Sunshine Act Meetings

Federal Register
Vol. 57, No. 108
Thursday, June 4, 1992

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 5, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 92–13254 Filed 6–2–92; 2:44 pm]
BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., Tuesday, June 9, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., Lower Lobby Hearing Room.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Application for the Chicago Mercantile Exchange for contract designation in Goldman Sachs Commodity Index futures and options.

CONTACT PERSON FOR MORE INFORMATION: Jean W. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 92–13255 Filed 6–2–92; 2:44 pm]
BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 12, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 92–13256 Filed 6–2–92; 2:44 am]
BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION.

TIME AND DATE: 11:00 a.m., Friday, June 19, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 92–13257 Filed 6–2–92; 2:44 pm]
BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 11:00 a.m., Friday, June 26, 1992.

PLACE: 2033 K St., N.W., Washington, D.C., 8th Floor Hearing Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Surveillance Matters

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 92–13258 Filed 6–2–92; 2:44 pm]
BILLING CODE 6351–01–M

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10 a.m., Tuesday, June 30, 1992.

PLACE: 2033 K St., NW., Washington, DC, 8th Floor Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Enforcement Matters

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.

[FR Doc. 92–13259 Filed 6–2–92; 2:44 pm]
BILLING CODE 6351–01–M

FEDERAL ELECTION COMMISSION

"FEDERAL REGISTER" NUMBER: 92–12668.

PREVIOUSLY ANNOUNCED DATE AND TIME: Thursday, June 4, 1992, 10:00 a.m., Meeting Open to the Public.

THE FOLLOWING ITEM WAS DELETED FROM THE AGENDA:

Advisory Opinion 1992–13: Mr. James M. Blackburn

DATE AND TIME: Tuesday, June 9, 1992, 10:00 A.M.

PLACE: 999 E Street, N.W., Washington, D.C.

STATUS: This meeting will be closed to the public.

ITEMS TO BE DISCUSSED:

Compliance matters pursuant to 2 U.S.C. § 437g.
Audits conducted pursuant to 2 U.S.C. § 437g, § 438(b), and Title 26, U.S.C.
Matters concerning participation in civil actions or proceedings or arbitration
Internal personnel rules and procedures or matters affecting a particular employee

DATE AND TIME: Thursday, June 11, 1992, 10:00 a.m.

PLACE: 999 E Street, N.W., Washington, D.C. (Ninth Floor).

STATUS: This meeting will be open to the public.

ITEMS TO BE DISCUSSED:

Correction and Approval of Minutes
Title 26 Certification Matters
Final Repayment Determination—Kemp for President
Final Repayment Determination—Bush-Quayle '88
Status of Regulations Projects (continued from meeting of May 14, 1992)
Administrative Matters

PERSON TO CONTACT FOR INFORMATION: Mr. Fred Eiland, Press Officer, Telephone: (202) 219–4155.

Delores R. Harris,

Administrative Assistant.

[FR Doc. 92–13191 Filed 6–2–92; 10:52 am]

BILLING CODE 6715–01–M

POSTAL RATE COMMISSION

Amended Notice of Meeting

[BAC 7710–FW]

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: Vol. 57, p. 21700, May 21, 1992.

PREVIOUSLY ANNOUNCED TIME AND DATE OF THE MEETING: 2:00 p.m., June 8, 1992.

CHANGES IN THE MEETING: 10:00 a.m., June 15, 1992.

CONTACT PERSON FOR MORE INFORMATION: Charles L. Clapp, Secretary, Postal Rate Commission, Room 300, 1333 H Street, NW., Washington, DC 20268–0001, Telephone (202) 789–6840.

Charles L. Clapp,

Secretary.

[FR Doc. 92–13221 Filed 6–2–92; 8:45 am]

BILLING CODE 7715–01–M

federal register

Thursday
June 4, 1992

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412 and 413

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-756-P]

RIN 0938-AF79

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1993 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In addition, in the addendum to this proposed rule, we are describing changes in the amounts and factors necessary to determine prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 1992. We are also setting forth proposed rate-of-increase limits for hospitals and hospital units excluded from the prospective payment systems.

Finally, we are proposing changes and clarifications to the criteria and procedures concerning the reclassification of hospitals by the Medicare Geographic Classification Review Board. These changes result from public comment and our analysis of hospital reclassifications for Federal fiscal year (FY) 1992. The changes would be effective for applications submitted by September 30, 1992 for geographic reclassifications to be implemented on October 1, 1993 (FY 1994).

DATES: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 3, 1992.

ADDRESSES: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-756-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses: Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C. 20201, or Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Due to staffing and resource limitations, we cannot accept audio, visual, or facsimile (FAX) copies of comments.

If comments concern information collection recordkeeping requirements, please address a copy of comments to: Office of Management and Budget, Office of Information and Regulatory Affairs, Room 3001, New Executive Office Building, Washington, DC 20503, Attention: Allison Herron Eydt.

In commenting, please refer to file code BPD-756-P. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-245-7890).

To obtain data used in deriving the standardized amounts and DRG relative weights, see section IX.B of the preamble, Public Requests for Data.

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FOR FURTHER INFORMATION CONTACT: Barbara Wynn, (410) 966-4529.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), a system of payment for the operating costs of acute hospital inpatient 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 for hospital inpatient operating costs 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 hospital inpatient prospective payment system are located in 42 CFR part 412. On August 30, 1991, we published a final rule (56 FR 43196) to implement changes to the prospective payment system for hospital operating costs for Federal fiscal year (FY) 1992.

For cost reporting periods beginning before October 1, 1991, hospital inpatient operating costs were the only costs covered under the prospective payment system. Payment for capital-related costs had been made on a reasonable cost basis because, under sections 1886(a)(4) and (d)(1)(A) of the Act, those costs had been specifically excluded from the definition of inpatient operating costs. However, section 4006(b) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) revised section 1886(g)(1) of the Act to require that, for hospitals paid under the prospective payment system for operating costs, capital-related costs would also be paid under a prospective payment system effective with cost reporting periods beginning on or after October 1, 1991.

Therefore, on August 30, 1991, we published an additional final rule (56 FR 43358) in which we revised the Medicare payment methodology for inpatient capital-related costs for hospitals paid under the prospective payment system for operating costs. As required by section 1886(g) of the Act, we replaced the reasonable cost-based payment methodology with a prospective payment methodology for hospital inpatient capital-related costs. Under the new methodology, effective for cost reporting periods beginning on or after October 1, 1991, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs.

We established the standard Federal rate for FY 1992 using the FY 1989 Medicare inpatient capital cost per discharge updated to FY 1992 by the estimated increase in Medicare capital costs per discharge. In addition, we established a 10-year transition period for hospitals to be paid for their capital-related costs under one of two different payment methods. Generally, hospitals with a hospital-specific rate below the Federal rate are paid based on a fully prospective payment methodology. Hospitals with a hospital-specific rate at or above the Federal rate are paid based on a hold-harmless method or 100 percent of the Federal rate, whichever

results in a higher payment. Beginning with hospital cost reporting periods beginning on or after October 1, 2001, all hospitals are paid the Federal rate except for certain new hospitals that have not completed their transition period. (See the August 30, 1991 final rule (56 FR 43358) for a complete discussion of the prospective payment system for hospital inpatient capital-related costs.)

Hospitals and hospital distinct-part units that are excluded from the prospective payment system under the regulations at part 412, subpart B continue to be paid for capital-related costs on a reasonable cost basis under the provisions of part 413, subpart G. Also, rural primary care hospitals are not currently subject to prospective payment rules as provided under section 1814(l) of the Act and the last sentence of section 1861(e) of the Act.

B. Major Contents of this Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs. This proposed rule would be effective for discharges occurring on or after October 1, 1992. Following is a summary of the major changes that we are proposing to make:

1. Changes to the DRG Classification and Weighting Factors

As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and weighting factors at least annually. Our proposed changes for FY 1993 are set forth in section II of this preamble.

2. Changes to the Hospital Wage Index

In section III of this preamble, we discuss revisions to the wage index and, in particular, the revisions necessary because of hospital geographic reclassifications.

3. Changes Concerning Reclassifications by the Medicare Geographic Classification Review Board

In section IV of this preamble, we discuss the criteria and procedures for hospital reclassifications by the Medicare Geographic Classification Review Board and set forth proposed changes concerning the following:

- General guidelines—reclassifications for individual hospitals
—Reclassification to a single geographic area.
—Individual urban hospital reclassification to a rural area.
—Special access rule for rural referral center and sole community hospitals seeking reclassification.
—Guidelines for a hospital requesting reclassification for wage index purposes.
—Application of numeric standards.
- Implementation of FY 1994 hospital reclassifications.
—Appropriate wage data.
—Revised labor market areas.
- Administrative and procedural guidelines.
—Withdrawing an application.
—Reopenings.

4. Other Changes to the Prospective Payment System for Inpatient Operating Costs

In section V of this preamble, we discuss several provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning the following:

- Outlier payments.
- Rural referral center criteria.
- Direct graduate medical education payments.

5. Changes to Capital Prospective Payment System Rules

In section VI of this preamble, we discuss several provisions of the regulations at 42 CFR part 412, subpart M, and set forth certain proposed changes concerning the following:

- Payments to new hospitals.
- Portion of hospital assets put in patient care service after December 31, 1990.
- Treatment of old capital costs when hospitals are leased after December 31, 1990.
- Obligated capital costs.
- Adjusting the hospital-specific rate—transfer-adjusted discharge and case-mix index for subsequent base periods.
- Redetermination of the hospital-specific rate.
- Effect of hospital mergers, consolidations or dissolution on the hospital-specific rate.
- Extraordinary circumstances exceptions payments.
- Minor technical corrections.

6. Changes for Hospitals Excluded from the Prospective Payment System

In section VII of this preamble, we discuss changes to the regulations at 42 CFR parts 412 and 413 for hospitals and units excluded under the prospective payment system. The proposed changes concern the following:

- Provisionally excluded hospitals and units.
- Definition of discharge for purposes of applying the rate-of-increase limits applicable to excluded hospitals and distinct part units.
- New hospital exemption applicable to excluded hospitals.
- Adjustments under the rate-of-increase ceiling.

7. Determining Prospective Payment Rates and Rate-of-Increase Limits

In the addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 1993 prospective payment rates for operating costs and capital-related costs. We are also proposing new target rate percentages for determining the rate-of-increase limits for cost reporting periods beginning in FY 1993 for hospitals and hospital units excluded from the prospective payment system.

8. Impact Analysis

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

9. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 1993 capital acquisition model and budget neutrality adjustment.

10. Report to Congress on the Update Factor

Section 1886 (e)(3)(B) of the Act requires that the Secretary report to Congress no later than March 1, 1992 on our initial estimate of an update factor for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system. This report is included as appendix C to this proposed rule.

11. Proposed Recommendation of Update Factor

As required by sections 1886(e)(4) and (e)(5) of the Act, appendix D provides our recommendation of the appropriate percentage change for FY 1993 for the following:

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

12. Discussion of Prospective Payment Assessment Commission Recommendations

The Prospective Payment Assessment Commission (ProPAC) is directed by the

provisions of sections 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 the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 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 hospital inpatient prospective payment systems 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 are printing ProPAC's March 1, 1992 report, which includes its recommendations, as appendix E of this document. The recommendations, and the actions we are proposing to take with regard to them (when an action is recommended), are discussed in detail in the appropriate sections of this preamble, the addendum, or the appendixes of this proposed rule. Those recommendations that are not specifically relevant to matters presented below are discussed in section VIII of this preamble. For a brief summary of the ProPAC recommendations, we refer the reader to pages 5 through 12 of the ProPAC report as set forth in appendix E of this proposed rule. ProPAC also produced technical appendixes in its March 1, 1992 report that provide background material and detailed analyses used in preparation of the ProPAC recommendations. For further information relating specifically to the ProPAC report or to obtain a copy of the technical appendixes, contact ProPAC at (202) 401–8986.

II. Proposed 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. 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 proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1992 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.[1] The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM). The intermediary enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

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

Currently, cases are assigned to one of 489 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).

In general, principal diagnosis determines MDC assignment. However, there are four DRGs to which cases are assigned on the basis of procedure codes rather than first assigning them to an MDC based on the principal diagnosis. These are the DRGs for liver and bone marrow transplant (DRGs 480 and 481, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

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, GROUPER does not consider other procedures; that is, nonsurgical procedures or minor surgical procedures generally not performed in an operating room are not listed as operating room (OR) procedures in the GROUPER 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.

The changes we are proposing to make to the DRG classification system for FY 1993 are set forth below.

2. Reassignment of Certain Endoscopic Procedures (DRGs 76 and 77)

Currently, the only endoscopic procedure performed on the respiratory system that is considered an OR procedure is procedure code 33.27 (Closed endoscopic biopsy of lung). This procedure code is assigned to DRG 76 or 77 (Other Respiratory System OR Procedures) [2] if the patient's principal

[1] Effective with discharges occurring on or after October 1, 1991, we allowed an expansion of the number of reported diagnosis and procedure codes from 5 to 9 and from 3 to 6, respectively. Hospitals are required to code at the new level effective with discharges occurring on or after April 1, 1992.

[2] A single title combined with two DRG numbers is used to signify pairs. Generally, the first DRG is for cases with CC and the second is for cases without CC. If a third number is included, it represents cases of patients who are age 0–17. Occasionally, a pair of DRGs are split on age > 17 and age 0–17.

diagnosis is classified in MDC 4 (Diseases and Disorders of the Respiratory System). If procedure code 33.27 is performed in connection with a principal diagnosis assigned to another MDC, and no other procedure related to that diagnosis is performed, the case is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis).

Based on inquiries from the industry as well as our own concerns, we have reviewed the appropriate assignment of two other respiratory system endoscopic procedures: Endoscopic excision or destruction of lesion or tissue of lung (procedure code 32.28) and Closed [endoscopic] biopsy of bronchus (procedure code 33.24). Currently, performance of these non-OR procedures affects DRG assignment only in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms). For principal diagnoses that are assigned to that MDC, the performance of procedure codes 32.28 or 33.24 results in assignment to medical DRG 412 (History of Malignancy with Endoscopy). The preliminary information we received was that procedure codes 32.28 and 33.24 should be considered OR procedures and be assigned to MDC 4 because they are similar to procedure code 33.27 in terms of resource use and complexity.

Our analysis of the FY 1993 Medicare provider analysis and review file (MEDPAR) data demonstrated that, in the medical DRGs in MDC 4, the cases in which either procedure code 32.28 or 33.24 was performed had, on average, higher charges and lengths of stay than did the other cases assigned to these DRGs. This was particularly true for cases that included a CC. A comparison of the average charge and length of stay of medical cases with codes 32.28 and 33.24 with the average charge and length of stay of cases in DRGs 76 and 77 with procedure code 33.27 demonstrates that these cases are very similar in terms of resource use.

Based on these findings, we are proposing that endoscopic procedure codes 32.28 and 33.24 be designated as OR procedures and assigned to DRGs 76 and 77 in MDC 4. Because of this new designation, these procedures would be removed from medical DRG 412 in MDC 17. If procedure code 32.28 or 33.24 appears on a claim with a principal diagnosis in MDC 17, it would be assigned to surgical DRG 408 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other O.R. Procedure) as is procedure code 33.27.

In addition, based on our analysis of average charges, we are proposing that procedure codes 32.28 and 33.24 be assigned to DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) when they are unrelated to the principal diagnosis and no OR procedure related to the principal diagnosis is performed. We note that procedure code 33.27 is assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis).

3. Automatic Implantable Cardioverter Defibrillator (AICD) Procedures (DRG 120)

For several years, we have received a great deal of correspondence concerning the appropriate DRG assignment of certain procedures involving automatic implantable cardioverter defibrillators (AICDs). Currently, when a patient whose principal diagnosis is classified to MDC 5 (Diseases and Disorders of the Circulatory System) receives a total AICD system implant or replacement (procedure code 37.94), the case is assigned to DRG 104 or 105 (Cardiac Valve Procedures with or without Cardiac Catheterization).

However, if a procedure is performed that involves the implantation or replacement of only part of the AICD system (that is, replacement or implant of either the leads or pulse generator only), the case is assigned to DRG 120 (Other Circulatory System OR Procedures). The related procedure codes are the following: 37.95 (Implantation of automatic cardioverter/defibrillator lead(s) only), 37.96 (Implantation of automatic cardioverter/defibillator pulse generator only), 37.97 (Replacement of cardioverter/defibrillator lead(s) only), and 37.98 (Replacement of automatic cardioverter/defibrillator pulse generator only). We note that if a case is coded with a pair of codes that indicates total implant (37.95 and 37.96) or total replacement (37.97 and 37.98), it groups to DRG 104 or 105.

The correspondence we have received has generally recommended that cases in which only part of an AICD system is implanted or replaced be reassigned from DRG 120 to a DRG that more accurately reflects the resources incurred in performing the procedure, preferably a DRG with a higher weight than that of DRG 120. This recommendation has been based on various studies commissioned by the manufacturer of the AICD device. These studies have concluded that the average standardized charges for implant or replacement of AICD leads or pulse generator only have been consistently understated in the MEDPAR file. For a detailed discussion of the previous years' comments and our responses on this subject, see the final rules dated September 1, 1989 (54 FR 36465), September 4, 1990 (55 FR 36023), and August 30, 1991 (56 FR 43216).

In the August 30, 1991 final rule, we described the various measures we had taken in an attempt to improve the MEDPAR charge and coding data on AICD devices. We furnished information given to us by commenters about potential improper coding and billing to the Peer Review Organizations (PROs) for their review. In addition, we sent an instruction to our fiscal intermediaries (Transmittal No. 1525, May 1991) to return to the hospital for review any inpatient claim with procedure code 37.94, 37.95, 37.96, 37.97, or 37.98 for which total charges are less than $17,000. (The manufacturer claimed that the device alone costs $13,500 and the additional $3,500 represents the average cost of a 4-day length of stay.) We also instructed the carriers to deny charges under Medicare 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. In the August 30, 1991 final rule, we stated that these changes should improve the AICD data in the FY 1991 MEDPAR file, and we would review those cases as a part of our FY 1993 DRG analysis (56 FR 43217).

Our analysis of the AICD cases in the FY 1991 MEDPAR data was based on 958 cases assigned to DRG 120 and 273 cases that were assigned to DRG 112 (Percutaneous Cardiovascular Procedures). (Cases that involve the implant or replacement of AICD lead or generator only group to DRG 112 when electrophysiologic (EP) studies (procedure code 37.26) are also performed.) Based on these cases, we found that the cases with AICD procedures that were classified in DRG 120 in FY 1991 had an average standardized charge of $19,380. The cases that grouped to DRG 112 had an average standardized charge of $32,626. Thus, the overall average standardized charge for these cases was $22,317.

Since the average standardized charge for all cases in DRGs 112 and 120 in FY 1991 was only approximately $14,000, we believe it is appropriate to propose a change in the classification of the AICD cases effective for FY 1993. Because it is generally not our policy to create single procedure DRGs, we are proposing to reassign AICD cases to an existing DRG. However, the current clinical composition and weights of the surgical DRGs in MDC 5 do not offer a perfect match for reclassification of the AICD

cases. After reviewing the current DRGs in terms of clinical coherence and similar resource use, we are proposing to reassign procedure codes 37.95, 37.96, 37.97, and 37.98, when they do not occur as pairs, to DRG 116 (Permanent Cardiac Implant without AMI, Heart Failure, or Shock). The average standardized charge of $17,214 for DRG 116 is higher than that of both DRGs 112 and 120 and, from a clinical perspective, we believe that the surgical implant of an AICD device is similar to a pacemaker implant. We considered assigning these cases to both DRGs 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock) and 116, so that AICD implants would be assigned in the same way permanent cardiac pacemakers are (that is, depending on principal diagnosis). However, our review of cases in which an AICD device is replaced or implanted showed no cases in which AMI, heart failure, or shock is a principal diagnosis. Therefore, in any case, all the AICD cases would group to DRG 116.

We believe that the reassignment to DRG 116 would help improve the payment for the AICD cases and would not disrupt the current MDC 5 surgical classification. Since DRG 116 is higher in the surgical hierarchy than DRG 112, the AICD cases that currently group to DRG 112 would also be reassigned to DRG 116. The new title of DRG 116 would be "Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure."

4. Major Joint and Limb Reattachment Procedures of Lower Extremity (DRG 209)

As a part of the DRG changes set forth in the August 30, 1991 final rule, we revised the classification of cases assigned to DRG 209. Before October 1, 1991, DRG 209 was titled: "Major Joint and Limb Reattachment Procedures", and procedures of both the upper and lower extremity were assigned that DRG. Effective with discharges occurring on or after October 1, 1991, former DRG 209 was split into two DRGs: DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) and DRG 491 (Major Joint and Limb Reattachment Procedures of Upper Extremity). (See 56 FR 43205.)

In the August 30, 1991 final rule, in response to a comment we received on the DRG 209 change, we stated that we would analyze the appropriate assignment of major limb reattachment procedures as part of our analysis of potential FY 1993 changes. The commenter suggested that major limb reattachment procedures be separated and assigned to a new DRG. The commenter believes that these procedures are clinically different from and incur higher costs than major joint replacement procedures. 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.

We analyzed the FY 1991 MEDPAR data for limb reattachment cases and found that there were no major limb reattachment cases in the 10 percent sample of all Medicare cases that we use for analyzing possible classification changes. That is, in the 10 percent sample, there were no cases of limb reattachments (of either upper or lower extremities) found in any DRG, including DRG 209 and DRG 485 (Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma). While these limb reattachment cases may be different clinically and in terms of resource consumption from the major joint replacement cases in DRG 209 and from the other cases in DRG 485, these cases appear to be especially rare in the Medicare population. Based on the lack of supporting data and the fact that few reattachment procedures are performed, we are not proposing any changes to the DRG assignment of major limb reattachment cases.

5. Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders (MDC 20)

In response to concerns that the alcohol/drug DRGs needed further refinement, alcohol/drug treatment hospitals and distinct part hospital units were excluded from the prospective payment system soon after its implementation. This exclusion was temporary until an adjustment to the DRG classification system would permit prospective payment to be made appropriately for alcohol and drug treatment services.

In 1986, in order to address previous data deficiencies and to ensure the most accurate analysis possible, a representative sampling of FY 1984 MDC 20 cases was analyzed using data abstracted from medical records. This study indicated that the use of CCs explained significant differences in resource use and improved overall homogeneity in the alcohol and drug DRG classification, particularly in DRGs 434 and 435. In addition, the effects of CCs explained more of the variation in resource utilization than did other variables studied, including the presence or absence of surgery. Therefore, the DRGs were restructured as follows:

DRG 433	Alcohol/drug abuse or dependence, left against medical advice.
DRG 434	Alcohol/drug abuse or dependence, detoxification or other symptomatic treatment, with CC.
DRG 435	Alcohol/drug abuse or dependence, detoxification or other symptomatic treatment, without CC.
DRG 436	Alcohol/drug dependence with rehabilitation therapy.
DRG 437	Alcohol/drug dependence, combined rehabilitation and detoxification therapy.

Based on this study, the exclusion of alcohol/drug treatment hospital and units from the prospective payment system was eliminated, and these hospitals and units were brought under the prospective payment system effective October 1, 1987 (FY 1988). (For a detailed discussion of this change, see the June 10, 1987 proposed rule (52 FR 22081), the September 1, 1987 final rule (52 FR 33036), and the September 1, 1987 final notice on DRG classification changes (52 FR 33143).)

Since that time, we have received inquires about the absence of any surgical partitioning in MDC 20. In particular, comments we received in response to the June 3, 1991 proposed rule were concerned that the performance of a surgical procedure on patients admitted for treatment for alcohol/drug related conditions that classify to MDC 20 had no influence on the DRG assignment. In the August 30, 1991 final rule, in response to these comments, we stated our intention to examine this issue as a part of our analysis of potential FY 1993 DRG classification changes (56 FR 43203.).

Our analysis of the FY 1991 MEDPAR data has revealed that the procedures reported for MDC 20 discharges were almost entirely therapeutic or diagnostic in nature. Only 1.5 percent of all procedures reported were operating room (OR) procedures. Since more than one OR procedure was often performed for a particular hospital stay, the total number of cases in MDC 20 that would result in a surgical DRG assignment is under 1 percent. We do not believe that this is a sufficient number of cases to create a surgical DRG in MDC 20. In addition, none of these OR procedures could be said to be related to the principal diagnosis that classified the case to MDC 20.

However, a review of the average charges for the surgical cases shows that these cases tend to be much more expensive than the medical cases that

group to that MDC. In fact, the average charge for a case with an OR procedure more closely resembles the average charge of those cases classified to DRGs 468 (Extensive OR Procedure Unrelated to Principal Diagnosis), 476 (Prostatic OR Procedure Unrelated to Principal Diagnosis), and 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis), depending on the assignment procedure. Therefore, to ensure equitable payment and to accommodate surgeries performed during alcohol/drug admissions, we are proposing that all cases classified in MDC 20 for which an OR procedure is performed would be assigned to DRG 468, 476, or 477 as appropriate, effective with discharges on or after October 1, 1992. DRGs 433 through 437 will otherwise remain as currently structured.

6. 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 a one or more DRGs. For example, in MDC 5, the surgical class "heart transplant" consists of a single DRG (DRG 103) and the class "coronary bypass" consists of two DRGs (DRGs 106 and 107). 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 procedure in the most resource-intensive surgical class, 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 lower 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 are proposing to modify the surgical hierarchy as set forth below. As we stated in the September 1, 1989 final rule (54 FR 36457), we are unable to test the effects of the proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights due to the unavailability of revised GROUPER software at the time this proposed rule is prepared. Rather, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification and then determine the average charge for each DRG. These average charges then serve as our best estimate of relative resource use for each surgical class. We test the proposed surgical hierarchy changes after the revised GROUPER is received and reflect the final changes in the DRG relative weights in the final rule. Further, as discussed below in section II.C of this preamble, we anticipate that the final recalibrated weights will be somewhat different from those proposed since they will be based on more complete data. Consequently, further revision of the hierarchy, using the above principles, may be necessary in the final rule.

At this time, we would revise the surgical hierarchy for MDCs 3, 5, 8, and 12 and the pre-MDC DRGs.

- In the pre-MDC DRGs, we propose to reorder Tracheostomy Except for Mouth, Larynx, or Pharynx Disorder (DRG 483) above Bone Marrow Transplant (DRG 481).
- In MDC 3, we propose to reorder Myringotomy with Tube Insertion (DRGs 61 and 62) above Cleft Lip and Palate Repair (DRG 52) and reorder Sinus and Mastoid Procedures (DRGs 53 and 54) above Sialoadenectomy (DRG 50).
- In MDC 5, we propose to reorder Amputation for Circulatory System Disorders Except Upper Limb and Toe (DRG 113) above Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure (DRGs 115 and 116) and to reorder Upper Limb and Toe Amputation for Circulatory System Disorders (DRG 114) above Cardiac Pacemaker (DRGs 117 and 118).
- In MDC 8, we propose to reorder Foot Procedures (DRG 225) above Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC (DRG 223).
- In MDC 12, we propose to reorder Testes Procedures (DRGs 338, 339, and 340) above Transurethral Prostatectomy (DRGs 336 and 337).

7. 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.

In previous years, we have made changes to the standard list of CCs, either the addition of new CCs or the deletion of CCs already on the list. For FY 1993, we are not proposing to make any changes to the current CC list.

In the September 1, 1987 final notice concerning changes to the DRG classification system (52 FR 33143), we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes to preclude coding of closely related conditions, to preclude duplicative coding or inconsistent coding from being treated as CCs, and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.

In the May 19, 1987 proposed notice concerning changes to the DRG classification system (52 FR 18877), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for a condition should not be considered CCs for one another.
- Conditions that may not co-exist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- The same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended to be only a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered complications or comorbidities of another diagnosis. For that reason and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC, stated above, as appropriate. (See the September 30, 1988 final rule for the revision made for the discharges occurring in FY 1989 (53 FR 38485), the September 1, 1989 final rule for the revision made for discharges occurring in FY 1990 (54 FR 36552), the September 4, 1990 final rule for the revision made for discharges occurring in FY 1991 (55 FR 36126), and the August 30, 1991 final rule for the revision made for discharges occurring in FY 1992 (56 FR 43209).)

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1992. (See section II.B.9, below, for a discussion of these changes.) These proposed changes are being 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 proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1992. Each table shows the principal diagnoses with proposed 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. Beginning with discharges on or after October 1, 1992, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6h—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1992, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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 $73.00 and on microfiche for $19.00, 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 to the CC Exclusions List (FYs 1989, 1990, 1991, and 1992) 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, 1992.

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 current DRG Definitions Manual, Eighth Revision, is available for $195.00, which includes $15.00 for shipping and handling. The Ninth Revision of this manual, which will include the changes proposed in this document as finalized in response to public comment, will be available in September 1992 for $195.00. These manuals may be obtained by writing 3M/HIS at: 100 Barnes Road, Wallingford, Connecticut 06492 or by calling (203) 949–0303.

Please specify the revisions requested.

8. 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 (Nonextensive 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 a prostatic

procedure is performed that is unrelated to the principal diagnosis.

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 are not proposing to move any procedures from DRGs 468 or 477 to one of the surgical DRGs.

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 are proposing to add the following four procedures to the list of nonextensive procedures that group to DRG 477:

04.41	Decompression of trigeminal nerve root.
04.42	Other cranial nerve decompression.
04.44	Release of tarsal tunnel.
04.49	Other peripheral nerve or ganglion decompression or lysis of adhesions.

These cases would group to DRG 477 instead of DRG 468 beginning with discharges on or after October 1, 1992.

9. Changes to the ICD–9–CM Coding System

As discussed above in section II.B.1 of this preamble, the ICD–9–CM is a coding system which is used 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 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 representatives of recognized organizations in the coding fields, such as the American Health Information Management Association (AHIMA) (formerly 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 to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on May 2, August 1 and 2, and December 5 and 6, 1991 and finalized the coding changes after consideration of comments received at the meetings and in writing in the 30 days following the December 1991 meeting. The initial meeting for consideration of coding issues for resolution in FY 1993 will be held on May 7, 1992. 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: 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: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, HCFA, Office of Coverage and Eligibility 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, 1992. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section IV of the addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classification.

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 GROUPER beginning with discharges occurring on or after October 1, 1992. 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 proposed DRG assignments for these revised codes.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 1993 recalibration as we did for FY 1992. (See the August 30, 1991 final rule (56 FR

43218).) That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we would use the most current charge information available, the FY 1991 MEDPAR file, rather than the FY 1990 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 are constructed from FY 1991 MEDPAR data, received by HCFA through December 1991, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1991 MEDPAR file includes data for approximately 10.2 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1991 MEDPAR file is as follows:

- All the claims were regrouped using the proposed DRG classification revisions discussed above in section II.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 1991 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 Medicare-approved 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 1990 MEDPAR data used to establish the FY 1992 weights, there were 37 DRGs that contained fewer than 10 cases. We propose to use that same case threshold in recalibrating the DRG weights for FY 1993. Using the FY 1991 MEDPAR data set, there are 38 DRGs that contain fewer than 10 cases. We computed the weight for the 38 low-volume DRGs by adjusting the original weights of these DRGs by the percent change in the average weight of the cases in the remaining DRGs.

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.

Section 1886(d)(4)(C)(iii) of the Act requires that reclassification and recalibration changes beginning with FY 1991 be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. We interpret section 1886(d)(4)(C)(iii) of the Act to require that we ensure the FY 1993 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 proposed rule, we are proposing to make a budget neutrality adjustment to assure the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

D. FY 1991 DRG Classification Changes and Their Effect on DRG Relative Weights and Payments

As described above in sections II.B and C of this preamble, each year we make changes to the DRG classifications in addition to recalibrating the relative weights based on the most recent charge data available. In the September 4, 1990 final rule, we made several major modifications to the DRGs effective with discharges occurring on or after October 1, 1990 (FY 1991). These changes included creating two new DRGs for liver and bone marrow transplants, which had recently been approved for coverage under the Medicare program. In addition, we added two DRGs for cases in which a tracheostomy is performed: one for patients with a disorder of the mouth, larynx, or pharynx and one for all other patients. Cases are assigned to these four DRGs prior to assignment to one of the MDCs.

