2071	2069	2062	2060
2030	2089	2082	2080	2072	2070	2068	2061
2031	*2042	2088	2081	2078	2071	2069	2062
2038	2030	2089	2082	2080	2072	2070	2068
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2048	2041	2038	2030	2089	2082	2080	2072
2049	2042	2040	2031	*2053	2088	2081	2078
2050	2048	2041	2038	2030	2089	2082	2080
2051	2049	2042	2040	2031	*2059	2088	2081
2052	2050	2048	2041	2038	2030	2089	2082

2088	2081	2078	2071	2069	2062	2060	4470
2089	2082	2080	2072	2070	2068	2061	4480
*2068	2088	2081	2078	2071	2069	2062	*25091
2030	2089	2082	2080	2072	2070	2068	4470
2031	*2070	2088	2081	2078	2071	2069	4480
2038	2030	2089	2082	2080	2072	2070	*27411
2040	2031	*2072	2088	2081	2078	2071	7880
2041	2038	2030	2089	2082	2080	2072	*317
2042	2040	2031	*2080	2088	2081	2078	3182
2048	2041	2038	2030	2089	2082	2080	*3180
2049	2042	2040	2031	*2082	2088	2081	3182
2050	2048	2041	2038	2030	2089	2082	*3181
2051	2049	2042	2040	2031	*2089	2088	3182
2052	2050	2048	2041	2038	2030	2089	*3182
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2058	2052	2050	2048	2041	2038	2030	*319
2059	2053	2051	2049	2042	2040	2031	3182
2060	2058	2052	2050	2048	2041	2038	*3912
2061	2059	2053	2051	2049	2042	2040	4290
2062	2060	2058	2052	2050	2048	2041	*3980
2068	2061	2059	2053	2051	2049	2042	4290
2069	2062	2060	2058	2052	2050	2048	*4220
2070	2068	2061	2059	2053	2051	2049	4290
2071	2069	2062	2060	2058	2052	2050	*42290
2072	2070	2068	2061	2059	2053	2051	4290
2078	2071	2069	2062	2060	2058	2052	*42291
2080	2072	2070	2068	2061	2059	2053	4290
2081	2078	2071	2069	2062	2060	2058	*42292
2082	2080	2072	2070	2068	2061	2059	4290
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2089	2082	2080	2072	2070	2068	2061	4290
*2069	2088	2081	2078	2071	2069	2062	*42299
2030	2089	2082	2080	2072	2070	2068	4290
2031	*2071	2088	2081	2078	2071	2069	*4290
2038	2030	2089	2082	2080	2072	2070	4290
2040	2031	*2078	2088	2081	2078	2071	*42971
2041	2038	2030	2089	2082	2080	2072	4290
2042	2040	2031	*2081	2088	2081	2078	*42979
2048	2041	2038	2030	2089	2082	2080	4290
2049	2042	2040	2031	*2088	2088	2081	*4470
2050	2048	2041	2038	2030	2089	2082	4470
2051	2049	2042	2040	2031	*2398	2088	*4480
2052	2050	2048	2041	2038	2030	2089	4480
2053	2051	2049	2042	2040	2031	*25070	*4572
2058	2052	2050	2048	2041	2038	4470	4572
2059	2053	2051	2049	2042	2040	4480	*45989
2060	2058	2052	2050	2048	2041	*25071	4290
2061	2059	2053	2051	2049	2042	4470	4470
2062	2060	2058	2052	2050	2048	4480	4480
2068	2061	2059	2053	2051	2049	*25080	4572
2069	2062	2060	2058	2052	2050	4470	*4599
2070	2068	2061	2059	2053	2051	4480	4290
2071	2069	2062	2060	2058	2052	*25081	4470
2072	2070	2068	2061	2059	2053	4470	4480
2078	2071	2069	2062	2060	2058	4480	4572
2080	2072	2070	2068	2061	2059	*25090	*4800

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501	501	501	*4912	505	505	505	505
502	502	502	4911	*4955	*502	*5064	*5089
503	503	503	4912	500	500	500	500
504	504	504	4918	501	501	501	501
505	505	505	4919	502	502	502	502
*4801	*4823	*4846	49320	503	503	503	503
500	500	500	49321	504	504	504	504
501	501	501	*4918	505	505	505	505
502	502	502	4912	*4956	*503	*5069	*5171
503	503	503	*4919	500	500	500	500
504	504	504	4912	501	501	501	501
505	505	505	*49320	502	502	502	502
*4802	*4824	*4847	4912	503	503	503	503
500	500	500	*49321	504	504	504	504
501	501	501	4912	505	505	505	505
502	502	502	*494	*4957	*504	*5070	*5178
503	503	503	500	500	500	500	500
504	504	504	501	501	501	501	501
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*4808	*4828	*4848	503	503	503	503	503
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502	502	502	*4950	*4958	*505	*5071	*51889
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*4809	*4829	*485	503	503	503	503	503
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502	502	502	*4951	*4959	*5060	*5078	*5198
503	503	503	500	500	500	500	500
504	504	504	501	501	501	501	501
505	505	505	502	502	502	502	502
*481	*483	*486	503	503	503	503	503
500	500	500	504	504	504	504	504
501	501	501	505	505	505	505	505
502	502	502	*4952	*496	*5061	*5080	*5199
503	503	503	500	500	500	500	500
504	504	504	501	501	501	501	501
505	505	505	502	502	502	502	502
*4820	*4841	*4870	503	503	503	503	503
500	500	500	504	504	504	504	504
501	501	501	505	505	505	505	505
502	502	502	*4953	*500	*5062	*5081	*5350
503	503	503	500	500	500	500	5350
504	504	504	501	501	501	501	9981
505	505	505	502	502	502	502	*5351
*4821	*4843	*4871	503	503	503	503	5350
500	500	500	504	504	504	504	*5352
501	501	501	505	505	505	505	5350
502	502	502	*4954	*501	*5063	*5088	*5353
503	503	503	500	500	500	500	5350
504	504	504	501	501	501	501	*5354
505	505	505	502	502	502	502	5350
*4822	*4845	*4911	503	503	503	503	*5355

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5350	6071	6071	*6259	6071
*5711	6072	6072	6190	6072
5711	6073	6073	6191	6073
*5738	*5993	*6079	6192	*7539
5711	6071	6071	6198	6071
*5739	6072	6072	*6298	6072
5711	6073	6073	6190	6073
*5970	*5994	*6084	6191	6190
6071	6071	6071	6192	6191
6072	6072	6072	6198	6192
6073	6073	6073	*6299	6198
*59780	*5995	*60881	6190	*7809
6071	6071	6071	6191	7880
6072	6072	6072	6192	7908
6073	6073	6073	6198	*7880
*59781	*5996	*60883	*683	7880
6071	6071	6071	683	*7889
6072	6072	6072	*7080	7880
6073	6073	6073	7080	*7907
*59789	*5998	*60885	*7081	7908
6071	6071	6071	7080	*7908
6072	6072	6072	*7098	7908
6073	6073	6073	683	*7909
*59800	*5999	*60886	7080	7908
6071	6071	6071	*74861	*7998
6072	6072	6072	500	7880
6073	6073	6073	501	7908
*59801	*6070	*60889	502	
6071	6071	6071	503	
6072	6072	6072	504	
6073	6073	6073	505	
*5981	*6071	*6089	*7528	
6071	6071	6071	6071	
6072	6072	6072	6072	
6073	6073	6073	6073	
*5982	*6072	*6190	6190	
6071	6071	6190	6191	
6072	6072	*6191	6192	
6073	6073	6191	6198	
*5988	*6073	*6192	*7529	
6071	6071	6192	6071	
6072	6072	*6198	6072	
6073	6073	6190	6073	
*5989	*60781	6191	6190	
6071	6071	6192	6191	
6072	6072	6198	6192	
6073	6073	*6199	6198	
*5990	*60782	6190	*7536	
6071	6071	6191	6071	
6072	6072	6192	6072	
6073	6073	6198	6073	
*5991	*60783	*6258	*7537	
6071	6071	6190	6071	
6072	6072	6191	6072	
6073	6073	6192	6073	
*5992	*60789	6198	*7538	

TABLE 6i.—NEW HIV-RELATED CONDITIONS NECESSARY FOR ASSIGNMENT TO MDC 25

Diagnosis code	Description	Major
136.8.....	Microsporidiosis.....	Yes.
176.0—176.9.....	Kaposi's sarcoma.....	Yes.
323.8.....	Other causes of encephalitis.	Yes.
421.0; 421.9.....	Endocarditis.....	Yes.
422.90—422.99.....	Myocarditis.....	Yes.

TABLE 6i.—NEW HIV-RELATED CONDITIONS NECESSARY FOR ASSIGNMENT TO MDC 25—Continued

Diagnosis code	Description	Major
425.9.....	Secondary cardiomyopathy.	No.
480.8.....	Viral pneumonia, NEC.	Yes.
481.....	Pneumococcal pneumonia.	Yes.
482.0—482.9.....	Other bacterial pneumonia.	Yes.

TABLE 6i.—NEW HIV-RELATED CONDITIONS NECESSARY FOR ASSIGNMENT TO MDC 25—Continued

Diagnosis code	Description	Major
580.0—583.9.....	Nephritis & nephropathy.	No.

BILLING CODE 4120-03-M

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEL V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28141	17.3258	5	7	12	21	35
002	5878	16.4376	4	7	12	20	33
003	4	16.7500	3	3	6	17	41
004	5123	14.5227	3	6	10	18	30
005	45677	7.1275	3	4	5	8	13
006	1114	2.8878	1	1	2	3	6
007	5829	22.8377	2	6	12	24	51
008	3063	5.1783	1	1	3	6	11
009	1757	10.9425	2	4	7	13	22
010	19633	11.3779	2	4	8	14	24
011	3919	6.4953	2	4	5	8	13
012	22221	10.5921	1	4	7	12	20
013	5453	9.0081	2	4	7	12	15
014	328359	10.3219	2	4	7	12	20
015	133739	5.5168	2	3	4	7	10
016	11269	9.4504	3	4	7	11	18
017	3513	5.9200	2	3	5	7	11
018	13326	8.0848	2	4	6	10	15
019	7410	5.3328	1	4	4	7	10
020	7233	12.5615	2	5	9	16	26
021	902	10.2328	3	5	7	12	19
022	9960	5.8892	2	3	4	7	10
023	3403	6.6300	2	3	4	7	10
024	52771	7.7145	1	2	5	8	13
025	23810	4.5736	1	2	3	5	15
026	49	4.4082	1	2	3	5	8
027	2652	8.2960	1	2	3	5	8
028	7764	9.6807	1	2	3	5	19
029	3773	4.9056	1	2	3	5	20
030	1	2.0000	2	2	3	6	10
031	3957	6.6123	1	2	3	6	2
032	3155	3.7420	1	2	2	4	2
034	12945	8.7650	1	2	3	4	13
035	3969	5.4916	2	2	3	4	7
036	21279	2.5704	1	2	3	4	18
037	2916	4.5055	1	2	2	3	10
038	866	2.7252	1	2	2	3	4
039	12974	1.8935	1	1	2	3	10
040	4021	3.1423	1	1	1	2	5
042	22180	2.7146	1	1	2	3	3
043	218	4.4633	1	1	2	3	8
044	2134	6.9817	2	2	2	3	5
045	2708	4.5000	3	4	5	8	7
046	2976	6.0225	1	2	4	6	12
047	2153	4.4320	1	2	4	6	8
048	2	8.0000	1	1	3	5	12
049	3890	11.1746	6	1	4	8	12
050	5331	2.8379	2	4	10	10	8
051	682	2.8871	1	1	7	14	10
052	184	3.7935	1	1	2	3	24
053	7686	3.1275	1	1	2	3	5
						4	6
						4	7
						3	7

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEL V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	4589	2.7400	1	1	1	2	5
056	1475	2.6902	1	1	1	3	6
057	727	5.5818	1	2	3	7	13
059	221	2.1357	1	1	1	2	4
061	397	4.6700	1	1	2	5	11
063	5054	6.1645	1	2	4	7	12
064	4871	9.1513	1	2	5	11	21
065	30842	4.1830	1	2	3	5	8
066	8590	4.1759	1	2	3	5	7
067	454	5.3744	2	3	4	7	10
068	17938	6.2194	2	3	5	7	11
069	6366	4.6376	2	3	4	6	8
070	35	4.6571	1	2	3	4	7
071	156	6.2244	2	3	5	7	13
072	699	4.8126	1	2	3	6	10
073	7250	6.0946	1	2	4	8	12
075	30657	14.1456	6	8	11	17	26
076	37659	14.8938	4	7	11	18	29
077	3893	6.8723	1	2	5	9	15
078	26199	10.3289	4	7	9	12	17
079	126283	12.2576	4	6	9	15	23
080	10195	8.3687	3	5	7	10	15
081	7	5.8571	1	4	6	7	8
082	71844	9.6758	2	4	7	12	20
083	7624	8.1737	2	4	6	10	15
084	2100	5.1362	1	2	4	6	9
085	16960	9.0550	2	4	7	11	18
086	2086	5.6598	2	3	5	7	11
087	67497	8.3852	2	4	7	10	16
088	135897	7.4992	3	4	6	9	14
089	388553	8.9597	3	5	7	11	16
090	54952	6.4239	3	4	6	8	11
091	42	5.5000	2	2	4	8	11
092	9049	8.9876	3	4	7	11	17
093	1600	6.6919	2	4	5	8	12
094	9290	9.3473	3	4	7	12	18
095	1352	5.6723	2	3	4	7	10
096	195210	7.2506	3	4	6	9	13
097	39444	5.3905	2	3	5	7	9
098	13	6.6923	2	2	4	7	11
099	32601	5.6143	2	2	4	7	11
100	11793	3.1984	1	2	3	4	6
101	20302	7.1835	2	2	5	9	14
102	4378	4.4928	1	3	5	6	9
103	213	36.0751	13	16	24	40	72
104	15396	22.5103	9	13	18	26	40
105	14588	16.2850	8	9	12	18	29
106	59869	15.7204	8	10	13	18	24
107	58583	13.9087	7	8	10	15	23
108	7961	16.6652	7	9	13	19	30
110	48020	14.5613	3	8	11	17	27