We also added two new MDCs, one for multiple significant trauma (MDC 24) and one for human immunodeficiency virus (HIV) infections (MDC 25), and we placed these two MDCs ahead of the other MDCs in the GROUPER. Thus, cases are assessed for assignment to these DRGs before the other 23 MDCs. MDC 24 consists of four DRGs (three surgical and one medical) and MDC 25 is made up of three DRGs (one surgical and two medical).

The FY 1991 changes were designed to improve payment equity by increasing the amount of variation in resource costs explained by the DRGs. For the most part, these new DRGs have extremely high weights, and the cases that are now classified to them receive much higher payments than they would have absent the changes.

When changes in DRG classifications are made, we account for the effect the changes will have on future program payments through the recalibration and normalization of the DRG weights. In the year in which the changes are effective, they are intended to be budget neutral; that is, the payments in that year should be no more or no less than the payments would have been without the changes. As discussed in more detail above, in section II.C of this preamble, recalibration is accomplished by processing the most recent, complete MEDPAR data through a revised GROUPER that encompasses the DRG classification changes and reweighting the DRGs based on the charges

submitted by the hospitals. After recalibration is complete, the new weights are normalized by an adjustment factor. The normalization process compares the average case weight before recalibration to the average case weight after reclassification and recalibration using the same set of MEDPAR data, and an adjustment is made to the new weights so that these two average case weights are the same.

When we conducted the normalization of the FY 1991 DRG weights, we used the FY 1989 MEDPAR data. The FY 1989 claims were first mapped into their FY 1990 equivalents and processed through the FY 1990 GROUPER to determine the average case weight for that year. Those same data were then remapped into their FY 1991 equivalents and processed through the FY 1991 GROUPER to estimate what would be the average case weight during that year. The new DRG weights were then adjusted so that the two average case weights (FYs 1990 and 1993) are equal. (In addition to this process, we also made a budget neutrality adjustment to ensure that aggregate payments made in FY 1991 would be no more than and no less than they would have been absent the DRG and wage index changes.)

Now that the MEDPAR file for FY 1991 is available, we can evaluate the effect of the new DRGs on the actual distribution of cases under the revised DRGs. We find that many more cases than we had originally estimated were classified into the new DRGs. In addition, there are many DRGs that experienced at least a 20 percent increase or decrease in percentage of cases assigned between FY 1989 and FY 1991 when both sets of cases are grouped using the FY 1991 GROUPER. These include several of the new DRGs, other DRGs that were revised effective with FY 1991, and some DRGs for which there was no major change.

The effect of these unanticipated changes in the distribution of cases and the resulting increase in average DRG weight resulted in a 1 percent increase in Medicare inpatient hospital program payments compared to the payments that would have resulted if we had not made DRG reclassification and recalibration changes in FY 1991. If we had been in possession of the actual FY 1991 cases when we established the weights for FY 1991, the overall average case-mix index would have been 0.99 percent lower than the actual FY 1991 case-mix index. The total case-mix change between FY 1990 and FY 1991 was 2.5 percent.

Although there can be many reasons for increases in the relative number of cases assigned to a particular DRG, including an increase in the frequency with which procedures are performed or an increase in inpatient treatment of certain diagnoses, we believe that the 1 percent increase attributable to the DRG classification and recalibration changes was, for the most part, caused by coding improvements made in response to the FY 1991 DRG changes. The increase in cases assigned to higher-weighted DRGs is most dramatic in the new tracheostomy DRG 483 and the three new HIV-related DRGs (488 through 490). When the FY 1989 and 1991 cases are separately classified using the FY 1991 GROUPER, the number of cases assigned to DRG 483 increases 30 percent between the 2 years and the number of cases assigned to DRGs 488 through 490 increases by 123 per cent. The following table illustrates the changes:

DRG	Number of cases in DRG		DRG cases as percent of total cases		
	Estimate	Actual	Estimate	Actual	Percent increase
483	25,191	32,751	0.25	0.32	30
488	261	473	0.003	0.005	81
489	1,801	4,187	0.02	0.04	133
490	780	1,679	0.01	0.02	115
Total MDC 24	2,842	6,334	0.03	0.06	123
Total cases	28,013	39,085	0.28	0.38	40

As noted above, we believe that the increases in the tracheostomy and HIV DRGs are due to the fact that hospitals changed their coding practices between FYs 1989 and 1991 in response to the FY 1991 DRG changes. Before implementation of the FY 1991 changes, there was no incentive to code a tracheostomy outside of MDC 4 nor was there any incentive to code secondary diagnoses of HIV. However, once these codes became significant for correct DRG classification, they were included on claims where they might previously have been left off.

Based on our analysis of the FY 1989 MEDPAR, we estimated that 55 percent of the cases reassigned to DRG 483 would have been classified to DRG 474 (Respiratory System Diagnoses with Ventilator Support) in MDC 4 before the FY 1991 changes. However, the actual number of cases reassigned from DRG 474 was lower while the number of cases reassigned from all other DRGs increased dramatically. The following table demonstrates these changes:

BREAKDOWN OF CASES ASSIGNED TO DRG 483 IN FY 1991

FY 1989 DRG	Estimate		Actual	
	Number of cases	Percent of DRG 483 cases	Number of cases	Percent of DRG 483 cases
DRG 474	13,929	55	11,851	36
All other DRGs	11,262	45	20,900	64
Total	25,191	100	32,751	100

This indicates that a significant number of cases assigned to other DRGs in the FY 1989 MEDPAR did not include a code for a tracheostomy procedure that was performed during the stay. Because DRG 483 had such a high relative weight in FY 1991 (14.0597) compared to the DRGs from which these cases were reclassified, the inability to predict correctly the actual case distribution resulted in a substantial unanticipated increase in program payments.

The new DRGs created for HIV cases experienced a similar influx of cases. In this case, the actual FY 1991 cases came from the DRGs we had predicted they would; however, they came in much larger numbers than we had estimated. For example, based on our analysis of the FY 1989 MEDPAR, we predicted that 21 percent of the cases reassigned to DRG 489 (HIV with Major Related Condition) would have been assigned to DRG 79 (Respiratory Infections and Inflammations with CC) absent the reclassification. The actual percentage of FY 1991 cases assigned to DRG 489 that would have been assigned to DRG 79 remained virtually constant at 22 percent. However, the estimated number of cases was 385 and the actual number was 922. Therefore, even though we correctly predicted the percent of cases in DRG 489 that would move from DRG 79, the number of cases more than doubled. While we recognize the incidence of HIV may have increased between FY 1989 and 1991, we believe a 123 percent increase must also be attributable to improved coding for HIV infection.

On a smaller scale, this type of change in coding happens every year in response to DRG changes. One example of such a change is the deletion of diagnoses from the list of CCs. When CCs are present in a case, hospitals will make sure to code at least one CC in order to classify a case in the higher-weighted "with CC" DRG. However, if that CC is deleted from the list of recognized CCs for the DRG and we predict that the case would now be classified in the non-CC DRG, it is possible that hospitals will simply code another CC present in the medical record in order to achieve the "with CC" classification. Therefore, cases that we had predicted would be classified to the "without CC" DRG actually remain as CC cases because of a change in coding.

Based on the FY 1989 MEDPAR, we had estimated that CC revisions effective for FY 1991 would change the distribution of cases in DRGs 320 and 321 (Kidney and Urinary Tract Infections Age > 17) by decreasing the number of cases assigned to DRG 320 (with CC). (The number of cases assigned to DRG 321 were estimated to remain about the same.) However, the actual number of cases assigned to DRG 320 in the FY 1991 MEDPAR file increased and the number of cases assigned to DRG 321 decreased. The number of cases assigned to DRGs 320 and 321 and their percent of total MEDPAR cases are shown below:

	Relative weight	Estimate DRG cases		Actual DRG cases	
		Number of cases	As percent of total cases	Number of cases	As percent of total cases
DRG 320	1.0055	145,039	1.47	162,874	1.60
DRG 321	.6507	34,523	0.38	28,718	0.28

Thus, the number of cases assigned to the higher-weighted DRG increased from the number we had estimated, and the number of cases assigned to the lower-weighted DRG decreased. As with DRG 483, the coding practice changes made in response to our reclassification of CCs resulted in additional program payments beyond those we had estimated.

This can also happen in response to surgical hierarchy changes or to changes in the procedures that effect classification. This can be seen in the movement of cases in MDC 5 between FYs 1989 and 1991. We completely reconstructed the majority of the surgical DRGs in MDC 5 effective for FY 1991 and there were significant deviations from the estimated frequency for each DRG. For example, the changes made in MDC 5 for FY 1991 resulted in a tremendous increase of cases coded with percutaneous cardiovascular procedures. We assigned these cases to DRG 112 effective with FY 1991 and, based on the FY 1989 MEDPAR, we estimated that 83,614 cases would group to this DRG. The FY 1991 MEDPAR shows that 128,778 cases were assigned to this DRG, an increase of 54 percent. Although this is the DRG that changed the most in terms of number of cases, virtually all of the revised MDC 5 DRGs experienced some change in the number of cases assigned in FY 1991 as opposed to our estimates.

Although we have experienced this type of case-mix increase before (see the September 1, 1989 final rule for a discussion of the inflationary effect of the FY 1987 DRG changes (54 FR 36469)), we are particularly concerned about this problem in light of the fact that we are seriously considering major changes to the DRG system to better explain the effects of severity of illness. Besides the mandate of section 1886(d)(4)(C)(iii) of the Act, which provides that aggregate payments may not be affected by DRG reclassification and recalibration changes, we do not believe it is prudent policy to make changes for which we cannot predict the effect on the case-mix index and, thus, payments.

Although we can predict that changes in certain hospital coding practices may result from DRG changes we make, it is not possible to predict which claims will be affected by these changes. Thus, in the reclassification and recalibration process, we can rely only on the code information included on actual cases. We are hoping that the expansion of the hospital bill to include nine diagnosis and six procedure codes will help to alleviate our problem to some extent. However, this change went into effect on April 1, 1992 and, thus, will not be reflected in a full year of MEDPAR data until FY 1993, which means it will not be available to us for purposes of weight construction until FY 1995.

We are strongly committed to making changes in the DRG system to improve payment equity; however, our current inability to predict the changes in coding behavior that may result from our revisions limits the extent to which we are willing to revise the system. Until such time as we are able either to improve our ability to predict coding changes by validating in advance the impact that potential DRG classification changes may have on coding behavior

or to make methodological changes to prevent building the inflationary effects of the coding changes into future program payments, we intend to make only relatively insignificant changes in the DRG classification system. As a general policy, we will consider the changes to be insignificant if, in the aggregate, we estimate that program payments would increase by less than 0.1 percent or $60 million if we have underestimated by 10 percent the number of cases that would receive more favorable payment under the DRG classification changes that provide incentives for coding improvement.

In this proposed rule, we believe that the proposed changes to MDC 4 and 17 involving certain endoscopic procedures and to MDC 20 involving recognition of OR procedures provide incentives for coding improvement since they involve recognition of procedures that do not currently affect DRG assignment. If we have made a 10 percent underestimation in the number of cases that are directly affected by these classification changes, we estimate that program payments would increase by .0204 percent, or $12 million. The potential for increased program payments is mostly related to our proposal to recognize certain endoscopic procedures as OR procedures.

Based on current coding practices, we estimate approximately 32,000 cases in MDCs 4 and 17 that are currently assigned to medical DRGs with an average case weight of 1.36508 would be assigned to surgical DRGs with an average case weight of 2.27465. If we have underestimated by 10 percent the number of cases that would be paid as surgical DRGs, program payments would increase by .02 percent. If we have underestimated by 10 percent the number of cases that would be affected by the DRG 20 change, we estimate program payments would increase by .0004 percent. Although we are proposing all changes that we believe are appropriate this year, this general policy will preclude our making significant refinements to the DRG system until we are able to protect program payments against the inflationary impact of those changes.

One approach to this problem that we have considered is maintaining the average case weight at 1.0 after recalibration, thereby eliminating the process of normalization. In other words, after recalibration, we would not scale the new weights upward to carry forward the cumulative effects of past case-mix increases. We would, instead, make an adjustment or include in the annual update factor a specific allowance for any real case-mix change that occurred during the previous year. This is a relatively simple and straightforward system for preventing the effects of year-to-year increase in case-mix index from accumulating in the DRG weights.

This methodology would have several advantages. First, it would be an easy and effective means of removing from the payment base inappropriate year-to-year case-mix increase (that is, case-mix increases mainly due to changes in coding practices). It would also streamline the current process of adjustments, where recalibration of the weights is followed by normalization, and the recommended update factor includes a negative adjustment to offset all case-mix increase estimated for the previous year followed by a positive increase to add back the real case-mix increase (that is, a genuine increase in the resources required to treat patients). Finally, the change would restore the meaning of the relative weights by bringing the average weight back to 1.0 each year. Thus, 1.0 would reflect the average resources used to treat the average Medicare inpatient hospital case, while a weight of 2.0 would reflect a case that requires twice the average resources to treat and a weight of 0.5 would reflect a case that requires one-half the average resources. Since the estimated average FY 1991 DRG relative weight is 1.367, this type of comparison is not readily accomplished using normalized DRG relative weights.

We are soliciting public comment on this and other possible approaches that could be implemented in the future by legislation or administratively to account for coding changes that result from revisions in the DRGs. Your comments should take our statutory mandates for prospectivity and budget neutrality into account.

III. Proposed Changes to the Hospital Wage Index

A. Background

Sections 1886(d)(2)(H) and 1886(d)(3)(E) of the Act require 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 this requirement, we construct an index that reflects average hospital wages in each urban and rural area as a percentage of the national average hospital wage.

For determining prospective payments to hospitals in FY 1992, the wage index is 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. The FY 1992 wage index reflected all corrections that had been made in the wage survey data through August 15, 1991.

Section 1886(d)(3)(E) of the Act requires that the hospital wage index be updated annually beginning October 1, 1993.

B. Updating the Wage Index Data

For discharges occurring on or after October 1, 1992, the proposed wage index would continue to be based solely on 1988 wage data. In addition, in determining the proposed wage index, we incorporated all corrections of errors that have been identified in the survey wage data since the construction of the wage index implemented for FY 1992 in the August 30, 1991 final rule.

The wage indexes are shown in Tables 4a through 4c in the addendum to this proposed 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 section 1886(d)(10) of the Act the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. The first hospital reclassifications based on the decisions of the MGCRB took effect on 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 were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is 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. Therefore, the wage index values were

determined by considering the following:

• If including the wage data for the redesignated hospitals reduces the MSA wage index value by 1 percentage point or less, the MSA wage index value applies to the redesignated hospitals deemed to be a part of that MSA. The MSA wage index value is determined exclusive of the wage data for the redesignated hospitals.

• 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 1 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. However, the resulting 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.

• Rural areas whose wage index values would be reduced by excluding the data for hospitals that have been redesignated to another area continue to have their wage index calculated as if no redesignation had occurred. Those rural areas whose wage index values increased as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index calculated exclusive of the redesignated hospitals.

• The wage index value for an urban area is calculated exclusive of the wage data for hospitals that have been reclassified to another area. However, the wage index for an urban area may not be reduced, as a result of geographic reclassification, below the Statewide rural average.

We note that, except for those rural areas where redesignations 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 redesignated from the area for purposes of their wage index. As a result, there are a few MSAs listed in Table 4a that have no hospitals remaining in the MSA. This is because the hospitals in the original MSA have been reclassified to another area by the MGCRB and our records indicate that there are no other hospitals currently classified in those areas. For those areas, we have listed the Statewide rural wage index value.

The proposed revised wage index values effective for discharges occurring on or after October 1, 1992 are shown in Tables 4a, 4b, and 4c of the addendum to this proposed 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 has a higher Statewide rural wage index value than the wage index value otherwise applicable to the redesignated hospitals.

Revised Table Names

Table 4—Wage Index for Urban Areas

Table 4b—Wage Index for Rural Areas

Table 4c—Wage Index for Redesignated Hospitals

The proposed FY 1993 wage index values incorporate all reclassification decisions made by the MGCRB as of March 30, 1992. As of that date, there were 1,150 hospitals reclassified for purposes of the wage index (including hospitals reclassified under both sections 1886(d)(8)(B) and 1886(d)(10) of the Act). This number does not include MGCRB decisions that are still under review by the Administrator. At the time this proposed wage index was constructed, the MGCRB had completed its review. Any changes that result from appeals and the Administrator's review process will be incorporated into the wage index values to be published in the final rule. The changes may affect not only the wage index value for specific geographic areas, but also whether redesignated hospitals receive the wage index of the area to which they are redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index for the area from which the hospitals are redesignated may be affected.

We note that hospitals that have been reclassified by the "MGCRB are permitted to withdraw their applications within 45 days of the publication of this **Federal Register** document. The request for withdrawal of an application for reclassification that would be effective in FY 1993 must be received by the MGCRB by July 20, 1992.

We caution that the proposed wage index value will change in the final rule to take into account the impact of revisions in reclassification decisions resulting from the appeals and review process, any withdrawal requests, and any wage index corrections that are made before publication of the final rule. A hospital that requests to withdraw its application may not request that the MGCRB decision be reinstated after publication of the final notice of prospective payment rates.

D. Midyear Corrections to the Wage Index Values

It has been our policy under § 412.63(p)(2) to make midyear corrections to the hospital wage data and adjust the wage index for the affected areas on a prospective basis. However, implementation of mid-year corrections has resulted in several problems concerning the reclassification of hospitals by the MGCRB.

In the June 4, 1991 final rule with comment period affecting the MGCRB (56 FR 25477), we indicated that the MGCRB would use the latest updated survey data, including midyear corrections, to assess reclassification requests. We adopted this policy in order to ensure that hospitals whose applications were submitted based on corrected wage data would be treated fairly. However, because wage data corrections are processed on an ongoing basis throughout the year, the outcome of a hospital's reclassification request may in some cases depend entirely on whether the intermediary's audit and our subsequent processing of its wage correction are completed before the MGCRB issues its decision on the hospital's application. That is, since the MGCRB makes its determination based on the data available at the time a hospital's case is being considered, whether a hospital meets the criteria for reclassification for purposes of the wage index may depend on the timing of the implementation of a wage correction.

Also, under section 1886(d)(8)(C) of the Act, the wage index applicable to reclassified hospitals is 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. As explained above, if the impact is a reduction of 1 percentage point or less, the reclassified hospitals receive the MSA wage index value. If the impact is a reduction of greater than 1 percentage point, the reclassified hospitals receive the wage index value that results from combining their wage data with the MSA data. This combined value is normally lower than the MSA value. Under our current policy, we have had instances in which a correction to the wage data for a hospital in an MSA has increased the impact of reclassifications on the MSA wage index value to greater than 1 percentage point. In these situations, reclassified hospitals that had been receiving the MSA wage index value became subject to the lower combined wage index value. Thus, solely as a result of another hospital's wage corrections, payments to these

reclassified hospitals were reduced midway through the fiscal year. These hospitals are confronted with an unanticipated reduction in revenues when their Medicare payments are abruptly reduced because of mid-year wage data corrections.

The current wage index based on 1988 calendar year data has been in effect since FY 1991. Thus, we believe that hospitals have had sufficient time to review their wage data and submit corrections where appropriate. Therefore, in order to resolve the problems described above, we are proposing to eliminate mid-year wage data corrections effective with requests for correction received on or after October 1, 1992.

Under this proposal, only those requests for wage data corrections that are submitted with supporting documentation and received by the fiscal intermediary no later than September 30, 1992 would be implemented as a mid-year wage index change. Changes based on those corrections would be made on a prospective basis in FY 1993 in accordance with our current policy. The specific requirements would be as follows:

- A hospital that wishes to make a correction to its reported wage data must submit to its fiscal intermediary a revised wage survey form (HCFA 2561) along with supporting documentation by no later than September 30, 1992.
- Within 30 days, the fiscal intermediary will review the data and adjust it as appropriate. Upon completion of its review, the fiscal intermediary will forward the hospital's request to the HCFA's Division of Hospital Payment Policy, along with a letter that summarizes the hospital's request and makes a recommendation concerning the appropriateness of the requested wage correction.
- HCFA will review the request and, if HCFA determines that a wage correction is warranted, the wage index value for the area in which the hospital is located will be revised on a prospective basis.
- In cases where the hospital submitted supporting documentation but additional information is required by the fiscal intermediary or HCFA, the hospital must submit the required information within 30 days of receiving the request.

As required by section 1886(d)(3)(E) of the Act, we will update the wage index data on an annual basis beginning October 1, 1993. We are currently collecting wage data on an ongoing basis as part of the Medicare cost report. Fiscal intermediaries are transmitting these wage data through the Hospital Cost Report Information System (HCRIS). We expect to use the latest data available through HCRIS to update the wage index on an annual basis. A hospital that wishes to make corrections to the wage data reported on its Medicare cost report will do so through its fiscal intermediary in accordance with the normal cost report revision or reopening procedures. Fiscal intermediaries will forward any corrections to HCFA through HCRIS, and we will incorporate those corrections into the wage index on an annual basis, at the same time we update the wage index for payment purposes.

E. Revised Metropolitan Statistical Area (MSA) Definitions Based on 1990 Census Data

In the August 30, 1991 final rule (56 FR 43202), we indicated that the Office of Management and Budget (OMB) expected to issue revised MSA definitions based on 1990 census data in June 1992. We had anticipated implementing the new MSA definitions in the FY 1993 final rule in accordance with our policy of adopting MSA changes at the beginning of the Federal fiscal year following OMB's announcement (see § 412.63(b)(4)). However, we pointed out potential problems associated with implementing major MSA changes (such as reconfiguring the wage index and standardized amounts and determining appropriate geographic reclassifications) in a final rule without prior notification in the proposed rule. We also solicited public comments on possible approaches to implementing the revised MSA definitions.

However, because of significant delays in obtaining the necessary data from the Bureau of Census, OMB does not expect to publish the revised MSA definitions by June 30, 1992, as originally planned. As of April 1, 1992, the census data were still not available and the Federal Executive Committee on Metropolitan Areas, which makes recommendations to OMB concerning the MSA definitions, had not yet initiated its review.

The delay in publication of the new MSA definitions will not allow us sufficient time to implement the revised MSAs in the FY 1993 final rule, which must be published by September 1, 1992. Therefore, we now plan to implement the revised MSA definitions based on 1990 census data in FY 1994. Since OMB's originally expected publication date was actually 1 year ahead of normal schedule (the MSAs based on 1980 census data were announced in 1983 and implemented in FY 1984), implementation of the revised MSAs in FY 1994 is within the 10-year census period. Therefore, we will announce the revised MSAs and describe their effect on the wage index and geographic reclassifications in the FY 1994 proposed rule.

IV. Proposed Changes Concerning Reclassifications by the Medicare Geographic Classification Review Board

A. Background

Section 6003(h)(1) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239), enacted on December 19, 1989, added section 1886(d)(10) to the Act to provide for creation of the Medicare Geographic Classification Review Board (MGCRB). On September 6, 1990, we published an interim final rule with comment period (55 FR 36754) that provided for the establishment of the MGCRB and set forth the criteria for the MGCRB to use in considering applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. The interim final rule also set forth requirements regarding the MGCRB's composition and operational procedures. On June 4, 1991, we published a final rule with comment period (56 FR 25458) that responded to comments on the September 6, 1990 interim final rule and implemented provisions of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508, enacted on November 5, 1990) concerning the MGCRB.

Guidelines concerning the criteria and conditions for hospital reclassification are located at 42 CFR part 412 subpart L, §§ 412.230 through 412.236. (Regulations concerning MGCRB composition and procedures are located at §§ 412.246 through 412.280.) The purpose of the criteria is to provide direction, to both the MGCRB and those hospitals seeking geographic reclassification, with respect to the situations that merit an exception to the rules governing the geographic classification of hospitals for purposes of payment under the Medicare prospective payment system. Hospitals may be reclassified individually or as a group for purposes of their wage index or standardized amount or both.

A request for reclassification must be filed by October 1 of the Federal fiscal year preceding the Federal fiscal year for which the reclassification decision would be effective. For example, a request for reclassification effective for FY 1994 must be filed by October 1, 1992. The MGCRB is required to issue its decision within 180 days of October 1, or

by March 30. A reclassification decision by the MGCRB is generally effective for 1-year. However, depending on its assessment of the facts supporting an individual hospital's or group of hospitals' request for reclassification, the MGCRB may provide for an automatic 1-year renewal of its decision.

Section 1886(d)(8)(D) of the Act requires that the effect of decisions of the MGCRB be budget neutral. Under this section, the Secretary is to adjust the standardized amounts for urban hospitals to ensure that total aggregate payments under the prospective payment system after implementation of the geographic reclassification provisions of sections 1886(d)(8)(B) and (C) and 1866(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. Also, the standardized amounts for rural hospitals 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 first reclassification decisions issued by the MGCRB became effective on October 1, 1991 for discharges occurring in FY 1992. On June 3, 1991, we published a proposed rule setting forth the proposed FY 1992 payment rates under the prospective payment system (56 FR 25178). The proposed FY 1992 standardized amounts and wage index values incorporated the reclassification decisions that had been made by the MGCRB as of March 30, 1991. The impact analysis in the proposed rule indicated that the reclassification decisions would have a significant impact on the distribution of program payments.

On August 30, 1991, we published a final rule (56 FR 43196) setting forth the FY 1992 prospective payment system rates. In the final rule, we responded to comments concerning the June 3, 1991 proposed rule and discussed the impact of the FY 1992 MGCRB reclassifications. In addition, we responded to comments concerning the June 4, 1991 final rule with comment period on the MGCRB procedures and reclassification guidelines.

The August 30, 1991 final rule reflected 930 hospital reclassifications approved by the MGCRB and the HCFA Administrator as of August 5, 1991 and effective for FY 1992. Over 75 percent of all reclassified hospitals are located in rural areas. As the following chart indicates, 75 percent of the reclassified rural hospitals were reclassified for their wage index, 11 percent were reclassified for their standardized amount, and 14 percent were reclassified for both.

Twenty-five percent of the hospitals reclassified for FY 1992 are located in urban areas. Of the reclassified hospitals located in other urban areas, 45 percent were reclassified for their wage index, 45 percent were reclassified for their standardized amount, and 10 percent were reclassified for both.

DISTRIBUTION OF HOSPITALS RECLASSIFIED FOR FY 1992

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

The effects of the MGCRB reclassification decisions on FY 1992 payments were significant. To meet the statutory budget neutrality requirements, each of the urban standardized amounts (large and other) was reduced 1.1 percent. Among all hospitals not reclassified, the overall impact of hospital reclassifications was an average decrease in payment per case of about 1 percent.

The overall impact on reclassified hospitals in FY 1992 was 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 received an average increase of nearly 16 percent. Urban hospitals that were reclassified only for purposes of their standardized amounts received an average decrease in payments per case of 0.2 percent. This was because the average decrease in the wage index values for the urban areas from which other hospitals were reclassified for purposes of their wage index was greater than the average increase in urban standardized amounts after reclassification to a large urban area. The decrease also reflected the budget neutrality adjustment for urban hospitals.

EFFECTS OF FY 1992 GEOGRAPHIC RECLASSIFICATIONS ON PAYMENTS PER CASE

	Percentage change in hospital payments per case from geographic reclassification
All reclassified hospitals	5.9
Standardized amount only	2.7
Wage index only	5.2
Both	8.8
All reclassified urban hospitals	3.7
Standardized amount only	−0.2
Wage index only	2.9
Both	15.9
All reclassified rural hospitals	8.0
Standardized amount only	5.7
Wage index only	6.8
Both	15.8
All nonreclassified hospitals	−1.0
Urban nonreclassified hospitals	−1.0
Rural nonreclassified hospitals	−0.1

(The above analysis pertains to the impact of the FY 1992 geographic reclassifications. Comparable data for FY 1993 reclassifications may be found in Appendix A of this proposed rule. We note that the number of hospital reclassifications has increased from 930 in FY 1992 to 1249 in FY 1993.)

In the August 30, 1991 final rule (56 FR 43198), we discussed comments concerning geographic reclassification issues raised in the June 3, 1991 and June 4, 1991 **Federal Register** documents. Many commenters addressed the impact of geographic reclassification on payments to hospitals.

Several commenters stated that we should suspend implementation of the June 4, 1991 final rule and extend the application deadline for FY 1993 reclassifications in order to allow time to reevaluate the appropriateness of the guidelines. A number of commenters pointed out potential problems with the application process in future years. In response to the comments, we stated that we intended to evaluate the FY 1992 reclassifications made under the current guidelines and to propose such revisions as may be appropriate for future application cycles. We solicited comments concerning possible acceptable approaches on potential changes to the reclassification

guidelines. We indicated that we would consider all comments received by October 29, 1991 in developing any proposed rulemaking document that we would issue concerning the reclassification guidelines. We noted that this process would not be completed in time to revise the guidelines for the application period for the FY 1993 reclassifications and that any revisions in the guidelines would be effective no earlier than FY 1994 reclassifications (for which the application period ends October 1, 1992).

We also indicated that any revisions to the guidelines would need to be considered in conjunction with potential changes to labor market definitions. HCFA as well as ProPAC is evaluating alternative methods for defining labor market areas, and refinements could be implemented as early as FY 1994. Thus, it is possible that MGCRB reclassification decisions based on revised guidelines could be implemented at the same time refined labor market areas are established.

B. Discussion of Comments

In response to our request in the August 30, 1991 final rule, for comments concerning the MGCRB guidelines, we received 134 letters by the October 29, 1991 deadline. Few of the comments dealt with the specifics of the guidelines; instead, most offered general comments on the merits of geographic reclassifications. For example, we received 106 similar letters from reclassified rural hospitals in support of the reclassification guidelines. The commenters stated that the guidelines were fair and equitable; that HCFA should refrain from making any changes until the impact of the prospective payment system for capital-related costs could be evaluated; that Congress created the MGCRB to remedy significant payment inequality in the prospective payment system; and that it was appropriate for urban hospitals to be affected adversely by the reclassifications since they had received relatively higher payments in the past.

In contrast, we received 28 letters from urban hospitals and associations stating the guidelines were too liberal and urging that they be tightened considerably. These commenters suggested eliminating the budget neutrality provision, removing the hold harmless provision that protects rural hospitals from receiving lower payments as a result of geographic reclassifications, and phasing in the reclassifications by paying 50 percent of the increased amount in FY 1992 and the entire amount in FY 1993. Since these proposals would require legislative changes, we are not addressing them in this document.

One commenter suggested using more recent wage survey data from the cost report instead of the HCFA wage survey. However, as we have previously indicated in response to comments recommending that more current wage data be used (see June 4, 1991 final rule (56 FR 25471)), it is essential to use standard data for the same time period so that the wage comparisons can appropriately reflect labor costs for the same point in time. Hospital payroll data for other than the cost reporting period ending in 1988 would not be audited or otherwise verified and, therefore, cannot be used. However, we note that, beginning in FY 1994, we will be updating the wage index annually based on a revised cost reporting form.

Two commenters suggested that the adjacency requirements should be removed in order to expand the number of hospitals eligible for reclassification and to allow hospitals to be reclassified into the MSA most relevant to the applicant's labor market. However, as we indicated in the June 4, 1991 final rule, in response to comments concerning the adjacency requirement (56 FR 25472), there is ample precedent for requiring that hospitals seeking reclassification to a different geographic area be located in a county that is adjacent (that is, contiguous) to that area. The adjacency requirement is consistent with the way OMB defines urban areas and is also consistent with the provision in section 1886(d)(8)(B) of the Act that allows hospitals in certain rural counties that are adjacent to more than one MSA to be deemed urban for prospective payment purposes. Accordingly, we are proposing no changes to the adjacency requirement.

Also, two commenters asked that we preserve the special access rule for sole community hospitals and rural referral centers. Our proposed changes affecting sole community hospitals and rural referral centers are discussed below, along with other proposed changes, in section IV. C. of this preamble.

C. Proposed Changes to the Regulations

The proposed changes in the reclassification guidelines as based on public comment and our analysis of the FY 1992 reclassifications. Since the effects of reclassifications must be budget neutral, increased payments to one group of hospitals are offset by reduced payments to other groups. Therefore, we must assure both that those hospitals meriting reclassification are afforded proper consideration and that other hospitals are protected from the effects of inappropriate reclassifications. In addition, a number of issues concerning the reclassification guidelines have arisen that warrant clarification in the regulations.