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEL V8.0

DRG	NUMBER DISCHARGE	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
111	723	8.9137	3	7	8	11	14
112	10306	6.4285	2	3	5	8	13
113	3634	19.4200	6	9	14	23	38
114	855	12.6688	3	6	10	15	24
115	738	14.4519	6	8	12	17	25
116	60126	7.5439	2	3	6	9	14
117	3297	5.6157	1	2	4	7	11
118	7893	4.3808	1	1	2	5	9
119	3731	6.1991	1	2	3	7	15
120	33071	12.9084	2	3	8	17	29
121	133199	10.0125	4	6	9	12	17
122	100409	7.2618	2	5	7	9	12
123	55918	5.5010	1	1	3	7	13
124	109838	5.9303	1	2	5	8	12
125	92468	3.1572	1	1	2	4	7
126	3902	21.8877	5	10	18	30	42
127	573627	7.9115	3	4	6	10	15
128	25346	8.5501	4	6	8	10	14
129	6831	4.6708	1	1	1	6	12
130	67163	8.2349	2	4	7	10	15
131	27248	6.0204	1	3	6	8	11
132	19818	6.3214	1	3	5	8	12
133	7067	4.8306	1	2	4	6	9
134	30666	5.1585	2	3	4	6	9
135	6538	7.0769	2	3	5	8	13
136	1524	4.2172	1	2	3	5	8
138	176411	6.0765	2	3	5	7	11
139	72525	3.8787	1	2	3	5	7
140	352655	4.6265	2	2	3	5	8
141	77089	5.8089	2	3	4	6	10
142	39455	3.9772	1	2	3	5	7
143	111106	3.4387	1	2	3	4	7
144	54371	7.3845	2	3	5	8	15
145	7920	4.3747	1	2	3	5	8
146	7026	14.3971	8	9	12	16	23
147	1891	9.7726	6	8	12	16	23
148	136231	16.7452	7	9	13	19	30
149	19974	9.7219	6	8	11	17	25
150	20678	14.0620	6	8	11	17	25
151	5440	8.0574	3	5	7	10	13
152	4524	10.7580	4	6	9	12	19
153	2328	7.4330	4	6	9	12	19
154	39225	18.9067	6	9	14	22	36
155	4908	9.1261	4	6	8	11	15
156	3	14.3333	8	8	12	23	36
157	13921	6.6665	2	3	5	8	13
158	11894	3.1696	1	2	2	4	6
159	15775	6.5431	2	3	5	8	12
160	13700	3.6055	1	2	3	5	7
161	27773	4.6288	1	2	3	5	9
162	29809	2.2909	1	1	2	3	9

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEE V8.0

DRC	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
163	12	4.9167	1	2	4	7	10
164	4556	11.6247	5	7	10	13	19
165	1962	7.5759	4	5	7	9	11
166	2636	7.5850	3	4	6	9	13
167	2272	4.4159	2	3	4	5	7
168	2073	6.6686	1	2	4	7	15
169	1757	2.7473	1	1	2	3	6
170	12428	16.5200	3	7	12	20	33
171	1562	7.4360	1	3	6	9	15
172	31570	10.4474	2	4	7	13	21
173	3771	5.4699	1	2	4	7	13
174	152332	7.1088	2	4	5	8	15
175	24567	4.5184	2	3	4	6	8
176	12775	7.8233	2	4	6	9	15
177	16391	6.3252	2	3	5	8	11
178	7258	4.5229	2	3	4	6	8
179	8047	9.5687	3	5	7	11	18
180	64580	7.7639	2	4	6	9	15
181	23146	4.6893	2	3	4	6	8
182	253981	6.3948	2	3	5	8	15
183	80631	4.3387	1	2	4	6	8
184	54	3.6111	1	2	3	5	8
185	4084	6.2835	1	2	4	6	13
186	1	6.0000	6	6	6	6	6
187	1334	3.5810	1	1	2	4	8
188	47885	7.4467	2	3	5	9	15
189	10073	3.9165	1	1	3	5	8
190	133	5.4436	1	3	4	7	10
191	10903	20.5709	7	10	15	25	40
192	1229	10.3727	4	6	9	12	18
193	12957	16.9577	7	10	14	20	30
194	1788	10.4687	4	7	9	13	18
195	19487	12.5946	6	8	10	15	21
196	2572	8.4094	4	6	8	10	13
197	64326	9.6110	4	5	8	11	17
198	40048	5.3002	2	3	5	6	9
199	2941	15.4736	5	7	12	20	30
200	1744	14.5619	2	5	10	18	30
201	5104	12.7406	3	5	9	16	26
202	14977	9.9615	2	5	8	12	20
203	29572	9.9080	2	4	7	10	15
204	36616	8.1248	2	4	6	10	15
205	20815	9.4383	2	4	7	12	19
206	2688	5.2541	1	2	4	7	11
207	36720	7.2421	2	3	6	9	14
208	14585	4.1531	1	2	3	5	8
209	246252	11.2919	6	8	10	13	17
210	107491	13.8498	6	8	11	15	23
211	32422	10.1980	5	7	9	12	16
212	15	6.1333	2	2	5	6	12
213	5655	13.3500	3	6	10	16	26

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEL V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
214	36977	11.3735	4	6	9	13	21
215	36567	6.8865	3	4	6	8	12
216	5341	14.6267	2	5	11	19	31
217	15458	22.2730	4	8	15	28	48
218	16901	9.5549	3	5	7	11	18
219	18079	5.8526	2	3	5	7	10
220	7	4.7143	1	2	3	7	7
221	4443	11.3783	2	4	8	14	23
222	5804	5.4747	1	2	4	7	11
223	13395	4.4118	1	2	3	5	8
224	8649	3.0502	1	2	3	4	5
225	11375	5.1714	1	2	3	6	11
226	5341	9.6130	2	3	6	12	21
227	7187	4.0710	1	2	3	5	8
228	4832	3.9191	1	1	2	4	8
229	3146	2.7521	1	1	2	3	5
230	3543	6.8868	1	2	4	8	15
231	9590	6.7581	1	2	4	8	16
232	746	7.5764	1	2	3	9	19
233	6077	12.9184	3	6	9	15	26
234	4098	6.3624	1	3	5	8	12
235	6211	12.5007	2	4	7	14	29
236	38080	9.4200	2	4	7	11	18
237	1704	6.1408	2	3	7	11	12
238	6194	14.3629	4	7	11	17	29
239	5981	10.3142	3	5	8	13	20
240	10987	9.9253	3	4	7	12	19
241	4385	5.9628	2	3	5	7	11
242	2407	11.5393	3	5	8	14	23
243	114143	6.8385	2	3	5	9	13
244	11271	7.7279	2	3	6	9	14
245	6289	5.3916	1	3	4	7	10
246	1847	5.8522	2	3	4	7	11
247	9722	5.0947	1	2	4	6	10
248	6327	6.4113	2	3	5	8	12
249	7923	6.6915	1	2	4	8	14
250	3473	6.6977	1	3	5	8	13
251	3634	3.5055	1	1	2	4	7
252	16784	8.4305	2	3	6	10	16
253	13598	4.9799	1	2	4	6	9
254	1	7.0000	7	7	7	7	7
255	9446	5.6161	1	2	4	6	11
256	27708	5.6140	2	3	5	6	9
257	27130	4.0376	2	3	4	6	9
258	3748	6.3807	1	2	4	6	13
259	4486	2.8433	1	2	4	7	13
260	3428	2.7932	1	2	2	3	5
261	1652	2.9401	1	1	2	3	5
262	25993	22.1390	5	9	15	26	44
263	4698	12.0385	3	5	9	15	25
264	4935	10.1457	2	3	6	12	22

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
266	4698	4.4085	1	2	3	6	9
267	431	4.5499	1	1	3	5	10
268	1578	4.5311	1	1	2	4	9
269	10481	12.3345	2	4	9	15	25
270	5281	4.4194	1	2	3	5	9
271	19459	12.5254	3	6	9	14	23
272	6972	9.7724	3	5	7	12	19
273	2572	7.3223	2	3	6	9	15
274	3465	10.3172	2	4	7	13	22
275	471	4.9130	1	2	3	6	10
276	896	5.6239	1	2	3	7	10
277	65941	8.7339	1	5	7	10	15
278	26013	6.4022	3	4	5	8	11
279	5	4.0000	2	2	3	4	9
280	13427	6.6226	2	3	5	8	13
281	8294	4.4697	1	2	3	5	8
283	5757	7.3385	2	3	5	8	13
284	2685	4.8060	1	2	3	6	9
285	4310	21.0865	6	9	15	25	42
286	1693	12.5960	5	8	13	23	41
287	6026	20.3699	5	8	13	24	41
288	501	11.0439	3	4	6	10	13
289	3810	5.9320	2	2	3	6	9
290	9331	3.8226	1	2	3	4	6
291	149	2.1342	1	1	2	2	4
292	4678	18.1849	4	7	13	22	36
293	554	8.0722	1	3	6	10	17
294	92585	7.5243	3	4	6	9	13
295	3338	6.0171	2	3	4	7	11
296	203493	8.5379	2	4	6	10	16
297	47168	5.3091	2	3	4	6	9
298	83	3.7952	1	1	3	5	9
299	834	7.3141	1	3	5	9	15
300	11378	9.4960	3	4	7	11	18
301	2155	5.6891	2	2	4	7	10
302	6705	16.6095	8	9	13	19	28
303	17273	14.0262	6	8	11	16	24
304	14567	13.7706	4	7	10	16	26
305	3936	6.8885	2	3	6	9	13
306	12181	9.3183	2	3	7	12	18
307	4700	4.9370	2	3	4	6	9
308	10293	9.6735	2	3	7	12	20
309	4766	4.3021	1	2	3	5	9
310	35591	5.7590	1	2	4	7	11
311	21389	2.8431	1	1	2	4	5
312	3542	5.8732	1	2	4	7	12
313	2255	2.8590	1	1	2	3	6
314	4	6.0000	1	1	2	3	8
315	26896	12.8539	1	3	6	16	28
316	47333	9.3754	2	4	7	12	19
317	1066	4.1623	1	1	2	4	8

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEE V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
318	6964	9.0872	2	3	6	11	19
319	1100	3.9945	1	1	2	5	8
320	155031	8.6488	3	4	7	10	15
321	30764	5.9310	2	3	5	7	10
322	45	5.8444	2	3	4	7	11
323	23662	4.1086	1	2	3	5	8
324	12373	2.6194	1	1	2	3	5
325	3921	6.0045	2	3	4	7	11
326	4130	3.8363	1	2	3	5	8
327	5	4.6000	1	1	2	3	5
328	1445	5.2145	1	2	3	5	8
329	345	2.7420	1	1	2	3	5
331	28059	7.6003	2	3	6	9	16
332	6536	4.3623	1	2	3	5	8
333	313	7.0032	1	2	3	5	8
334	15782	10.0523	6	7	9	11	16
335	8878	7.8613	5	6	7	9	11
336	103547	6.1651	3	3	4	5	6
337	90508	4.0558	2	3	4	5	6
338	8357	5.3437	1	1	2	3	5
339	3790	4.4071	1	1	2	3	5
340	1	2.0000	2	2	2	2	2
341	14578	4.4113	1	2	3	5	8
342	540	4.2111	1	2	3	5	8
343	1	2.0000	2	2	2	2	2
344	3981	6.0829	2	3	5	7	11
345	2597	5.0181	1	2	3	5	8
346	8506	8.6403	2	3	6	9	16
347	1175	4.1217	1	1	2	3	5
348	4409	5.7151	1	2	3	5	8
349	2030	3.0645	1	1	2	3	5
350	8113	5.9733	2	3	5	7	11
351	4	4.2500	3	3	4	5	6
352	922	4.7397	1	2	3	5	8
353	2284	13.1125	5	7	10	13	23
354	8605	8.7555	4	5	7	9	15
355	6193	5.4053	4	4	5	6	8
356	29357	4.6865	2	3	4	5	7
357	6818	12.7077	5	7	10	13	23
358	20312	7.0048	4	4	5	6	8
359	26844	4.9217	3	4	5	6	8
360	9043	5.4823	2	3	4	5	7
361	344	5.3081	1	2	3	5	8
363	5109	4.7751	1	2	3	5	8
364	2932	3.7190	1	1	2	3	5
365	3642	10.9561	3	4	5	6	8
366	5252	10.2039	2	3	4	5	7
367	974	4.3018	1	2	3	5	8
368	1473	7.8391	3	4	5	6	8
369	2686	4.7450	1	2	3	5	8
370	593	8.0523	3	4	5	6	8