Accordingly, we are proposing the following changes to the guidelines, which we believe will result in more appropriate reclassifications. The changes would be effective for applications submitted by October 1, 1992 for geographic classifications to be implemented on October 1, 1993 (FY 1994). The proposed changes would not affect reclassifications that would be effective for discharges occurring in FY 1993. Given the 1-year time lag between the effective date of any proposed changes to the MGCRB regulations and the effect of these changes on hospital reclassifications, we believe it is essential that the following proposed changes be implemented in time to affect applications that will be processed by the MGCRB during FY 1993.

1. General Guidelines—Reclassifications for Individual Hospitals

a. *Reclassification to a Single Geographic Area (§ 412.230(a)(1)).* Section 412.230(a)(1) provides that an individual hospital may seek reclassification to "an adjacent urban or rural area" for purposes of using the other area's standardized amount, wage index, or both. As evidenced by the use of the singular in describing the area to which a hospital could be reclassified (i.e., an adjacent rural or urban area), the intent of this provision is that a hospital may seek reclassification to only one area. There is no provision for a hospital to seek reclassification to more than one area. Nevertheless, because the regulations do not specifically prohibit reclassifications to more than one area, several hospitals have been granted reclassification to two separate areas—one for the wage index and one for the standardized amount.

We do not believe it is appropriate for a hospital to be reclassified to more than one area. The purpose of the MGCRB process is to permit hospitals that are disadvantaged by their geographic classification to obtain a more appropriate classification to the area with which they have the most economic interaction. Accordingly, although hospitals may be reclassified either for purpose of the wage index, standardized amount, or both, we did not intend to allow hospitals to qualify for reclassification to one area for its wage index and another area for its standardized amount in those situtions where they cannot qualify for

reclassification to one area for both the standardized amount and wage index purposes. Therefore, we are proposing to revise § 412.230(a)(1) to specify that a hospial may seek reclassification to only one area. In situations where a hospital can qualify for the wage index of one area and the standardized amount of another area, the hospital must decide which area it wishes to be reclassified to and must indicate its decision in its application.

b. *Individual Urban Hospital Reclassification to a Rural Area (§ 412.230(a)).* Section 412.230 sets forth the guidelines "for an individual hospital seeking redesignation to a different rural or urban area." However, there is no provision under the regulations for a hospital to seek reclassification from an urban area to a rural area for purposes of the wage index. In the preamble to the June 4, 1991 final rule (56 FR 25468), under the General Principles section, we specifically listed the various types of permissible reclassifications (that is, rural to urban, urban to urban, and rural to rural). We believe that our intent was clear that a hospital must already be located in a rural area if it is seeking reclassification to "another rural" area or "a different rural" area. However, the MGCRB has approved several requests from urban hospitals for reclassification to rural areas for purposes of the wage index.

The regulations do not provide for such reclassifications, nor do we believe whose reclassifications are appropriate. Although an urban hospital may be located near the border of a rural area, generally that hospital's competitive marketplace is more closely tied to the urban hospitals in its MSA than to the rural hospitals that are dispersed throughout the rural counties in the State. On the other hand, since rural areas are made up of all rural counties in an entire State, for a rural hospital to meet the proximity criteria for reclassification to another rural area, it would have to be located within 35 miles of the State border and, therefore, could be more like rural hospitals in the next State than the rural hospitals in its own State. Accordingly, while we allow a rural hospital to be reclassified to another rural area, we do not believe it is appropriate to allow an urban hospital to be reclassified to a rural area. Therefore, we are revising § 412.230(a)(1) to clarify that the only types of reclassifications that are permissible are rural to urban, urban to urban, and rural to rural reclassifications.

c. *Special Access Rule for Rural Referral Centers and Sole Community Hospitals Seeking Reclassification § 412.230(a)(4).* Section 1886(d)(10)(D)(i)(III) of the Act requires that the MGCRB guidelines include criteria for considering information provided by a hospital with respect to the effects of the hospital's geographic classification on access to inpatient hospital services for Medicare beneficiaries. Generally, access to care is not an issue except for those areas serviced by rural referral centers and sole community hospitals. Under the special access guidelines at § 412.230(a)(4), we exempt rural referral centers and sole community hospitals from the adjacency and proximity requirements in §§ 412.230(a)(2) and (a)(3). If a rural referral center or sole community hospital can qualify for reclassification on the basis of its wages or costs and is unable to meet the proximity requirements in § 412.230(a)(3), it can apply for reclassification based on the need to provide access to care for Medicare beneficiaries. If the MGCRB finds that the hospital qualifies for reclassification under § 412.230(a)(4), it must be reclassified to the MSA closest to the hospital. Alternatively, a sole community hospital or rural referral center may apply for reclassification under the general proximity criteria in § 412.230(a)(3), in which case the hospital would not be limited to reclassification to the closest urban area.

Consistent with the change we are proposing to § 412.230(a)(1), we are proposing that a sole community hospital or rural referral center may not apply under both the special access rule and the general proximity criteria in order to reclassify to different areas for wage index and standardized amount purposes. In the past, some hospitals have qualified under § 412.230(a)(2) and § 412.230(a)(3) for either the wage index or standardized amount reclassification, and used the special access guidelines at § 412.230(a)(4) to waive the adjacency and proximity requirements and qualify for reclassification to the closest urban area for the other reclassification. Again, the intent of the guidelines is to allow a hospital to seek reclassification to the one area with which it has the most economic interaction, either under the special access rule, if applicable, or under the proximity guidelines.

d. *Guidelines for a Hospital Requesting Reclassification for Wage Index Purposes.* Currently, under § 412.230(e), a hospital meeting the proximity requirement may be reclassified for purposes of the wage index if it can demonstrate that its wages are at least 85 percent of the average hourly wage for the area to which it requests reclassification. A hospital that cannot meet the 85 percent standard may nevertheless qualify for reclassification if it can demonstrate that its average hourly wage, when adjusted for occupational mix, is at least 90 percent of the average hourly wage for the area to which it requests reclassification. There are no requirements regarding the relationship between the average hourly wage of the hospital and the average hourly wage of the hospitals in its original labor market area. Using these criteria, the MGCRB reclassified more than 843 hospitals for purposes of their FY 1992 wage index.

In the August 30, 1991 final rule, we stated that we would reexamine the guidelines and propose revisions for future application cycles, if appropriate (56 FR 43202). To assess whether the wage index reclassifications were appropriate, we examined the average hourly wages of the reclassified hospitals and compared them to the average hourly wages for the hospitals in their original labor market area and in the area to which they were reclassified.

In addition, we determined the amount of variation in the average hourly wages among hospitals in the same labor market area. We divided the wages for each hospital in the prospective payment system by the average hourly wage for each hospital's original labor market area. We found that, on average, hospitals have an average hourly wage that is 96 percent of the average hourly wage for their labor market. The average hospital hourly wage is less than the average hourly wage for the area because the latter is hour-weighted and larger hospitals tend to have higher wages. We determined that the national standard deviation was 12 percent. Assuming a normal distribution, 68 percent of hospitals nationwide have an average hourly wage that is at least 84 percent and less than 108 percent of the average hourly wage of the area in which they are located.

The relationship between the average hourly wage of reclassified hospitals and the average hourly wage in their original labor market area is demonstrated by the table below. We found that 36 percent of the reclassified hospitals had wages that were less than 100 percent of wages in the area from which they were reclassified. An additional 35 percent had wages that were less than 108 percent of, or one national standard deviation above, their

old area. An additional 17 percent had wages that were less than 115 percent of their original labor market area.

1992 WAGE INDEX RECLASSIFICATIONS

	Percent of wage index reclassifications	Number of hospitals
Hospitals with wages less than 100% of old wage area	36	
Wage only		242
Wage and rate		51
Hospitals with wages greater than 100% and less than 108% of old wage area	35	
Wage only		216
Wage and rate		70
Hospitals with wages greater than 108% and less than 115% of old wage area	17	
Wage only		120
Wage and rate		22
Hospitals with wages greater than 115% of old wage area	12	
Wage only		76
Wage and rate		18
Total wage reclassifications		815

Note.—Table includes only hospitals for which cost reporting data for FY 1989 are available.

We believe the reclassification process was established to provide a mechanism that would allow hospitals to effect a change in their geographic location only in those situations where hospitals had been clearly disadvantaged by their current classification. As the above analysis demonstrates, however, hospitals may be reclassified under the current wage guidelines even though, as evidenced by the relationship between their average hourly wages and their old wage area, they may not be disadvantaged by remaining in their original labor market area. Based on this analysis of the FY 1992 reclassifications, we are proposing to revise the guidelines to ensure that hospitals are appropriately reclassified.

We believe that a hospital should not be reclassified unless its average hourly wage is significantly out-of-line with the average hourly wages of the area in which it is located and is in line with the average hourly wages of the area to which it requests reclassification. The changes we are proposing reflect this belief that the purpose of the MGCRB is to address only those situations in which a hospital is clearly disadvantaged by its wage index value under the existing labor market area definitions. In our view, the reclassification of hospitals whose wages are comparable to those of other hospitals in their labor market area results in a fundamental restructuring of labor market areas that is more appropriately handled systematically through refinement in the labor market area definitions than on an individual hospital basis through the MGCRB process. (As noted above in section IV.A. of this preamble, we are evaluating alternative methods for defining labor market areas, and refinements could be implemented as early as FY 1994.)

Specifically, our proposal would add the requirement that a hospital cannot be reclassified unless its average hourly wage is at least 108 percent of the average hourly wage of the area in which it is located. The 108 percent threshold is based on the average hospital wage as a percentage of its area wage (96 percent) plus one standard deviation (12 percent). Currently, the 85 percent standard for the relationship between the hospital's wages and the average hourly wage of the area to which it requests reclassification (found in § 412.230(a)) approximates the average hospital wage as a percentage of its area wage less one standard deviation. (To be consistent, this proposal would also replace the 85 percent standard with an 84 percent standard (96 percent minus one standard deviation)). Thus, to qualify for a wage index reclassification, a hospital would be required to have an average hourly wage that is more than one national standard deviation above its original labor market area and not less than one national standard deviation below its new labor market area. We estimate that 71 percent of the hospitals that were reclassified in FY 1992 would not have qualified for wage index reclassifications if this guideline had been in effect. This includes 89 percent of the urban hospitals and 66 percent of the rural hospitals that qualified for wage index reclassifications in FY 1992.

We are proposing to adopt this change as an additional standard for wage index reclassifications. We believe it is reasonable and appropriate to require that a hospital's wages be out-of-line with its own area and not merely that its wages be in line with the area to which it seeks to be reclassified. We believe that the 108 percent standard, which takes into account the average variation in average hourly wages within a labor market area, is appropriate.

As noted above, we believe the reclassification process was established to provide a mechanism that would allow hospitals to effect a change in their geographic classification only in those situations where hospitals had been clearly disadvantaged by their current classification. Since a hospital's wage index value is limited by the average of all the salaries and hours in its labor market area, it could be disadvantaged if it is near the border of that area and incurs labor costs that are significantly above the average for the area, and at the same time must compete with hospitals in another area that has higher wage costs.

Therefore, we believe it is appropriate to require a hospital to demonstrate that it is at least one national standard deviation above the average hourly wage for its labor market area. We believe that this is an accepted statistical measure of variation from a norm. In addition, with respect to the existing requirement that a hospital's wages be at least 85 percent of the average hourly wage for the area to which it requests reclassification, we are proposing to reduce the threshold to 84 percent to provide a consistent normative standard for both required components of the reclassification process. The 84 percent standard is one standard deviation (12 percent) below the average hospital wage as a percentage of its area wage (96 percent).

In proposing this revision to the wage guidelines, we also considered three other options. One alternative guideline we considered was to require that a hospital could not be reclassified unless its average hourly wage was at least as great as the average hourly wage of the area in which it was located. Since the wage index is based on the average hourly wage of the area, a hospital whose average hourly wage is less than the average hourly wage of the area in which it is located is not disadvantaged by its original wage index. To the contrary, the hospital is already receiving a wage index adjustment that more than compensates for its wage levels. Therefore, we believe reclassification for purposes of receiving an even higher adjustment would not be appropriate. Moreover, since the salaries and hours of all hospitals in a given labor market area make up the average hourly wage, it is fully expected that some hospitals will have an average hourly wage that is above the average for that area and some will have an average hourly wage that is below it. For these reasons, we believe it is more appropriate to adopt a guideline that would require a hospital to have an average hourly wage that is out of line with its own labor market area.

A second alternative guideline we considered was to require that a hospital can not be reclassified unless its average hourly wage is at least 115 percent of the average hourly wage of

the area in which it is located. To qualify for a wage reclassification under this option, a hospital would be required to have an average hourly wage that is at least 15 percent above the average hourly wage of the area in which it is located and no more than 15 percent below the average hourly wage of the area to which it requests reclassification. Thus, this option would retain the current 85 percent standard for the relationship between the hospital's wages and the average hourly wage of the area to which it requests reclassification. This option provides a consistent 15 percent "out-of-line" test for both the comparison with a hospital's own labor market area and the area to which it seeks reclassification. While we believe it is reasonable to require a hospital to have an average hourly wage that is out-of-line with other hospitals in its area before it is eligible for reclassification, we believe that the 115 percent requirement may be too stringent and that a more reasonable test would be to require that the hospital's average hourly wage be at least one national standard deviation above the average for its own labor market area.

Finally, we considered proposing no change in the guidelines in FY 1994. While we recognize the adverse impact that the revised guideline would have on hospitals that would no longer qualify for wage index reclassifications, there are other considerations that lead us to reject this option and propose a revised guideline. First, given the budget neutrality provision, we believe we have a responsibility to all hospitals to ensure that only appropriate reclassifications occur. Second, the results of our analysis clearly indicate that a significant number of hospitals are being reclassified that are not disadvantaged by their current wage index. In addition, the FY 1994 wage index will reflect more recent wage data and revised labor market areas. An improved wage index and redefined labor market areas may help mitigate the impact of no longer qualifying for reclassification. In this regard, we anticipate that some rural hospitals will be located in urban areas after the MSAs are revised to reflect the 1990 census.

Accordingly, we are proposing to review the wage index guidelines at § 412.230(e) to specify that a hospital can be reclassified only if its average hourly wage is least 108 percent of the average hourly wage of hospitals in its original labor market area and at least 84 percent of the average hourly wage of the hospitals in the area to which it is seeking reclassification or 90 percent of the average hourly wage after adjustment for occupational mix. (The 90 percent standard based on occupational mix would remain unchanged.) Although we are proposing to make these changes, we specifically invite comment on the alternative options we considered as well as on our proposal.

We note that the hospital-specific wage data currently supplied to hospitals by HCFA during the application process already reflect the average hourly wage for the hospitals's own labor market area. Therefore, the proposed additional wage criterion would not significantly increase the documentation a hospital must submit to support its application. For purposes of determining whether a hospital meets the 108 percent criterion, the hospital's average hourly wage is included in the average for its labor market area.

While the proposed changes would have a significant effect on the number of hospitals that qualify for wage index reclassifications, we note that these changes would not affect hospital reclassifications until FY 1994, and thus would coincide with the next update to the HCFA wage index and the revised labor market definitions. We believe the use of more recent data in computing the area wage index values, coupled with improved labor market areas, should help to mitigate the impact the proposed changes might have on payments to hospitals, since the wage index will better reflect hospital wage levels within each labor market area.

In addition, our analysis indicates that if the proposed guidelines had been in effect in FY 1992, the urban budget neutrality adjustment would have been 51.6 percent lower. In other words, the urban standardized amount would have been reduced by 0.57 percent instead of 1.1 percent.

e. *Guidelines for a Hospital Seeking Reclassification for Purposes of its Standardized Amount.* A hospital qualifies for reclassification for purposes of its standardized amount if it can demonstrate that its costs per case are more comparable to the amount the hospital would be paid if it were reclassified than to the amount it is paid under its current classification. Accordingly, in order for a hospital to qualify for reclassification for purposes of its standardized payment amount, § 412.230(d)(2) requires that a hospital demonstrate that its case-mix adjusted cost per discharge is at least equal to its current rate plus 75 percent the difference between that rate and what it would receive if it were reclassified.

We are not proposing a change in the guideline for individual hospital reclassifications for purposes of the standardized amount. As a general principle, we believe that inefficient hospitals should not be rewarded by geographic reclassification. Accordingly, in reviewing the guidelines, we wanted to determine whether the criteria for reclassification for purposes of the standardized amount result in the reclassification of hospitals that have high costs because they are operating inefficiently rather than because they are comparable to the hospitals in the area to which they are seeking reclassification. However, our examination of the characteristics of the hospitals that were reclassified for their standardized amount does not indicate there is a significant incidence of inappropriate reclassifications. Although rural hospitals that were reclassified for only the standardized amount have an average occupancy rate that is nearly 4 percentge points below the mean for rural hospitals (41 percent), rural hospitals that were reclassified for both the standardized amount and the wage index as well as other urban hospitals that were reclassified to large urban areas have average occupancy rates that are comparable to the average urban hospital occupancy rate.

Further, any revision in the guideline for standardized amount reclassifications would have limited impact. Any revised guideline would not take effect before FY 1994, and in FY 1995, under section 1886(b)(3)(B)(i)(x) of the Act, the other urban and rural rates will be merged into a single rate. The large urban rate will be only 1.6 percent larger. These changes will reduce the significance of the standardized amount reclassifications.

Moreover, there is no commonly accepted measure of hospital efficiency that could be used to establish an objective standard for reclassification. As with the other guidelines for reclassification, we believe that an objective standard for efficiency would be necessary to ensure that all hospitals are treated fairly and consistently, to facilitate the application process, and to expedite the determination process for geographic reclassifications. Therefore, we are not proposing a change in the guideline for individual hospital reclassifications for purposes of the standardized amount.

f. *Application of Numeric Standards.* The regulations at § 412.120(b)(1) specify that in order to qualify for reclassification, an urban hospital must be located "no more than 15 miles" and a rural hospital "no more than 35 miles"

from the adjacent area to which it seeks redesignation. In addition, § 412.230(e) specifies that the average hourly wage of a hospital seeking reclassification must be equal to "at least 85 percent" or, if adjusted for occupational mix, "at least 90 percent" of the average hourly wage of hospitals in the labor market area to which it seeks reclassification. Section 412.232(c) sets forth the same criteria for group reclassifications. We believe the words "no more than" and "at least" clearly describe our intent that these numeric standards represent the maximum and minimum acceptable standards. In other words, we intended that any figure greater than 35 miles (such as 35.4) or any figure less than 90 percent (such as 89.9 percent) would not meet these standards.

In a number of its decisions, the MGCRB has interpreted the regulations at §§ 412.120(b)(1) and 412.230(e) to require the use of standard rounding rules to evaluate the data contained in reclassification applications against the numeric standards contained therein. However, as explained above, we believe that the plain meaning of the current regulations clearly indicates that we did not intend these standards to be subject to the rules of rounding. Moreover, the application of rounding rules is inconsistent with HCFA's past practices and policies governing the application of numeric standards. For example, the Medicare statute establishes a number of numeric standards such as those related to the qualifying criteria for disproportionate share hospital adjustments and special status as Medicare-dependent small rural hospitals. These standards are set forth in the statute as minimum criteria described in terms of whole numbers. In applying these standards, HCFA has consistently precluded rounding in determining whether a hospital qualifies for a special payment status, and Congress has not indicated any contrary intent that would override that interpretation. Accordingly, the Administrator has reversed MGCRB decisions where a hospital's reclassification request had been approved on the basis of rounding to meet the prescribed standards. In order to ensure that this policy is applied consistently throughout the adjudicative process, we are modifying the MGCRB regulations in each section where a numeric standard is set forth to specify that rounding is not permitted.

2. Implementation of FY 1994 Hospital Reclassifications

a. *Appropriate Wage Data.* As noted above, requests for geographic reclassification by the MGCRB must be filed by October 1 of the Federal fiscal year preceding the Federal fiscal year for which the reclassification decision would be effective. Thus, a request for reclassification for FY 1994 must be filed by October 1, 1992. The MGCRB will consider the request and makes its determination during FY 1993 and the reclassification becomes effective for FY 1994.

Current regulations at §§ 412.230(e)(2) and 412.232(d)(2) specify that the wage data that hospitals submit in support of their applications for geographic reclassification should be taken from the most recent HCFA hospital wage survey. For applications for reclassification effective either for FY 1992 or 1993, the most recent wage data has been from the HCFA survey covering hospitals with cost reporting periods ending in calendar year 1988. However, section 1886(d)(3)(E) of the Act requires that the hospital wage index be updated annually beginning October 1, 1993. This means that in FY 1994, the wage index will be based on the HCFA wage data covering hospitals with cost reporting periods beginning in FY 1990. However, this data will not be available on October 1, 1992, when the MGCRB begins to consider applications for FY 1994 geographic reclassifications (although it may become available later in FY 1993). To ensure that all hospitals are treated equitably, we believe that the MGCRB should base its determinations on the wage data that are in effect for prospective payment purposes during the fiscal year in which the MGCRB makes its decision, even if more recent wage survey data becomes available during that time period. This policy is necessary because the wage data will be submitted throughout the year as part of the HCRIS system and are subject to change as additional cost reports are submitted and the status of the cost reports change from "as submitted" to "settled." The comparison of a hospital's average hourly wage to that of other hospitals is subject to change until the final wage index is issued around each September 1 for the coming fiscal year. We note that while some hospitals would benefit from the updated data, other hospitals would benefit from a delay in using the updated data.

Therefore, we are proposing to revise §§ 412.230(e)(2) and 412.232(d)(2) to clarify that the appropriate wage data are the data used to construct the wage index in effect for prospective payment purposes during the year in which the MGCRB considers the applications. Because the wage data will be updated annually beginning in FY 1994, there will always be a 1-year lag between the wage data used by the MGCRB to make its determinations and the data used to develop the wage index in effect during the year reclassification is effective.

b. *Revised Labor Market Areas.* As noted in section III.E. of this preamble, in FY 1994 we expect to implement revised MSA definitions based on the 1990 census data. The revised labor market areas that will be effective for FY 1994 will be based on the new MSA definitions that will be announced by OMB later this year, as well as any refinements in the labor market area definitions that our analysis indicates would be appropriate. As in the past, we anticipate significant changes to the MSA definitions, including the creation, elimination, or merging of MSAs, as well as the movement of counties from one MSA to another.

OMB is not expected to publish revised MSA definitions until later this year, by which time most or all hospitals may have already submitted their applications for FY 1994 reclassification. Even if the revised MSA definitions were to be published in time for some hospitals to submit new or revised requests for reclassification, it would not be equitable or administratively feasible for the MGCRB to use two different sets of MSA definitions in making its determinations on reclassification requests. For example, if an MSA is revised to comprise different counties, the average hourly wage for that area would also change. This could affect a hospital's eligibility for reclassification. It will not be administratively feasible for us to develop a new wage index based on the reconfigured MSAs in time for the MGCRB to take the revised labor market areas into account in considering applications during FY 1993. In addition, a hospital's ability to meet the proximity guidelines may be affected by the new MSAs. To be consistent and equitable to all hospitals, hospitals that are applying for geographic reclassification effective in FY 1994 will need to base their requests on the current MSA definitions, and the MGCRB will make its determinations during FY 1993 based on the MSA definitions used for prospective payment purposes in FY 1993.

In constructing the FY 1994 wage index, it will be necessary for us to group hospitals into their appropriate labor market areas based on the reconfigured MSAs and any other refinements in the labor market area definitions, and to determine where reclassified hospitals should be located and if a reclassification is appropriate.

For example, the revised labor market area definitions could place a rural hospital into a different urban area than the labor market area to which it has been reclassified by the MGCRB. In such a case, it may no longer be to the hospital's advantage to be reclassified into the area to which it requested reclassification. In order to address situations such as these, the proposed rule on the prospective payment system for FY 1994 will provide a detailed discussion of our proposed policies concerning the effects of the new labor market area definitions on the geographic reclassification of hospitals. We note that, as provided in § 412.273(a)(2), a hospital will have 45 days from publication of the FY 1994 proposed rule to withdraw its application for reclassification if it determines that such reclassification would not be advantageous in view of the revised wage data or new labor market areas that will be implemented in FY 1994. The revised MSA definitions will be used by the MGCRB in making determinations for FY 1995 reclassification requests, which must be submitted to the MGCRB by October 1, 1993.

3. Administrative and Procedural Guidelines

a. *Withdrawing an Application § 412.273.* The June 4, 1991 final rule with comment period (56 FR 25458) added § 412.273 to the regulations to provide that a hospital may withdraw an application for reclassification at any time before the MGCRB issues a decision. The regulation further provides that a hospital may withdraw its application following an MGCRB decision provided the request for withdrawal is received within 45 days of HCFA's annual publication of proposed changes to the prospective payment system. However, § 412.273 does not specify to whom a hospital should submit its request for withdrawal. Moreover, although § 412.256(d) sets forth the appeal rights of a hospital that disagrees with a decision of the MGCRB dismissing the hospital's application for reclassification, the regulations do not provide similar appeal rights for a hospital whose request for withdrawal has been denied.

We propose to revise § 412.273 to specify that a hospital's request for withdrawal of an application must be submitted to the MGCRB. Additionally, we propose to add a new paragraph (c) to § 412.273 to provide appeal rights for a hospital whose request for withdrawal has been denied by the MGCRB. We propose that a hospital may request that the Administrator review the MGCRB's denial within 15 days of the date of the notice of denial. Within 20 days of receipt of the hospital's appeal request, the Administrator will either affirm or reverse the denial.

b. *Reopening.* Section 1886(d)(10)(C)(iii) of the Act establishes time limits for MGCRB and Administrator decisions to ensure that the effects of reclassification are reflected in the new standardized amounts and wage index values that take effect on October 1 of each year for hospitals under the prospective payment system. Therefore, prompt adjudication by either the MGCRB or the Administrator is essential to ensure that the budget neutrality requirement in section 1886(d)(8)(D) of the Act is met when the annual prospective payment system rates are established.

We have received several requests for reopening of MGCRB decisions after the 15-day appeals period set forth in § 412.276(a), as well as requests for reopening of decisions issued by the Administrator. Section 412.276(a) of the regulations provides that a decision by the MGCRB is final and binding unless the decision is reviewed and changed by the Administrator. Neither the statute nor the regulations gives the MGCRB the authority to reopen its decision. We have considered possible revisions to the MGCRB regulations to provide for reopening. However, due to the statutory deadlines provided in section 1886(d)(10)(C) of the Act, we do not believe that a decision by the MGCRB or the Administrator should be subject to subsequent reopening either on motion of the hospital or the applicable reviewing authority. As noted above, administrative finality is essential under this particular review scheme to achieve budget neutrality. Accordingly, we do not believe it would be appropriate to provide for reopening of decisions, in the same way as provided under § 405.750 or § 405.1885, for decisions by the MGCRB or the Administrator concerning applications for geographic reclassification filed under section 1886(d)(10) of the Act.

We further believe procedures for reopening MGCRB decisions are unnecessary because existing regulations provide ample opportunity for final resolution of issues that may arise in the adjudication of applications for reclassification. For example, hospitals that are dissatisfied with MGCRB decisions concerning their requests for reclassification may appeal those decisions to the Administrator within the time period in § 412.276(a). (As noted above, hospitals would also have the right to appeal both MGCRB decisions concerning requests to withdraw an application and MGCRB dismissals.) In addition, the Administrator may review a MGCRB decision at his or her discretion within the time period prescribed in § 412.278(c).

We believe that this review process provides sufficient protection for hospitals and HCFA in those instances where a provider or the Administrator believes that a case has been decided incorrectly by the MGCRB. Accordingly, no additional mechanism to revise MGCRB decisions is necessary or appropriate.

However, under § 412.278(f)(4), a decision of the Administrator is not subject to further review. Thus, there are currently no further appeals or reopening rights available to a hospital following a decision by the Administrator. Since the Administrator's review process provides sufficient opportunity to resolve the substantive issues raised by a reclassification application, we do not believe any further review of those issues is warranted. However, given the multiple computations required in adjudicating reclassification applications, we believe that we should provide a brief time period in which the Administrator would have the limited authority to correct inadvertent mathematical or computational errors that would otherwise result in incorrect reclassification. The Administrator would also have the authority to correct a reclassification decision if the evidence that was considered in making the decision clearly shows on its face that an error was made ("facial error").

Examples of mathematical or computational errors include but are not limited to: The erroneous entry of data for the respective cost or wage comparison calculation (for example, transposing figures from the applicable lines of the cost report) or errors due to incorrect mathematical computations. An example of a facial error would be a decision that includes incorrect identifying information for the affected hospital(s), for example, Smith Hospital instead of Smythe Hospital or Waco, Oklahoma instead of Waco, Texas. However, as explained above, substantive issues such as the Administrator's determination to use only wage survey data that has been properly approved and issued for official use by HCFA, or a challenge to the methodology used in determining the respective cost or wage comparison calculation, may not be reviewed during this limited amendment period.

The time period for amending Administrator decisions must be very short to ensure that all reclassification decisions are made in time to be incorporated into the wage index adjustments required by the budget neutrality provisions described above. Accordingly, we are proposing to add a new paragraph (g) to § 412.278 to provide that, within 10 days following a decision issued by the Administrator, a hospital may request that the Administrator amend the decision only to correct mathematical or computational errors, or facial errors. The Administrator would promptly review the hospital's request and amend the decision, if necessary, within 5 days following receipt of the hospital's request for amendment. The Administrator, at his or her discretion, may also amend the decision to correct mathematical, computational, or facial errors within 15 days following the issuance of his or her initial decision. The Administrator's amended decision would be final and would not be subject to judicial review. In accordance with these proposed changes, we also would revise § 412.278(f)(3) to state that the Administrator's decision issued under §§ 412.278 (a) or (c) is final unless it is amended under § 412.278(g).

c. *Technical Changes to § 412.278(f)(1).* In title 42 of the Code of Federal Regulations, parts 400 to 429, revised as of October 1, 1991, on page 331, the text of § 412.278(f)(1) was printed incorrectly. The correct text, which describes what evidence the Administrator may consider in reviewing an MGCRB decision on a hospital's reclassification request, was originally published as § 412.278(c) in our September 6, 1990 interim final rule (55 FR 36770) and was redesignated as § 412.278(f)(1) in our June 4, 1991 final rule with comment period (56 FR 25489). In addition, technical changes to paragraph (f)(1) are needed to clarify that the Administrator may review comments submitted by HCFA or a hospital during the appeals and discretionary review process. These changes should have been included in our June 4, 1991 final rule but were inadvertently omitted.

Accordingly, we are proposing to republish § 412.278(f)(1), with the above-mentioned technical changes, to ensure that this section of the Code of Federal Regulations is correct and to incorporate the necessary references to comments submitted during the appeals and discretionary review process.

V. Other Proposed Changes to the Prospective Payment System for Inpatient Operating Costs

A. Outlier Payments (§ 412.82)

1. Background

Section 1886(d)(5)(A) of the Act requires the Secretary to pay an additional amount beyond the basic prospective payment amount for a hospital inpatient case that involves an extremely long length of stay or extraordinarily high costs to treat when compared to other discharges classified in the same DRG. We refer to these atypical cases as "day outliers" and "cost outliers," respectively. Section 1886(d)(5)(A)(iii) of the Act specifies that outlier payments approximate the marginal cost of care beyond the outlier threshold. The purpose of the outlier payment is to protect the hospital from significant financial loss in individual cases.

In the two final rules published on August 30, 1991 that implemented changes to the inpatient operating prospective payment system and a new prospective payment system for capital-related costs for FY 1992 (56 FR 43196 and 43358, respectively), we established a unified outlier payment methodology for capital and operating outlier cases. Under § 412.82, for day outliers, an additional per diem payment is made for each covered day of care beyond the length of stay threshold. The per diem payment is equal to 60 percent of the average per diem payment (operating and capital) for the DRG, which is calculated by dividing the standard payment for that DRG by the geometric mean length of stay for the DRG. The capital portion of the day outlier payment is multiplied by the applicable Federal transition percentage during the transition to a prospective payment system for capital-related costs.

For cost outliers, we pay 75 percent of charges, adjusted to equal capital and operating costs, beyond the cost outlier threshold. Charges are adjusted to cost using hospital-specific cost-to-charge ratios and standardized to eliminate the effects of the indirect costs of medical education and the costs of treating a disproportionate share of low income patients, for both operating costs and capital-related costs. As with day outliers, the capital portion of the cost outlier payments is then multiplied by the applicable Federal blend percentage. Cases that qualify as both day and cost outliers are paid under the methodology that yields the highest combined capital and operating payment.

The current outlier payment methodology reflects refinements that we have made since the inception of the prospective payment system to improve the financial protection for high cost cases. In the September 30, 1988 final rule, we refined the payment methodology for day outlier cases that also could qualify as cost outlier cases (53 FR 38502). Previously, our policy was to pay all outlier cases that met the day outlier criteria as day outliers. Our revised policy, as set forth in the September 30, 1988 final rule, is to pay the greater of the day outlier payment amount or the cost outlier payment amount for these cases. This change rectified an inequity in the payment system that resulted in underpaying extremely costly day outlier cases that we would have paid as cost outlier cases except for the fact that they also qualified as day outliers.

In the September 30, 1988 final rule, we also raised the marginal cost factor for cost outliers from 60 to 75 percent in order to target outlier payments to the most costly cases. (As explained below, the marginal cost factor for the burn DRGS is 90 percent.)

We also provided that in determining the cost outlier payment for a case, the hospital's costs would be determined based on hospital-specific cost-to-charge ratios, rather than the national average cost-to-charge ratio used in the original outlier payment policy. The use of hospital specific cost-to-charge ratios enhances the accuracy with which exceptionally costly cases are identified and outlier payments computed, given the wide variation in cost-to-charge ratios across hospitals. This increased accuracy was particularly important given that the types of hospitals that had higher cost-to-charge ratios than the national average (and therefore received lower cost outlier payments using the national ratio rather than the hospital-specific ratio) were the hospitals that performed least well in the early years of the prospective payment system.

In the same final rule, we also implemented changes for the payment of burn outlier cases to reflect section 4008(d)(1)(A) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203). Section 4008(d)(1)(A) required the Secretary to pay both day and high cost burn outlier cases using a 90 percent marginal cost factor. This provision was effective for discharges occurring on or after April 1, 1988 and before October 1, 1989. We implemented this change in the September 30, 1988 final rule (53 FR 38505). In the September 1, 1989 final rule (54 FR 36479), we explained that we would continue to compute cost outlier burn cases that were discharged on or after October 1, 1989 using the 90

percent marginal cost factor to determine payment, but beginning with discharges occurring on or after October 1, 1989, we would compute payments for day outlier burn cases using the same maraginal cost factor of 60 percent used to compute payment for all other types of day outlier cases.

2. Proposed Changes to the Payment Methodology for Day Outliers

In the August 30, 1991 final rule implementing the prospective payment system for hospital inpatient capital-related costs, we stated that, as part of our ongoing study of possible refinements to outlier payment policy, we would examine whether changes in the marginal cost factors used to determine outlier payments would be appropriate in light of the inclusion of capital in the outlier payment (56 FR 43383). The 60 percent figure that was originally used for both day and cost outliers, and is still used for day outliers, was derived from a variety of studies for operating cost payments.[3] We believe that the marginal cost factor should be set at a level that is appropriate for Medicare cases, and that is based on more recent data for operating and capital costs.

The RAND Corporation's most recent research for HCFA (under cooperative agreement 99–C—98489/9–08) used FY 1990 MEDPAR data and hospital-specific data from cost reporting periods beginning in FY 1989 (or FY 1988 if the later year was not available) to estimate a Medicare marginal cost factor specifically for day outlier cases.[4] RAND found that the current methodology of establishing a per diem payment based on 60 percent of the DRG payment divided by the geometric mean length of stay for the DRG exceeds the additional costs of an outlier day by approximately 25 percent. In addition, the data suggest that 38.2 percent of day outlier payments go to cases that are profitable once the outlier payments are included. The incremental cost study that RAND completed for ProPAC [5] indicated that the later days of a stay have considerably lower costs than the earlier days, for both medical and surgical DRGs. In addition, the average cost per day in the DRGs studied tended to be constant by the 10th day in almost all cases.

RAND's most recent work for HCFA also examined the relation between costs and length of stay. A regression was developed for each DRG with at least 50 day outlier cases in which the cost per case, standardized for the payment adjustments, and including capital costs, was related to the outlier portion of the stay as follows:

standardized cost = a + b × (LOS—threshold)

This form of the regression implies that total costs for the pre-threshold portion of the stay are constant by DRG, and that the incremental cost of outlier days is also a constant. The results indicate a linear relation between total costs and length of stay (LOS). In addition, the incremental costs of an outlier day vary linearly with the ratio of the DRG weight divided by the mean length of stay (either geometric or arithmetic, although the arithmetic mean performs somewhat better). This indicates that the basic form of the per diem payment is appropriate. That is, DRGs with a low ratio of DRG weight to mean length of stay have a lower per diem payment, so the correlation of the low ratio with low incremental costs means that the payment varies appropriately with costs. The geometric mean and the arithmetic mean are very highly correlated ($R^2 = .94$).

RAND then conducted a study of day outlier cases in all DRGs to determine the coefficients in the following equation:

standardized cost per case = a + b × ((LOS—threshold) × DRG per diem)
where DRG per diem = DRG weight × standardized amount ÷ mean LOS

In this case, the estimate of b provides the percent of the DRG per diem payment represented by the incremental cost of an outlier day. RAND found that incremental costs would equal the DRG per diem payment at a factor of approximately 0.54 using the arithmetic mean and 0.39 using the geometric mean. Further, sensitivity analysis indicated that these results are relatively insensitive to modest changes in the cost outlier threshold.

RAND then simulated various day outlier payment policies. All simulations continued to use the geometric mean length of stay for the DRG to determine the day outlier threshold, but tested different ways of calculating the per diem payment. (The geometric mean is the appropriate mean to use in calculating the day thresholds, because it adjusts for the low tail of the length of stay distribution being truncated at 0, since there are no negative lengths of stay.) The geometric mean is calculated as the antilog of the mean of the log length of stay. Because the logs of two different numbers are closer together than the numbers themselves, the geometric mean compresses the distribution. As a result, day outlier cases have a smaller effect on the geometric mean than they do on the simple average (the arithmetic mean). The arithmetic mean length of stay is therefore larger than the geometric mean length of stay.

In particular, RAND compared current policy to a policy model that used the arithmetic mean length of stay in the computation of the per diem payment, with a marginal cost factor of 0.55.[6] Under the current policy simulation, 38.2 percent of day outlier payments go to cases that are profitable after the outlier payments are made, while 26.3 percent of total outlier payments go to these cases. Under the simulation using the arithmetic mean and a 0.55 marginal cost factor, only 15.2 percent of outlier payments go to profitable cases.

Using the results of the RAND study, we simulated outlier thresholds and payments using the FY 1991 MEDPAR data to determine the impact of changing the per diem payment calculation across types of outlier cases. We used identical day outlier thresholds, in order to isolate the effects of the change in outlier payment policy, rather than any possible effect of changing the thresholds.[7]

There are four types of outlier cases: cases that qualify only as day outliers, cases that qualify only as cost outliers, cases that qualify under both methodologies ("dual outliers") and are paid as day outliers, and dual outliers that are paid as cost outliers. An optimal outlier policy, in terms of protecting hospitals against financial risk, would

[3] Summarized in J. Lipscomb, I. Raskin, and J. Eichenholz, "The Use of Marginal Cost Estimates in Hospital Cost-Containment Policy," Hospital Cost Containment: Selected Notes for Future Policy, ed. M. Zubkoff, I. Raskin, and R. Hanft (New York: Prodist, 1978), pp. 527–532.

[4] A technical paper, Carter, G.M. and Rumpel, J.D., "Payment Rates for Unusual Medicare Hospital Cases," serves as the basis of the following discussion and explains this research in more detail. The paper is available upon request from HCFA.

[5] Carter, G.M. and Melnick, G.A., "How Services and Costs Vary by Day of Stay for Medicare Hospital Stays," March 1990.

[6] While the simulation using the arithmetic mean length of stay and a 0.55 marginal cost factor also used a slightly different cost outlier methodology, the impact of the change in cost outlier methodology is negligible on the distribution of outlier payments to profitable cases.

[7] The thresholds for the current policy simulation were the geometric mean length of stay plus the lesser of 28 days or 3 standard deviations for day outliers for both simulations. For cost outlier payments the thresholds were the greater of 2.0 times the DRG rate or $34,250 for current law and $29,750 for the alternative policy simulation. The simulations were done using FY 1991 MEDPAR cases, and FY 1992 payment rates and payment adjustments.

provide equal protection (in terms of the ratio of payments for the case to the costs of the case) across all types of outlier cases. Thus, under an optimal policy, there would be no additional risk for a hospital that admits one type of outlier case relative to another.

The results of our simulation are presented in the table below. Under current policy, the payment to cost ratios for outlier cases vary from 0.6549 for dual outliers paid as day outliers to 0.4773 for cost only outliers. The modified day outlier policy yields payment to cost ratios varying from 0.5667 to 0.4891 for the same types of cases:

PAYMENT TO COST RATIOS FOR DIFFERENT TYPES OF OUTLIER CASES

Type of payment	Current day outlier policy		Revised outlier policy	
Outlier case	Ratio	Cases	Ratio	Cases
Day only	0.5970	81,517	0.5350	70,242
Dual, paid day	0.6549	23,617	0.5667	20,580
Dual, paid cost	0.5469	32,117	0.5521	46,429
Cost only	0.4773	76,924	0.4891	107,913
All outliers	0.5426	214,175	[1] 0.5215	245,164

[1] Under the alternative policy, we are able to lower the threshold for cost outliers and, as a result, more cases qualify for cost outlier payments than under the current policy (as illustrated by the higher number of outlier cases). Since the additional outlier cases qualify for smaller payments than cases that qualify under the current policy, the ratio of payments to costs is smaller than under the current policy. Yet, total payment for the additional outlier cases would increase under the alternative policy.

In view of the significant potential for improvements in payment equity across types of outlier cases, we are proposing to revise the day outlier payment policy effective for discharges occurring on or after October 1, 1992. Specifically, we are proposing to revise §412.82(c) to reflect that the per diem payment would be calculated using the arithmetic mean and a 0.55 marginal cost factor. That is, the per diem day outlier payment under the prospective payment system for operating costs would be determined by dividing the standard DRG payment by the arithmetic mean length of stay for that DRG, and multiplying the result by 0.55. During the transition to a prospective payment system for capital, the capital portion of the day outlier payment would also be multiplied by the Federal payment blend percentage. (For cost reporting periods beginning in FY 1993, the blend percentage would be 20 percent for fully prospective hospitals, a hospital-specific percentage that reflects the ratio of Medicare inpatient new capital costs to Medicare inpatient total capital for hospitals receiving hold harmless payments, and 100 percent for hospitals receiving 100 percent of the Federal rate.)

The RAND study suggested that the optimal day outlier policy would be to pay only the marginal cost (rather than the full incremental cost) of the additional days of care beyond the threshold. For cost outlier cases, we pay 75 percent of the costs beyond the cost outlier threshold. If we were to adopt this same policy for day outlier cases, the marginal cost factor would be set at .40 (.55 x .75) for day outlier cases. We considered adopting a 2-year phase-in of this policy by proposing a .50 marginal cost factor for day outliers in FY 1993 and moving to a .40 marginal cost factor in FY 1994. However, because of the significant impact this change would have on those hospitals with longer lengths of stay that have more day outlier cases than average, we believe it would be more appropriate to adopt an incremental change to a .55 marginal cost factor in FY 1993 and evaluate its effects before considering additional revisions to the day outlier payment policy. However, we invite public comments on adopting this optimal policy.

The proposed change in the payment policy for day outliers would provide better protection against costly cases for hospitals, while maintaining a more appropriate level of payments for cases with extraordinarily long lengths of stay that are not also extraordinarily costly. In particular, we believe that this change would ensure that we pay hospitals for day outlier cases no more than the cost of care during the outlier portion of the stay, thus reducing the number of outlier cases that are profitable. While we expect that many outlier cases will move from the day outlier payment methodology to the cost outlier payment methodology based on this proposed change, our analysis indicates that many day-only outlier cases will remain profitable.

We note that the arithmetic mean for the proposed FY 1993 DRGs is set forth in Table 7b.

3. Analysis of the Factors that Affected FY 1991 Outlier Payments

Section 1886(d)(5)(A)(iv) of the Act requires that the total amount of additional payments made for outliers for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year. In establishing the FY 1991 prospective payment system payment rates and outlier thresholds, we used FY 1989 billing data. We estimated that outlier payments would equal 5.1 percent of DRG payments and set the outlier thresholds at the geometric mean length of stay for the DRG plus the lesser of 29 days or three standard deviations of the length of stay for day outliers, and the greater of 2.0 times the DRG rate or $35,000 for cost outliers. To estimate the outlier payments, we used the FY 1991 final standardized amounts and wage index values as established in the September 4, 1990 final rule (55 FR 35990), and hospital-specific data from 1989 and 1990 (the most recent we had available). ProPAC, in its June 1991 report to Congress, estimated that FY 1991 outlier payments would equal 5.6 percent of total payments (p. 45).

Preliminary analysis of the FY 1991 billing data indicates that actual outlier payments were 4.0 percent of total DRG payments. We estimate that outlier payments will increase between 0.1 and 0.2 percentage points as later billing data become available. The 4.0 percent is based on the ratio of outlier payments to the sum of the standardized amount and outlier payments, exclusive of additional payments for indirect teaching costs and for serving a disproportionate share of low income patients. If the indirect teaching and disproportionate share payments are included in the calculation, the outlier payment percentage is 4.1 percent. The following table compares the outlier cases and payments we estimated in developing the FY 1991 outlier payment policies compared to the actual FY 1991 outlier experience.

Type of outlier case	Outlier payment as percent of standard payment		Outlier cases as percent of total cases	
	Estimated	Actual	Estimated	Actual
Day outliers only	1.4	1.2	1.2	0.9
Dual outliers paid as day outliers	1.1	0.8	0.8	0.2
Dual outliers paid as cost outliers	1.7	1.2	1.2	0.2
Cost outliers only	0.9	0.9	0.9	0.4
Total	5.1	4.0	4.0	1.7

The difference between estimated and actual FY 1991 outlier payments did not affect the percentage of outlier cases paid as day outlier cases (63 percent in the estimated and 62 percent in the actual) or the amount of outlier payments made under the day outlier formula (48 percent of payments were made under the day outlier formula, while we estimated that figure at 49 percent). The following table summarizes the effect of the difference between estimated and actual FY 1991 outlier payments on payments and number of cases by type of outlier case:

COMPARISON OF FY 1991 PREDICTED AND ACTUAL OUTLIER CASES AND PAYMENTS

Type of outlier	Percentage of outlier cases		Percentage of outlier payments	
	Estimate	Actual	Estimate	Actual
Meets day threshold only	52	52	27	29
Meets day and cost thresholds, paid using day methodology	11	10	22	19
Meet day and cost thresholds, paid using cost methodology	14	12	34	30
Subtotal—all cases meeting day threshold	77	74	83	78
Meets cost threshold only	23	26	17	22
Total	100	100	100	100

In order to understand why the estimate of FY 1991 outlier payments did not match more closely actual FY 1991 outlier payments, we examined several factors which could have caused the difference between the predicted outlier payments and the actual payments. We conducted this analysis to ensure that our methodology for estimating outlier payments continues to be appropriate, and that the difference in predicted and actual FY 1991 outlier payments was primarily a function of data changes that we could not predict. The possible sources for the difference could be unanticipated changes in covered inpatient hospital charges, the hospital-specific cost-to-charge ratio, and the payment adjustments used to standardize hospital charges, all of which affect cost outlier payments, or changes in the mix of inpatient cases between the FY 1989 MEDPAR data used to estimate FY 1991 outlier cases and the actual FY 1991 cases. Accordingly, we have analyzed these potential sources for the difference.

a. *Inflation in Covered Charges.* To determine cost outlier payments, we inflate covered hospital inpatient charges. The inflation factor is based on the historical annual rate of increase in covered charges per case after removing the affects of case mix changes.

If the charge inflation factor was too large, we would have overestimated the costs of cost outlier cases, and would therefore have set the outlier thresholds at a higher level than if we had known the actual lower rate of inflation in covered charges. In estimating FY 1991 covered charges, we used an 11.4 percent annual inflation factor and multiplied the FY 1989 covered charges by 1.241 (1.114 × 1.114). This was the best estimate of annual charge inflation available at the time we estimated the FY 1991 outlier payments. The 11.4 percent amount had been used previously to estimate outlier payments. Until this year, we have not been able to re-estimate the inflation factor because of the impact of the Catastrophic Coverage Act of 1988 (Pub. L. 100–360) on FY 1989 and FY 1990 claims data. Section 101 of Public Law 100–360 caused covered charges to increase during FY 1989 and FY 1990 in part because of the increased number of covered days of care resulting from the elimination of the limitation on hospital inpatient benefit days under catastrophic coverage. Using those years' data to re-estimate the charge inflation factor would have resulted in an incorrect charge inflation factor. The distortions in covered hospital inpatient charges resulting from the enactment of Public Law 100–360 also prevent us from directly determining the increase in covered charges between FY 1989 and FY 1991. Therefore, we determined the compounded annual rate of increase between FY 1988 and FY 1991 after removing the affects of case mix changes. To do this, we calculated the average covered charge per discharge for both FY 1988 and FY 1991, and divided by the national average case mix index for each year. We determined that the total increase in charges per case, net of case mix change, was 33.85 percent, or 10.2 percent compounded annually. Based on this analysis, we estimate that charges increased 21.4 percent between FY 1989 and FY 1991, or 10.2 percent annually compared to the 11.4 percent annual inflation factor used to estimate FY 1991 outlier payments. We note that the new charge inflation figure may increase once additional FY 1991 cases are included in the MEDPAR data, since the cases that appear in later updates of the data tend to have higher charges.

b. *Cost-to-Charge Ratios.* To determine cost outlier payments, we multiply covered charges by a hospital's cost-to-charge ratio. We used the latest cost-to-charge ratios (from 1989 and 1990 hospital specific data) available at the time we estimated FY 1991 outlier payments. It is possible that the cost-to-charge ratios used to estimate the FY 1991 outlier payments were higher than those used to make actual FY 1991 outlier payments. If the cost-to-charge

ratios used to determine estimated FY 1991 outlier payments were higher than the actual FY 1991 cost-to-charge ratios, then the adjusted costs we used to determine cost outlier payments would have been higher than those used to calculate actual outlier payments. Thus, we would have estimated higher outlier payments than if we had used the actual cost-to-charge ratios. The average cost-to-charge ratio we used to estimate FY 1991 outlier payments was 0.6741, while the average cost-to-charge ratio used to compute actual FY 1991 payments was 0.6606. The difference between the two cost-to-charge ratios indicates hospital's charges have been increasing more rapidly than their costs. On average, using the 0.6741 percent cost-to-charge ratio overstated estimated costs by 2.0 percent compared to what costs would have been using the actual cost-to-charge ratios used to make outlier payments in FY 1991.

c. *Payment Adjustments.* To determine cost outlier payments, we standardize a hospital's charges for indirect teaching and disproportionate share adjustments (IME and DSH). Ordinarily, we use the hospital-specific data from the previous year (1989 and 1990 data in this case) to estimate both adjustments. However, because of changes in the disproportionate share formula, we had to compute some disproportionate share adjustment factors using available 1988 hospital cost report data in estimating FY 1991 payments.

If the DSH and IME payment adjustment factors we used to set the FY 1991 thresholds were lower than those used to make FY 1991 payments, we would again overestimate the costs used to determine cost outlier payments, since we divide the charges by a figure of one plus the IME and DSH adjustment factors. Thus, we would have estimated higher outlier payments than if we had used the actual IME and DSH adjustment factors that were used to determine payments. The average DSH adjustment factor we used to estimate FY 1991 outlier payments was 0.0336, while the factor used to determine actual outlier payments averaged 0.0265 for the first quarter of FY 1991 (before the payment formula for large hospitals in urban areas was changed) and 0.0290 for the rest of FY 1991. Since the actual DSH adjustment factors were lower than those we used to estimate FY 1991 outlier payments, our estimate would have understated the FY 1991 costs of hospitals receiving a disproportionate share adjustment.

The IME factor used to estimate FY 1991 outlier payments was 0.0226, while the average IME adjustment factor used to determine actual payments was 0.0218. Thus, our estimate would have understated the costs of hospitals receiving an indirect teaching adjustment.

We note that while the DSH and IME adjustment factors that are used to determine the additional payments for DSH and IME are subject to retroactive adjustment during the cost report settlement process, there is no retroactive adjustment in the cost outlier payment determination. That is, even if the DSH and IME factors change during the cost report settlement process, there is no retroactive change in the cost outlier determination to take into account the effect the revised DSH and IME factors would have had on the adjusted charges used to determine the cost outlier payment.

d. *Effect of Revised Adjustment Factors.* To test the effects of the charge inflation factor, the cost-to-charge ratios, and the payment adjustment factors, we used the FY 1989 MEDPAR data, a revised charge inflation factor of 10.2 percent, and the cost-to-charge ratio, IME and DSH adjustment factors used to determine actual outlier payments in FY 1991 to determine what thresholds we would have set to yield 5.1 percent outlier payments if this more recent data had been available. To approximate the cost-to-charge ratios and the IME and DSH factors that were used to determine cost outlier payments, we used the factors on the September 30, 1990 provider-specific file to determine outlier payments for discharges occurring on or after October 1, 1990 and before January 1, 1991 and the factors on the March 31, 1991 provider-specific file to determine payments for discharges occurring on or after January 1, 1991. We used these two files because, as stated above, the DSH payment formula changed effective for discharges occurring on or after January 1, 1991. In addition, we used the three sets of standardized amounts and two wage indexes in effect during FY 1991 rather than the standardized amounts and wage index established in the September 4, 1990 final rule. The thresholds we would have established if these data had been available at that time would have been the geometric mean length of stay for the DRG plus the lesser of 28 days or three standard deviations for day outliers, and the greater of 2.0 times the DRG rate or $32,500 for cost outliers. (The actual FY 1991 thresholds were the geometric mean length of stay for the DRG plus the lesser of 29 days or three standard deviations for day outliers, and the greater of 2.0 times the DRG rate or $35,000 for cost outliers.) We then ran the FY 1991 cases through these outlier thresholds, and we determined that the actual FY 1991 outlier payments would have been 4.3 percent of DRG payments. Since all of the payment adjustments were the same in the two runs, the difference between this percent and the 5.1 percent of DRG payments that we estimated must be related to the differences in the cases in the FY 1989 MEDPAR compared to the FY 1991 MEDPAR.

e. *DRG Classification Changes.* In FY 1991, we made significant changes to the DRG classification system that included the establishment of several higher weighted DRGs. By improving the amount of variation in resource costs explained by the DRGs, in setting the FY 1991 outlier payment policy, we were able to lower the outlier thresholds compared to the thresholds that would have been required if we had not made the DRG classification changes.

The DRG classification changes and their effect on FY 1991 aggregate program payments are discussed in Section II.B, above. Our analysis indicates that aggregate payments were one percent higher than they would have been if we had not made the DRG classification changes. The increase is largely attributable to changes in hospital coding practices in response to the DRG changes. The coding improvements also had an effect on actual FY 1991 outlier payments. The following example illustrates how the DRG reclassification changes affected outlier payments.

When comparing the assignment of FY 1991 cases using the FY 1990 and FY 1991 GROUPERs, almost 1,000 cases that would have been in DRG 14 (Specific Cerebrovascular Disorders Except TIA) using the FY 1990 GROUPER moved to DRG 483 (Tracheostomy Except for Mouth, Larynx, or Pharynx Disorder). The average length of stay for these cases was 51 days, and the average standardized charges were $88,401. Total payments for these cases can be calculated with the following data:

DRG	DRG weight	Geometric mean length of stay	Day outlier threshold
14	1.2212	7.3	36
483	14.0597	40.0	68

The payments calculated below assume a cost-to-charge ratio of 0.6606 (the average FY 1991 cost-to-charge ratio), and that the hospital is located in

a large urban area. Using the standardized amounts for a large urban area effective for January 1, 1991 and a wage index value of 1.0 (to which the average charges have been standardized), the payments are calculated as follows:

PAYMENT IN DRG 14 COMPARED TO PAYMENT IN DRG 483

	DRG payment	Outlier payment	Total payment	Outlier percentage
DRG 14.....	$4,277	$17,548	$21,825	80.4
DRG 483.....	49,245	—	49,245	0

In estimating the FY 1991 outlier payments, we assigned all the cases in the FY 1989 MEDPAR data to the DRG to which the case would be assigned in FY 1991 based on the diagnoses and procedures indicated on the bill. In the above example, the case in DRG 14 would have been reassigned to DRG 483 if the tracheostomy procedure code had been included on the bill. If the case were assigned to DRG 483, the outlier payment simulation to establish the outlier thresholds would have properly included no outlier payment for the case. On the other hand, if the tracheostomy procedure code had not been included on the bill, the case would have continued to be assigned to DRG 14. If the case were assigned to DRG 14, the outlier simulation would have included an outlier payment and a lower standard payment than would actually occur in FY 1991. The simulation would overstate the outlier payment percentage and the outlier thresholds would be set higher than they would be if the case were fully coded. If the case had been an actual FY 1991 case, it would have been fully coded with the tracheostomy procedure code since the presence of the code would affect payment (whereas it did not in FY 1989). As this example illustrates, coding improvements made in response to the DRG classification changes lowers the outlier payments as a percentage of DRG payments in two ways: It lowers outlier payments, and thus lowers the numerator, and increases DRG payments, and thus increases the denominator.

While we believe that the coding improvements had a significant impact on the outlier payment percentage, we are unable to isolate the effects of these changes from other changes in the distribution of cases or from the effects of the elimination of catastrophic coverage. However, we note that as a result of the DRG classification changes, total program payments are .99 percent higher than they would have been if the reclassification changes had not been made. Thus, while the DRG reclassification changes had the effect of decreasing outlier payments, they also had the effect of increasing total program payments and there was no reduction in aggregate payments in FY 1991.

f. *Repeal of Public Law 100–360 and Changes in Length of Stay.* The Medicare Catastrophic Coverage Repeal Act of 1989 (Pub. L. 101–234) repealed Public Law 100–360, effective January 1, 1990. Thus, the FY 1989 MEDPAR data included claims that were still covered under the provisions of Public Law 100–360. In estimating the FY 1991 outlier payments, we estimated the effect of catastrophic coverage by comparing the outlier percentage modeled on covered days and charges and on total days and charges using pre-catastrophic billing data and catastrophic billing data. We estimated that outlier payments would be 93 percent of the amounts based on FY 1989 covered days and charges. Therefore, we set the thresholds based on a 5.5 percent outlier percentage (5.1 divided by .93) but reduced the standardized amount by only 5.1 percent. It is possible that we underestimated the effect of catastrophic coverage by using the FY 1989 claims rather than the FY 1991 claims.

Because of catastrophic coverage, we cannot make a direct comparison between the average covered length of stay in FY 1989 and FY 1991 to determine if a change might have affected the number of cases qualifying for day outlier payments. However, we do know that the total average length of stay decreased from 8.548 in FY 1989 to 8.372 in FY 1991. Assuming that in the absence of catastrophic coverage the ratio of covered days to total days would remain constant, the reduction in the total average length of stay implies that there was a reduction in the average length of stay independent of the repeal of catastrophic coverage. This could have reduced the number of cases qualifying for outlier payments.

We note that in making the adjustment for catastrophic coverage in the FY 1991 final rule, we adjusted only our estimate of outlier payments. We did not adjust the estimated number of day outlier cases directly. Therefore, we would expect a reduction in the comparison between estimated day outlier cases and actual day outlier cases. Day outlier cases as a percentage of total cases declined from 1.5 percent to 1.3 percent. We are unable to isolate the reduction attributable to the elimination of catastrophic coverage from other changes in the average length of stay and the DRG classification changes.

g. *Conclusion.* All of the differences between the data we used to estimate the FY 1991 outlier thresholds and the actual data used for determining FY outlier payments could not have been predicted at the time of estimation. We note that in past years we have paid out both less and more than the estimated percent of DRG payments, as the following table illustrates:

Fiscal year	Estimated outlier payment	Actual outlier payment
1984	1.4	1.1
1985	2.5	1.7
1986	3.75	[1] 2.5
1987	5.0	4.0
1988	5.0	6.7
1989	5.1	[2] 6.0
1990	5.1	5.2
1991	5.1	(est.) 4.0

[1] Shortfall due to statutory delay (until May 1, 1986) in the implementation of updated thresholds reflecting decreases in Medicare length of stay.

[2] Includes additional outlier payments attributable to the Medicare Catastrophic Coverage Act of 1989.

NOTE.—For the first three years of the prospective payment system, estimated payments were expressed as a percentage of total payments, even though outlier payments were made only on the Federal portion of the prospective payment system payments. For FY 1984, the thresholds were set to provide outlier payments equal to 5.7 percent of Federal payments; for FY 1985 and FY 1986, the target was 5.0 percent of Federal payments. Actual figures for FY 1985–1987 are estimates based on cost report data. In addition, the estimated payment for FY 1988 increased to 5.1 percent as the result of changes to payments effective April 1, 1988.

In all cases, we set the outlier thresholds based on the most current data we had available. Accordingly, we do not believe that it is appropriate to make an adjustment in prospective payment system payments to account for the difference between the estimated and actual FY 1991 outlier payments, just as we have not made adjustments in earlier years (see 51 FR 31525; 52 FR 33048; 53 FR 38508; 54 FR 36500; 55 FR 36077; and 56 FR 43227).

Although outlier payments were 4.0 percent of total standard DRG payments (exclusive of DSH and IME) instead of 5.1 percent, there was no reduction in total standard DRG payments between the payment per case estimated in the FY 1991 final rule and the actual FY 1991 total standard payment per case. As the following table illustrates, the lower outlier payments were more than offset by the increase in standardized amount payments.

	FY 1991 payment per case	
	Estimated	Actual
Average standardized amount payment	$4414.13	$4533.33
Average Outlier Payment	237.36	188.81
Total standard DRG payment per case	4651.49	4722.14

The average total payment per case increased 1.5 percent over the amount estimated in the FY 1991 final rule. We would expect an increase in the average payment for increases in the case mix index (CMI). The observed CMI increase was 2.5 percent. After removing the increase attributable to the FY 1991 DRG reclassification changes, the net CMI increase is 1.5 percent. Thus, the payment increases attributable to the DRG classification changes offset the payment reductions attributable to lower outlier payments. Moreover, the average payment per case increase of 1.5 percent exceeds our estimate that real case mix change was between 1.0 and 1.25 percent.

Finally, we note that we set the estimated outlier payment percentage at 5.1 percent each year. Thus, the 1.1 percent reduction in outlier payments is not permanent. In contrast, except to the extent the difference between observed and real case mix increase is taken into account in the update factor, the observed CMI increase is built permanently into the payment amounts.

4. FY 1992 Outlier Payments

We anticipate that FY 1992 outlier payments will be less than the 5.1 percent that we estimated when we set the outlier thresholds. The FY 1992 thresholds were set using FY 1990 cases that did not reflect the coding effects of the FY 1991 DRG classification changes. In addition, the first quarter of the FY 1990 data included the effects of catastrophic coverage, for which an adjustment was made in estimating FY 1992 outlier payments. Thus, the considerations involved in estimating the FY 1992 outlier payments and comparing them to a current estimate based on FY 1991 cases and more recent data are similar to those applicable to comparing the estimated FY 1991 outlier payments to the actual outlier payments in that year.