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	5TH PERCENTILE	90TH PERCENTILE
37	736	4.3628	3	3	4	5	6
372	372	4.9194	2	2	3	5	10
373	2451	2.5451	1	2	2	3	3
374	83	3.0241	2	2	2	3	5
375	7	4.0000	2	2	3	4	5
376	136	3.7353	1	2	2	4	7
377	28	5.8571	1	1	3	7	13
378	149	4.3087	2	3	4	5	6
379	239	3.0544	1	1	2	3	6
380	66	1.9242	1	1	2	2	3
381	238	2.1176	1	1	1	2	4
382	70	1.4429	1	1	1	1	3
383	865	4.4486	1	2	3	6	8
384	115	3.0522	1	1	2	4	6
385	1	5.0000	5	5	5	5	5
389	25	8.4800	2	4	6	10	16
390	22	6.0909	1	2	5	14	14
391	2	2.0000	2	2	2	2	2
392	2365	15.4063	5	7	11	19	30
393	1	11.0000	11	11	11	11	11
394	2079	10.6647	1	2	6	13	24
395	72427	6.5510	2	3	5	8	13
396	18	4.3889	1	1	2	4	11
397	11656	7.6703	2	3	6	9	15
398	13797	8.6625	3	4	7	10	16
399	2009	5.5162	1	2	4	7	10
400	7862	14.1110	3	6	10	17	30
401	6390	15.2219	3	6	11	19	31
402	2695	5.4134	1	2	4	7	12
403	27125	11.9599	2	5	8	15	25
404	5874	5.7819	1	2	4	8	12
405	3	13.0000	3	3	16	20	20
406	3898	14.9151	4	7	11	19	31
407	1169	6.7066	2	4	6	8	12
408	6695	7.2877	1	2	4	8	16
409	7091	9.8284	2	4	5	13	22
410	135763	3.6130	1	2	3	5	6
411	208	4.3269	1	1	2	4	8
412	253	2.9842	1	1	2	3	7
413	10243	11.0914	2	4	8	14	23
414	2239	6.8057	1	2	4	8	14
415	26657	21.0096	5	9	15	26	42
416	125116	10.6382	2	5	8	13	20
417	30	6.3000	2	3	6	10	16
418	13267	8.4852	3	4	7	9	14
419	16839	7.6475	2	4	6	7	10
420	4047	5.5869	2	3	4	7	10
421	14773	5.6748	2	3	4	7	10
422	109	5.5321	2	3	4	7	10
423	6619	11.847C	3	5	8	14	24
424	2922	23.6485	2	7	15	27	47

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
425	17513	6.8859	2	3	5	8	14
426	6868	7.8308	2	3	5	9	16
427	1953	7.8551	2	3	5	10	18
428	1180	10.7924	2	4	7	13	24
429	30019	12.3399	3	4	7	13	23
430	57140	12.7816	3	5	9	16	26
431	301	9.1751	2	3	6	11	20
432	532	6.8684	1	2	4	7	18
433	5718	4.6884	1	1	3	6	11
434	18621	8.0887	2	3	5	9	17
435	13262	7.0013	2	3	5	8	15
436	2297	19.1615	6	12	20	28	29
437	9721	17.6113	6	10	16	25	29
439	1036	11.8137	1	3	7	13	27
440	4445	13.9170	2	4	9	17	30
441	860	3.5709	1	1	2	4	7
442	10933	10.4148	1	3	7	13	22
443	5269	4.0096	1	1	3	5	9
444	4231	7.1227	2	3	5	8	13
445	2659	4.7853	1	2	4	6	9
446	2	2.5000	2	2	3	3	3
447	3063	3.5573	1	1	2	4	7
448	1	61.0000	61	61	61	61	61
449	29661	6.0364	1	2	4	7	12
450	8448	3.5297	1	1	2	4	7
451	5	3.0000	1	1	2	4	5
452	16342	6.3113	1	2	4	7	13
453	6128	3.7887	1	2	3	5	7
454	4103	7.5447	1	2	4	8	15
455	1235	3.6672	1	1	2	4	7
456	210	11.5095	1	2	6	13	27
457	166	6.0904	1	1	2	10	15
458	1724	23.5737	5	10	18	30	48
459	565	15.7699	3	6	11	19	31
460	2563	9.2790	2	4	7	11	19
461	6496	5.1178	1	1	2	4	12
462	6386	18.4519	5	9	16	24	35
463	9564	6.8439	2	3	5	8	13
464	3239	4.2513	1	2	3	5	8
465	690	2.8552	1	1	2	3	6
466	4161	5.5064	1	1	2	5	11
467	3804	5.0862	1	1	2	4	9
468	64577	19.4401	4	8	15	24	38
471	6195	15.7525	8	13	21	31	41
472	219	37.7352	4	10	18	27	41
473	8464	17.3004	2	6	11	18	28
475	75736	14.3178	2	6	11	21	31
476	11275	17.7970	7	10	14	21	31
477	36764	10.6450	1	3	7	13	23
478	96399	11.0903	2	4	8	14	23
479	21541	5.9588	1	3	5	8	11

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
ELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V8.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
480	32	51.7813	13	15	38	66	128
481	55	41.2909	20	28	37	48	71
482	5845	17.9211	6	9	13	20	32
483	25702	52.2390	15	25	41	64	95
484	296	23.8345	2	8	20	33	48
485	1642	18.7533	7	9	13	21	34
486	2378	18.3768	2	8	13	22	37
487	2662	11.4159	2	5	9	14	23
488	357	22.7255	6	11	19	29	43
489	2639	14.5047	3	6	10	17	29
490	1274	9.4199	1	3	5	11	19

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEUR V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28140	17.3257	5	7	12	21	35
002	5871	16.4272	4	7	12	20	33
003	4	16.7500	3	3	6	17	41
004	5121	14.5202	3	6	10	18	30
005	45677	7.1275	3	4	5	8	13
006	1114	2.8878	1	1	2	3	6
007	5835	22.8161	2	6	12	24	51
008	3056	5.1810	1	1	3	6	11
009	1757	10.9425	2	4	7	13	22
010	19636	11.3844	2	4	8	14	24
011	3916	6.4591	1	4	8	14	13
012	22221	10.5921	2	4	7	12	20
013	5453	9.0081	3	4	7	10	15
014	328359	10.3219	2	4	7	12	20
015	133739	5.5168	2	3	4	7	10
016	11251	9.4609	3	4	7	11	18
017	3531	5.9046	2	3	5	7	11
018	13289	8.0923	2	4	7	10	15
019	7445	5.3316	1	4	6	7	10
020	7231	12.5629	2	5	9	16	26
021	902	10.2328	3	5	7	12	19
022	9960	5.8892	2	3	4	7	10
023	3403	6.6300	1	3	5	8	13
024	52587	7.7293	2	3	5	9	15
025	23984	4.5640	1	2	3	5	8
026	49	4.4082	1	2	3	5	8
027	2644	8.2924	1	2	5	10	19
028	7730	9.7026	1	3	6	12	20
029	3782	4.9014	1	2	3	6	10
030	1	2.0000	2	2	2	2	2
031	3948	6.6175	1	2	4	8	13
032	3164	3.7437	1	2	3	4	7
034	12926	8.7686	2	3	6	10	18
035	3988	5.4955	1	2	4	7	10
036	21279	2.5704	1	1	2	3	4
037	2916	4.5055	1	2	3	5	10
038	866	2.7252	1	1	2	3	5
039	12974	1.8935	1	1	1	2	3
040	4021	3.1423	1	1	2	3	8
042	22180	2.7146	1	1	2	3	5
043	218	4.4533	2	2	4	5	7
044	2134	6.9817	3	4	5	8	12
045	2708	4.5000	1	2	4	8	12
046	2969	6.0263	1	2	4	8	12
047	2161	4.4308	1	1	3	5	8
048	2	8.0000	6	6	10	14	24
049	3890	11.1746	2	4	7	14	24
050	5331	2.8379	1	1	2	3	5
051	682	2.8871	1	1	2	3	6
052	184	3.7935	1	1	2	3	7
053	7686	3.1275	1	1	2	3	7

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	4589	2.7400	1	1	1	2	5
056	1475	2.6902	1	1	1	3	6
057	727	5.5818	1	2	3	7	13
059	221	2.1357	1	1	1	2	4
061	397	4.6700	1	1	2	5	11
063	5054	6.1646	1	2	4	7	12
064	4871	9.1513	1	2	5	11	21
065	30842	4.1830	1	2	3	5	8
066	8590	4.1759	1	2	3	5	7
067	454	5.3744	2	3	4	7	10
068	17866	6.2260	2	3	5	7	11
069	6438	4.6368	2	3	4	6	11
070	35	4.6571	2	3	4	6	8
071	156	6.2244	2	3	5	7	13
072	699	4.8126	2	3	4	7	10
073	7250	6.0946	2	3	5	8	12
075	30656	14.1444	1	6	11	17	26
076	37638	14.8958	4	7	11	18	29
077	3886	6.8183	4	7	11	18	24
078	26199	10.3289	4	7	11	18	24
079	126078	12.2573	4	7	11	18	24
080	10270	8.3759	3	5	9	15	23
081	7	5.8571	1	4	7	10	15
082	71844	9.6758	2	4	6	12	20
083	7617	8.1767	2	4	6	12	15
084	2107	5.1353	2	4	6	10	9
085	16941	9.0609	2	4	7	11	18
086	2115	5.6430	2	4	7	11	11
087	67497	8.3952	2	4	7	10	16
088	135897	8.9614	3	4	6	9	14
089	388112	7.4992	3	4	6	11	16
090	55225	6.4234	3	4	6	11	11
091	42	5.5000	2	4	6	8	11
092	9036	8.9696	3	4	7	11	17
093	1613	6.6993	2	4	6	11	17
094	9260	9.3541	2	4	6	12	18
095	1379	5.6911	2	4	6	12	10
096	194708	7.2539	2	4	6	12	13
097	39946	5.3982	2	4	6	9	9
098	13	6.6923	2	4	6	7	11
099	32498	5.6175	2	4	6	7	11
100	11896	3.2114	2	4	6	7	6
101	20283	7.1869	2	4	6	9	14
102	4397	4.4883	2	4	6	9	9
103	213	36.0751	1	16	24	40	72
104	15396	22.5103	9	13	18	26	40
105	14598	16.2850	8	9	12	18	29
106	58865	15.7204	8	10	13	18	24
107	58583	13.9087	7	8	10	15	23
108	7961	16.6652	7	8	10	15	23
110	47955	14.5721	3	8	11	17	27

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENT*	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
111	7211	8.9118	3	7	8	11	14
112	103153	8.4287	2	3	5	8	13
113	36342	19.4208	6	9	14	23	38
114	8561	12.6688	3	6	10	16	24
115	7380	14.4519	6	8	12	17	25
116	60126	7.5439	2	3	6	9	14
117	3297	5.6157	1	2	4	7	11
118	7893	4.3808	1	1	2	5	9
119	3731	6.1991	1	2	3	7	15
120	33071	12.9064	2	3	8	17	29
121	133199	10.0125	4	6	9	12	17
122	100409	7.2618	2	5	7	9	12
123	55918	5.5010	1	1	3	7	13
124	109938	5.9303	1	2	5	8	12
125	92468	3.1572	1	1	2	4	7
126	3884	21.8718	5	10	18	30	42
127	573627	7.9115	3	6	8	10	15
128	25346	8.5501	4	6	8	10	14
129	6831	4.6708	1	1	1	6	12
130	67455	8.2319	2	4	7	10	15
131	26956	6.0039	1	3	6	8	11
132	12923	5.5824	1	2	4	7	10
133	4578	4.4045	1	2	3	5	7
134	30666	5.1585	2	3	4	6	9
135	6530	7.0816	2	3	5	8	13
136	1532	4.2121	1	2	3	5	8
138	176131	6.0792	2	3	5	7	11
139	72805	3.8805	1	2	3	5	7
140	352856	4.6265	2	2	4	6	8
141	76938	5.8130	2	3	4	7	10
142	38606	3.9764	1	2	3	5	7
143	111108	3.4387	1	2	3	4	6
144	61208	7.4233	2	3	6	9	15
145	10464	4.6673	1	2	3	5	9
146	7016	14.4059	8	9	12	16	24
147	1901	9.7643	6	8	9	11	14
148	133987	16.7552	7	9	13	19	30
149	20318	8.7397	6	7	9	11	14
150	20552	14.0668	6	8	11	17	25
151	5466	8.0675	3	5	7	10	13
152	4514	10.7638	4	6	9	12	19
153	2338	7.4358	4	5	7	9	11
154	39172	18.9199	6	9	14	22	36
155	4961	9.1264	4	6	8	11	15
156	3	14.3333	8	8	12	23	23
157	13890	6.6734	2	3	5	8	13
158	11925	3.1707	1	2	2	4	6
159	15759	6.5473	2	3	5	8	12
160	13716	3.6040	1	2	3	5	7
161	27683	4.6369	1	2	3	5	9
162	29399	2.2913	1	1	2	3	4