Using the FY 1991 cases and the FY 1992 payment data, we currently estimate that FY 1992 operating outlier payments will be approximately 3.6 percent of FY 1992 total. DRG payments, and that FY 1992 capital outlier payments will also be approximately 3.6 percent of capital DRG payments. (If indirect teaching and disproportionate share payments are included in the calculation, the estimated outlier percentage is 3.7 percent.) The 3.6 percent estimate for FY 1992 is lower than the 4.0 actual outlier percentage for FY 1991 largely because of changes in the payment adjustment factors. The estimate is based on the December 31, 1991 update to the provider-specific file. These data indicate that the payment adjustment factors for DSH and IME have increased relative to the factors used to pay outlier cases in FY 1991 (which were also used to set the FY 1992 thresholds). The increases would have the effect of reducing the hospital's costs in determining cost outlier payments. In addition, the average cost-to-charge ratio has decreased. This would also have the effect of decreasing the hospital's costs. The comparative payment adjustment factors are as follows:

	FY 1992 final rule estimated (3/31/91 update)	FY 1992 current estimate (12/31/91 update)
DSH factor	.0349	.0399
IME factor	.0492	.0512
Cost-to-charge ratio	.6138	.5992

While we estimate that outlier payments for FY 1992 will be lower than expected, we also anticipate that total DRG payments will be higher than expected based on the newer cases that reflect the FY 1991 DRG changes discussed above. Even though our latest estimates of FY 1992 outlier payments indicate that payments will likely fall short of the 5.1 percent outlier pool, for a number of reasons we do not plan to revise the outlier pool or thresholds midway through the current fiscal year to reflect the estimated outlier shortfall.

In accordance with sections 1886(d)(6) and 1886(e)(5)(B) of the Act, we must publish the annual rates for the prospective payment system by September 1 before each fiscal year. The intent of this requirement is to provide hospitals with advanced notice of the prospective payment rates that will be in effect for the upcoming fiscal year. In order to comply with this requirement, all aspects of the rate setting computations must necessarily be made using the latest data available at the time of publication. This is true not only in establishing the outlier pool, but also in forecasting the increase in the hospital market basket, recalibrating the DRG relative weights, and computing the various required budget neutrality adjustments. We do not believe Congress contemplated that we would revise any one of these estimates based on later data that becomes available midway through the fiscal year, nor do we believe it is appropriate to do so. Although in this instance our outlier estimates were understated, there are also instances where our estimates have been overstated, not just for outlier payments, but for other elements of the prospective payment system as well. For example, our market basket rate of increase forecasts used to establish the standardized amounts have been overstated for the past two years; however, we have not revised those forecasts as later data became available during the year. Moreover, with respect to estimating the outlier payment pool, we believe we have complied with the intent of section 1886(d)(5)(A)(iv) of the Act that we establish the pool based on "projected or estimated" total payments for the fiscal year. Accordingly, we are not revising the current outlier thresholds based on this latest estimate of outlier payments for FY 1992.

We are using the payment adjustment data on the December 31, 1991 provider-specific file and a 10.2 percent charge inflation factor to establish the proposed FY 1993 outlier thresholds. The proposed thresholds, set forth below, are lower than the FY 1992 thresholds in order to restore the outlier payment percentage to 5.1 percent based on the most current available data.

5. FY 1993 Proposed Outlier Thresholds

For FY 1993, we propose to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 23 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 $34,500. The thresholds we would propose if we were not implementing the change in day outlier payment methodology discussed above would be: for day outliers, the geometric mean length of stay for each DRG plus the lesser of 26 days or 3 standard deviations, and for cost outliers, the greater of 2.0 times the prospective payment rate for the DRG or $38,500.

The proposed thresholds would slightly increase the proportion of outliers paid as cost outliers relative to those paid as day outliers. We estimate 44.7 percent of cases would be paid using the cost outlier methodology and 55.3 percent would be paid using the day outlier methodology, compared to 41.3 percent of cases being paid using the cost outlier methodology without the proposed day outlier payment change. Cases that meet the day outlier

threshold but that would be paid using the cost outlier methodology, because it yields the higher payment, would increase from 14.0 percent to 17.9 percent of all outlier cases under the proposed policy.

Our simulation of FY 1993 outlier payments based on FY 1991 MEDPAR data indicates that the percentage of outlier cases that would qualify as day outliers is about 73.2 percent under the proposed policy. The cases qualifying as day outliers would receive 75.8 percent of operating outlier payments in FY 1993. An estimated 26.8 percent of outlier cases would be cost only outlier cases, which would receive about 24.2 percent of operating outlier payments under the proposed policy. 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	
	Current policy	New policy	Current policy	New policy	Current policy	New policy	Current policy	New policy
Meets day threshold only	47.5	46.2	25.1	18.5	24.7	18.2	25.0	18.4
Meets day and cost thresholds, paid using day methodology	11.2	9.2	20.7	13.7	20.4	13.5	20.6	13.7
Meets day and cost thresholds, paid using cost methodology	14.0	17.9	32.2	43.7	30.9	41.8	32.1	43.5
Meets cost threshold only	27.3	26.8	22.1	24.2	24.0	26.5	22.3	24.4
Subtotal—all cases meeting day threshold	72.7	73.2	77.9	75.8	76.0	73.5	77.7	75.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds would result in the same percentage of outlier payments for capital-related costs as for operating costs. We estimate the proposed thresholds would result in outlier payments equal to 5.1 percent of operating DRG payments and 5.1 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors that would be applied to the standardized amounts and the capital Federal rate for FY 1993 are as follows:

Standardized amount		Capital Federal rate
Urban	Rural	
0.944828	0.978085	0.9490

6. Other Changes Concerning Outliers

We propose to remove certain provisions of § 412.82 that are now obsolete. One provision in § 412.82(c) sets forth the factors to be used to compute day outlier payments during the transition period to the prospective payment system for inpatient hospital operating costs. It applied to cost reporting periods beginning before October 1, 1987 and is no longer applicable. We also propose to remove paragraph § 412.82(d). This provision was implemented to conform our regulations to section 4008(d)(1)(A) of Pub. L. 100–203 which directed the Secretary to compute day and high cost outlier payments for burn cases using a marginal cost factor of 90 percent in place of the 60 percent and 75 percent factor we used to calculate day and high cost outlier payments for other types cases. As explained in section C.1., the statute was effective only for discharges occurring on or after April 1, 1988 and before October 1, 1989. Unlike payments for high cost, burn outliers, we did not continue to use a 90 percent marginal cost factor to compute payments for day outlier burn cases following expiration of the statutory provision. Therefore we are proposing to delete § 412.82(d) since it is no longer applicable in determining day outlier payments.

Table 8a in section IV of the addendum to this proposed 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, 1992, these Statewide average ratios replace the ratios published in the August 30, 1991 final rule (56 FR 43196). Table 8b contains comparable Statewide average capital cost-to-charge ratios. We propose that these average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.316374 or greater than 1.27564 and capital cost-to-charge ratios lower than 0.014496 or greater than 0.248882. 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 would be applied to all hospital-specific cost-to-charge ratios based on cost report settlements occurring during FY 1992.

B. 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 in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- Number of discharges is at least 5,000 discharges per year or, if 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 would follow the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value includes 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 § 412.105).

These values are based on discharges occurring during FY 1991 (October 1, 1990 through September 30, 1991) and include bills posted to HCFA's records through December 1991. Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1992, a hospital's case-mix index value for FY 1991 would have to be at least—

- 1.2791; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

The median case-mix values by region are set forth in the table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.1789
2. Middle Atlantic (PA, NJ, NY)	1.1865
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.2779
4. East North Central (IL, IN, MI, OH, WI)	1.2099
5. East South Central (AL, KY, MS, TN)	1.2247
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	1.1978
7. West South Central (AR, LA, OK, TX)	1.2766
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3073
9. Pacific (AK, CA, HI, OR, WA)	1.2761

The above numbers will be revised in the final rule to the extent required if additional bills are received for discharges through September 30, 1991.

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 each hospital's FY 1991 case-mix index values in Table 3c in section IV of the addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

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)(II) of the Act, the national standard is set at 5,000 discharges. However, we are proposing to update the regional standards. The proposed regional standards are based on discharges for urban hospitals' cost reporting periods that began during FY 1990 (that is, October 1, 1989 through September 30, 1990). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1992, the number of discharges a hospital must have for its cost reporting period that began during FY 1991 would have to be at least—

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

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,236
2. Middle Atlantic (PA, NJ, NY)	8,353
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7,029
4. East North Central (IL, IN, MI, OH, WI)	8,096
5. East South Central (AL, KY, MS, TN)	5,576
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	5,957
7. West South Central (AR, LA, OK, TX)	5,251
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7,511
9. Pacific (AK, CA, HI, OR, WA)	5,393

We note that all the regional standard now exceed the national of 5,000. Therefore, 5,000 discharges is now the standard all hospitals will have to meet. We reiterate that to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1992, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1991 would have to be at least 3,000.

3. Retention of Referral Center Status

In the August 31, 1984 final rule, we announced that we were instituting a periodic review of the status of hospitals that qualified for a payment adjustment as a referral center (49 FR 34746). That final rule stated that this review would allow us to determine if these hospitals continued to meet the criteria for referral center status. The final rule stated that we would grant referral center status to a hospital for a 3-year period. At the end of the 3 years, we would evaluate a hospital's performance in meeting the criteria for qualifying as a referral center. A hospital would have been required to meet the criteria for at least 2 of those 3 years. If it did, the hospital would retain its referral center status for another 3-year period. If the hospital did not meet the criteria for at least 2 of the 3 years, the hospital's status as a referral center would end with the last day of the third cost reporting period for which it received the referral center payment adjustment.

Before we were able to implement this review, the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) was enacted on October 21, 1986. Section 9302(d)(2) of Public Law 99–509 stated that any hospital that was classified as a rural referral center on the date of the enactment of that law would continue to be classified as a referral center for cost reporting periods beginning on or after October 1, 1986 and before October 1, 1989. Thus, any hospital that was classified as a referral center as of October 21, 1986 (the date of enactment of Public Law 99–509) was guaranteed this status through its cost reporting period beginning before October 1, 1989.

We again attempted to implement the referral center triennial reviews in 1989. In the May 8, 1989 proposed rule (54 FR 19653) and in the September 1, 1989 final rule (54 FR 36466), we reiterated the review criteria and the methodology that we would follow in performing the reviews. However, since some referral centers had been so classified for more than 3 years, the triennial review would be limited to the hospital's compliance during the last 3 years.

Shortly after implementation of the triennial review procedures on October 1, 1989, Congress enacted the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239) on December 18, 1989. Section 6003(d) of that Act stated that any hospital that was classified as a referral center as of September 30, 1989, including those so classified as a result of section 9302(d)(2) of Public Law 99–509, would continue to be classified

as a referral center for cost reporting periods beginning on or after October 1, 1989 and before October 1, 1992. In the September 4, 1990 final rule (55 FR 36070), the regulations at § 412.96(g)(2) were revised to reflect this provision. These regulations state that referral center status for those hospitals that do not meet the retention criteria will terminate with the first cost reporting period beginning on or after October 1, 1992.

We believe it is important that the rural referral center benefit be available only to those hospitals that continue to be in compliance with the statutory criteria for designation. Therefore, with the expiration of the requirement of section 6003(d) of Public Law 101–239 on October 1, 1992, we are implementing the retention criteria and methodology specified in § 412.96(f) that we had developed previously. These criteria and methodology were discussed in the June 10, 1985 proposed rule (50 FR 24380), in the September 3, 1985 final rule (50 FR 35676) and in the September 1, 1989 final rule (54 FR 36486).

Basically, to retain status as a referral center, a hospital will have to meet the criteria for classification as a referral center specified in § 412.96 (b)(1) or (b)(2) or (c) for 2 of the last 3 years or it must qualify on the basis of the requirements for the current year. A hospital may meet any one of three sets of the specific criteria for individual years during the 3-year period or the current year. For example, a hospital may meet the two mandatory requirements in § 412.96 (c)(1) (case-mix index) and (c)(2) (number of discharges) and the optional criterion in paragraph (c)(3) (medical staff) during the first year. During the second or third year, the hospital may meet the criteria under § 412.96(b)(1) (rural location and appropriate bed size).

A hospital will have to meet all of the criteria within any applicable section of the regulations in order to meet the retention criteria for a given year. That is, it will have to meet all of the criteria of § 412.96(b)(1) or § 412.96(b)(2) or § 412.96(c). For example, if a hospital meets the case-mix index standards in § 412.96(b)(2) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards would have to be met in the same year.

In accordance with § 412.96(f)(2), the review process will be limited to the hospital's compliance during the last 3 years. Thus, if a hospital meets the criteria for at least 2 of the last 3 years or for the current year the criteria for FY 1993 outlined above in section V.C.1 and 2 of this preamble, it will retain its status for another 3 years. No hospital will be subject to a review until the end of its third full cost reporting period as a referral center. We have constructed the following chart and example to aid hospitals and qualify as referral centers under the criteria in § 412.96(c) in projecting whether they will retain their status as a referral center.

Under § 412.96(f), to qualify for a 3-year extension effective with cost reporting periods beginning in FY 1993, a hospital must meet the mandatory criteria in § 412.96(c) for FY 1993 or it must meet the criteria for 2 of the last 3 years as follows.

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the **Federal Register** on
1992	1990	1990	August 30, 1991.
1991	1989	1989	September 4, 1990.
1990	1988	1988	September 1, 1989.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1988. The hospital has fewer than 275 beds. Its status as a referral center is protected through June 30, 1993 (the end of its cost reporting period beginning July 1, 1992). To determine if the hospital should retain its status as a referral center for an additional 3-year period, we will review its compliance with the applicable criteria for its cost reporting periods beginning July 1, 1990, July 1, 1991, and July 1, 1992. The hospital must meet the criteria either for its cost reporting period beginning July 1, 1993 or for two out of the three past periods. For example, to be found to have met the criteria, at § 412.96(c)(2) for its cost reporting period beginning July 1, 1991, the hospital's case-mix index value during FY 1989 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 4, 1990 final rule. The hospital's total number of discharges during its cost reporting year beginning July 1, 1989 must have equaled or exceeded 5,000 or the regional standard as published in the September 4, 1990 final rule.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96 (b)(i) and (b)(1)(ii) (that is, rural location and appropriate bed size (500 or more beds for discharges occurring before April 1, 1988 and 275 or more beds thereafter)), we will look at the number of beds shown for indirect medical education purposes (as defined at § 412.105(b)) on the hospital's cost report for the appropriate year. We will consider only full cost reporting periods when determining a hospital's status under § 412.96(b)(1)(ii). This definition varies from the bed size criterion used to determine a hospital's initial status as a referral center because we believe it is important for a hospital to demonstrate that it has maintained at least 275 beds throughout its entire cost reporting period, not just for a particular portion of the year.

C. Direct Graduate Medical Education Payment (§ 413.86)

Section 1886(h) of the Act sets forth the provisions governing direct payments for graduate medical education. As implemented by regulations at § 413.86, HCFA pays a hospital a fixed amount per full time equivalent (FTE) resident employed by the hospital. Under § 413.86(f), HCFA determines the number of hospital resident FTEs by applying a weighting factor to each resident.

In order to be given an FTE weight of greater than zero, under § 413.86(h), a foreign medical graduate must pass the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), or before July 1, 1986, have received certification from, or passed an examination of the Educational Committee for Foreign Medical Graduates. On or after September 1, 1989, the National Board of Medical Examiners Examination (NBMEE), parts I and II, may be substituted for the FMGEMS. Failure to meet the qualifying requirements on the part of a foreign medical graduate results in an FTE weight of zero being assigned to that resident. The hospital, as a result, would not receive any direct graduate medical education payments for that resident.

Both the FMGEMS and the NBMEE are about to be replaced by the United States Medical Licensing Examination (USMLE). Beginning June 1, 1992, foreign medical graduates will have the option of taking the USMLE or the FMGEMS. Effective in July 1, 1993, only the USMLE will be administered, and foreign medical graduates must pass steps I and II in order to receive certification. Therefore, we are proposing to revise § 413.86(h) to reflect this change in the examination requirements.

We note that section 1886(h) of the Act references only the FMGEMS. Therefore, we intend to seek a technical amendment so that the statute will

provide explicitly for recognition of successor tests. We expect the Congress to act on the technical amendment within one year.

VI. Proposed Changes to Capital Prospective Payment System Rules

A. Payments to New Hospitals (§§ 412.300, 412.302, 412.324, and 412.328)

The August 30, 1991 final rule implementing the capital prospective payment system established special payment provisions for new hospitals (56 FR 43418). Under § 412.324(b), a new hospital is paid 85 percent of its allowable Medicare capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient. Beginning with the third year, the hospital is paid under the fully prospective or hold-harmless payment methodology, as appropriate. If the hospital is paid under the hold-harmless payment methodology, the hospital's hold-harmless payments for its old capital costs continue for up to 8 years.

As defined under § 412.300(b), a new hospital is one that has operated (under previous or present ownership) for less than 2 years and does not have a 12-month cost reporting period that ends on or before December 31, 1990. As a result of situations brought to our attention since the publication of the August 30, 1991 final rule, we are proposing to refine the definition of a new hospital and clarify how we would treat facilities that have operated for more than 2 years but do not have a 12-month cost reporting period ending on or before December 31, 1990. These changes are necessary to ensure that hospitals that actually had an existing asset base on or before December 31, 1990 are not inadvertently provided with an extended transition period and potentially higher payments than other hospitals.

We believe that it is essential to maintain the integrity of the capital prospective payment system by allowing only truly new providers of hospital care to qualify for the new hospital exemption. The exemption is intended to protect hospitals that come under the capital prospective payment system without a historic asset base and need special consideration for their original plant and equipment costs during their initial years of operation. Therefore, we are proposing to clarify that the new hospital exemption under the capital prospective payment system would not apply to a facility that opens as an acute care hospital if that hospital operated in the past under current or previous ownership and has a historic asset base.

Examples of hospitals with an existing asset base that open as acute care hospitals include a hospital that closes and subsequently reopens (under either its original or different ownership), and a facility that changes its certification from a specialty hospital that is excluded from the capital prospective payment system to an acute care hospital. Although a facility may be treated as a new hospital for certification or other payment purposes when it has previously operated as a hospital, it would not qualify for a new hospital exemption under the capital prospective payment system. As is the case with other acute care hospitals, Medicare program payment has been made to the facility in the past under reasonable cost reimbursement rules, either for the same physical assets or for assets that have been replaced, and the hospital had old capital costs as of December 31, 1990. If the facility were permitted to qualify for the new hospital exemption, we would be extending its cut-off date for old capital beyond the date allowed other hospitals with an existing asset base. We believe it is inappropriate to provide the hospital with a special payment protection that is not afforded other hospitals that were in operation before the effective date of the capital prospective payment system. The reasonable cost payment protection under the new hospital exemption should only be available to those hospitals that have not received reasonable cost payments in the past and need special protection during their initial period of operation.

Also, we propose to clarify that a hospital that replaces its entire facility (with or without a change of ownership) does not qualify for a new hospital exemption. Although the hospital may experience a significant change in its asset base, we believe it would be inappropriate to provide the hospital with special payment protection. If we were to allow new facilities built by existing hospitals to qualify for the new hospital exemption, we would provide an inappropriate incentive for hospitals to replace their existing plant instead of renovating or expanding their current facility. If the capital prospective payment system is to be effective in encouraging prudent capital spending, payment must be neutral with respect to decisions concerning whether to renovate or replace existing assets.

Therefore, we are proposing to amend the definition of a new hospital at § 412.300(b) to clarify that the exemption applies only to hospitals that have been in operation for less than 2 years and does not apply to the following situations:

- A hospital that changes status from an excluded hospital paid under section 1886(b) of the Act to an acute care hospital subject to the provisions of section 1886(d) of the Act.
- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 years.
- A hospital that closes and then reopens under either the same or different ownership.
- A hospital that builds a new or replacement facility at the same or a new location, even if a change in ownership or new leasing arrangements are involved.

Consistent with these changes, we are proposing to revise § 412.328 to clarify that if a hospital (other than a new hospital) does not have a 12-month cost reporting period ending on or before December 31, 1990 as an acute care hospital, the hospital's hospital-specific rate would be based on the hospital's old capital costs per discharge in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12-months) ending after December 31, 1990. All other transition payment rules apply to the hospital effective with the first cost reporting period that it is subject to the capital prospective payment system.

We are also proposing to clarify the old capital definition applicable to hospitals that qualify for a new hospital exemption. Under § 412.328(a)(2), a new hospital's base period is its 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient. Although the preamble of the August 30, 1991 final rule (56 FR 43418) stated our intent to treat the hospital's base year costs as old capital costs, the regulations do not explicitly contain this provision. We are proposing to revise § 412.302 to define a new hospital's old capital costs as its allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of its base period cost reporting period. The limitations in § 412.302(b) that apply to old capital costs would also apply to a new hospital except that the limitations would be based on the hospital's old capital costs for assets that were put in use as of the later of December 31, 1990 or the last day of its base period cost reporting period. We are not proposing any change in the obligated capital provisions with respect to new

hospitals; that is, new hospitals are subject to the same rules on obligated capital as other hospitals (see § 412.302(c)).

B. Portion of Hospital Assets Put in Patient Care Service After December 31, 1990 (§ 412.302)

In the preamble to the August 30, 1991 final rule, we addressed a comment concerning how a situation involving a portion of a hospital that was leased to another party as of December 31, 1990 should be treated if the hospital subsequently takes possession of the space and uses it for patient care (56 FR 43396). We responded to the comment by indicating that the space, which would be a nonreimbursable cost center in the hospital's base year, would be recognized as old capital when it is subsequently used by the hospital for patient care. Although we addressed this specific situation in our response to comments in the final rule, we did not establish a general principle to follow in situations where nonreimbursable cost centers in the base year subsequently become allowable cost centers. We believe that such situations regularly occur in hospital operations and must be specifically addressed in our rules defining old and new capital.

We propose to revise § 412.302(b) to address situations in which a hospital may have a nonreimbursable cost center or otherwise incur unallowable hospital costs for a depreciable asset as of December 31, 1990. Examples of these unallowable costs include costs attributable to space or equipment that is leased to another party or used to provide non-hospital services in part of a building or department that is also used to provide acute care inpatient hospital services. To the extent the costs of such space or equipment become allowable inpatient hospital capital-related costs after December 31, 1990, those costs would be recognized as old capital costs as long as a portion of the asset was in use for hospital inpatient care as of December 31, 1990. The allowable costs that could be recognized as old capital costs would be subject to the current provisions at § 412.302(b). If no portion of an asset was used to provide hospital inpatient care as of December 31, 1990, any allowable hospital inpatient capital-related costs of the asset would be recognized as new capital costs when the asset was returned to hospital inpatient care service.

We considered proposing that any portion of an asset that was not used for patient care as of December 31, 1990, and was subsequently put in use for patient care, would be classified as new capital. This approach would be consistent with our definition of old capital costs since the nonreimbursable portion of the asset's costs was not an allowable cost as of December 31, 1990 because the asset was not in use for patient care. However, this approach would require that we classify the same asset as old capital with respect to the portion that was in use for patient care as of December 31, 1990, and as new capital with respect to the portion that was in use for nonhospital care as of December 31, 1990. We believe that for purposes of cost finding and the determination of allowable inpatient hospital costs, an individual asset should be considered as either old or new capital, but not both. Therefore, we are proposing that if a portion of an asset was in use for hospital patient care as of December 31, 1990, subject to the limitations in § 412.302(b) on old capital costs, we would recognize as old capital costs any costs for other portions of the asset that subsequently become allowable. If no portion of an asset was in use for hospital patient care as of December 31, 1990, the asset would be classified as new capital if it is subsequently put in use for hospital patient care. We have chosen December 31, 1990 as the cut-off date because the old capital definition implicitly assumes that an asset was put in use on or before December 31, 1990 and continues in use as of December 31, 1990. We do not believe that an asset that was put in use for hospital patient care before December 31, 1990 but was taken out of hospital patient care service by December 31, 1990 should be classified as old capital and receive the same protection under the hold-harmless provision as an asset that was actually in use for hospital patient care as of December 31, 1990.

The proposed policy provides protection for space or equipment costs that are an integral part of assets that otherwise qualify as old capital, while preventing an inappropriate extension of the hold-harmless protections to buildings and equipment that were not used for hospital patient care as of December 31, 1990. We wish to avoid incentives for hospitals to circumvent the capital prospective payment system by converting existing assets that are used to provide nonhospital patient care into hospital assets that would be protected under the hold-harmless methodology while receiving payment under Medicare program benefits for the replacements for the non-hospital assets on a reasonable costs basis. This could occur, for example, if beds in a building used to provide skilled nursing facility services in a multiple-facility complex were converted to acute care beds and new SNF beds were put in service.

C. Treatment of Old Capital Costs When Hospitals Are Leased After December 31, 1990 (§ 412.302(b))

The August 30, 1991 final rule addressed how various situations involving changes of ownership and sale-and-leaseback transactions are treated under the capital prospective payment system (56 FR 43395 and 43405). Since publication of the final rule, an additional situation has been brought to our attention that merits clarification. When an entire hospital operation is leased without transfer of the asset costs of the previous operator, those asset costs on which the old capital determination was based are no longer the allowable capital-related costs of the hospital. At that time, the new owner's lease costs become the allowable capital-related costs of the hospital. Under § 412.302(b)(3), which limits old capital lease costs to the lease amount obligated as of December 31, 1990, the hospital's lease costs would be new capital. However, in other change of ownership situations occurring after the December 31, 1990 cut-off date for old capital, we allow the old capital determinations applicable to the old owner to continue to apply to the new owner (see 56 FR 43395 and 43405). We believe that it is appropriate to deal with the leasing of the entire facility in a similar manner.

We propose to revise § 412.302(b) to allow continued recognition of the base period old capital cost determinations in situations where a hospital is leased without assumption of the hospital's asset costs. However, we would limit the amount of allowable capital-related costs that could be recognized as old capital to the amount that could be recognized for the same assets in the last cost reporting period before the current operating lease became effective. Any cost above that limitation would be paid for as new capital cost. This policy would affect only those hospitals eligible for capital prospective payments on the basis of the hold-harmless methodology. In those cases, a hospital would not be held harmless for any increased costs resulting from the lease arrangement entered into after December 31, 1990. This approach would be consistent with the general policy of extending the hold-harmless protection only to capital commitments entered into by the December 31, 1990 cut-off date. It would also be consistent with the limitation on the valuation of a new owner's basis in an asset that undergoes

change of ownership, set forth in section 1861(v)(1)(O) of the Act.

For purposes of determining old capital costs, treatment of lease costs that involve leasing of portions of a hospital's operation or assets would continue to be subject to the provisions of § 412.302 (b)(3) and (c)(1)(vi).

D. Obligated Capital Costs (§ 412.302(c))

1. Deadline for Putting Assets in Use

Capital-related costs attributable to assets that are put in use after December 31, 1990 but for which the hospital was obligated as of December 31, 1990 may be recognized as old capital costs under certain conditions. Under the general rule related to contractual obligations (§ 412.302(c)(1)) and the special rule relating to construction-in-progress (§ 412.302(c)(3)), one condition is that the asset be put in use for patient care before October 1, 1994. Under the rule relating to hospitals affected by a lengthy certificate-of-need (CON) process (§ 412.302(c)(2)), the asset must be put in use before the earlier of October 1, 1996 or 4 years from the date the certificate-of-need was approved. Under § 412.302(c)(1)(iv), if a hospital experiences delays due to extraordinary circumstances beyond its control, HCFA may extend the deadline for putting an asset in use to no later than September 30, 1996. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

The current regulations do not establish a process for granting an extension in the deadline. We are proposing to require that a hospital requesting an extension of the deadline must notify its intermediary of the extraordinary circumstances that delayed, or will delay, completion of the project beyond the original deadline. The request for an extension must be in writing and filed with the intermediary by the later of January 1, 1993 or within 180 days of the event leading to the delay. The request must describe the circumstances contributing to the delay and explain why they are extraordinary and beyond the hospital's control. The request must also explain why the delay cannot be overcome and must provide a new estimated completion date established by the contractor, supplier, or other servicing party. The intermediary would review and verify the documentation submitted by the hospital. The intermediary would forward the request and the results of its review to HCFA within 60 days. Unless additional information is required, HCFA would notify the intermediary of its decision on the request within 90 days of receiving the request from the intermediary.

2. Deadline for Notifying Intermediary of Obligated Capital

Section 412.302(c)(1)(v) provides that a hospital must notify its intermediary that it has obligated capital within 90 days of the date the hospital first becomes subject to the capital prospective payment system. The hospital's notification must include documentation establishing that the capital project meets the criteria for recognition as obligated capital and a description of the project and its estimated costs as of December 31, 1990. The intermediary determines whether the applicable criteria are met and notifies the hospital of its decision before the close of the hospital's first cost reporting period under the capital prospective payment system. The intermediary's determination is contingent on the asset being put in use for patient care by the applicable date.

We established the notification and review process for obligated capital for three basic reasons that we still believe are appropriate. First, the old capital cost determination for obligated capital relates to the status of the project and its estimated costs as of December 31, 1990. We believe a prompt submission contemporaneous with when the project was obligated and when the intermediary would be performing base year audits would facilitate both the submission of proper supporting documentation and the determination process. In addition, we want to fix as soon as feasible the amount of obligated capital that will be recognized as the assets are put in use in order to refine the capital acquisition model used for budget neutrality calculations. Finally, we believe that it is appropriate for hospitals to know in advance whether a project will be recognized as old capital and the amount of the limitation on the project costs that will be recognized as old capital costs.

Since the publication of the final capital prospective payment rule, intermediaries and hospital representatives have indicated that although the notification requirement was clearly set forth in the August 30, 1991 final rule (56 FR 43450) and in the interim hospital-specific rate notification letters sent to hospitals at least 30 days prior to their first cost reporting period under the capital prospective payment system, some hospitals did not notify their intermediary of obligated capital within the required 90 days after the beginning of their first cost reporting period under the capital prospective payment system. Also, since the notification deadline occurs before the end of the third month after a hospital becomes subject to capital prospective payments, some hospitals missed the deadline due to confusion over the distinction between 90 calendar days and a 3-month period.

In view of the shorter timeframe for some hospitals between the publication of the August 30, 1991 final rule and the start of their first cost reporting period under the capital prospective payment system, and to avoid disadvantaging some hospitals that might not have understood the importance of making a timely submission to the intermediary, we have decided to revise § 412.302(c)(1)(v) to extend the deadline for submission of obligated capital cost documentation. We propose to require that a hospital must notify its intermediary of any obligated capital by the later of October 1, 1992 or 90 calendar days after the hospital becomes subject to the capital prospective payment system.

We believe the extension would provide adequate time for all hospitals to familiarize themselves with the requirements for submitting the obligated capital documentation to the intermediary. Also, this action provides a renewed opportunity to submit documentation for hospitals that previously did not submit a notification of obligated capital because of concern about meeting one or more of the qualifying criteria. However, hospitals should be aware that even if they may later meet criteria which they initially anticipated could not be met, there would be no further relief from the notification deadline for submission of obligated capital cost documentation.

Consistent with the extension of the notification deadline for the hospital, we would also extend the deadline for the intermediary's notification to the hospital of its obligated capital determination. We would provide that the intermediary would have 1 year from the date the hospital submits its complete documentation to advise the hospital of its decision.

3. Certificate-of-Need Approvals

Under § 412.302(c)(2), a capital project that is affected by a lengthy certificate-of-need (CON) approval process may qualify as old capital if certain conditions are met. One of the conditions is that the hospital filed the initial CON application on or before December 31, 1989 and had not received

approval as of September 30, 1990. If the hospital received approval no later than September 30, 1990, we believe it is reasonable for the hospital to have entered into a contractual obligation for the project on or before December 31, 1990, in which case the project would qualify under the general rule for obligated capital.

Since the publication of the August 30, 1991 final rule, we have identified situations where the State granted an approval that is conditional upon the hospital fulfilling certain requirements. Since the August 30, 1991 final rule did not describe what would constitute a CON approval, we are proposing to clarify how conditional approvals will be treated under the obligated capital rule.

The conditions in the CON approval may or may not prevent the hospital from proceeding with project activities without delay. For example, a requirement that the hospital obtain adequate financing would not prevent the hospital from entering into a contractual obligation to initiate the project by December 31, 1990. Similarly, conditions related to making minor design modifications would not impede the hospital's ability to proceed with the project. On the other hand, if the hospital received an approval as of September 30, 1990 that was contingent upon a major change in the scope of the project, it would be unreasonable to expect the hospital to enter into a contract for or otherwise proceed with the project by December 31, 1990, since additional planning and design activities may be required.

We propose to amend § 412.302(c)(2)(i)(B) to provide that if a hospital received conditional CON approval for a project, the intermediary would assess the nature of the conditions and determine whether the hospital received sufficient approval for the scope of the project to proceed with the project without undue delay. We believe that the intermediary could best ascertain whether such conditions were sufficient in themselves, given the specific circumstances, to prevent a hospital from proceeding with the project without delay. As is the case with other obligated capital determinations, there would be an internal review process for the intermediary to obtain guidance on questionable cases.

E. Adjusting the Hospital-Specific Rate—Transfer-Adjusted Discharge and Case-Mix Index for Subsequent Base Periods (§§ 412.328 (b)(3) and (c)(1))

Section 412.328(b)(3) provides for the determination of a transfer adjustment factor for each hospital. The transfer adjustment factor is used to adjust the discharge count and the case-mix index used to calculate each hospital's hospital-specific rate. Payment for transfer cases is made on a per diem rate basis, not to exceed the full DRG rate. There is no distortion in the hospital-specific rate if the transfer is paid at the full DRG rate. However, to the extent that a transfer is paid on the per diem rate, the hospital-specific rate would either be understated by counting the transfer as a full discharge, or overstated by excluding the transfer entirely from the discharge count. In developing the August 30, 1991 final rule, we determined that it was not administratively feasible to remove the costs associated with such transfer cases from the allowable capital-related costs in the base period. Instead, we adopted an adjustment to the discharge count to assure that transfers are counted in determining the hospital-specific rate only to the extent that a hospital received a proportionate payment for them. To determine the transfer adjustment factor, we first construct a beneficiary file for a particular cost reporting period from MEDPAR (for the initial base year determinations, the MEDPAR data received as of June 30, 1991). We then count each case as the lower of 1.0 or the result obtained by dividing the length of stay (LOS) for a case by the geometric mean LOS for the case DRG. Thus, a weighted average of the cases represents a proportion of a discharge in each transfer case, not to exceed 1.0. To determine the transfer adjustment factor for each hospital, we then add together the adjusted discharges and divide by total discharges, including transfers.

We also provided in § 412.328(c) for a similar adjustment to the case-mix index for each hospital by multiplying the DRG weight for a transfer case by the ratio of the actual LOS for the case to the geometric mean LOS for the DRG. Using the transfer-adjusted discharge count and case-mix index, we ensured that a hospital's hospital-specific rate would match its costs per discharge.

We provided only for the transfer adjustment factors for the initial base year period in the August 30, 1991 final rule. Therefore, we are proposing to amend §§ 412.328(b)(3) and 412.328(c) to apply appropriately updated transfer adjustment factors for later cost reporting periods that may be used as base periods in the case of a new hospital or a hospital-specific rate redetermination. For later base periods beginning before October 1, 1991, HCFA would determine the discharge transfer adjustment factor for a hospital using the applicable base period MEDPAR data on file as of the December 31 or June 30 update occurring at least 6 months after the close of the base period involved. Thus, for cost reporting periods ending on or before June 30, 1991 the transfer-adjusted case mix index and discharge transfer adjustment factor in Table 9 would be considered final values. Values for cost reporting periods ending after June 30, 1991 through December 31, 1991 would be published in the final rule. For subsequent periods beginning on or after October 1, 1991, the intermediary for the hospital would determine the discharge transfer adjustment factor for a base period using the most recent billing data available from the Provider Statistical and Reimbursement System as of the date of the final determination of the hospital-specific rate. The transfer-adjusted case-mix index would be determined by using the same data that is used to determine the discharge transfer adjustment factor.

F. Redetermination of the Hospital-Specific Rate (§ 412.328(f))

Section 412.328(f) provides that upon request by a hospital paid under the fully prospective payment methodology, the intermediary redetermines the hospital-specific rate to reflect changes in old capital costs as determined in a cost reporting period beginning subsequent to the base period but no later than the hospital's cost reporting period beginning in FY 1994 (or the cost reporting period beginning after obligated capital that is recognized as old capital is put in use, if later). New capital costs are excluded for the calculation of the revised hospital-specific rate. The revised hospital-specific rate is effective with the beginning of the new base period and continues through the remainder of the transition unless the hosptial requests another redetermination. If the revised hospital-specific rate is higher than the Federal rate (after taking into account the estimated effect of outliers and the payment adjustments), the hospital is paid under the hold-harmless methodology effective with the beginning of the new base period.

Section 412.328(f) (as amended by the January 27, 1992 correction notice (57 FR 3016) to the August 30, 1991 final rule) requires that hospital request for a redetermination of the hospital-specific rate must be made not later than 90 days after the close of the hospial's first cost reporting period beginning on or after October 1, 1991, or the cost reporting period that will serve as the new base year, whichever is later.

Since publication of the August 30, 1991 final rule, we have received a number of questions regarding the basic criteria for a hospital-specific rate determination and the process for requesting a redetermination. These questons indicate confusion over when a request for redetermination is appropriate, what responsibilities the hospital has in requesting a redetermination, and whether a hospital is bound by the outcome of the intermediary determinaton of the revised hospital-specific rate. To help to resolve these issues, we are proposing the following clarifications to the regulations.

We would amend § 412.328(f)(1)(i) to clarify that a redetermination is permitted only when there is an increase in the hospital's old capital costs. We would state explicitly that no redetermination would be made to recognize other conditions that could affect the hospital-specific rate, such as a decline in utilization that produced an increase in the hospital's old capital cost per discharge. As discussed in the preamble to the August 30, 1991 final rule (56 FR 43389), we provided for hospital-specific rate redeterminations as a way of addressing certain situations in which a hospital's base year costs may be sufficiently distorted that they should not be used to determine the hospital's payments throughout the transition period. We selected the redetermination approach over other alternatives since we felt it was most consistent with our decision to provide for limited recognition of obligated capital costs. We believe that a redetermination of the hospital-specific rate based on the hospital's capital cost in the subsequent cost reporting period is a reasonable and appropriate way to take these increases in old capital costs into account for hospitals paid under the fully prospective methodology.

However, we do not believe a redetermination is appropriate when the hospital-specific rate is affected by factors other than an increase in old capital costs. This would include an increase in a hospital's old capital cost per discharge that is solely related to a decline in utilization. We noted in the preamble to the August 30, 1991 final rule that one purpose of moving to a per discharge payment was to enable the Medicare program to provide incentives for efficiency by ending subsidies for underutilized capacity (56 FR 43363). We indicated that building an occupancy adjustment into the hospital-specific rate would undermine the incentives of the prospective payment system. Further, we noted that we did not believe a redetermination of the hospital-specific rate to reflect fluctuations in occupancy rates was appropriate (56 FR 43412). With regard to special payment protection policies, we noted that although the minimum payment level provides protection against large utilization declines, we explicitly provided that payments would not be made under the extraordinary circumstances exceptions policy for financial losses attributable to declines in patient volume (56 FR 43411). Similarly, it was not our intent to protect hospitals from financial losses attributable to declines in patient volume through the hospital-specific rate redetermination process.

Current regulations provide that a request for redetermination must be made within 90 days of the close of the affected cost reporting period, when the cost report is ordinarily due. We propose to amend § 412.328(f)(1)(iii) to extend the deadline to coincide with the cost report due date and any extension in the cost report filing date granted by the intermediary. We believe revising the regulations to conform with existing administrative practice on the cost report filing deadline is appropriate since the cost report contains essential documentation for redetermining the hospital-specific rate. We note that if the hospital does not file the cost report timely in accordance with the filing date established by the intermediary, the redetermination request must nevertheless be filed timely to receive intermediary consideration.

We believe that hospitals must recognize the significance of requesting a redetermination for increased old capital costs for themselves and for the intermediary who must process the request and make the final hospital-specific rate determination. We wish to avoid unnecessary requests, that is, situations where the redetermined hospital-specific rate would be lower than the hospital's current rate. As a result, we propose to revise § 412.328(f)(1)(iii) so that a hospital requesting a redetermination must submit, along with the cost report for the period it is requesting as its new base year, an estimate indicating that its new hospital-specific rate would be higher than its current rate. In our view, the hospital is an active participant in the redetermination process and thus should not initiate a request unless it has a reasonable expectation of a positive outcome. However, since at the time a redetermination is requested the hospital's current old capital costs have not been audited and the Medicare statistical data is subject to change, we also propose to amend § 412.328(f)(3) to provide that if the intermediary determines after audit that the new hospital-specific rate is lower, the hospital would be allowed to withdraw its request within 60 days of the intermediary's notification to the hospital of the redetermined rate. This change would protect a hospital that acted responsibly in requesting a redetermination.

G. Effect of Hospital Mergers, Consolidations or Dissolution on the Hospital-Specific Rate (§ 412.331)

In the preamble to the August 30, 1991 final rule, we discussed the appropriate method to determine capital prospective payments when multiple hospitals merge or consolidate during the transition period (56 FR 43405). However, the guidelines set forth in that discussion were not incorporated into the regulations. Also, we did not address situations where a hospital would separate into two or more hospitals after the base period.

Situations involving these types of changes in hospital structure are increasingly being brought to our attention, and we believe that the policies should be incorporated in the regulations. Therefore, we propose to add § 412.331 to incorporate the guidelines provided in the preamble to the final rule of August 30, 1991 for mergers and to establish rules for dealing with situations where a hospital separates into two or more hospitals.

In addition to incorporating the guidelines contained in the August 30, 1991 final rule for consolidation and merger cases, we would clarify that the recalculation of the hospital-specific rate would be applicable only to those cases that meet the previously existing reasonable cost reimbursement rules regarding the criteria for recognizing a merger or consolidation for Medicare program purposes under § 413.134(k). In cases in which the merger or consolidation rules are not met, the transaction involved would simply be treated as a normal asset acquisition for Medicare program purposes. As a result, in situations in which a hospital acquires the assets of another hospital after December 31, 1990, those asset costs would be treated under the rules for determining old capital and new capital costs at § 412.302. Thus, if the transaction occurs after December 31, 1990, the acquired assets and their related capital costs would be considered new capital unless the conditions for recognizing obligated capital assets as old capital under

§ 412.302(c) were met or the provisions for merger and consolidation under our proposed § 412.331 were applicable.

As discussed in the preamble to the August 30, 1991 final rule (56 FR 43405), we would provide that if hospitals merge or consolidate into one hospital after the base year but during the transition period, the hospitals' latest 12-month or longer cost reporting periods ending on or before December 31, 1990 would be combined to determine a discharge-weighted average hospital-specific rate. In addition, we would provide that if, after the base year, a multi-campus hospital splits into two or more separate hospitals that are subject to the capital prospective payment system, the intermediary would determine if the base year capital-related costs and other statistical data for each of the resulting hospitals can be reconstructed from the original hospital's financial and other records. If that data can be determined, the hospital-specific rate for each of the resulting hospitals would be recomputed for the original base year under the current rules. If reconstruction of the necessary data is not feasible, each hospital's hospital-specific rate would be recalculated by establishing the respective hospital's base year as its first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) subsequent to the dissolution.

In determining each hospital's old capital costs, the amount that would be recognized as old capital would be limited to the capital-related costs attributable to assets that were in patient care use as of December 31, 1990, and the hospitals would be subject to all other transition period rules. The interim payments for such hospitals would be determined by the intermediary on the basis of the best data available prior to receipt of the new base period cost reports. The final hospital-specific rates would be applied retroactively to the later of the hospitals' first cost reporting period under the capital prospective payment system or the effective date of the dissolution in accordance with § 412.336(c)(2).

H. Extraordinary Circumstances Exceptions Payments (§ 412.348(e))

Section 412.348(e) provides that a hospital may request an additional payment if the hospital incurs an unanticipated capital expenditure in excess of $5 million (net of insurance proceeds) due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, fire, or earthquake. A hospital must apply to the HCFA Regional Office within 180 days of the extraordinary circumstance causing the unexpected expenditures in order to qualify for exceptions payments. We propose to amend the requirement in § 412.348(e)(2) to acknowledge the possibility that eligible events could occur prior to, or early in, the hospital's first cost reporting period under the capital prospective payment system. Consistent with our proposal to extend the deadline for obligated capital notifications discussed above, we propose to change the deadline for extraordinary circumstances applications to the later of October 1, 1992 or within 180 days of the occurrence of the extraordinary circumstances.

I. Special Payment Protections

1. Hospitals with High Medicare Usage

In response to the February 28, 1991 proposed rule concerning the capital prospective payment system, we received comments urging special payment protection for hospitals with a high Medicare utilization. We responded in the August 30, 1991 final rule (56 FR 43410) that we recognize that hospitals with a high Medicare utilization rate are potentially more at risk financially than hospitals with low Medicare utilization under the capital prospective payment system, since Medicare is their predominant revenue source. At the same time, however, we observed that under the previous capital payment methodology, these hospitals had less incentive than other hospitals to make efficient capital decisions because a higher proportion of their costs were paid by Medicare based on reasonable costs. As a result, we indicated that we would analyze why these hospitals tend to have higher capital costs and examine whether special treatment for high Medicare hospitals might be appropriate under the capital prospective payment system.

In performing the analysis for this proposed rule, we defined high Medicare hospitals as those with a Medicare utilization (Medicare inpatient days divided by total inpatient days) of at least 65.0 percent in both FY 1988 and 1989, as determined using Medicare cost report data. We examined only those hospitals that qualified in both years because Medicare utilization is somewhat volatile, and we wanted to ensure that our analysis concentrated on those hospitals that consistently have a high Medicare utilization.

Although it is clear that hospitals with high Medicare utilization are dependent on Medicare revenues, it is also important to know whether Medicare beneficiaries are dependent on these hospitals for access to care. To examine this question, we studied the market shares of high Medicare utilization hospitals compared to other hospitals. Market areas are defined as all of those ZIP codes which, when rank-ordered in numerical importance, contribute 75 percent of a hospital's Medicare discharges. The market share of a hospital was then defined as the percentage of Medicare discharges in the hospital's market area that are treated by that hospital. We examined the hospital's market share for all Medicare discharges and for Medicare medical (nonsurgical) discharges. We examined the medical discharges separately to determine if certain groups of Medicare patients were more likely to use high Medicare hospitals. We used discharges from the FY 1988 MEDPAR data.

We compared the market shares of those high Medicare utilization hospitals that were not already subject to special exceptions protection (through their status as sole community hospitals (SCHs) or urban hospitals with at least 100 beds and a DSH patient percentage of at least 20.2 (high DSH) to those hospitals that did not have high Medicare utilization but were afforded the special exceptions protection. In this way, we could determine whether the high Medicare hospitals are more similar to the hospitals afforded special payment protection or to the hospitals in the general exceptions pool. The following table summarizes our market share data (urban or rural location was determined without regard to reclassification by the Medicare Geographic Classification Review Board):

HOSPITAL MEDICARE MARKET SHARES (AS A PERCENT OF MARKET AREA MEDICARE DISCHARGES)

Hospital type	Total discharges	Medical discharges
SCH or high utilization DSH, nonhigh Medicare utilization:		
All	.3325	.4108
Urban	.2074	.2228
Rural	.4989	.6603
High Medicare utilization, non-SCH, and low utilization DSH:		
All	.3611	.4863
Urban	.2859	.3573
Rural	.3965	.5470
Non-high utilization Medicare, non-SCH, and low utilization DSH:		
All	.3308	.4074
Urban	.2649	.3002

HOSPITAL MEDICARE MARKET SHARES (AS A PERCENT OF MARKET AREA MEDICARE DISCHARGES)—Continued

Hospital type	Total discharges	Medical discharges
Rural	.4091	.5348

The analysis indicates that, while the high Medicare hospitals are dependent on Medicare patients, Medicare patients are not dependent on these hospitals since only 36 percent of Medicare patients residing in their service areas use these hospitals.

The only group of high Medicare utilization, non-SCH, and low utilization DSH hospitals whose market share is significantly higher (in a statistical sense) than the nonhigh Medicare utilization group is urban hospitals with regard only to medical discharges. In addition, the high Medicare utilization, urban hospitals are the only ones that have higher market shares (both total discharges and medical discharges) than SCH and high DSH hospitals. (High Medicare utilization, rural hospitals do have a slightly higher market share for medical discharges.) However, we determined that the high Medicare utilization, urban hospitals treat, on average, 36 percent of the medical discharges and 29 percent of all discharges in their service area. Thus, it appears that there are alternative sources of care available to Medicare beneficiaries that are admitted to high Medicare utilization, urban hospitals.

To determine the effect of high Medicare utilization on capital cost per case, we used the data based on cost reporting periods beginning in FY 1988 and 1989 to run regressions similar to those used in developing the final rule to implement the capital prospective payment system. That is, we used as dependent variables the natural log of Medicare inpatient costs per case, standardized to remove the effects of case-mix index differences. We ran regressions using both total cost per case and capital cost per case. In addition, in the capital regressions, we included age and financing variables in order to eliminate the effects of different age and financing levels on the estimate of the impact of high Medicare utilization on Medicare capital cost per case. The independent variables were:

- The natural log of the hospital wage index based on 1988 wage data.
- The disproportionate share patient percentage for urban hospitals with at least 100 beds.
- Dummy variables for large urban (urban areas with more than 1,000,000 population) and other urban location.
- The ratio of interns and residents to average daily census for teaching hospitals.
- A dummy variable for data used from data from cost reporting periods beginning in FY 1989.
- The natural log of the hospital's occupancy rate.
- Various dummy variables relating to high Medicare utilization status, and large urban, other urban, and rural location of those high Medicare hospitals. These variables do not show the effects of location independent of Medicare utilization, since location is controlled for elsewhere in the equations.
- The capital age and financing variables. These variables include:

—The natural log of the average age of total assets [8]
—The natural log of the average remaining usable life of total assets [9]
—The natural log of the ratio of total liabilities to total assets, and
—The natural log of the ratio of total fixed assets to total assets.

First, we ran a regression using capital cost per case, but without the age and financing variables. In this regression, high Medicare utilization, large urban hospitals have higher capital costs per case, everything else being equal, but the coefficient is not statistically significant.

High Medicare utilization hospitals located both in other urban and rural areas have lower capital costs per case, everything else being equal, but only the rural coefficient is statistically significant. The results are summarized below:

CAPITAL COST PER CASE REGRESSION WITHOUT CAPITAL AGE AND FINANCIAL VARIABLES

Type of high Medicare hospital	Coefficient	t-Statistics
Large urban	.069	1.505
Other urban	−.062	−1.10
Rural	−.090	−3.83

[8] (defined as the ratio of accumulated depreciation to current depreciation)
[9] (defined as the ratio of remaining depreciation to current depreciation)

Including the age and financing variables in the capital cost regression results in different coefficients and t-statistics, but again, none is statistically significant:

CAPITAL COST PER CASE REGRESSION INCLUDING CAPITAL AGE AND FINANCING VARIABLES

Type of high Medicare hospital	Coefficient	t-Statistic
Large urban	.0379	.805
Other urban	−.0419	−.771
Rural	.0351	1.665

We have found that there is no evidence, once we control for payment adjustments, occupancy, and the capital age and financing variables, that high Medicare utilization hospitals have higher capital costs per case than hospitals with average or low Medicare utilization.

Since the payment adjustments for the prospective payment system for capital-related costs are based on the total cost regressions, we also examined the effects on total cost per case (adjusted for case-mix index) of high Medicare utilization. Again, we controlled for the payment adjustments and for occupancy, to ensure that the only effects that we found in the utilization variables were those of high Medicare utilization. In the equation of total cost per case, the regression coefficients were as follows:

TOTAL COST PER CASE REGRESSION

Type of high Medicare hospital	Coefficient	t-Statistic
Large urban	.0294	1.445
Other urban	−.0214	−.658
Rural	.0170	1.632

Again, none of the coefficients is statistically significant.

The capital cost per case regression results are consistent with the preliminary data on actual payments under the capital prospective payment system. The most recent provider-specific file contains capital data for 44.1 percent of prospective payment hospitals, and 43.3 percent of high Medicare hospitals. The payment methodologies of those hospitals for which we have data are as follows:

PAYMENT METHODOLOGY BY HOSPITAL TYPE

Type of hospital	Number hosps	Fully prospective	Hold harmless	100% Federal rate
All	2477	69.5%	17.2%	13.3%
High Medicare	197	76.7	15.7	4.6
Urban	41	48.8	31.7	19.5
Rural	156	84.0	11.5	4.5
Others	2280	68.9	17.4	13.8
Urban	1109	59.9	21.6	18.6
Rural	971	80.6	11.7	7.7

High Medicare utilization, urban hospitals are more likely to receive hold harmless payments than nonhigh Medicare utilization, urban hospitals, but the group of high Medicare utilization, rural hospitals have essentially the same proportion of hold harmless hospitals as other rural hospitals. These data confirm that the group of high Medicare utilization hospitals is not homogeneous, and that the rural hospitals in particular are quite similar to other rural hospitals. We will continue to monitor the payment status of high Medicare utilization hospitals as we receive updated data from the fiscal intermediaries.

Finally, we examined the effect on resource use of having an older Medicare patient population than other hospitals. Data provided by the Association of High Medicare Hospitals indicate that high Medicare utilization hospitals have a higher proportion of older Medicare patients than do other hospitals. Although older patients tend to have longer lengths of stay, analysis performed at HCFA's request by 3M/Health Information Systems indicates that, on average, older patients require relatively fewer resources than other patients assigned to the same DRG. Since this finding indicates the DRG relative weight tends to overcompensate hospitals that have a higher proportion of older Medicare patients, it does not support a payment adjustment for high Medicare utilization hospitals.

The DRG relative weights are based on the average charge for cases assigned to the DRG that have been standardized for the hospital wage index and for the payment adjustments for indirect teaching and serving a disproportionate share of low income patients. In its analysis, 3M/Health Information Systems determined for each DRG the average standardized charge by age group and computed the ratio of the age group average standardized charge to the average standardized charge for the DRG. The ratios were separately determined for all patients, and for patients who were discharged alive or who died in the hospital. A discharge-weighted average ratio for each age group across all DRGs was then determined. The results were as follows:

RATIO OF AVERAGE STANDARDIZED CHARGES IN AGE GROUP TO AVERAGE STANDARDIZED CHARGE IN CATEGORY

Age group	Percent of Medicare patients	All discharges	Live discharges	Deaths
<65	9.7	1.12357	1.12751	1.31438
65–74	41.0	0.98710	0.98377	1.11434
75–84	34.7	0.99134	0.98914	0.98374
>84	14.6	0.97461	0.98358	0.81954
All patients	100.0	1.000	1.000	1.000

Based on our analyses, we do not find any reason to propose a payment adjustment or any special exceptions provisions for high Medicare utilization hospitals at this time. Their Medicare market shares are not appreciably different from those of nonhigh Medicare utilization hospitals. Their capital costs per case, and their total costs per case, are not higher than other hospitals, once the payment adjustments, occupancy and, for capital costs, the age and financing variables are controlled for. Finally, there is no evidence that the older patients that high utilization Medicare hospitals treat require more intensive resource use that would warrant a payment adjustment. We will, however, continue to monitor the characteristics of high Medicare hospitals, particularly once the data on their capital payment status is completely available.

2. Financially Distressed Hospitals That Serve Low Income Patients

Since the publication of the August 30, 1991 final rule, several organizations representing financially distressed hospitals that serve a large volume of low-income patients have expressed concern that their payments under the capital prospective payment system may be insufficient for the hospitals to obtain the necessary financing to undertake needed capital projects in the future. The organizations note that these hospitals do not have internal reserves that can be used to finance their capital projects and rely heavily on the Medicare and Medicaid programs for their revenues. If the funding from these sources is not adequate to cover the financing costs, the hospitals will not be able to complete the renovation and construction projects that are needed to preserve access to care for low-income populations. They recommend several changes in the capital prospective payment system policies to address the needs of those hospitals whose projects do not qualify under the obligated capital rules. These include: extending the deadline for putting obligated capital in use in order to be recognized as old capital; paying 85 percent of obligated capital costs for 10 years from the date the asset is put in use instead of ending the hold-harmless payments at the end of the transition; raising the minimum payment floor for hospitals with a high

percentage of low income patients from the 80 percent floor under the current rule to 90 percent and making it, and the extraordinary circumstances exception, permanent; and revising the extraordinary circumstances exception to include major capital projects undertaken by financially distressed hospitals that are needed to preserve access to care by low income populations.

The changes recommended by the organizations representing financially distressed hospitals are similar to suggestions made in the public comments that we considered in developing the August 30, 1991 final rule. We believe it would be premature to modify the policies in that rule until we have had an opportunity to assess their impact. We are sensitive to the needs of these hospitals, and we intend to monitor closely their situation as well as that of other hospitals under the prospective payment system. As we gain additional experience under the capital prospective payment system for capital-related costs, we will be in a better position to evaluate what changes, if any, would be appropriate in our special protection payment policies.

J. Minor Technical Corrections

We propose making the following technical changes to the regulations:

- Section 412.113(a)(2)(E) would be corrected to note that sole community hospitals, as defined in § 412.92, are excluded from the capital payment reduction for periods prior to a hospital's cost reporting period beginning on or after October 1, 1991.
- Section 413.134(f)(2)(iii)(D) would be corrected to change the last reference for capital prospective payment system purposes to § 412.344(a)(2).
- Section 412.302(c)(1)(ii) would be revised to clarify that the qualifying criterion for obligation of moveable equipment is that it was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990.

In addition, we are making a series of minor conforming changes throughout 42 CFR parts 412 and 413. These conforming changes are needed to ensure that our regulations specify which provisions apply to the prospective payment system for operating costs, which provisions apply to the prospective payment system for capital-related costs, and which provisions apply to both systems.

VII. Proposed Changes for Hospitals Excluded From the Prospective Payment System

A. Provisionally Excluded Hospitals and Units (§§ 412.22, 412.23, 412.25, 412.30, and 412.32)

1. Changes in the Status of Excluded Hospitals and Psychiatric and Rehabilitation Distinct-Part Hospital Units (§§ 5412.22 and 412.25)

Since the inception of the prospective payment system for operating costs of hospital inpatient services on October 1, 1983, certain types of specialty-care hospitals and hospital units have been excluded from that system under section 1886(d)(1)(B) of the Act. These currently include psychiatric and rehabilitation hospitals and distinct part units, children's hospitals, and long-term care hospitals. Section 6004(a)(1) of Public Law 101–239 amended section 1886(d)(1)(B) of the Act to provide that certain cancer hospitals are also excluded. The preamble to the January 3, 1984 final rule implementing the prospective payment system for operating costs (49 FR 235) stated that a hospital's or unit's status (that is, whether it is subject to, or excluded from, the prospective payment system) would be determined at the beginning of each cost reporting period. It also provided that changes in a hospital's or unit's status that result from meeting or failing to meet the criteria for exclusion would be implemented prospectively only at the start of a cost reporting period, that is, starting with the beginning date of the next cost reporting period (49 FR 243). However, this policy is not set forth in the regulations.

Current regulations at § 412.25(b) specify that changes in the bed size or square footage of an excluded unit may be made only at the start of the cost reporting period. However, that regulation does not deal specifically with the case in which an existing hospital changes the function of the unit, adds an entire new unit, or converts an existing excluded unit to an acute care unit paid under the prospective payment system. As a result, questions have arisen as to whether such changes could be allowed at times other than the start of a cost reporting period.

We believe that such changes should not be allowed. Serious cost reporting problems could arise if hospitals were allowed to add new excluded units or to vary the size of existing units, after the start of a cost reporting period. Under Medicare cost-finding principles, certain types of indirect costs of patient care such as capital costs, maintenance of the hospital's physical plant, and housekeeping expenses, are allocated to a unit solely on the basis of the square footage that unit occupies at the end of the cost reporting period. If, during a cost reporting period, an excluded unit acquires more square footage or a new unit opens, a full year's worth of the indirect costs identified above will be allocated to the unit, even though the unit (or the added space) may have functioned for only a part of the year. If the square footage of a unit decreases during a cost reporting period, some indirect costs associated with the space lost from the unit will not be allocated to the unit, causing unit costs to be understated. In either case, a change during the cost period will cause a misallocation of cost and lead to either excessive or inadequate payments.

To avoid this result, and to clarify our policy in this area, we propose to revise §§ 412.22 and 412.25 to specify that changes in the status of each hospital or hospital unit would be recognized only at the start of a cost reporting period. Except in the case of retroactive payment adjustments for excluded rehabilitation units described in § 412.30(c), any change in a hospital's or unit's compliance with the exclusion criteria that occurs after the start of a cost reporting period would not be taken into account until the start of the following period. This policy would also apply to any unit which is added to a hospital during the hospital's cost reporting period.

For example, if, at some point in a cost reporting period, a currently participating hospital stopped admitting adult patients and began admitting only patients under the age of 18, it could not be excluded from the prospective payment system as a children's hospital before the start of the next cost reporting period. If a currently participating hospital opened a psychiatric unit after a cost reporting period has begun and the unit met the applicable exclusion criteria, services furnished in that unit would be paid for under the prospective payment system for the rest of that period, and the unit would not be excluded from the prospective payment system until the start of the next cost reporting period. If a currently participating hospital had an existing excluded unit and wished to convert the space to acute care use, the change would be recognized only at the start of the next cost reporting period.

In applying this principle to a newly opened unit that is seeking to be excluded from the prospective payment system, we encountered difficulties because existing regulations do not specify when a new unit is considered to

be opened. Questions have arisen as to whether a unit that has no patients at the start of a cost reporting period could be said to open at that time. In order to remove any confusion as to when we consider a unit open, we propose to revise § 412.25(a) to specify that as a requirement for exclusion, a hospital unit must be fully equipped and staffed, and be capable of providing inpatient psychiatric or rehabilitation care, as of the first day of the first cost reporting period for which all other exclusion requirements are met. A unit that meets this requirement would be considered open regardless of whether there are any inpatients in the unit.

2. Exclusion of New Rehabilitation Hospitals and Distinct-Part Rehabilitation Units With Initial Cost Reporting Periods of Less Than 12 Months (§§ 412.23 and 412.30)

Under § 412.23(b)(8), a new rehabilitation hospital may be provisionally excluded from the prospective payment system for its first full 12-month cost reporting period of Medicare participation based on a written certification that the patients it intends to serve meet the criteria for patients needing rehabilitation services set forth in 412.23(b)(2). The regulations, however, do not address the case of a new hospital that begins operating at a time other than at the start of its regular 12-month cost reporting period. Similarly, our regulations at § 412.30 do not specify how a new rehabilitation unit that is a distinct part of a new hospital is to be treated when the hospital begins operations at a time other than at the start of its regular cost reporting period. New hospitals often begin operating at times other than the start of their regular cost reporting periods because of construction delays or other difficulties in starting a new facility. The cost reporting instructions in section 2414.1 of the Medicare Provider Reimbursement Manual allow a new hospital to select an initial cost period of not less than 1 month and not more than 13 months to cover the period between the actual startup date and the beginning of the hospital's preferred 12-month cost reporting cycle.

To avoid requiring a new rehabilitation hospital to operate under the prospective payment system from the date it opens until the beginning of its first full 12-month cost reporting period, we propose to revise § 412.23(b)(8) to permit provisional exclusion of the hospital for both the initial period it may elect under section 2414.1 of the Provider Reimbursement Manual and for the next full 12-month period. The provisional exclusion would be effective for no more than two consecutive cost reporting periods with a combined total provisional exclusion period not to exceed 25 months.

Under the proposed policy, a separate retroactive adjustment would be made for each cost reporting period during which the hospital is provisionally excluded from the prospective payment system but does not meet the condition that at least 75 percent of the hospital's patients require intensive rehabilitative services (known as the 75-percent rule) set forth in § 412.23(b)(2). During the second cost reporting period of provisional exclusion, the hospital's compliance with the 75-percent rule would be assessed, and the status of the hospital for its third cost reporting period would depend on whether the hospital met the 75-percent requirement for its second cost reporting period.