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
163	12	4.9167	1	2	4	7	10
164	4557	11.6230	5	7	10	13	19
165	1961	7.5778	4	5	7	9	11
166	2628	7.5909	3	4	6	9	13
167	2280	4.4202	2	3	4	5	7
168	2062	6.6945	1	2	4	7	15
169	1768	2.7415	1	1	2	3	6
170	12423	16.5287	3	7	12	20	33
171	1567	7.3957	1	3	6	9	15
172	31557	10.4493	2	3	7	13	21
173	3784	5.4704	1	2	4	7	11
174	151196	7.1197	2	2	5	8	13
175	25703	4.5689	2	3	4	6	8
176	12775	7.8233	2	3	4	6	15
177	15979	6.3652	2	3	5	8	11
178	7670	4.5362	2	3	4	6	8
179	8047	9.5687	3	5	7	11	18
180	64435	7.7725	2	4	6	9	15
181	23391	4.6978	2	3	4	6	8
182	252919	6.4020	2	3	4	6	15
183	81693	4.3431	1	2	3	5	8
184	54	3.6111	1	2	3	4	5
185	4084	6.2835	1	2	3	4	13
186	1	6.0000	6	6	6	6	6
187	1334	3.5810	1	1	2	4	8
188	47781	7.4524	2	3	5	9	15
189	10177	3.9257	1	1	3	5	8
190	133	5.4436	1	3	4	7	10
191	10901	20.5765	7	10	15	25	40
192	1231	10.3404	4	6	9	12	18
193	12818	16.9673	7	10	14	20	30
194	1771	10.5370	4	7	9	13	18
195	19507	12.6046	6	8	10	15	21
196	2586	8.4169	4	6	8	10	13
197	64265	9.6255	4	5	8	11	17
198	40231	5.3100	2	3	5	6	9
199	2941	15.4736	5	7	12	20	30
200	1744	14.5619	2	5	10	18	30
201	5104	12.7406	3	5	9	16	26
202	14977	9.9515	2	4	8	12	20
203	29572	9.9080	2	4	7	13	20
204	36616	8.1248	2	4	6	10	15
205	20778	9.4421	2	4	7	12	19
206	2725	5.2826	1	2	4	7	11
207	36546	7.2530	2	3	6	9	14
208	14759	4.1625	1	2	3	5	8
209	240458	11.3931	6	8	10	13	17
210	106128	13.8161	6	8	11	15	23
211	32049	10.1703	5	7	9	12	16
212	16	5.7500	1	2	5	6	7
213	5630	13.3172	3	6	10	16	26

TABLE 78 - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
214	35941	11.3791	4	6	9	13	21
215	38594	6.8823	3	4	6	8	12
216	7168	14.8963	3	6	11	19	31
217	15457	22.2735	4	8	15	28	48
218	16559	9.5443	3	5	11	11	18
219	17568	5.6153	2	3	5	7	10
220	7	4.7143	1	2	3	7	7
221	4878	11.2612	2	5	8	14	23
222	6030	5.5277	1	2	4	7	11
223	13413	4.4091	1	2	3	5	8
224	8632	3.0514	1	2	3	4	5
225	11375	5.1714	1	2	3	4	11
226	5345	9.6362	2	3	6	12	21
227	7183	4.0500	1	2	3	5	8
228	4839	3.9149	1	1	2	4	5
229	3139	2.7560	1	1	2	3	14
230	3527	6.8665	1	2	4	8	16
231	9578	6.7587	1	2	3	9	19
232	746	7.5764	1	2	3	15	26
233	6078	12.9210	3	6	9	18	12
234	4098	6.3599	1	3	5	8	29
235	8210	12.5018	2	4	7	14	12
236	38079	9.4202	2	4	7	11	18
237	1704	6.1408	2	3	4	7	12
238	6184	14.3629	4	7	11	17	29
239	5881	10.3142	3	5	8	13	20
240	10939	9.9284	3	4	7	12	19
241	4413	5.9803	2	3	5	7	11
242	2407	11.5393	3	5	8	14	23
243	114134	6.8384	2	3	5	9	13
244	11265	7.7269	2	3	6	9	14
245	6295	5.3957	1	3	4	7	10
246	1847	5.8522	2	3	4	7	11
247	9722	5.0947	1	2	4	8	10
248	6327	6.4113	2	3	5	8	12
249	7923	6.6915	1	2	4	8	14
250	3486	6.7002	1	2	5	8	13
251	3640	3.5099	1	1	2	4	7
253	16791	8.4184	2	3	6	10	16
254	13590	4.9929	1	2	4	6	9
255	1	7.0000	1	2	4	7	7
256	9246	5.6161	1	2	4	6	11
257	27707	5.6150	2	3	5	6	9
258	27132	4.0367	2	3	4	5	6
259	3748	6.3826	1	2	4	7	13
260	4486	2.8417	1	2	4	3	5
261	3428	2.7932	1	1	2	3	5
262	1652	2.9401	1	1	2	3	6
263	25981	22.1450	5	9	15	26	44
264	4710	12.0314	3	5	9	15	25
265	4927	10.1551	2	3	7	12	22

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TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
266	4706	4.4084	1	2	3	6	9
267	431	4.5499	1	1	3	5	10
268	1578	4.5311	1	1	2	4	9
269	10457	12.3856	2	4	9	15	25
270	5311	4.4265	1	2	3	5	9
271	19459	12.5254	3	6	9	14	23
272	7048	9.8527	3	5	7	12	19
273	2498	7.0208	3	3	5	8	14
274	3465	10.3172	2	4	7	13	22
275	471	4.9130	1	2	3	6	10
276	896	5.6239	1	2	4	7	10
277	65676	8.7557	3	5	7	10	15
278	26278	6.3713	3	4	5	8	11
279	5	4.0000	2	2	3	4	9
280	13421	6.8174	2	3	5	8	13
281	8300	4.4796	1	2	3	5	8
283	5765	7.3778	2	3	5	8	14
284	2714	4.8165	1	2	3	5	9
285	4310	21.0865	6	9	15	25	42
286	1693	12.5960	5	8	13	23	41
287	6026	20.3699	5	8	13	23	41
288	501	11.0439	3	4	6	10	13
289	3810	5.9320	2	2	3	4	6
290	9331	3.8226	1	2	2	3	4
291	149	2.1342	1	1	2	2	3
292	4667	18.2023	4	7	13	22	36
293	565	8.1257	1	3	6	11	17
294	92585	7.5243	3	4	6	11	13
295	3338	6.0171	2	3	4	7	11
296	202509	8.5557	2	3	6	10	15
297	48152	5.2999	2	3	4	6	10
298	83	3.7952	1	1	3	5	9
299	834	7.3141	1	3	5	9	15
300	11368	9.4962	3	4	7	11	18
301	2165	5.7058	2	2	4	7	10
302	6705	16.6095	8	9	13	19	28
303	17273	14.0262	6	8	11	16	24
304	14417	13.8455	4	7	10	16	24
305	4086	5.8769	2	3	5	9	13
306	12143	9.3273	3	4	7	12	18
307	4738	4.9491	2	3	4	6	9
308	10256	9.6895	2	3	7	12	20
309	4803	4.3092	1	2	3	5	9
310	34984	5.7871	1	2	3	4	11
311	21996	2.8788	1	1	2	4	5
312	3531	5.8816	1	2	4	7	12
313	2266	2.8605	1	1	2	3	6
314	4	6.0000	1	1	2	3	9
315	26895	12.8535	1	3	6	16	28
316	47333	9.3754	2	4	8	12	19
317	1066	4.1623	1	1	2	4	8

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
318	6955	9.0966	2	3	6	11	19
319	1109	3.9766	1	1	2	5	8
320	154713	8.6559	3	4	7	10	15
321	31082	5.9231	2	3	5	7	10
322	45	5.8444	2	3	4	7	11
323	21468	4.2504	1	2	3	5	9
324	14567	2.6347	1	1	2	3	5
325	9889	6.0153	2	3	4	7	11
326	4162	3.8275	1	2	3	5	9
327	5	4.6000	1	1	2	3	5
328	1442	5.2171	1	2	3	5	9
329	348	2.7529	1	1	2	3	5
331	27932	7.6051	2	3	6	11	19
332	6656	4.3993	1	2	3	5	9
333	313	7.0032	1	2	3	5	9
334	15754	10.0598	6	7	9	10	16
335	8906	7.8550	5	6	7	11	16
336	102987	6.1737	3	3	5	7	11
337	91068	4.0589	2	3	4	5	7
338	8357	5.3437	1	1	2	3	5
339	3790	4.4071	1	2	2	3	5
340	1	2.0000	1	1	2	2	3
341	14578	4.4113	1	2	2	3	5
342	540	4.2111	1	1	2	2	3
343	1	2.0000	2	2	2	2	3
344	3981	6.0829	2	2	3	5	9
345	2597	5.0181	1	2	3	5	9
346	8499	8.6457	2	3	6	11	19
347	1182	4.1091	1	1	2	3	5
348	4397	5.7228	1	2	3	5	9
349	2042	3.0637	1	1	2	3	5
350	8113	5.9733	2	3	5	9	16
351	4	4.2500	3	3	4	5	9
352	922	4.7397	1	2	3	5	9
353	2284	13.1125	5	7	10	14	23
354	8601	8.7581	4	5	7	10	15
355	6197	5.4039	4	4	5	6	8
356	29357	4.6865	2	3	4	5	7
357	6818	12.7077	5	7	10	15	23
358	20285	7.0069	4	4	6	8	11
359	26871	4.9223	3	4	5	6	7
360	9043	5.4823	2	3	4	5	7
361	344	5.3081	1	2	3	4	5
363	5109	4.7751	1	2	3	4	5
364	2932	3.7190	1	1	2	3	4
365	3642	10.8561	3	4	6	8	11
366	5243	10.2056	2	3	4	5	7
367	983	4.3469	1	2	3	4	5
368	1473	7.8391	3	4	6	8	11
369	2686	4.7450	1	2	3	4	5
370	590	8.0729	3	4	6	8	11

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEL V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
371	739	4.3613	3	3	4	5	6
372	372	4.9194	2	2	3	5	10
373	2451	2.5451	1	2	3	3	3
374	83	3.0241	2	2	2	3	5
375	7	4.0000	2	2	2	4	5
376	136	3.7353	1	2	2	4	7
377	28	5.8571	1	1	3	7	13
378	149	4.3087	2	3	4	5	6
379	239	3.0544	1	1	2	3	3
380	66	1.9242	1	1	1	2	4
381	238	2.1176	1	1	1	2	3
382	70	1.4429	1	1	1	1	3
383	865	4.4486	1	2	3	5	9
384	115	3.0522	1	1	2	4	6
385	1	5.0000	5	5	5	5	5
389	25	8.4800	2	4	5	10	16
390	22	6.0909	1	4	5	6	14
391	2	2.0000	2	2	2	2	2
392	2365	15.4063	5	7	11	19	30
393	1	11.0000	11	11	11	11	11
394	2079	10.6547	1	2	6	13	24
395	72427	6.5510	2	3	5	8	13
396	18	4.3889	1	1	2	4	11
397	11656	7.6703	2	3	6	9	15
398	13781	8.6654	3	4	7	10	16
399	2025	5.5210	1	2	4	7	10
400	7862	14.1110	3	6	10	17	30
401	6379	15.2275	3	6	11	19	31
402	2706	5.4401	1	2	4	7	12
403	27120	11.9631	2	5	8	15	25
404	5879	5.7724	1	2	4	8	12
405	3	13.0000	3	3	16	20	20
406	3903	14.9188	4	7	11	19	31
407	1184	6.6589	2	4	6	8	12
408	6695	7.2877	1	2	4	8	16
409	7091	9.8284	2	4	5	13	22
410	134772	3.5377	1	2	3	4	6
411	208	4.3269	1	1	2	4	8
412	253	2.9842	1	1	2	3	7
413	10233	11.1088	2	4	8	14	23
414	2249	6.7408	1	2	4	8	14
415	26657	21.0096	5	9	15	26	42
416	125116	10.6382	2	5	8	13	20
417	30	6.3000	2	3	6	8	10
418	13267	8.4852	3	4	7	10	16
419	16790	7.6529	2	4	6	9	14
420	4096	5.5891	2	3	4	7	10
421	14773	5.6748	2	3	4	7	10
422	109	5.5321	2	3	4	7	10
423	6619	11.8470	3	5	8	14	24
424	2922	23.6485	2	7	15	27	47