We propose to revise § 412.30(a) in order to provide similar treatment for rehabilitation units in hospitals that are newly participating in the Medicare program. Under the proposed revision, when a hospital begins participating in the Medicare program and concurrently opens a rehabilitation unit that meets the applicable exclusion criteria, the unit would be provisionally excluded from the prospective payment system from the first day of the hospital's participation through the end of the second cost reporting period. Again, we would specify that the combined total Provisional exclusion period not exceed 25 months. We also propose to revise the regulations to make it clear that a hospital that has undergone a change of ownership or leasing as defined in § 489.18 would be treated as a newly participating hospital for purposes of qualifying for the prospective payment system exclusion, even though the hospital itself is not newly participating because it has previously participated under the old ownership.

3. Removal of Provisions for Excluded Alcohol/Drug Hospitals and Units (§§ 412.23 and 412.32)

Existing regulations at §§ 412.23(c) and 412.32 apply to the exclusion of alcohol/drug hospitals and units. However, as reflected in § 412.32, the exclusion for alcohol/drug hospitals and units ended with cost reporting periods beginning on or after October 1, 1987. Because this exclusion is no longer in effect, we are proposing to delete §§ 412.23(c) and 412.32.

B. Definition of Discharge for Purposes of Applying the Rate-of-Increase Limit Applicable to Excluded Hospitals and Hospital Distinct Part Units (§ 413.40(c))

We are proposing to revise the regulations to include a definition of "discharge" for purposes of applying the rate-of-increase limit applicable to hospitals and hospital distinct part units excluded from the prospective payment system. Section 412.4(a) defines a discharge for purposes of the prospective payment system as any of the following occurrences: the patient is formally released from the hospital, the patient dies in the hospital, or the patient is transferred to a hospital or unit that is excluded from the prospective payment system. There is no definition of discharge specific to the rate-of-increase provision in § 413.40. However, our policy has been that the definition of § 412.4(a) should be followed in applying the rate-of-increase limit.

We are proposing to change that policy to conform to current practice. There are situations in which a Medicare beneficiary has exhausted Medicare benefits during his or her stay and the actual discharge of the patient does not occur until a subsequent cost reporting period. Hospitals excluded from the prospective payment system bill Medicare on an interim basis until the time benefits are exhausted. As a result, the payments and costs of the services are reflected in one cost reporting period but, using the discharge definition in § 412.4(a), the discharge would not be counted until the subsequent cost reporting period. In many cases, since the final discharge bill does not include services covered by the Medicare program beyond those already paid on an interim basis, hospitals do not submit a final bill to Medicare upon the patient's release from the hospital.

To account for benefits-exhausted cases in excluded hospitals and units, the Provider Statistical and Reimbursement System (PS&R), which is designed to capture all statistical and payment data through the claims processing system, has an interface program that counts a discharge when an interim bill is submitted for a beneficiary that has exhausted Medicare benefits, instead of counting a discharge on a no-payment bill that is submitted at discharge. This helps to ensure consistency in the collection of discharge data because hospitals always bill when a patient has exhausted Medicare benefits, but may or may not bill when there are no

Medicare covered services in the final discharge bill. In most cases, the PS&R data are used as cost report settlement statistics, with the result that a discharge is counted for purposes of the rate-of-increase limit when an interim bill is submitted showing benefits are exhausted. This practice provides for agreement between the cost reporting period in which costs are incurred and the application of the rate-of-increase limit. Because the practice of counting a discharge when benefits are exhausted results in a more appropriate discharge count for purposes of the rate-of-increase limit, we are proposing to conform our policy to the current practice. We would revise § 413.40(c)(2) to indicate that a discharge would be defined as set forth in § 412.4(a), except when the beneficiary exhausts Medicare inpatient hospital benefits (including the election to use lifetime reserve days) during the inpatient stay. In that case, the patient would be considered discharged on the date that Medicare benefits are exhausted.

C. New Hospital Exemption Applicable to Excluded Hospitals (§ 413.40 (b), (e), and (f))

Excluded hospitals and units receive payment for the inpatient hospital services they furnish on the basis of reasonable cost, subject to rate-of-increase limits. Under the rate-of-increase limits, an annual target amount (stated as the 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, updated for inflation, is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

Under § 413.40 (e) and (f), a new hospital may be exempted from the rate-of-increase limit on its inpatient operating costs if the hospital files a request with its fiscal intermediary within 180 days of receiving the notice of program reimbursement for the hospital's second cost reporting period. (This would be the first cost reporting period for which a hospital is subject to the rate-of-increase limit on its inpatient operating costs.) As specified under § 413.40(f)(1)(i), a new hospital is a provider of hospital inpatient services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years. The new hospital exemption expires at the end of the first cost reporting period beginning at least two years after the date the hospital admits its first patient. The last cost reporting period for which the exemption is in effect is the base period for determining the target amount applicable to subsequent cost reporting periods.

We are proposing to make three changes to the provisions of § 413.40(f)(1)(i) concerning new hospital exemptions from the rate-of-increase limit. The first proposed change would make the new hospital exemption automatic rather than at the hospital's discretion. The underlying premise of the rate-of-increase limit is that a hospital's costs are comparable between the base year and the cost reporting periods subject to the limit. The reason for allowing an exemption to the rate-of-increase limit during the early years of a hospital's operations is to recognize that certain cost distortions may be present when a hospital is beginning its operations. Typically, the first year of a hospital's operation is not representative of its future operations for two reasons. First, the patient load tends to be lower than the load the hospital maintains once it is fully established. Second, the hospital may not immediately offer its full range of services. Since the first year of operation is commonly atypical, we do not believe it would be appropriate to base the target amount on the hospital's inpatient operating costs per discharge for its first year of operation.

Under current regulations, which allow a hospital the option of whether or not to request a new hospital exemption, we in effect allow the hospital to select either its first or third cost reporting period as the base year for its rate-of-increase limit. Since the hospital does not have to file the request for a new hospital exemption until well into its third cost reporting period, the hospital can easily determine which base year would afford it the greater financial advantage. Thus, by having the choice of requesting or foregoing an exemption, a new hospital could obtain a competitive advantage over other hospitals simply because it is a new hospital.

To remedy this situation, we propose to revise § 413.40(f)(1)(i) to apply the exemption automatically to all new hospitals rather than making the exemption contingent on a request from the hospital.

Under current policy, a hospital may be in operation for 3 or more years before it is subject to the rate-of-increase limit. (Cost reporting periods of less than 12 months, which may occur when the hospital begins operation or there is a change of ownership, extend the exemption period beyond 3 years.) We believe that a hospital's second year of operation should be sufficiently representative to be used to establish the target amount. Therefore, we propose to reduce the new provider exemption to 2 years. A new hospital would be exempt from the rate-of-increase limit through its cost reporting period ending at least 2 years after the hospital accepts its first patient. The base period would be the first 12-month cost reporting period that begins at least 1 year after the hospital accepts its first patient.

Our third proposed change in the new hospital exemption concerns the issue of whether a participating facility that reorganizes and/or changes the basis of its participation in the Medicare program is a new hospital, even though it continues to provide the same services as it did before the reorganization. For example, we are aware of cases in which an acute care hospital had a distinct-part unit (for example, a rehabilitation unit) that eventually split off from the main hospital and became a separate hospital. Under our current regulations, the rehabilitation hospital would meet the criteria for a new hospital and, thus, could qualify for a new hospital exemption.

Another example involved a rehabilitation hospital that added an acute care distinct-part unit. Eventually, the acute-care portion of the facility expanded to a point where the facility sought to participate in the Medicare program as an acute-care hospital with a distinct-part rehabilitation unit. Again, under the current regulations, the distinct-part unit would qualify for an exemption because the hospital technically meets the criteria for a new hospital.

In both examples, the former distinct-part units qualified for a new hospital exemption because they were in existence for less than 3 years as the type of hospital for which they were approved to participate in the Medicare program. However, in a broader sense, these hospitals were not new. As hospitals, they still served the same markets and employed the same staffs as when they operated as distinct-part units. The hospitals in these examples did not have to experience many of the difficulties (such as penetrating new markets or hiring personnel) that are characteristic of a hospital that is beginning its initial operations. Thus, for purposes of establishing rate-of-increase limits on these hospitals' costs, there were no significant cost distortions associated with being a new hospital. Rather, any cost distortions that would affect the comparability of cost reporting periods stemmed from a

change in the organization of the facility's operation rather than in the type of services it provided to patients in the excluded portion of the facility. Therefore, to preclude hospitals from qualifying for a new hospital exemption based solely on such operational reorganizations, we are proposing to revise § 413.40(f) to specify that a hospital will qualify as a new hospital only if it has not previously provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program.

However, we also recognize that it would not be appropriate to subject these types of hospitals or distinct-part units to the ceiling that applied before the hospital's reorganization. Therefore, when the operational structure of hospital or distinct unit changes (that is, a freestanding rehabilitation hospital becomes a distinct part unit or vice versa), we are proposing to revise § 413.40(b)(1) to clarify that the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification.

We note that the proposed change would mean that the new hospital exemption would not apply to hospitals that change the basis of their certification but do not experience a significant change in organizational structure or in the type of services provided. An example might be a hospital that commenced operations as an acute care hospital subject to the prospective payment system with the intention of qualifying as an excluded long-term care hospital only after its experience demonstrates that the hospital has an average length of stay greater than 25 days. Under current policy, the exemption as a new hospital would begin with the first date of the cost reporting period for which the hospital is certified as a long-term care hospital. Under the revised policy, the exemption would begin with the first day of the cost reporting period in which the hospital began to serve a patient population with an average length of stay greater than 25 days, whether or not the certification is effective for that period. Thus, if the hospital served the requisite population from the outset, the new hospital exemption would be effective as of the date on which the hospital admitted its first patient.

Similarly, a rehabilitation or psychiatric hospital with an average length of stay greater than 25 days may be certified as either a specialty hospital or a long-term care hospital. A hospital that changes its basis of certification while continuing to furnish the same type of specialty services would not qualify as a new hospital. For example, if a hospital furnishing rehabilitation services to patients with an average length of stay greater than 25 days changed its certification from a rehabilitation hospital to a long-term care hospital, the hospital would not qualify for a new hospital exemption and the original target amount would continue to apply. The proposed policy would be effective for Medicare certifications occurring on or after October 1, 1992.

D. Adjustments Under the Rate-of-Increase Ceiling (§ 413.40(g))

Section 413.40(g)(3) provides that HCFA may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of hospital inpatient services between its base year and the cost reporting period subject to the rate-of-increase ceiling. Section 413.40(g)(3)(ii) was added in the August 30, 1991 final rule to clarify those circumstances under which HCFA may adjust the amount of operating costs in establishing the ceiling without a formal request from a hospital (56 FR 43232). Although this clarification was not intended to limit HCFA's authority to adjust base year costs to only those factors specifically stated in § 413.40(g)(3)(iii), we believe the current regulations could be interpreted to preclude HCFA from making adjustments except under the specified circumstances. However, there may be other cases in which the base period is not a representative base for adjusting future costs. This would include cases in which the hospital had extremely low Medicare utilization during the base period, or cases in which there was a significant change in Medicare coverage during the base year (for example, as a result of the Medicare Catastrophic Coverage Act of 1988). In such cases, the base periods would not be appropriate for establishing a target amount for limiting cost increases in future periods. Therefore, we are proposing to revise § 413.40(g)(3)(iii) to specify the circumstances when HCFA may adjust the amount of operating costs. These circumstances would include, but would not be limited to, adjustments to take into account the factors set forth under § 413.40(g)(3)(ii) (A), (B), (C), (E), and (F).

VIII. ProPAC Recommendations

We have reviewed the March 1, 1992 report submitted by ProPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations 1, 2, and 11 concerning the update factors for inpatient operating costs are discussed in Appendix D of this proposed rule. The remaining recommendations are discussed below.

A. Updating Capital Payment Rates (Recommendation 3)

Recommendation: ProPAC recommends that a single update factor be developed for adjusting operating and capital prospective payment rates. The update framework should be consistent with that currently used by ProPAC to develop the prospective payment operating rate update recommendation and should be put into use for FY 1994.

Response: In the August 30, 1991 final rule (56 FR 43414), we established the capital update methodology to be used through FY 1995. Under that methodology, we will update the capital Federal rate and the hospital-specific rates for hospitals paid under the fully prospective payment methodology using a lagged 2-year moving average of actual increases in Medicare inpatient capital costs per discharge, adjusted for case mix index change. The capital update proposed in the Addendum to this **Federal Register** document is based on the average increase in Medicare inpatient capital costs between 1988 and 1990. The capital update established in FY 1995, the last year in which we will use the current methodology, will be based on the average increase in Medicare inpatient capital costs between 1990 and 1992. We established this methodology in response to hospital industry concerns regarding the uncertainty of the capital update over the first few years of the prospective payment system for capital-related costs. We believe that it would be inappropriate to change the method of updating capital payments before FY 1996, because of this desire of the industry for more certainty regarding capital updates.

We believe that it is appropriate to establish a capital-specific update framework until the prospective payment systems for capital-related and operating costs are unified in a single payment system. The development of an update framework for capital payment is conceptually and empirically more difficult than the development of a framework for updating operating payments. For this reason, and in order to solicit comments and to refine our framework, we included a preliminary discussion of an update framework for the capital prospective payment system in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR

43522). In the FY 1993 final rule, we will publish a more detailed discussion of the proposed framework, including an empirical illustration of the proposed update framework. This illustration will show the consistency and relationships of the framework with historical trends in operating and capital-related costs through 1990 and with the proposed FY 1993 update. Comments will be solicited on this framework, and we will provide successively improved frameworks in the final rules for FY 1994 and FY 1995. We will continue to solicit comments on these refined frameworks in order to improve the framework that will be adopted for FY 1996. Until this framework is appropriately refined, we believe that using the lagged increase in actual capital costs, adjusted for case-mix index change, is the most reasonable approach to take regarding capital updates.

B. Level of Indirect Medical Education and Disproportionate Share Adjustments to the Prospective Payment System for Operating Payments (Recommendation 4)

Recommendation: ProPAC recommends that the indirect medical education adjustment to the prospective payment system for operating payments be reduced from its current level of 7.7 percent to 7.0 percent for FY 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

Response: ProPAC's recommended reduction of 0.7 percentage points in the operating adjustment for indirect medical education (IME) represents approximately one-third of the difference between the current level of 7.7 percent (set forth at section 1886(d)(5)(B)(ii) of the Act) and 5.7 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 5.7 percent increase in Medicare inpatient operating costs per case.

ProPAC uses a statistical model to generate its estimate of the effect of teaching on Medicare inpatient operating costs that does not control for the hospital's costs of treating a disproportionate share of low income patients. Controlling for these costs would result in a substantially lower estimate of IME costs because of the overlap in hospitals receiving IME and disproportionate share (DSH) payments. We believe that it is appropriate to control for the effects of DSH status when estimating the effects of teaching. Not controlling for the effects of all of the payment variables would distort the results of the regressions by attributing some of the effects of the missing variables to the variables present in the regression. We strongly believe that payment for the indirect costs associated with graduate medical education should be based on the best estimate of the added costs incurred in treating Medicare patients and that payments in excess of this amount are an inappropriate use of Medicare trust funds. We further believe, as stated below in our response to ProPAC's Recommendation 5 with respect to the IME adjustment for capital-related costs, that the appropriate level of the IME adjustment is that currently paid in the prospective payment system for capital-related costs. This adjustment is based on regressions on total cost per case, controlling for all of the prospective payment system payment adjustments, including DSH.

ProPAC further recommends that the reduction in IME payments for the prospective payment system for operating costs be returned to teaching hospitals that also receive DSH payments through a modification in the DSH adjustment for operating costs. We do not agree that the reduction in IME payments should be returned to teaching hospitals that also receive DSH payments. These hospitals currently have payment-to-cost ratios that are significantly higher than other hospitals. While we believe that it is possible to improve payment equity across all classes of hospitals by returning at least a portion of the IME payments to all hospitals, any such increase in payments to hospitals must be examined in the larger context of health care reform.

We strongly disagree that the low total operating margins (which are based on the facility's overall operations, not just Medicare patients) of DSH hospitals that also receive IME payments should be relevant to the distribution of Medicare payments. These lower total margins are associated with the fact that DSH hospitals that also receive IME payments 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. We continue to believe that 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 payments to a class of hospitals that are not underpaid relative to the costs of treating Medicare beneficiaries.

C. Consistency of Indirect Medical Education and Disproportionate Share Adjustments to Prospective Payment System Capital and Operating Payments (Recommendation 5)

Recommendation: ProPAC recommends that the same level of IME and DSH payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in FY 1994. Further, ProPAC believes that the methods of determining these adjustments in the prospective payments for operating costs should also be applied to the prospective payments for capital-related costs as follows:

- The measure of teaching intensity used for the IME adjustments should be defined in terms of the ratio of residents per bed.
- The criteria for designation as a DSH should be based on urban or rural location and number of beds.

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the prospective payment rate.

Response: We agree with ProPAC that an appropriate policy would be to apply the same DSH and IME adjustments to the prospective payments for operating costs and for capital-related costs. However, we continue to believe that the appropriate level of the adjustments is that justified by the total cost regressions, as developed in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43378). That is, the adjustments for both operating and capital payments should reflect the effect on total costs per case of IME and DSH status. We implemented these IME and DSH adjustments under the capital prospective payment system. We cannot implant them under the prospective payment system for operating costs since the IME and DSH operating adjustments are set by statute. Until we have statutory authority to change the IME and DSH adjustments to operating payments, we are faced with choosing between using different adjustments for capital and operating payments or making the IME and DSH adjustments to

capital payments at the same levels used for operating payments. Since our regression analysis indicates the adjustments to operating payments are not reflective of the effect that IME and DSH status have on Medicare costs per discharge, we believe it would be inappropriate to use these adjustments for capital payments. Thus, we have decided to use different adjustments and base the adjustments to capital payments on the results of the total cost regressions.

With regard to the ProPAC recommendation that the criteria for designation as a disproportionate share hospital should be based on urban or rural location and number of beds, we believe that the only hospital groups that should receive the DSH adjustment are those with significantly higher costs due to their disproportionate share of low income patients. As explained in further detail in the August 30, 1991 final rule implementing the prospective payment system for capital-related costs (56 FR 43378), we found no evidence in the total cost regressions that costs for any rural hospital grouping were significantly correlated with the DSH patient percentage. We also found no evidence that there is a correlation between the total costs per case of urban hospitals with fewer than 100 beds and their DSH patient percentage. For urban hospitals with at least 100 beds, we did not find a threshold disproportionate share patient percentage above which a higher adjustment formula was appropriate, nor did we find a threshold patient percentage below which no correlation between costs and patient percentage exists. For these reasons, we continue to believe that the DSH adjustment to capital payments, which provides an adjustment to only urban hospitals with more than 100 beds and does not require a threshold patient percentage, is correctly formulated and should apply to payments for operating costs as well.

We also disagree with the recommendation that the ratio of interns and residents to beds be used as the measure of teaching intensity for the IME adjustment to capital payments. As discussed in the August 30, 1991 final rule (56 FR 43380), we believe that the ratio of residents to average daily census is a more appropriate measure of teaching intensity. Residency programs are intended to provide participants the opportunity to treat patients in a supervised setting. We believe that the indirect costs of a teaching program are more highly correlated with the ratio of residents to the average number of patients than with the ratio of residents to available beds, both occupied and unoccupied. This expectation is borne out by our regression results, which show both a smaller standard error and a slightly larger t-statistic when the resident-to-day ratio is used than when the resident-to-bed ratio is used in the cost regression.

In the August 30, 1991 final rule, we also stated our concern regarding the potential for manipulation of the bed count in order to increase teaching payments. In this regard, we note that the General Accounting Office, in its report on the IME adjustment for operating costs, refers to average daily census as a more "verifiable" statistic than beds. (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.)

D. Improvements in Labor Market Definitions (Recommendation 6)

Recommendation: ProPAC believes that the current prospective payment system labor market definitions need to be improved or replaced as soon as possible. Suitable alternative definitions, however, are not immediately available. In cooperation with the American Hospital Association (AHA) and HCFA, ProPAC is developing alternative labor market definitions that may alleviate many of the current problems. On the basis of this effort, ProPAC hopes to be able to recommend substantially revised labor market definitions for FY 1994.

Response: We agree with the Commission that the current labor market areas could be improved, and look forward to working with ProPAC and the AHA in examining potential improvements in the labor market definitions and the hospital wage index. At a minimum, we anticipate that the hospital wage index will be improved in FY 1994, due to the changes in the MSAs resulting from the 1990 census and the use of more recent wage data.

E. Medicare Transfer Payment Policy (Recommendation 7)

Recommendation: Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. ProPAC believes that hospitals are penalized by the current payment for transfers and that further examination of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.

Response: Since a Medicare discharge is the basis of payment under the prospective payment system, it is necessary to distinguish between discharges in which a patient has received complete treatment and discharges in which the patient is transferred to another acute-care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation irrespective of the length of time the patient spent in the sending hospital prior to transfer, this would create a strong incentive to increase transfers, thereby unnecessarily endangering patients' health and increasing program outlays. Therefore, in a transfer situation, the regulations at § 412.4(d) provide that full payment is made to the final discharging hospital, and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred. The per diem rate is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the average length of stay for the DRG into which the case falls. Transferring hospitals are also eligible for outlier payments for cases that meet the cost outlier criteria, but are not eligible for day outlier payments. Two exceptions to the transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) or DRG 456 (Burns, Transferred to Another Acute Care Facility), which are not paid on a per diem basis but receive the full DRG payment instead.

In the past, we have reviewed the transfer payment policy for potential improvements. The September 3, 1986 final rule (51 FR 31489) pointed out that, based on our analysis of the possible effects of making a single payment for all the hospitals involved in a transfer case, it was not possible to develop such a policy that would be equitable or administratively feasible. That is, we determined that a single payment based only on the DRG classification of one hospital would probably not be sufficient to be split equitably among the two or more hospitals based on the actual resources that each expended in the episode of care.

We issued a report to Congress in 1988 on the impact of outlier and transfer payment policies upon rural hospitals (Review of the Impact of

Outlier and Transfer Payment Policy upon Rural Hospitals, DHHS, 1988). We examined the ratio of payments under the prospective payment system to total charges in the transferring hospital by length-of-stay and found that the ratios were actually highest for the shortest lengths-of-stay and declined as length-of-stay increased. Furthermore, the ratios for cases with lengths-of-stay of up to 3 days exceeded those for all inpatient stays paid under the prospective payment system. Although the focus of that report was primarily on the impacts of outlier and transfer policy on rural hospitals, it concluded that the current policy was more practical than another potential alternative, establishing separate DRG categories for transfer cases.

ProPAC's report indicates that payment-to-cost ratios for transfer cases in the transferring hospitals were substantially below average for cases with short lengths-of-stay, but that the ratios were closer to average for cases with lengths-of-stay approximating the average. Since ProPAC's findings differ from those in our 1988 report to Congress, we intend to review ProPAC's results to determine whether refinements in the transfer payment policy are now warranted. (A ProPAC technical report containing the results of their analysis is scheduled for publication in April 1992.)

Any change in the transfer payment methodology needs to be evaluated in terms of its potential for creating incentives that may adversely affect the quality of care received by Medicare beneficiaries. For example, the declining per diem rate in a graduated per diem methodology would create an incentive for initiating transfers earlier in the course of treatment, potentially endangering patients' health. The magnitude of this incentive would depend on the gradation of the rate.

We share ProPAC's concern that the transfer payment policy not create substantial disincentives to the transfer of patients for recuperative care at a local hospital after completion of any specialty treatment provided in the tertiary hospital. However, we believe that, in light of the alternatives we have reviewed, our policy adequately maintains the efficiency incentives of the prospective payment system while establishing relatively neutral financial incentives to transfer or accept transfer patients. A decision to transfer a patient should be based upon the medical facts of a patient's case and not the financial effects upon the hospital.

F. Payment for Hemophilia Blood Clotting Factor (Recommendation 8)

Recommendation: ProPAC believes that current prospective payment system policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, ProPAC may reevaluate this issue.

Response: In 1989, ProPAC recommended implementation of a temporary, add-on payment for the costs of providing blood clotting factor to patients with hemophilia. ProPAC believed the add-on payment was necessary because of the rapidly increasing costs for clotting factor due in large part to manufacturing processes designed to reduce the risk of transmitting the human immunodeficiency virus. In response to ProPAC's recommendation, Congress enacted section 6011 of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239), which amended section 1886(a)(4) of the Act to provide that hospitals paid under the prospective payment system receive an additional payment for the costs of administering blood clotting factor to hemophiliacs who are hospital inpatients. This add-on payment was effective for blood clotting factor furnished on or after June 19, 1990 and before December 19, 1991. A detailed discussion of this provision and its implementation can be found in the April 20, 1990 final rule with comment period (55 FR 15157) and the September 4, 1990 final rule (55 FR 36000).

ProPAC states that its analysis indicated that, in FY 1990, there were fewer than 3,000 Medicare discharges with hemophilia. Not all of them required blood clotting factor, and the vast majority of hospitals (94 percent) treated five or fewer cases. Therefore, ProPAC concluded that even though hemophiliacs are more costly to treat than the average case within a given DRG, there are insufficient data to indicate that these differences are due to the administration of clotting factor.

HCFA data analysis resulted in similar findings. Evaluation of hospital admissions in which blood clotting factor was administered (from June 19, 1990, when the add-on was implemented, to October 1, 1991) identified only 97 hemophilia inpatients. We found, as did ProPAC, that not only was there a low volume of patients, but also, there were very few hospitals with a significant number of cases. Only eight hospitals administered clotting factor to four or more hemophilia patients. The impact of the increased cost of the clotting factor was distributed across 35 hospitals submitting claims for administering clotting factors to inpatients with hemophilia during the time period under analysis, with the majority of hospitals incurring only one admission.

As ProPAC states, the costs for the clotting factor are included in the hospital charges and are, therefore, reflected in the DRG weights. Under the prospective payment system, we do not pay for the costs of individual cases; rather, payment is based on an averaging process, as the cases in each DRG vary in resource requirements and length of stay. Given a normal distribution, most cases will require resources close to the average, with some cases costing more and some costing less. With the low volume of hemophilia inpatients requiring clotting factor, the higher costs for these cases are offset by the lower costs for other cases in the same DRG. In addition, the system does make provision for exceptionally high cost cases through outlier payments. Approximately 9 percent of the cases we analyzed received outlier payments.

We agree with ProPAC that, given the low volume of cases and the fact that these cases are not concentrated in a few hospitals, there is not sufficient justification to reinstate the add-on payment. Therefore, we support ProPAC's recommendation concerning the add-on payment for blood clotting factor provided to hemophilia patients.

G. Payment for Epilepsy Cases (Recommendation 9)

Recommendation: The current DRG assignment should be revised to account for the resource requirements of patients with epilepsy receiving intensive neurodiagnostic monitoring. ProPAC analyzed Medicare data from FY 1990 to identify patients with epilepsy in DRGs 24, 25, and 26 (Seizure and Headache) and found that payment-to-cost ratios were lower for patients with epilepsy compared to other patients in the same DRGs. These payment differences were greater for patients with intractable epilepsy and for those receiving neurodiagnostic monitoring. The Commission also found that the majority of patients with epilepsy were not concentrated in any hospital type but that hospitals providing specialized epilepsy services had a higher percentage of patients with epilepsy who receive monitoring. Therefore,

ProPAC believes that the Secretary should evaluate the current DRG assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring.

Response: HCFA analyzed FY 1991 MEDPAR data and identified 22,223 discharges with a principal diagnosis of epilepsy in DRGs 24, 25, and 26. Although epilepsy represents 29 percent of all patients classified to these DRGs, intractable epilepsy accounts for only 3.7 percent (2,780 cases). Our findings parallel those of ProPAC, with epilepsy cases diagnosed as intractable having higher average charges ($7310) than the nonintractable cases ($6274). These charges compare to $6393 for all cases classified to DRG 24, 25, and 26. The following table summarizes the comparison of average charges between epilepsy and other cases assigned to the same DRGs. For each entry, the number of cases is included in the parentheses.

# DRG	Intractable epilepsy	Nonintractable epilepsy	All epilepsy	All cases
24	$8867	$7260	$7440	$7400
	(1,606)	(13,727)	(15,333)	(53,661)
25	$5027	$3901	$4093	$3977
	(1,173)	(5,700)	(6,873)	(22,386)
26	$4070	$5959	$5848	$7174
	(1)	(16)	(17)	(54)
All cases	$7310	$6274	$6403	$6393
	(2,780)	(19,443)	(22,223)	(76,101)

If video and radio-telemetered electroencephalographic monitoring (procedure code 89.19) is performed, the result is higher charges, with both intractable and nonintractable patients receiving this service averaging a charge of $7215, while those without the service had an average charge of $6471. The differential in charges for intractable epilepsy cases with and without telemonitoring service, however, was less than 3 percent. With only 2 percent of the cases reporting codes for video-telemonitoring, and only two cases reporting psychological services, it is impossible to reach a definitive conclusion concerning the use and cost of neurodiagnostic services.

Evaluation of ancillary charges resulted in similar findings. That is, average ancillary charges were slightly above average for intractable patients and slightly below for nonintractable patients. Since 90 percent of the epilepsy admissions are for nonintractable cases and only 10 percent are for intractable, these slightly higher treatment costs for intractable cases are distributed across DRGs 24, 25, and 26, with some charges occurring above the average and some below. Given this distribution of cases, the average ancillary charge for all epilepsy patients ($3,431) was actually lower than the average charge for all patients in these DRGs ($3,541).

To measure the impact on hospitals of providing services to patients with intractable epilepsy, we evaluated utilization by these patients at the hospital level, identifying high-volume hospitals (defined as hospitals treating 10 or more intractable epilepsy cases). We found that for intractable epilepsy patients, there were 1,042 hospitals providing service to 2,780 patients, with fewer than 4 percent of these hospitals having 10 or more cases (40 hospitals). Only 22 percent of the claims submitted by the high-volume hospitals for intractable epilepsy patients had charges that were higher than the average charge for the DRG for all patients. In addition, for approximately one-half of the claims submitted by these hospitals for all epilepsy patients in DRGs 24, 25, and 26, the average charge for treating intractable cases was less than the average charge for treating nonintractable cases.

Our evaluation of the relationship between Medicare costs and Medicare payments, for the first 7 years of prospective payment, identified only three high-volume hospitals with a negative average Medicare operating margin. (A negative operating margin means that a hospital incurred costs in excess of payment for its Medicare patients.) Without a high concentration of cases in a few hospitals, the impact of treating intractable epilepsy is distributed across many hospitals treating a low volume of these patients, with no significant impact on profit margins. This is consistent with the overall design of the prospective payment system. Under that system, payment is based on an averaging process, with some cases incurring costs in excess of payment while for others payment exceeds costs. The incentive is for hospitals to treat a mix of patients and, thus, achieve a balance between costs and payments.

As part of our analysis, we also examined the charge data from those 25 hospitals that were identified by the National Association of Epilepsy Centers as hospitals that specialize in the treatment of epilepsy. Based on our data, these epilepsy specialty centers did not necessarily treat a high volume of Medicare intractable epilepsy patients. The volume of these cases ranged from 0 to 34. In addition, there was no consistent pattern concerning charges for either intractable or nonintractable epilepsy. The 10 specialty hospitals that were also high-volume hospitals (that is, treated 10 or more epilepsy cases) had average charges lower than the national average for these cases. We evaluated Medicare operating margins for the specialty centers, again reviewing the relationship between cost and payment for treating Medicare patients. As with the high-volume hospitals, the overall average operating margin for the first 7 years under prospective payment was positive. Only two centers (one of which was also a high-volume hospital) experienced an overall negative operating margin.

As ProPAC suggested, HCFA has evaluated the current DRG assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring. While the results of our analysis confirm that intractable epilepsy patients incur higher charges on average than do patients with nonintractable epilepsy, particularly those receiving neurodiagnostic monitoring, these differences are not significant enough to warrant any DRG classification change.