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPEL V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
425	17513	6.8859	2	3	5	8	14
426	6868	7.8308	2	3	5	9	16
427	1953	7.8561	2	3	5	10	18
428	1180	10.7924	2	4	7	13	23
429	30019	12.3399	3	4	7	13	24
430	57140	12.7816	3	5	9	16	26
431	301	9.1761	2	3	6	11	20
432	532	6.8684	1	2	4	7	16
433	5718	4.6884	1	1	3	6	11
434	18621	8.0887	2	3	5	9	17
435	13262	7.0013	2	3	5	8	15
436	2297	19.1615	6	12	20	28	29
437	9721	17.6113	6	10	16	25	29
439	1036	11.8137	1	3	7	13	27
440	4445	13.9170	2	4	9	17	30
441	860	3.5709	1	1	2	4	7
442	10932	10.4135	1	3	7	13	22
443	6269	4.0078	1	1	3	5	9
444	4202	7.1378	2	3	5	8	13
445	2688	4.7868	1	2	4	6	9
446	2	2.5000	2	2	3	3	3
447	3063	3.5573	1	1	2	4	7
448	1	61.0000	61	61	61	61	61
449	29608	6.0423	1	2	4	7	12
450	8501	3.5250	1	1	2	4	7
451	5	3.0000	1	1	2	4	5
452	16316	6.3213	1	2	4	7	13
453	6154	3.7727	1	2	4	7	13
454	4099	7.5482	1	2	4	7	15
455	1239	3.6683	1	2	4	8	15
456	210	11.5095	1	2	6	13	27
457	166	6.0904	1	2	6	13	27
458	1724	23.5737	5	10	18	30	48
459	565	15.7699	3	6	11	19	31
460	2563	9.2790	2	4	7	11	19
461	6496	5.1178	1	1	2	4	12
462	6386	18.4519	5	9	16	24	35
463	9544	6.8529	2	3	5	8	13
464	3259	4.2409	1	2	3	5	8
465	690	2.8652	1	1	2	3	6
466	4161	5.5064	1	1	2	3	6
467	3804	5.0862	1	1	2	3	6
468	64224	19.4700	4	8	15	24	38
471	6195	15.7525	8	13	21	31	41
472	219	37.7352	4	6	10	18	26
473	8464	17.3004	4	6	10	18	26
475	75719	14.3178	2	4	7	11	18
476	11279	17.7986	2	4	7	11	18
477	37103	10.6724	1	3	7	13	22
478	96459	11.0879	2	4	7	13	22
479	21471	5.9474	1	2	5	8	11

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY90 MEDPAR UPDATE 06/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
480	32	51.7813	13	15	38	66	128
481	55	41.2909	20	28	37	48	71
482	5845	17.9211	6	9	13	20	32
483	25702	52.2390	15	25	41	64	96
484	306	23.8039	2	8	20	33	48
485	2307	18.1747	7	9	13	20	32
486	1734	18.9764	1	7	14	24	41
487	2716	11.3262	2	5	9	14	23
488	392	22.8061	6	11	18	28	43
489	2941	14.3495	3	6	10	17	29
490	1278	9.3005	1	3	5	10	19
491	5734	7.0042	3	4	6	8	12
492	991	13.8628	2	4	6	23	35

BILLING CODE 4120-03-C

STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS

[Case weighted] August 1991

State	Urban	Rural
Alabama	0.4995	0.5379
Alaska	0.6487	0.8176
Arizona	0.5897	0.6283
Arkansas	0.6119	0.5807
California	0.5380	0.5736
Colorado	0.6030	0.6490
Connecticut	0.6971	0.7515
Delaware	0.6161	0.6342
District of Columbia	0.6683	—
Florida	0.5135	0.5233
Georgia	0.6040	0.5886
Hawaii	0.6040	0.7478
Idaho	0.6865	0.6897
Illinois	0.5803	0.6466
Indiana	0.6759	0.7134
Iowa	0.6720	0.7340
Kansas	0.6410	0.7170
Kentucky	0.5993	0.5820
Louisiana	0.5832	0.5821
Maine	0.7143	0.6601
Maryland	0.7666	0.7934
Massachusetts	0.7358	0.8902
Michigan	0.5749	0.6658
Minnesota	0.6625	0.7168
Mississippi	0.6132	0.5979
Missouri	0.5528	0.5769
Montana	0.6509	0.6899
Nebraska	0.6111	0.7094
Nevada	0.5008	0.7454
New Hampshire	0.6918	0.7069
New Jersey	0.7903	—
New Mexico	0.5416	0.5970
New York	0.6664	0.7204
North Carolina	0.6686	0.5961
North Dakota	0.7191	0.6878
Ohio	0.8501	0.6701
Oklahoma	0.5716	0.6182
Oregon	0.6366	0.6881
Pennsylvania	0.5311	0.5976
Puerto Rico	0.5270	0.6887
Rhode Island	0.7650	—
South Carolina	0.5701	0.5491
South Dakota	0.6493	0.6659
Tennessee	0.5697	0.5789
Texas	0.5729	0.6748
Utah	0.6533	0.6457
Vermont	0.6877	0.6942
Virginia	0.5927	0.6097
Washington	0.7119	0.7374
West Virginia	0.6127	0.5785
Wisconsin	0.7525	0.7502
Wyoming	0.7223	0.7582

STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS

[Case weighted] August 1991

State	Ratio
Alabama	0.0627
Alaska	0.0854
Arizona	0.0767
Arkansas	0.0704
California	0.0536
Colorado	0.0578
Connecticut	0.0426
Delaware	0.0656
District of Columbia	0.0463
Florida	0.0714
Georgia	0.0639
Hawaii	0.0750

STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS—Continued

[Case weighted] August 1991

State	Ratio
Idaho	0.0852
Illinois	0.0589
Indiana	0.0751
Iowa	0.0660
Kansas	0.0626
Kentucky	0.0730
Louisiana	0.0783
Maine	0.0519
Maryland	0.0583
Massachusetts	0.0715
Michigan	0.0615
Minnesota	0.0656
Mississippi	0.0686
Missouri	0.0627
Montana	0.0805
Nebraska	0.0617
Nevada	0.0530
New Hampshire	0.0655
New Jersey	0.0632
New Mexico	0.0649
New York	0.0660
North Carolina	0.0537
North Dakota	0.0818
Ohio	0.0681
Oklahoma	0.0705
Oregon	0.0658
Pennsylvania	0.0568
Puerto Rico	0.0784
Rhode Island	0.0424
South Carolina	0.0778
South Dakota	0.0739
Tennessee	0.0699
Texas	0.0738
Utah	0.0648
Vermont	0.0603
Virginia	0.0647
Washington	0.0782
West Virginia	0.0648
Wisconsin	0.0640
Wyoming	0.0804

TABLE 9.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS

Area	1982-88 percentage difference	1984-88 percentage difference
Rural Connecticut	14.831	17.111
Rural Hawaii	—	8.903
Rural Massachusetts	11.457	15.086
Boston-Lowell-Brockton-Lawrence-Salem, MA	—	9.313
Caguas, PR	—	12.837
Charlottesville, VA	—	8.807
Charlotte-Gastonia-Rock Hill, NC-SC	—	13.400
Fayetteville-Springdale, AR	—	8.316
Florence, AL	—	8.406
Florence, SC	10.636	9.502
Fort Myers-Cape Coral, FL	—	8.941
Fort Pierce, FL	9.049	—
Fort Walton Beach, FL	—	9.069
Hartford-Middletown-New Britain, CT	—	8.477
Macon-Warner Robins, GA	—	12.931

TABLE 9.—PERCENTAGE DIFFERENCE IN WAGE INDEXES FOR AREAS THAT QUALIFY FOR A WAGE INDEX EXCEPTION FOR EXCLUDED HOSPITALS AND UNITS—Continued

Area	1982-88 percentage difference	1984-88 percentage difference
Manchester-Nashua, NH	8.083	9.418
Modesto, CA	—	8.300
New Haven-West Haven-Waterbury, CT	8.215	12.426
New London-Norwich, CT	—	8.558
Odessa, TX	13.455	16.733
Orange County, NY	—	8.551
Panama City, FL	—	9.367
Portsmouth-Dover-Rochester, NH	8.496	—
Providence-Pawtucket-Woonsocket, RI	—	9.163
Provo-Orem, UT	—	10.394
Rochester, MN	8.194	—
St. Joseph, MO	—	8.411
Tallahassee, FL	—	10.408
Victoria, TX	10.590	9.128
Worcester-Fitchburg-Leominster, MA	8.089	14.941

Appendix A—Regulatory Impact Analysis

I. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish an initial regulatory impact analysis for any final rule that meets one of the Executive Order 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 603 of the RFA. With the exception of 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 100 beds located outside of a Metropolitan Statistical Area or New England County Metropolitan Area.

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.

II. Changes in the Final Rule

In this final impact analysis, we are focusing on the aspects of the final rule that have been revised from those presented in the proposed rule (and, thus, were part of the initial impact analysis). In general, the changes in this final impact analysis are the result of using later or more complete hospital data. Since publication of the June 3, 1991 proposed rule, the latest hospital market basket data project an increase of 4.4 percent compared to the 3.8 percent increase reported in the proposed rule. This means that standardized amounts for urban hospitals will be increased by 2.8 percent rather than by 2.2 percent as presented in the proposed rule. Similarly, the standardized rates for rural hospitals will be increased by 3.8 percent rather than 3.2 percent; and the hospital-specific rates for sole community hospitals and Medicare-dependent, small rural hospitals will be increased by 4.4 percent. The market basket for excluded hospitals is now projected to increase 4.7 percent compared to 4.0 percent projected at the time of the proposed rule. Thus, the rate-of-increase limit for excluded hospitals will be increased by the new market basket rate of increase.

Also, since publication of the proposed rule, the Medicare Geographic Classification Review Board (MGCRCB)

has approved another 360 applications for reclassification on the basis of wage index, standardized amount or both. In connection with reclassifications by the MGCRCB, one of the effects of these decisions has been a reduction of the wage index values for certain urban areas to levels below the Statewide wage index for rural areas. This rule implements a new interpretation of section 1886(d)(8)(C)(iii) of the Act that establishes the Statewide wage index value for rural areas within a State as the floor below which wage index values may not fall as a result of MGCRCB decisions. As explained in section IV.C of the preamble to this final rule, we are expanding the application of this provision to urban areas with wage index values that have been above the Statewide rural wage index value, and that have fallen below the Statewide rural wage index value as a result of decisions by the MGCRCB. We discuss the impact of reclassified hospitals, in detail, in section V.C of this impact analysis.

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

In general, hospitals became subject to the prospective payment system for operating costs with the start of their cost reporting period beginning on or after October 1, 1983. As of August 6, 1991, 5,495 hospitals (approximately 84 percent of all Medicare-participating hospitals) were identified as Medicare-participating, short-term, acute care hospitals. Of this number, only 59 hospitals remain excluded from the prospective payment system under section 1814(b)(3) of the Act (that is, under a State cost control system) or a demonstration project. (The hospitals are located in the State of Maryland and in the Finger Lakes region of New York State, respectively.) Thus, as of August 6, 1991, about 5,436 hospitals were operating under the prospective payment system.

Among the 5,436 prospective payment hospitals, there are over 1,160 hospitals that are 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 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 1,200 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.

As of August 6, 1991, 706 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 increases in their operating costs per case. These hospitals include psychiatric, rehabilitation, long-term care, and children's hospitals. Another almost 1,830 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 are also paid on the basis of reasonable cost subject to limits on the rate of increases in their operating costs per case. In addition, there are currently nine hospitals that HCFA has designated as cancer research or treatment hospitals that are excluded from the prospective payment system.

IV. Impact on Excluded Hospitals and Units

As noted in the preceding section of this impact analysis, almost 990 Medicare hospitals, and 1,820 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 4005 of Public Law 101-508 amended section 1886(b)(1) of the Act to provide that an excluded hospital or unit with cost reporting periods beginning on or after October 1, 1991 will be paid 50 percent of the costs in excess of the target amount. This additional payment, however, is not to exceed 10 percent of the target amount after any exceptions or adjustments are made to the target amount for the cost reporting period.

We do not possess data that are sufficiently current to enable us to model the impact of the payment provisions for hospitals excluded from the prospective payment system with any degree of certainty. In general, excluded hospitals will benefit from the rate-of-increase payment method to the degree they are able to keep their inpatient operating costs below their rate-of-increase limit. Our revision of the rate of increase in the market basket for excluded hospitals from 4.0 percent to 4.7 percent will benefit those hospitals that have experienced price increases above the rate of increase that was presented in the proposed rule. Yet, at the same time, limiting payment increases to the market basket rate of increase provides an adequate incentive for hospitals to constrain spending.

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

A. Limitations of Our Analysis

As has been the case in previously published prospective payment system regulatory impact analyses, the following quantitative analysis is limited to presenting the projected effects of the final policy and rate changes on current and projected payment rates. In the analysis that follows, we examine the effects of both statutory and final policy changes on hospital payments by projecting estimated payments under each set of statutory or policy changes compared to the current payment amounts. That is, we project the effects of each statutory or policy change on payments while holding all other payment variables constant. Thus, we are not attempting to predict behavioral responses to the 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 reasonable one. Wherever possible, we have included quantitative representations of the changes being implemented in this document.

B. 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 fiscal year 1990 billing data, hospital-specific data for fiscal year 1990, and cost report data from hospitals with cost reporting periods beginning in fiscal year 1989. It should be noted that, because of hospital mergers, openings, closings, and terminations from the Medicare program since fiscal year 1990, the set of hospitals used in the impact analysis may differ slightly both in composition and number from those hospitals that are currently participating in the

Medicare program. As in previous analyses, we compared the estimated effects of changes being implemented in this document to our estimate of the payment amounts under policies in effect for the previous payment period. Normally, we compare the final payments to payments that went into effect at the beginning of the current fiscal year. However, section 4007 of Public Law 101-508 froze all Medicare Part A payments from October 21, 1990 through December 31, 1990 and made changes in the payment policies effective January 1, 1991. Thus, in this analysis, we are comparing the final changes in hospital prospective payments to the rates that went into effect on January 1, 1991, which were announced in a final rule with comment published January 7, 1991 (56 FR 568). In order to simulate the impact of the final payments, we have treated all hospitals in our data base as if they have cost reporting periods that begin on October 1, the beginning of the Federal fiscal year. Only by establishing the same cost reporting period for all hospitals can we show the effect of policy changes on payments for comparable 12-month periods.

Our analysis has several limitations. First, it does not take into account behavioral changes that hospitals may adopt in response to the policy changes being implemented in this final rule. Second, as a result of gaps in our data, we are unable to quantify some of the effects of the changes contained in this rule. Third, 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 facilities to estimate the payments for fiscal year 1991 and the projected payments under the policies for fiscal year 1992 that serve as the bases of our simulation.

To illustrate the effects of hospital reclassifications for fiscal year 1992 as a

result of MGCRB decisions, we are dividing the analysis presented in Table I into two parts. The first part shows changes in payments to hospitals based on their actual geographic location. The second part of the analysis shows changes in payments based on a hospital's geographic classification for purposes of the standardized amount under the prospective payment system after any reclassifications under section 1886(d)(8) or (10) of the Act, rather than its actual geographic location, when there is a difference between the two. For example, our analysis in Table I of hospital payments based on actual geographic location shows that the number of hospitals in large urban, other urban, and rural areas is 1,503, 1,431, and 2,535, respectively. The analysis of hospitals that incorporates reclassifications shows the number of large urban, other urban, and rural hospitals to be 1,641, 1,520, and 2,308, respectively. These effects of geographic reclassification for purposes of obtaining higher payments per case are evident from a comparison of the two analyses within Table I.

The following analysis examines in column 1 of Table I the effects of the annual DRG reclassification and the recalibration of the DRG weights required by section 1886(d)(4)(C) of the Act. In column 2 of Table I, we show the effects of the geographic reclassifications by the MGCRB. For both columns 1 and 2, we hold constant all the payment variables except those associated with the provision under examination. In the last column (column 3), we present the combined effect of all changes being presented in this final rule. That is, column 3 displays the combined effects of the previous two columns as well as changes in the outlier payments and in the update and budget neutrality factors. Thus, this last column is the only one that reflects the effects of all the quantifiable final policy changes on simulated fiscal year 1991 payments.

TABLE I—IMPACT OF CHANGES IN THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR FY/1992

[By Geographic Location]

	No. of hospitals ¹	DRG reclassification and recalibration ²	Hospital geographic reclassification ²	All Changes ⁴
		(1)	(2)	(3)
All Hospitals.....	5,469	0.0	0.0	3.0
Large Urban Areas (Populations Over 1 Million).....	1,503	0.0	-1.0	1.9
Other Urban Areas (Populations of 1 Million or Fewer).....	1,431	0.0	-0.3	2.6
Rural Areas.....	2,535	-0.1	3.9	7.3
Urban Hospitals.....	2,934	0.0	-0.7	2.2
0-99 Beds.....	688	-0.1	-0.9	1.9

TABLE I—IMPACT OF CHANGES IN THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR FY/1992—Continued

[By Geographic Location]

	No. of hospitals ¹	DRG reclassification and recalibration ²	Hospital ¹ geographic reclassification ³	All Changes ⁴
		(1)	(2)	(3)
100-199 Beds	854	-0.1	-0.6	2.1
200-299 Beds	628	0.0	-0.6	2.2
300-499 Beds	549	0.0	-0.7	2.3
500 or More Beds	212	0.2	-0.8	2.3
Rural Hospitals	2,535	-0.1	3.9	7.3
0-49 Beds	1,239	-0.1	1.2	5.1
50-99 Beds	778	-0.1	2.8	6.7
100-149 Beds	272	-0.2	4.6	8.0
150-199 Beds	119	-0.2	5.2	8.2
200 or More Beds	127	0.0	5.6	8.4
Urban by Region:				
New England	175	0.1	-0.3	2.5
Middle Atlantic	466	0.1	-0.7	1.8
South Atlantic	424	0.0	-0.9	2.1
East North Central	485	0.1	-0.2	2.8
East South Central	169	0.0	-1.0	2.2
West North Central	185	0.1	-0.9	2.3
West South Central	359	-0.1	-1.0	2.1
Mountain	115	0.0	-0.9	2.3
Pacific	507	-0.1	-0.7	2.2
Puerto Rico	49	0.0	-0.4	2.3
Rural by Region:				
New England	59	0.0	1.6	5.0
Middle Atlantic	93	0.0	3.5	6.7
South Atlantic	343	-0.2	5.0	8.1
East North Central	347	-0.1	3.6	7.0
East South Central	301	-0.1	4.1	7.5
West North Central	568	-0.1	3.3	6.9
West South Central	411	-0.2	4.9	8.3
Mountain	245	-0.1	2.5	6.3
Pacific	162	-0.1	3.3	7.0
Puerto Rico	6	0.1	0.5	4.7
By Payment Classification				
Large Urban Areas (Populations Over 1 Million)	1,641	0.0	-0.5	2.4
Other Urban Areas (Populations of 1 Million or Fewer)	1,520	0.0	-0.4	2.6
Rural Areas	2,308	-0.1	3.0	6.6
Teaching Status:				
Non-Teaching	4,269	-0.1	0.6	3.6
Resident/Bed Ratio Less Than 0.25	970	0.0	-0.4	2.5
Resident/Bed Ratio 0.25 or Greater	230	0.2	-0.8	2.2
Operating System Disproportionate Share Hospitals (DSH):				
Non-DSH	3,980	0.0	0.2	3.3
Urban DSH:				
100 Beds or More	1,128	0.0	-0.5	2.3
Fewer than 100 Beds	81	-0.1	1.1	4.2
Rural DSH:				
Sole Community Hospitals (SCH)	64	-0.1	2.0	6.1
Rural Referral Centers (RRC) (Includes Hospitals That are Both SCH and RRC)	33	-0.1	4.2	6.8
Other Rural DSH Hospitals:				
100 Beds or more	42	-0.2	0.9	4.8
Fewer than 100 Beds	141	-0.2	0.9	4.8
Urban Teaching and DSH:				
Both Teaching and DSH	597	0.1	-0.7	2.1
Teaching and no DSH	523	0.1	-0.5	2.5
No Teaching and DSH	612	-0.1	0.2	2.9
No Teaching and no DSH	1,429	-0.1	-0.3	2.6
Other Special Status:				
Non Special Status Hospitals	1,080	-0.2	2.6	6.6
RRC	185	-0.1	5.3	8.0
SCH	503	-0.1	1.2	5.4
Medicare-Dependent Hospitals (MDH)	515	-0.1	0.8	4.9
SCH and RRC	45	0.0	3.0	6.3
SCH or MDH	1,063	-0.1	1.5	5.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
All Reclassified Hospitals	930	-0.1	5.9	8.8
All Non reclassified Hospitals	4,487	0.0	-1.0	2.0
All Reclassified Urban Hospitals	201	0.0	3.7	6.4
All Reclassified Rural Hospitals	729	-0.1	8.0	11.1
Other Reclassified Hospitals:				
(Section 1886(D)(8)(B))	52	-0.1	6.7	3.1
Type of Ownership:				
Voluntary	2,986	0.0	-0.1	2.8
Proprietary	835	-0.1	0.1	3.1
Government	1,507	0.0	0.5	3.5

TABLE I—IMPACT OF CHANGES IN THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR FY/1992—Continued

[By Geographic Location]

	No. of hospitals ¹	DRG reclassification and recalibration ² (1)	Hospital geographic reclassification ³ (2)	All Changes ⁴ (3)
Medicare Utilization as a Percent of Inpatient Days:				
0-25	354	0.1	-1.0	1.8
25-50	2,886	0.0	0.0	3.0
50-65	1,655	0.0	0.2	3.2
Over 65	374	-0.1	-0.2	2.9

¹ Because data necessary to classify some hospitals by category were missing, these hospitals were omitted from the analysis. Therefore, the total number of hospitals in each category may not equal the national total. Hospital specific data and discharge are from FY 1990, and hospital cost report data are from reporting periods beginning in FY 1989.

² Recalibration of the DRG weights and classification changes are based on FY 1990 MEDPAR data and are performed annually in accordance with section 1886(d)(4)(C) of the Act.

³ Under section 1886(d)(10) of the Act, a hospital may apply to the Medicare Geographic Classification Review Board for the purpose of obtaining a higher wage index, standardized payment amount, or both. Under section 1886(d)(8)(D) of the Act, changes in the geographic designation of hospitals must be budget neutral and payments to rural hospitals after reclassification cannot be lower than they would be absent reclassification.

⁴ This column shows the combined effects of all the previous columns as well as the effects of updating the FY 1991 standardized payment amounts by the rates of increase as mandated by section 1886(b)(3)(B)(i)(VII) of the Act as added by sections 4002 (a) and (c) of Public Law 101-508. The estimates of operating outlier payments contain an adjustment to remove the effects of the elimination of the day limitation on inpatient hospital services under Public Law 101-360. In addition, this column captures interactive effects that we are not able to quantify.

C. The Impact of the Final Changes to the DRG Classifications and Weights

In column 1, we present the combined effects of revising the assignment of diagnosis and procedure codes to different DRGs, the addition or elimination of diagnosis or procedure codes or DRGs, and the subsequent recalibration of the DRG weights incorporating these redefined DRGs. Section 1886(d)(4)(C)(i) of the Act requires us each year to perform these reclassifications and recalibration of the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

The redistributional impact of the DRG reclassification and recalibration changes across hospital groupings appears to be negligible. At most, the impact is either a reduction or an increase of 0.2 percent for a few hospital groupings while most hospitals appear to experience a 0.1 percent or lower effect. The impact of DRG reclassification and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral.

D. The Impact of MGCRB Reclassification on Hospitals

As discussed in section I.A.1 of the preamble to this final rule, section 6003(h)(1) of Public Law 101-239 added section 1886(d)(10) to the Act (which was later amended by section 4002(h) of Public Law 101-508) to provide for the establishment of the MGCRB. The MGCRB considers applications by hospitals for geographic reclassification for purposes of receiving a different index value or standardized amount under the

prospective payment system. The first hospital reclassifications based on decisions of the MGCRB will take effect October 1, 1991. Under section 1886(d)(10) of the Act, the MGCRB may reclassify a hospital to an adjacent rural or urban area with which it has a close proximity for the purposes of using the other area's standardized amount, wage index value, or both. (A rural referral center or a sole community hospital may be redesignated to an area that is not an adjacent county.)

Both the final fiscal year 1992 standardized payment amounts and wage index values incorporate all reclassification decisions made by the MGCRB as of August 5, 1991. By that date, 930 hospital reclassifications were approved by the MGCRB. This number does not include any hospitals that have also been reclassified under provisions of section 1886(d)(8)(B) of the Act that deems certain rural counties adjacent to one or more urban areas as belonging to the urban area.

Over 75 percent of all reclassified hospitals are located in rural areas (nearly 730 hospitals). This represents almost 29 percent of all rural hospitals in our data base. Of the total number of rural hospitals that were reclassified, 75 percent were reclassified for the purpose of increasing their wage index. Eleven percent of rural reclassified hospitals were reclassified for purposes of their standardized amounts and about 14 percent were granted reclassification for purposes both their wage index and their standardized payment amount.

Among the 148 hospitals located in other urban areas that were reclassified, almost 45 percent were reclassified for the purpose of increasing their wage index value while another 45 percent

were reclassified for purposes of both their wage index value and standardized amount. The following table shows the percentage of reclassified hospitals by their actual geographic location.

DISTRIBUTION OF RECLASSIFIED HOSPITALS

Geographic location	Percent reclassified for both wage index value and standardized amount	Percent reclassified for standardized amount	Percent reclassified for wage index value
Large Urban	1.9	0.0	98.1
Other Urban	45.3	10.1	44.6
Rural	13.6	11.0	75.5

Viewed from the standpoint of the geographic reclassification categories, 71.8 percent of reclassified hospitals were reclassified for purposes of their wage index value, 10 percent were reclassified for purposes of their standardized amount, and 18 percent were reclassified for the purposes of both their wage index value and standardized payment amount.

Our analysis of the effects of hospital reclassifications on the average payment per case is similar to our analysis of the distribution of reclassified hospitals. That is, we analyzed the changes in payments per case for hospitals in large urban, other urban, and rural locations for each of the three reclassification categories. We analyzed these effects for both those hospitals that were reclassified and for

those that were not. There are two ways in which the reclassification of hospitals affect payment to nonreclassified hospitals. These are: (1) Through changes in the wage index, and (2) through the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act.

The effects of the MGRB reclassification decisions are significant. The overall impact on reclassified hospitals is to increase their payment per case by an average 5.9 percent. Hospitals located in rural areas that were reclassified for purposes of both their wage index value and their standardized amount will receive the largest percentage increase in payments per case. They can expect an average increase of nearly 16 percent on the basis of reclassification alone. The 15 hospitals located in urban areas that were reclassified for purposes of their standardized amounts will receive an average decrease in payments per case of 0.2 percent. This outcome reflects the reclassification of other hospitals from

their labor market area. Thus, for the hospitals remaining in the labor market area after the wage index reclassifications, the decrease in the wage index value for the area was greater than the increase in their standardized amount after reclassification to a large urban area. The decrease also reflects the budget neutrality adjustment for urban hospitals.

Among hospitals that were not reclassified, the overall impact of hospital reclassification is an average decrease in payment per case of about 1 percent. Nonreclassified urban hospitals (comprising about 61 percent of nonreclassified hospitals) can expect a 1 percent decrease in payments per case. The 0.1 percent decrease for nonreclassified rural hospitals is attributable to rural referral centers whose payments decreased as a result of the urban budget neutrality adjustment factor.

As noted above, nonreclassified urban hospitals are affected by reclassification

through changes in their area wage index and the reclassification budget neutrality factor. We have examined the effects of wage index changes resulting from reclassification on urban area that have lost hospitals. As explained in section III.C. of the preamble, we received several comments pointing out the negative effects of reclassification on those hospitals that remain in urban areas from which some hospitals have been reclassified. The wage index value for 30 urban areas was reduced by 2 percent or more. Sixteen urban areas had their wage index value reduced by more than 5 percent, and one urban area had its wage index value drop by 20 percent. By establishing the Statewide rural wage index value as a floor, hospitals in the three most severely affected urban areas will receive some relief. The following table shows the effects of reclassification and the benefit of applying the Statewide wage index value:

MSA	Wage index value before reclassification	Wage index value after reclassification	Percent difference	Rural wage index value	Percent difference
Janesville-Beloit, WI.....	0.8482	0.6737	-20.6	0.8453	-0.3
Hamilton-Middletown, OH.....	0.9403	0.8229	-12.5	0.8461	-10.0
Canton, OH.....	0.8829	0.7878	-10.8	0.8461	-4.2

In the following table, we present the detailed impact of reclassification on hospitals located in large urban, other urban, and rural areas for each of the three geographic classification categories. The columns in this table

show: (a) The average percentage change in payments per case because of reclassification; (b) the average payments per case that were in effect since January 1, 1991; (c) payments that are effective October 1, 1991; and (d) the

total percentage change in the average payment per case resulting from all changes being implemented in this final rule.

EFFECTS ON PAYMENTS PER CASE OF GEOGRAPHIC RECLASSIFICATION OF HOSPITALS

	(a) Percentage change in hospital payments/case from geographic reclassification ¹	(b) Average FY 1991 payments per case	(c) Average FY 1992 payments per case	(d) Percentage change in payments per case from all changes ²
All reclassified hospitals.....	5.9	4,372	4,758	8.8
Standardized amount only.....	2.7	4,536	4,792	5.6
Wage index only.....	5.2	4,263	4,614	8.2
Both.....	8.8	4,665	5,198	11.4
All reclassified urban hospitals.....	3.7	5,448	5,798	6.4
Standardized amount only.....	-0.2	6,121	6,297	2.9
Wage index only.....	2.9	5,547	5,858	5.6
Both.....	15.9	5,176	5,618	6.5
All reclassified rural hospitals.....	8.0	3,693	4,101	11.1
Standardized amount only.....	5.7	3,559	3,863	8.6
Wage index only.....	6.8	3,987	4,056	10.0
Both.....	15.8	3,794	4,483	18.2
All nonreclassified hospitals.....	-1.0	5,486	5,597	2.0
Urban nonreclassified hospitals.....	-1.0	5,826	5,935	1.9
Rural nonreclassified hospitals.....	-0.1	3,282	3,407	3.8

¹ This column shows the percentage change in payments resulting from decisions of the MGRB and is comparable to values in column 2 of Table I.

² This column includes all changes being implemented in this final rule. See footnote 4 in Table I and the discussion in section V.E. of the impact analysis for an explanation of this column.

Column 2 of Table I details the effects of hospital reclassification on the other hospital groupings. Among rural hospitals, the larger hospitals (by bed size) have benefited more than the smaller hospitals. Hospitals with 200 or more beds are expected to receive an average increase of 5.6 percent compared to an average increase of 1.2 percent for rural hospitals with fewer than 50 beds. Urban hospitals, on the other hand, can expect roughly the same decreases across the different bed size groupings. The range of payment decreases is from 0.9 for hospitals with fewer than 100 beds to 0.6 for hospitals with 200 to 299 beds.

Among the rural hospitals receiving special payments, rural referral centers are expected to benefit the most while Medicare-dependent, small rural hospital can expect the smallest benefit from hospital reclassification. In general, disproportionate share hospitals will benefit from hospital reclassification with exception of urban disproportionate share hospitals with 100 or more beds. They can expect a decrease of 0.5 percent per case. Also, major teaching hospitals can expect an average decrease of 0.8 percent.

The geographic analysis by census division shows that hospitals in the rural South Atlantic census division receive the largest increase of any of the other rural census divisions. That increase is expected to be 5.0 percent. No urban census division is expected to receive increased payments as a result of hospital reclassification. Urban hospitals in the East South Central and Mountain census divisions are projected to experience the largest decrease in payments, which is of 1.0 percent.

From the foregoing analysis, it is evident that the provisions allowing the geographic reclassification of hospitals result in the redistribution of payments from hospitals in the generally higher paying urban areas to hospitals in the generally lower paying rural areas.

E. Combined Effects of All Changes

In column 3 of Table I, we present the expected effects of all final changes for FY 1992 compared to expected payments under policies in effect for FY 1991. In addition to the changes being implemented for DRG weights (presented in column 1) and the effects of reclassified hospitals (presented in column 2), we incorporated the update factors being implemented for large and other urban areas and rural areas, changes in the outlier thresholds, and revisions and to the wage index. Although we have not explicitly analyzed these changes in this impact analysis, they are discussed in the

addendum to the final rule and in the preamble. As explained in our introductory remarks to the quantitative analysis section, some changes cannot be captured because we lack current data and the data we do possess may be incomplete. There may also be interactive effects between the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 3 may not equal the sum of the previous columns plus the other variables we are able to identify.

In addition to the update factors to the standardized amounts being implemented (that is, 2.8 percent for urban hospitals and 3.8 percent for rural hospitals), we are adjusting the outlier thresholds to incorporate the prospective payment system for hospital inpatient capital-related costs. In section V.C. of the preamble to this final rule, we provide a detailed explanation of the effects of incorporating outlier payments for capital with outlier payments for the operating portion of the prospective payment system. That analysis shows that there will be very little change in the proportion of outlier cases meeting the day and cost outlier thresholds given our final changes to the outlier thresholds. Under the final thresholds that will include outlier payments for capital, 59.9 percent of the cases used to model these thresholds will be paid as day outliers (that is, paid a per diem amount based either on the number of days exceeding the DRG geometric mean length of stay plus the lesser of 32 days or 3.0 standard deviations), and 40.1 of the cases will be paid as high cost outliers (that is, paid once costs exceed the lesser of 2 times the DRG payment rate or \$44,000).

In addition to adjusting the outlier threshold to account for the inclusion of capital in the prospective payment system, we adjusted the outlier model to account for the effects of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360) on outlier payments. The provisions of that statute were effective for discharges occurring on or after January 1, 1989. They were subsequently repealed by the Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101-234) for discharges occurring on or after January 1, 1990. As a consequence of these two provisions, Medicare patients discharged from a hospital during the first quarter of FY 1990 were subject to the extended coverage provisions under Public Law 100-360, while patients discharged during the remainder of FY 1990 were subject to the more restrictive coverage provision that were in effect before January 1, 1989. As discussed in section II.A.4.d of

the addendum to this final rule, we developed an adjustment factor that we believe appropriately accounts for the extended coverage provisions that were in effect during the first 3 months of FY 1990.

At the national level, our simulation of the final FY 1992 prospective payment rates shows that the average payment to hospitals will increase 3.0 percent. Geographically, hospitals located in large urban areas can expect an increase of 1.9 percent with hospitals in the other urban areas receiving an increase of 2.6 percent. Overall, payments to urban hospitals are projected to increase 2.2 percent. Hospitals in rural areas can expect an increase in the average payment of 7.3 percent. Small, rural hospitals with fewer than 50 beds and with 50 to 99 beds can expect payment increases of 5.1 and 6.7 percent, respectively.

The analysis by census division shows that among urban hospitals, those in East North Central census division are projected to receive the largest increase in payments per case of 2.8 percent. It should be noted that, with the exception of the New England and Middle Atlantic census divisions, there is a difference of only 0.2 percentage points. The projected increases for the urban New England and Middle Atlantic census divisions are 2.5 and 1.8 percent, respectively. Among the rural areas, the West South Central census division will receive the largest increase of in payments per case of 8.3 percent. The smallest increase is projected for the rural hospitals in Puerto Rico. We project this increase to be 4.7 percent. With the exception of Puerto Rico, the smallest increase of 5.0 percent is for rural hospitals in the New England census division.

Consistent with our expectations, reclassified hospitals will gain the most under policies being implemented in this document. Rural reclassified hospitals are projected to receive an 11.1 percent payment increase. As a group, hospitals that were not reclassified can expect an increase of 2.0 percent.

Among hospitals grouped by special payment status, rural referral centers can expect an average of an 8.0 percent increase in payments. When looked at from the type of ownership, government-controlled facilities can expect to receive an increase of 3.5 percent compared to a 2.8 percent increase for voluntary hospitals.

As a general conclusion, the single factor that dominates the outcome of our simulation (other than the update factor) is the reclassification of hospitals. Because of the requirements to maintain

budget neutrality, our simulation shows a general redistribution of prospective payments from hospitals located in urban areas to hospitals located in rural areas. This reflects the reclassification of many rural hospitals to urban areas. But it should be noted that some urban area hospitals have also been reclassified from other urban to large urban areas for purposes of the

standardized amount or to another labor market area for purposes of the wage index value.

Table II presents the projected average payments per case under the changes for FY 1992 for urban and rural hospitals and for the different categories of hospitals shown in Table I, and it compares them with the average estimated per case payments that were

effective January 1, 1991. 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, 1991 to October 1, 1991 equals the percentage changes shown in the last column of Table I.

TABLE II.—COMPARISON OF PAYMENT PER CASE

[Fiscal year 1992 compared to fiscal year 1991]

	Number of hospitals	Average FY 1991 payment per case	Average FY 1992 payment per case	Percentage change ¹
		(1)	(2)	(3)
By Geographic Location				
All Hospitals.....	5,469	5,293	5,449	3.0
Large Urban Areas (Populations Over 1 Million).....	1,503	6,322	6,443	1.9
Other Urban Areas (Populations of 1 Million or Fewer).....	1,431	5,223	5,361	2.6
Rural Areas.....	2,535	3,495	3,750	7.3
Urban Hospitals.....	2,934	5,795	5,924	2.2
0-99 Beds.....	688	4,203	4,284	1.9
100-199 Beds.....	854	4,933	5,038	2.1
200-299 Beds.....	628	5,429	5,551	2.2
300-499 Beds.....	549	5,950	6,085	2.3
Over 500 Beds.....	212	7,344	7,511	2.3
Rural Hospitals.....	2,535	3,495	3,750	7.3
0-49 Beds.....	1,239	2,993	3,145	5.1
50-99 Beds.....	778	3,246	3,463	6.7
100-149 Beds.....	272	3,553	3,839	8.0
150-200 Beds.....	119	3,664	3,966	8.2
200 or More Beds.....	127	4,149	4,497	8.4
Urban by Region:				
New England.....	175	6,228	6,385	2.5
Middle Atlantic.....	466	6,475	6,593	1.8
South Atlantic.....	424	5,431	5,545	2.1
East North Central.....	485	5,600	5,755	2.8
East South Central.....	169	4,984	5,092	2.2
West North Central.....	185	5,627	5,756	2.3
West South Central.....	359	5,219	5,331	2.1
Mountain.....	115	5,625	5,754	2.3
Pacific.....	507	6,553	6,699	2.2
Puerto Rico.....	49	2,235	2,287	2.3
Rural by Region:				
New England.....	59	4,302	4,517	5.0
Middle Atlantic.....	93	4,027	4,298	6.7
South Atlantic.....	343	3,627	3,922	8.1
East North Central.....	347	3,502	3,748	7.0
East South Central.....	301	3,102	3,335	7.5
West North Central.....	568	3,255	3,481	6.9
West South Central.....	411	3,164	3,427	8.3
Mountain.....	245	3,780	4,017	6.3
Pacific.....	162	4,270	4,571	7.0
Puerto Rico.....	6	1,479	1,548	4.7
By Payment Classification				
Large Urban Areas (Populations Over 1 Million).....	1,641	6,209	6,355	2.4
Other Urban Areas (Populations of 1 Million or Fewer).....	1,520	5,146	5,278	2.6
Rural Areas.....	2,308	3,453	3,680	6.6
Teaching Status:				
Non-Teaching.....	4,269	4,359	4,516	3.6
Resident/Bed Ratio Less Than 0.25.....	970	5,768	5,913	2.5
Resident/Bed Ratio 0.25 or Greater.....	230	9,151	9,351	2.2
Operating System Disproportionate Share Hospitals (DSH):				
Non-DSH.....	3,980	4,759	4,917	3.3
Urban DSH:				
100 Beds or More.....	1,128	6,471	6,622	2.3
Fewer than 100 Beds.....	81	3,948	4,113	4.2
Rural DSH:				
Sole Community Hospitals.....	64	3,417	3,623	6.1
Rural Referral Centers (RRC) (Includes Hospitals that are Both SCH and RRC).....	33	4,096	4,374	6.8
Other Rural DSH Hospitals:				
100 Beds or More.....	42	3,126	3,274	4.8
Fewer than 100 Beds.....	141	2,750	2,883	4.8
Urban Teaching and DSH:				
Both Teaching and DSH.....	597	7,258	7,412	2.1
Teaching and No DSH.....	523	5,861	6,006	2.5

TABLE II.—COMPARISON OF PAYMENT PER CASE—Continued

[Fiscal year 1992 compared to fiscal year 1991]

	Number of hospitals	Average FY 1991 payment per case	Average FY 1992 payment per case	Percentage change ¹
		(1)	(2)	(3)
No Teaching and DSH	612	5,073	5,221	2.9
No Teaching and No DSH	1,429	4,663	4,804	2.6
Other Special Status:				
Non Special Status Hospitals	1,060	3,009	3,207	6.6
RRC	185	3,969	4,285	8.0
SCH	503	3,581	3,773	5.4
Medicare-Dependent Hospitals (MDH)	515	3,154	3,310	4.9
SCH and RRC	45	4,338	4,609	6.3
SCH and MDH	1,063	3,570	3,763	5.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
All Reclassified Hospitals	930	4,372	4,758	8.8
All Nonreclassified Hospitals	4,487	5,486	5,597	2.0
All Reclassified Urban Hospitals	201	5,448	5,798	6.4
All Reclassified Rural Hospitals	729	3,693	4,101	11.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	52	4,026	4,150	3.1
Type of Ownership:				
Voluntary	2,986	5,468	5,623	2.8
Proprietary	835	4,749	4,898	3.1
Government	1,507	4,872	5,042	3.5
Medicare Utilization as a Percent of Inpatient Days:				
0-25	354	7,219	7,351	1.8
25-50	2,886	5,533	5,697	3.0
50-65	1,655	4,618	4,767	3.2
Over 65	374	4,472	4,600	2.9

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

Appendix B—Recommendation of Update Factors for Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Social Security Act (the Act) apply to setting update factors for services furnished in FY 1992 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i) of the Act, as modified by section 4002 (a) and (c) of Public Law 101-508, set the FY 1992 applicable percentage increases for prospective payment hospitals for FY 1992 as the market basket percentage increase minus 1.6 percentage points for hospitals located in urban areas and the market basket percentage increase minus 0.6 percentage points for hospitals located in rural areas. Section 1886(b)(3)(B)(ii) of the Act governs the target rate-of-increase limits for hospitals excluded from the prospective payment system and the hospital-specific rate applicable to sole community and Medicare-dependent small rural hospitals. In accordance with section 1886(d)(3)(A) of the Act, we are updating the average standardized amounts, the hospital-specific rates and the target rate-of-increase limits for hospitals excluded from the prospective payment system as provided for in section 1886(b)(3)(B) of the Act, as set forth above.

Sections 1886(e) (2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1, 1991 an update factor that takes into account changes in the market basket index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for FY 1992 that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. As required by section 1886(e)(5) of the Act, we published the recommended FY 1992 update factors that are provided for under section 1886(e)(4) of the Act as appendix D of the proposed rule (56 FR 25323).

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

We received two public comments concerning our proposed recommendation. After consideration of the arguments presented, we have decided that our final recommendation will be the same as our proposed recommendation. That is, we are

recommending that the standardized amounts be increased by an amount equal to the market basket percentage increase minus 1.6 percentage points for hospitals located in urban areas and the market basket percentage increase minus 0.6 percentage points for hospitals in rural areas. Based on the currently forecasted market basket increase of 4.4 percent, the recommended updates are 2.8 percent for hospitals in urban areas and 3.8 percent for hospitals in rural areas.

We are recommending that the hospital-specific rate applicable to sole community hospitals and Medicare-dependent, small rural hospitals be updated by an amount equal to the market basket percentage increase minus 1.6 percentage points or 2.8 percent. With the exception of the higher update for the rural standardized amount, we believe that the considerations used to develop our update recommendation for the standardized amounts are also applicable to the hospital-specific rates for sole community and Medicare-dependent, small rural hospitals. Our recommendation for a higher update to the rural standardized amount is intended to reduce the differential between the standardized amounts for other urban and rural hospitals, which is not an applicable consideration for hospital-specific rates.

In recommending these increases, we have followed section 1886(e)(4) of the Act which indicates we should take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC.

We are recommending an update that is consistent with the Administration's budget proposal that all hospitals receive an update in their payments for FY 1992 based on the current market basket forecast with the adjustments set forth in Public Law 101-508. The latest forecast shows that the FY 1992 market basket at 4.4 percent.

Our recommendation is supported by our analyses, which measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix. We believe our analyses support a recommendation that the standardized amounts applicable to urban hospitals and the hospital-specific rates applicable to sole community hospitals and Medicare-dependent small rural hospitals be updated in FY 1992 by an amount equal to the market basket percentage increase minus 1.6 percentage points. However, we believe a differential update for the standardized amount applicable to rural hospitals is appropriate in order to phase out the differential between the rural and other urban standardized amounts. Therefore, we are recommending that the rural standardized amount be updated by an additional 1.0 percentage point, for a total update of 3.8 percent (that is, market basket minus 0.6 percentage points).

We note that we are in the process of refining our analytical framework for the update recommendation. Our intent is to develop an expanded conceptual framework and appropriate measures for each component that would be used to support our update recommendations for FY 1993 and thereafter. Although we solicited public comments on the appropriate factors and measures that we should consider, the only comment we received was from ProPAC.

Comment: We received a comment from ProPAC on the analytical framework used to support our update recommendation. While the Commission generally agreed with our analysis, they took issue with our negative adjustment for changes in practice patterns on the basis that earlier recommended adjustments for site of care substitution were sufficient. ProPAC also recommended that our framework

should include an adjustment for within-DRG changes in case complexity.

Response: Our observation of cumulative changes in average length of stay since the beginning of the prospective payment system is the proxy we use to estimate change in practice patterns. We have recommended and will continue to recommend only gradual adjustments for this factor over time. We have yet to adjust fully for the cumulative decline in average length of stay since the inception of the prospective payment system. As we indicated in our proposed recommendation, there is still a residual—1.85 days that has not been accounted for in earlier updates.

We do not agree that a separate item in the analytic framework for within-DRG case complexity is necessary. We believe that changes related to within-DRG case complexity are adequately reflected in scientific and technological advances and in the practice pattern components of the framework. However, we will evaluate this issue further in conjunction with the overall refinement of our analytical framework for the update recommendation.

Comment: One commenter stated that our recommended update for new science and technology of 0.5 percent is inadequate and is inconsistent with ProPAC's findings with respect to the costs of new technologies such as low osmolar and nonionic contrast media, which ProPAC cites as two of the most significant cost-increasing technologies in FY 1992. The commenter stated that HCFA should provide an add-on to the DRG payment for nonionic contrast material such as the one provided for physician payment in the proposed rule concerning a fee schedule for physicians' services, published in the Federal Register on June 5, 1991 (56 FR 25792).

Response: While we recognize that low osmolar and nonionic contrast media are more expensive than other radiological agents, we believe that the use of these agents in the inpatient setting should also have the effect of reducing hospital costs by preventing complications from occurring during the patients' stay. Therefore, the use of this technology for high-risk patients has considerable potential for cost savings. Moreover, while the use of this new technology may be appropriate for certain high-risk patients, its routine use for all patients may not serve to enhance patients' health status. To the extent new technologies are not quality enhancing, an adjustment would not be appropriate. In addition, although the direct cost of these agents can be readily identified, there is no empirical

measure for the incremental operating costs associated with the appropriate diffusion of these and other new technologies. Therefore, until a usable measure for the incremental operating costs associated with the implementation of new sciences and technologies is developed, we believe that this adjustment should continue to be set at a conservative, stable level.

Comment: We received a comment from ProPAC concerning our recommended update to the hospital-specific rates applicable to sole community hospitals and Medicare-dependent, small rural hospitals. The Commission specifically questioned why we did not recommend the same update to these hospital-specific rates as the rural update to the Federal rates, that is, market basket minus 0.6 percentage points.

Response: Our analytical framework supports an update for all hospitals of market basket minus 1.6 percentage points. The differential update recommended for the standardized amounts applicable to rural hospitals is necessary to reflect the phasing out of the differential between the rural and other urban standardized amounts. We do not believe the additional 1.0 percent update should apply to the hospital-specific rate. Sole community hospitals and Medicare-dependent, small rural hospitals are assured payment at the greater of the Federal rate or the hospital-specific rate. Thus, hospitals that are paid the hospital-specific rate already benefit by receiving a higher rate than other rural hospitals. We do not believe that these high cost rural hospitals that are already receiving higher payments should also benefit from a payment change intended for rural hospitals paid at a lower Federal rate. Rather, based on the update supported by our analytical framework, we are recommending that the hospital-specific rate applicable to sole community hospitals and Medicare-dependent, small rural hospitals be updated by the market basket minus 1.6 percentage points or 2.6 percent.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

We received several items of correspondence during the public comment period concerning our proposed recommendation for updating the rate-of-increase limits. After consideration of all the arguments presented, we have decided that our final recommendation will be the same as our proposed recommendation. We recommend an average update for

excluded hospitals that will result in total payments comparable to those that would result from an update equal to the market basket rate of increase. The market basket for excluded hospitals is currently estimated at 4.7 percent. However, we recommend that excluded hospitals and units whose base year began during the period FY 1983 through FY 1987 receive a higher update than hospitals whose base year began in FY 1982 or after FY 1987.

We recommend that excluded hospitals and units with an FY 1982 base year or a base year that began after FY 1987 receive an update equal to the market basket percentage increase minus 0.9 percent. The -0.9 percentage point adjustment is to account for the forecast error in the FY 1990 market basket rate of increase. Generally, we believe that increased costs for quality-enhancing new technologies should be offset by productivity gains and that explicit adjustments in the rate-of-increase limit for productivity and new technology are inappropriate.

In addition, we recommend a higher update for hospitals and units that were excluded in the early years of the prospective payment system. We believe this is appropriate because the updates applied to excluded hospitals in fiscal years 1986, 1987, and 1988 were considerably less than the market basket rate of increase and were based on some considerations appropriate only to hospitals subject to the prospective payment system.

We believe any increase in aggregate payments to excluded hospitals and units is premature until these issues are more fully evaluated. In this regard, we note that the Secretary is required by section 4005(b) of Public Law 101-508 to report to the Congress on recommendations for potential modifications to the rate-of-increase limits system as well as the possible replacement of that system with a prospective payment system. At the same time, we believe the analysis of the cumulative difference between the market basket rate-of-increases and the update factors supports a recommendation for differential

updates. We have used the results of the analysis to determine differential update factors that will result in program outlays that will approximate the outlays that would result from a 4.7 percent update. Our recommended update factor is 3.8 percent for all excluded hospitals and units plus an additional update for hospitals and units that became subject to the ceiling during the period FY 1984 through FY 1988. The recommended updates are as follows:

Base year began in FY	General update	HCFA recommended additional adjustment	HCFA recommended FY 1992 update
1982	3.8		3.8
1983	3.8	1.4	5.2
1984	3.8	2.8	6.6
1985	3.8	4.6	8.4
1986	3.8	2.9	6.7
1987	3.8	1.4	5.2
1988 and later..	3.8		3.8

Comment: As noted above, we received a number of comments concerning our recommended update for hospitals and units excluded from the prospective payment system. While all commenters supported our recommendation for a differential update for excluded hospitals and units, most objected to limiting aggregate payments to the market basket rate of increase. One commenter suggested that our reasons for limiting the amount of the adjustments were purely budget-driven and suggested that we eliminate incentive payments in order to fund the full update. ProPAC supported our recommendation and agreed that additional study is necessary before granting an across-the-board increase. ProPAC also suggested that we factor in the lower exceptions adjustments that would result from providing the full allowance.

Response: We believe the analysis of the cumulative difference between the market basket rate-of-increases and the update factors supports a recommendation for differential updates. However, we believe any increase in aggregate payments to excluded hospitals and units is

premature as it is not clear that such an expenditure is warranted or that any increase in payments is more appropriately distributed to excluded hospitals through a differential update factor rather than through a more targeted approach. While some hospitals have been adversely affected by the rate-of-increase limits, others have received substantial incentive payments. We continue to believe that further analysis is needed to understand why some hospitals have fared well and others have not before we can determine whether an across-the-board increase is more appropriate than one targeted toward groups of hospitals whose costs are systematically above the rate-of-increase limit. In addition, we believe that the lower updates are only part of the reason why hospitals with early base years are more financially vulnerable than hospitals that more recently became subject to the rate-of-increase limits. Another consideration is that these hospitals have been subject to the limits for a longer period of time and, in the case of those hospitals with an FY 1982 or FY 1983 base year, have a target amount that was established before the prospective payment system was implemented.

We note that, in estimating the additional update that would maintain aggregate payment increases at the market basket level, we did consider the savings that would result from reduced exceptions adjustments as well as the additional payments that would be made to excluded hospitals for 50 percent of their costs that are up to 10 percent above their target amount under section 4005(a) of Public Law 101-508. We do not agree with the comment that we should eliminate incentive payments in order to fund the full adjustment. It would be inappropriate to penalize efficient hospitals that have maintained their costs below the rate-of-increase limits in order to pay hospitals whose costs may have exceeded the limit because of inefficiency.

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