We note that the data for both intractable and nonintractable cases were inconsistent across DRGs as well as among hospitals. Without accurate coding for the intensive services required for these patients, we cannot document consistent and reliable differences between patients receiving neurodiagnostic services and those not using these services. With minimal differences in average charges between intractable epilepsy cases and those of the DRG overall, given the distribution of cases across a large number of

hospitals and the inconsistencies between both the high-volume hospitals and the epilepsy treatment centers, we find there is insufficient evidence to justify a DRG modification at this time. Therefore, we are not proposing any revision to the current DRG assignment for epilepsy patients.

H. Essential Access Community Hospital Program (Recommendation 10)

Recommendation: ProPAC recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, ProPAC believes that overall system efficiency may be improved without sacrificing access to care.

Response: On October 25, 1991, we published a proposed rule in the **Federal Register** to implement the Essential Access Community Hospital (EACH) program, including criteria that facilities would have to meet to qualify to be designated as EACHs or rural primary care hospitals (RPCHs) (56 FR 55382). These criteria were based on the provisions of section 1820 of the Act (the statutory section that establishes the EACH program). That section of the Act does not include any mechanism for waiving the statutory requirements for designation as an EACH or RPCH.

In response to our proposed rule, we received a number of comments recommending greater flexibility in the application of the statutory provisions cited by ProPAC, including the criteria for designation as an RPCH. The provisions for which commenters recommended waiver included those provisions relating to the certification of the need for temporary inpatient care, the bed-size and length-of-stay limitations for RPCHs, and the criteria related to the bed size or location of EACHs and their responsibilities with respect to RPCHs. Some commenters expressed the opinion that HCFA should waive some or all of these provisions; other commenters recommended that we publish final regulations to permit the designation of "intermediate EACHs" that would appear to be similar in concept to the larger facilities that ProPAC believes should be encouraged to become more efficient through appropriate restructuring of their services.

We are considering these comments and will respond to them in the preamble to the final rule implementing the EACH program. We do not believe it would be appropriate to adopt any of the ProPAC recommendations outside of the rulemaking process.

I. PRO Review and Quality of Care (Unnumbered Recommendation)

Recommendation: ProPAC believes the Peer Review Organization (PRO) program should continue to monitor, at the case and facility levels, the care furnished to Medicare beneficiaries. Although the Commission commends the planned expansion of epidemiologic patterns of care studies using the Uniform Clinical Data Set, these more general analyses should not replace all case-level and facility-level quality review. Further, funding should be sufficient to allow PROs to perform case-level and facility-level review, as well as more general analyses of broad patterns of care.

Response: We intend to continue to monitor the care furnished to Medicare beneficiaries at the case and facility levels, as ProPAC recommends. HCFA has developed a new strategy for the PRO program, consistent with the recommendations in the 1990 Institute of Medicine Report, "Medicare: A New Strategy for Quality Assurance," to continuously improve quality of care, and to strengthen the ability of health care organizations and practitioners to assess and improve their own performance. This strategy is called the Health Care Quality Improvement Initiative (HCQII). Central to the HCQII is a fundamental change in the PRO program from its emphasis on individual (and often isolated) clinical errors to an increased emphasis on general improvements in medical care. Under the HCQII, PROs will use statistical quality control to examine variations in both the processes and the outcomes of care. PROs will then share these data with hospitals and physicians and work with them to interpret and apply the findings.

The HCQII is a program designed to shift the emphasis of Medicare quality assurance activity from review of individual cases to the review of patterns of care and patterns of outcomes. The Initiative is intended to move mainstream medical care toward best available practices, in contrast with a previous emphasis that focused on correcting unusually bad care.

The Initiative grows out of program experience, health services research, and modern quality management theory. Health services research indicates that there is wide variation in both practices and outcomes for most conditions and procedures. Modern quality management shows that the emphasis on quality improvement should be on improving the usual processes of care rather than identifying an isolated problem with an individual case. The Initiative depends on collection of data through the Uniform Clinical Data Set, which will provide detailed clinical information.

PROs will continue to review individual cases under HCQII. About one-half of PRO resources will be expended on review of individual cases over the next 4 years. This review will continue to be carried out by local physicians working for the local PRO. Reviewing individual cases is an important complement to reviewing patterns of care and outcomes of care. Although there will be increased emphasis on pattern analysis and education, HCFA will continue to identify and act on individual quality problems. Hospitals that do not improve will be subject to increasingly severe actions, including sanctions. However, HCFA believes that education in concert with analysis of current patterns will produce greater improvements in care practices than do sanctions.

The Cooperative Cardiovascular Project is the first major clinical project of the HCQII. The Project will coordinate activities of PROs and the health care and research communities to improve care for patients with myocardial infarction, coronary artery bypass grafting, and percutaneous transluminal coronary angioplasty. The Project is being planned cooperatively by a group of interested organizations representing hospitals, consumers, researchers, and regulators. The Project will examine processes of care and outcomes of care for patients with these three conditions, identify areas in which practices can be improved, develop programs for improvement, and track the success of hospitals and medical staffs in achieving this improvement.

J. Update Factor for Payments to Dialysis Facilities (Recommendation 12)

Recommendation: ProPAC is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. ProPAC recommends that HCFA expedite work necessary to complete its data base of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis

facilities and maintain a data base with this information.

Response: Section 4201(b) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) directed ProPAC to conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end-stage renal disease (ESRD) patients under the Medicare program. Based on this information, ProPAC was directed to make recommendations to Congress regarding the method or methods of payment and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under Medicare should be established for dialysis services furnished during FY 1993 and the methodology to be used to update these payments for subsequent fiscal years. These recommendations were to be submitted as a report to Congress by March 1, before the beginning of each fiscal year, beginning with March 1, 1992 for FY 1993. The study was to examine the following factors: hemodialysis and other treatment modalities, adjustment factors for facility's characteristics, adjustments for labor and nonlabor costs, profit margin, and adjustments for patient complexity and costs associated with positive outcomes.

ProPAC believes that existing evidence, based on 1988 audit data, does not justify a rate increase at this time. The 1988 audit sample was designed to estimate the median costs of a dialysis service in an efficiently operated renal facility, that is, to set a rate for payment, and not to determine the costs of dialysis services that were affected by other factors (such as volume, type of ownership, and location of facility) as referenced by the statute. ProPAC concluded that the 1988 audit data were not representative of the proportion of patients treated at home, the types of dialysis provided, and the characteristics of all dialysis facilities. Thus, the Commission determined that this sample was not adequate to address the issues raised by Congress in Public Law 101-508 and that more extensive cost data was needed.

We agree with ProPAC's assessment that the 1988 audit data were not sufficient to address the issues raised by Congress, as the audits were not designed to provide data on the issues raised in the Congressional mandate. We have been developing data and have recently completed a data base of unaudited renal cost data. We are maintaining computer files of cost report data for renal facilities with fiscal years ending in 1988, 1989, 1990 and 1991, and have initiated an analysis of these data. ProPAC is aware that we now have data in the format required and has requested access to these data.

ProPAC is also recommending that we annually audit a representative sample of cost reports to use in evaluating payments and costs by type of treatment and setting. This is an appropriate recommendation for rate-setting purposes, but we do not believe it would be cost effective to conduct annual audits under the prospective payment system, since there is no recovery of Medicare funds to offset the costs of these audits, nor does the Secretary have the authority under Public Law 101-508 to set rates. Moreover, we believe that a representative set of audits could be useful to the Secretary to set annual payment rates, if the Secretary had the authority to set rates. We believe that to conduct audits without the authority to use these results to set rates would result in inefficient use of government expenditures.

Presented below are tables that provide data from 1990 ESRD facility surveys, including both hospital-based and independent facilities, and a table that shows the percentage of patients by treatment modalities. Tables 1, 2 and 3 provide information concerning the universe of renal facilities. Over the past 10 years, the number of independent facilities has increased significantly. These facilities account for the majority of dialysis treatments. The 1990 data show that independent facilities account for 66 percent of all renal facilities and furnish dialysis service to 66 percent of all dialysis patients.

Table 3 shows that for 1990, 39 percent of renal facilities furnish 68 percent of outpatient maintenance dialysis treatments. This is in contrast to the situation in 1983, when the original base rates were established. At that time, the rates were weighted using the costs experiences of small renal units, especially hospitals, which then dominated the dialysis industry. This resulted in overpaying the more efficient larger facilities. We believe that ProPAC should consider a payment method that establishes different rates for the larger, more efficient renal facilities that benefit from economies of scale. For facilities that meet certain limited criteria, we are considering a different payment structure based on the characteristics of these facilities. For example, pediatric hospitals and small rural facilities, with less than a defined number of treatments, might qualify for an adjusted rate that reflects the relative inefficiencies associated with low volume. For hospitals, a case-mix adjustment would be appropriate to eliminate the administrative burden and costs borne by hospitals filing for an exception to their payment rates.

Table 4 documents that in 1990 the treatment modalities for 97 percent of renal patients were outpatient hemodialysis, CAPD (continuous ambulatory peritoneal dialysis) or CCPD (continuous cycling peritoneal dialysis). This percentage continues to grow and the rate structure should reflect this shift in treatment modalities. The numbers of intermittent peritoneal dialysis (IPD) and home hemodialysis patients are insignificant and diminishing, and no special payment structure should be established for these treatment modalities. Patients on IPD should be reflected in any case-mix adjustment proposed by ProPAC. Since 1982, the percentage of patients on home hemodialysis has decreased from 6.7 percent to 1.9 percent. Of these home patients, 2 percent of renal facilities account for 43 percent of all patients. In total, 21 percent of renal facilities account for 78 percent of all home dialysis patients. If ProPAC recommends setting a separate home dialysis rate, we would suggest that only those facilities that have a significant home patient population be used to establish the payment rate in order to reflect the economic efficiencies and training expertise of such programs.

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TABLE 1: HOSPITAL DATA FROM 1990 ESRD FACILITY SURVEY

RANGE OF HOSPITAL FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	18	0	0	38	0
1 – 2,499	168	210548	1830	2643	1253
2,500 – 4,999	157	579238	4222	5795	3689
5,000 – 7,499	114	711744	5057	6958	6243
7,500 – 9,999	96	837722	6035	7922	8726
10,000 – 14,999	77	934659	6884	9004	12138
15,000 – 19,999	39	671950	4721	6214	17229
20,000 OVER	20	541086	3807	5000	27054
TOTAL	689	4486947	32556	43574	6512

RANGE OF RURAL HOSPITAL FACILITIES TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	1	0	0	0	0
1 – 2,499	55	80717	628	657	1468
2,500 – 4,999	67	236009	1708	2134	3523
5,000 – 7,499	20	121127	874	1032	6056
7,500 – 9,999	6	49533	369	409	8256
10,000 – 14,999	2	21475	162	215	10738
15,000 – 19,999	0	0	0	0	0
20,000 OVER	0	0	0	0	0
TOTAL	151	508861	3741	4447	3370

RANGE OF URBAN HOSPITAL FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	17	0	0	38	0
1 – 2,499	113	129831	1202	1986	1149
2,500 – 4,999	90	343229	2514	3661	3814
5,000 – 7,499	94	590617	4183	5926	6283
7,500 – 9,999	90	788189	5666	7513	8758
10,000 – 14,999	75	913184	6722	8789	12176
15,000 – 19,999	39	671950	4721	6214	17229
20,000 OVER	20	541086	3807	5000	27054
TOTAL	538	3978086	28815	39127	7394

TABLE 2: INDEPENDENT DATA FROM 1990 ESRD FACILITY SURVEY

RANGE OF INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	18	0	0	509	0
1 – 2,499	229	287459	4541	4950	1255
2,500 – 4,999	271	1014465	7990	8885	3743
5,000 – 7,499	242	1480978	10828	12563	6120
7,500 – 9,999	189	1636675	11935	13691	8660
10,000 – 14,999	223	2723589	19342	22803	12213
15,000 – 19,999	80	1372358	9670	11024	17154
20,000 OVER	55	1502806	9844	11801	27324
TOTAL	1307	10018330	74150	86226	7665

RANGE OF RURAL INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	2	0	0	90	0
1 – 2,499	96	127496	1438	1515	1328
2,500 – 4,999	101	371603	2730	3061	3679
5,000 – 7,499	64	382890	2755	2927	5983
7,500 – 9,999	30	258095	1790	1950	8603
10,000 – 14,999	14	165124	1139	1247	11795
15,000 – 19,999	2	33119	216	287	16560
20,000 OVER	1	20388	151	217	20388
TOTAL	310	1358715	10219	11294	4383

RANGE OF URBAN INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs
NO TREATMENTS	16	0	0	419	0
1 – 2,499	133	159963	3103	3435	1203
2,500 – 4,999	170	642862	5260	5824	3782
5,000 – 7,499	178	1098088	8073	9636	6169
7,500 – 9,999	159	1378580	10145	11741	8670
10,000 – 14,999	209	2558465	18203	21556	12241
15,000 – 19,999	78	1339239	9454	10737	17170
20,000 OVER	54	1482418	9693	11584	27452
TOTAL	997	8659615	63931	74932	8686

TABLE 3: INDEPENDENT & HOSPITAL DATA FROM 1990 ESRD FACILITY SURVEY

RANGE OF HOSPITAL & INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs	% OF UNITS	CUMUL %	% OF RXS	CUMUL %
NO TREATMENTS	36	0	0	547	0	1.8%	1.8%	0.0%	0.0%
1 – 2,499	397	496007	6371	7593	1254	19.9%	21.7%	6.0%	6.0%
2,500 – 4,999	428	1593703	12212	14680	3724	21.4%	43.1%	11.4%	17.4%
5,000 – 7,499	356	2192722	15885	19521	6159	17.8%	61.0%	14.9%	32.3%
7,500 – 9,999	285	2474397	17970	21613	8682	14.3%	75.3%	16.8%	49.1%
10,000 – 14,999	300	3658248	26226	31807	12194	15.0%	90.3%	24.6%	73.7%
15,000 – 19,999	119	2044308	14391	17238	17179	6.0%	96.2%	13.5%	87.2%
20,000 OVER	75	2043892	13651	16801	27252	3.8%	100.0%	12.8%	100.0%
TOTAL	1996	14505277	106706	129800	7267	100%		100%	

RANGE OF RURAL HOSPITAL & INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs	% OF UNITS	CUMUL %	% OF RXS	CUMUL %
NO TREATMENTS	3	0	0	90	0	0.7%	0.7%	0.0%	0.0%
1 – 2,499	151	208213	2066	2172	1379	32.8%	33.4%	14.8%	14.8%
2,500 – 4,999	168	607612	4438	5195	3617	36.4%	69.8%	31.8%	46.6%
5,000 – 7,499	84	504017	3629	3959	6000	18.2%	88.1%	26.0%	72.6%
7,500 – 9,999	36	307628	2159	2359	8545	7.8%	95.9%	15.5%	88.1%
10,000 – 14,999	16	186599	1301	1462	11662	3.5%	99.3%	9.3%	97.4%
15,000 – 19,999	2	33119	216	287	16560	0.4%	99.8%	1.5%	98.9%
20,000 OVER	1	20388	151	217	20388	0.2%	100.0%	1.1%	100.0%
TOTAL	461	1867576	13960	15741	4051	100%		100%	

RANGE OF URBAN HOSPITAL & INDEPENDENT FACILITIES' TREATMENTS

RANGE	UNITS	HEMO RXS	HEMO PATs	TOTAL PATs	AVG RXs	% OF UNITS	CUMUL %	% OF RXS	CUMUL %
NO TREATMENTS	33	0	0	457	0	2.1%	2.1%	0.0%	0.0%
1 – 2,499	246	289794	4305	5421	1178	16.0%	18.2%	4.6%	4.6%
2,500 – 4,999	260	986091	7774	9485	3793	16.9%	35.1%	8.4%	13.0%
5,000 – 7,499	272	1688705	12256	15562	6208	17.7%	52.8%	13.2%	26.2%
7,500 – 9,999	249	2166769	15811	19254	8702	16.2%	69.1%	17.0%	43.3%
10,000 – 14,999	284	3471649	24925	30345	12224	18.5%	87.6%	26.9%	70.2%
15,000 – 19,999	117	2011189	14175	16951	17190	7.6%	95.2%	15.3%	85.4%
20,000 OVER	74	2023504	13500	16584	27345	4.8%	100.0%	14.6%	100.0%
TOTAL	1535	12637701	92746	114059	8233	100%		100%	

TABLE 4: PERCENTAGE OF PATIENTS BY TREATMENT MODALITIES

YEAR	HEMO OUTPAT	IPD OUTPAT	ALL TRAIN MODES	HEMO HOME	IPD HOME	CAPD HOME	CCPD HOME	TOTAL
1982	79.92%	1.35%	0.89%	6.68%	1.24%	9.92%	0.00%	100.0%
1983	79.22%	1.03%	0.79%	6.01%	1.10%	11.85%	0.00%	100.0%
1984	79.22%	0.75%	0.61%	5.26%	0.33%	12.74%	1.09%	100.0%
1985	79.30%	0.69%	0.67%	4.70%	0.27%	13.25%	1.12%	100.0%
1986	80.05%	0.56%	0.59%	4.04%	0.21%	13.11%	1.44%	100.0%
1987	80.62%	0.45%	0.36%	3.64%	0.17%	13.03%	1.74%	100.0%
1988	81.40%	0.34%	0.55%	3.02%	0.31%	12.57%	1.81%	100.0%
1989	81.96%	0.27%	0.36%	2.51%	0.14%	12.77%	1.99%	100.0%
1990	81.99%	0.22%	0.35%	1.91%	0.15%	13.07%	2.31%	100.0%
TOTAL	80.62%	0.56%	0.54%	3.88%	0.37%	12.60%	1.43%	100.0%

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K. Outpatient Payment Reform (Recommendation 13)

Recommendation: ProPAC believes that a prospective payment system for outpatient services should be implemented. Outpatient facility payment reform should ultimately include all providers of outpatient services, such as hospitals, physicians' offices, and free-standing ambulatory surgical centers. The same payment method should apply to the facility or technical component of all services. The payment rate, however, should be adjusted to reflect justifiable cost differences such as wages and case mix. Further, cost differences that have some societal benefit, such as standby capacity and emergency capabilities, should also be reflected in the payment rate. Where feasible, the unit of payment should be based on bundled related services.

Response: This recommendation raises a number of important issues. We are committed to the development of a prospective payment system for hospital outpatient departments. We believe the system we design should result in certain benefits, such as increasing payment equity among providers, constraining Medicare expenditures, and protecting beneficiaries' access to services, while promoting predictability and administrative simplicity. In addition, we agree with ProPAC that ideally the same prospective payment system should eventually be extended to the other outpatient settings.

In its discussion of this recommendation, ProPAC raises the concern that our current research focuses only on hospital-provided outpatient services, and they encourage the expansion of research to other outpatient facilities as well. For example, ProPAC notes that the Ambulatory Patient Groups (APGs) classification system was developed for use in the hospital outpatient setting, and questions whether APGs can be appropriately applied in the nonhospital setting.

It is true that we have initially focused on the development of the Congressionally mandated prospective payment system for hospital outpatient services. However, we see this as a first and necessary step to a comprehensive system that could be applied to nonhospital settings as well. In addition, we do not believe that there is any feature inherent in a clinically-based case-mix classification system such as APGs that would preclude it from being used as the payment method for other outpatient settings.

L. Medicare Volume Performance Standard (Recommendation 14)

Recommendation: Services provided in the hospital outpatient setting should be included in the Medicare Volume Performance Standard (MVPS) to the extent that these services are included when provided in other settings. Certain services, such as laboratory tests and therapy, currently are included in the MVPS when they are furnished in free-standing settings. ProPAC believes that hospital-provided outpatient services should also be incorporated in the VPS. Their inclusion will make incentives to control volume consistent across sites of care.

Response: In theory, we agree that services provided in the outpatient department of hospitals should be included in the MVPS because physicians should be held accountable for the services they order as well as provide. However, until a process is established for obtaining more timely data from the intermediaries than currently exists through the cost report process, only clinical diagnostic laboratory tests provided in the outpatient department can feasibly be brought into the MVPS.

With respect to other hospital outpatient department services, the data needed to include these services in the MVPS are not available on a timely basis as long as payment continues on a reasonable cost basis. While charge data from the hospital outpatient department can be obtained in a timely manner, we would not be able to obtain accurate expenditure information for the purpose of measuring performance under the MVPS for the year ending September 30 because of varying fiscal year ending dates for cost reports and delays in settlement of the cost report. Thus, we do not think it is feasible to include in the MVPS any hospital outpatient services that are paid for on a reasonable cost basis.

M. Cost Data Collection for Outpatient Providers (Recommendation 15)

Recommendation: A mechanism should be implemented for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers.

Response: We have specifically chosen not to require Medicare-participating ambulatory surgical centers (ASCs) to submit annual cost reports, primarily to avoid imposing on ASCs the burden and expense that these reports engender. Some ASCs, especially the smaller facilities, would have difficulty absorbing the added expense of maintaining billing and recordkeeping systems necessary to satisfy an annual Medicare cost report requirement. Additional facility costs would, in turn, be reported to Medicare, inflating Medicare ASC payment rates and beneficiary co-payments (see Recommendation 16 below) as well as Medicare administrative costs. Therefore, we do not concur with the ProPac recommendation that an annual cost report would be an appropriate mechanism for the systematic and comprehensive collection of data for free-standing settings.

We surveyed Medicare-participating ASCs in 1986 to collect procedure-specific cost data for use in setting ASC payment rates. Also, an ASC survey will be conducted during 1992. These surveys collect information regarding charges, costs, and volume on a procedure-specific basis. One portion of the 1992 survey will ask ASCs to identify component services of selected high-volume procedures and to report their actual costs in furnishing those services. The data reported for this "procedure costing" portion of the 1992 survey as well as the more general charge, cost, and utilization data collected from all ASCs are validated by random on-site audits of a representative sample of facilities. We have found this method of data collection to be cost effective at both the national and provider level and minimally disruptive to the industry. The increase in the number of Medicare-certified ASCs from slightly fewer than 500 in 1986 to more than 1400 in 1992 suggests that our current data collection procedures are not a significant impediment to Medicare participation by ASCs.

HCFA is currently sponsoring research to obtain facility cost data (that is, excluding physician professional service costs) on a sample of about 400 frequently found procedures in hospital outpatient departments, ambulatory surgical centers, and physicians' offices. The research, due to HCFA in 1993, will demonstrate a methodology for collecting and anylyzing these data and enable us to explore the reasons for differences in costs between types of outpatient sites. After the report is delivered, HCFA will be able to determine whether or not the data collection should be performed periodically.

N. Beneficiary Liability (Recommendation 16)

Recommendation: Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively

should be limited to 20 percent of the payment amount allowed by Medicare.

Response: We recognize ProPAC's concern. We have been reviewing this issue in the context of our development of a comprehensive prospective payment system for all hospital outpatient services. We are working to develop an approach that will be fair to beneficiaries, while minimizing the negative financial impact on the Medicare program.

O. Quality of Care in Outpatient Settings (Recommendation 17)

Recommendation: ProPAC is concerned about the lack of Federal quality oversight in many ambulatory care settings. As more services are furnished in outpatient settings, ProPAC believes the Secretary should enhance existing methods and develop new ones to assess and monitor the quality of care provided to beneficiaries in these settings.

Response: We agree with ProPAC's recommendation regarding the need for better assessment and monitoring of the quality of care provided to beneficiaries in ambulatory care settings. We have two projects underway that we expect will give us the necessary information to review patient care provided in physician offices and other ambulatory settings. In both cases, PROs have joined with academic medical experts to develop this information, and in both cases the approach is educational rather than regulatory.

In response to a Request for Proposal issued in 1989, the Wisconsin Peer Review Organization was awarded a contract to review care in physician offices. Data are being abstracted for records from 10 medical conditions commonly found in the Medicare population. Evaluation of risk-adjusted outcomes for these conditions will provide clues as to which patterns of interventions are likely to affect patient outcomes significantly.

The second project was awarded in 1990 to the Delmarva Foundation for Medical Care (the PRO for Maryland). Under this 3-year project, primary care physicians will be compared to their peers on the adequacy of record documentation and the performance of routine clinical functions such as testing, prescribing and monitoring drugs, procedures and diagnoses.

Both of these projects will emphasize providing physicians with data regarding their performance. We believe that the results obtained from these two projects will help us to implement an effective system of ambulatory care review.

In addition, section 4205(c) of Pub. L. 101–508 sets forth a number of requirements to enhance PRO/carrier coordination. In February 1991, all PROs were directed to exchange with carriers all medical policies and review guidelines, including screens and criteria, for new technologies and invasive procedures. In August 1991, five PROs and carriers (Connecticut, Maryland, North Carolina, Texas, and Wisconsin) began a pilot project for further exchange of information, including lists of physicians, to examine any commonality in their medical review activities. This pilot project should also prove beneficial in examining physicians who treat patients primarily on an outpatient basis.

Furthermore, HCFA has created a Fourth Scope of Work Workgroup to examine and develop a revised scope of work for the PROs as we begin implementing the HCQII to focus on evaluating quality of care in terms of the outcomes of care. (See the detailed discussion of HCQII above, in section VIII.I of this preamble.) We will continue to pursue pilot projects among the PROs to field test methods of performing review in ambulatory care settings. The results of these field tests will be used to design and implement a national program of review of ambulatory care.

P. Payment for Hospital-Provided Outpatient ASC–Approved Surgery (Recommendation 18)

Recommendation: ProPAC believes that payments for ambulatory surgery performed in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and freestanding ASC payments. These rates should be computed in a budget neutral fashion, that is, aggregate spending should neither increase or decrease. National rates should be based on the classification system used to determine payments to free-standing ASCs. However, ProPAC believes this classification system should be revised, as noted in Recommendation 19. The rates should be updated annually using an appropriate update factor.

Response: We agree with ProPAC that payment for ambulatory surgery performed in the hospital outpatient setting should be fully prospective. As noted in Recommendation 13 above, we are in the process of developing a comprehensive prospective payment system for all hospital outpatient services. However, additional research and evaluation are needed before such a comprehensive prospective payment system can be implemented. Therefore, we anticipate that we will first propose a limited transitional prospective payment system for hospital outpatient services. We are currently evaluating a number of approaches for implementing this transitional system, among them proposals that, as ProPAC recommends, would use ASC data to help establish payment rates for hospital outpatient surgical services.

Q. Revision of the Classification System Used to Group Ambulatory Surgery Cases (Recommendation 19)

Recommendation: The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and freestanding ambulatory surgical centers (ASCs) should be used to establish the payment groups.

Response: In compliance with section 1833(i)(2)(A) of the Act, the current ASC payment classification system groups Medicare covered Physicians' Current Procedural Terminology (CPT) codes so as to assure that the standard overhead payment amount established for the procedures in each group takes into account the costs incurred by ASCs generally in providing services furnished in connection with the performance of those procedures.

Absent a complete revision of those sections of the Act that provide for the ASC benefit under Medicare, Part B, combining hospital data with free-standing ASC data to establish a classification system for payments to ASCs would not be in compliance with the law.

R. Payment for Hospital-Provided Outpatient Radiology Services (Recommendation 20)

Recommendation: ProPAC believes that payments for radiology services provided in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and the technical component of the Medicare fee schedule for physicians. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. The national rates should be updated annually using an appropriate update factor.

Response: We agree with ProPAC that payment for radiology services performed in the hospital outpatient setting should be fully prospective. Again, we are in the process of developing a comprehensive prospective

payment system for all hospital outpatient services. As noted above, we anticipate that we will first propose a transitional system and we are in the process of evaluating a number of approaches for implementing such a system. For radiology services, we will evaluate, among other approaches, using the blend recommended by ProPAC.

S. Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services (Recommendation 21)

Recommendation: ProPAC believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.

Response: We currently do not have access to the necessary data to implement this recommendation. For example, hospitals would have to maintain records that would provide a breakdown of salaries and personnel hours attributable to inpatient and outpatient services. We are concerned that any future requirement for collecting the necessary data might place an undue administrative burden on hospitals. However, we encourage comments from hospitals with respect to how burdensome it would be to maintain such detail.

We would welcome comments from hospitals on this recommendation, particularly with regard to the scope and effects of the additional collection that would be required to carry out this recommendation.

T. Nursing Facility Wage Index (Recommendation 22)

Recommendation: The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

Response: ProPAC simulated a nursing facility wage index with limited data and found significant differences from the hospital wage index. However, ProPAC indicates that these differences could be due to differences in State regulations that affect nursing homes. The differences in State regulations should be minimized drastically with the implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203), effective October 1, 1990, which made the certification requirements for SNFs virtually identical for both Medicare and Medicaid.

ProPAC states that another potential reason for the failure of the hospital wage index to reflect adequately the variation in SNF wages is the skill-mix differences between hospital and nursing facility personnel. We agree that there may be a skill-mix difference between hospitals and skilled nursing facilities. We do not know whether the differences in the skill mix would result in a different wage index.

ProPAC also notes that the current system contributes to inequitable Medicare SNF payments across regions. For example, almost half of the facilities in New England and almost a third of those in the Mid-Atlantic region receive less than 85 percent of their costs. This compares with an average of only 15 percent of the facilities in other regions. We believe, however, that factors other than the current wage index are responsible for the higher than average costs being reported for the facilities in New England and the Mid-Atlantic States. Among these factors are the nursing shortage and the fact that some of those States pay for SNF services under Medicaid using a prospective case-mix system, which encourages facilities to admit higher cost, resource-intensive patients.

Furthermore, based on our experience with similar attempts to mandate the establishment of a home health agency (HHA) based wage index for determining HHA cost limits, we believe it advisable to continue using the hospital wage index for SNFs until the SNF payment system is totally revised through legislation.

U. Nursing Facility Case-Mix Adjustment (Recommendation 23)

Recommendation: ProPAC believes that the payment system should recognize differences in the costs of care for different types of patients. Therefore, it supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

Response: As ProPAC indicates, the Secretary will conduct a demonstration to implement a case-mix adjustment to Medicare SNF payments. The demonstration is scheduled to begin in July 1993, and we will consider its findings.

IX. Other Required Information

A. Paperwork Reduction Act

Sections 412.230 and 412.273 contain information collection requirements that are subject to Office of Management and Budget (OMB) review under the Paperwork Reduction Act. Section 412.230 has been approved by OMB through October 1993 under OMB control number 0938–0573. Section 412.273 contains a new requirement whereby a hospital may request the Administrator to review a denial. Burden associated with this collection of information is estimated to be 1 hour per respondent. A notice will be published in the **Federal Register** when approval is obtained. Organizations and individuals desiring to submit comments regarding the burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, may submit them to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

B. Requests for Data from the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format; however, some files are available on diskette. Data sets are listed below with the cost of each. Anyone wishing to purchase data tapes should submit a written request along with a certified check or money order (payable to HCFA) to cover the cost of the tapes or diskettes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room 3–A–12 Security Office Park Building, 6325 Security Boulevard, Baltimore, MD 21207.

1. Expanded Modified MEDPAR File

The file contains records for 100 percent of Medicare beneficiaries using hospital inpatient services. The file is stripped of most data elements that would identify beneficiaries. The hospitals are identified. The file is available to persons qualifying under the terms of the Notice of Proposed New Routine Use for an Existing System of Records published in the **Federal Register** on December 24, 1984 (49 FR 49941), which was amended by the July

2. 1985 Notice of Proposed New Routine Use for an Existing System of Records (50 FR 27361). Under the requirements of these notices, a data release agreement must be signed by the purchaser before release of these data.

Expanded Modified MEDPAR—Hospital Inpatient Periods Available: FY 1988 through FY 1991

Price: $3,150.00 per fiscal year

2. HCFA Hospital Wage Index Survey

This tape contains three files. Included are the hospital hours and salaries for 1988 used to create the wage indexes used in the Medicare Hospital Prospective Payment System (PPS) as well as all wage indexes used since October 1, 1983. It also contains a list of State and county codes used by SSA and FIPS (Federal Information Processing Standards), county name, and Metropolitan Statistical Area (MSA), since October 1, 1983.

Periods Available: FY 1993 PPS Update

File Cost: $460.00

3. H180 Extract, Cost Reporting Periods Ending January 1, 1982 through September 29, 1983

The H180 Extract contains cost, statistical, financial, and other information from the Medicare Hospital Cost Report (HCFA Form 2552–81). The data set includes as submitted, final settled and reopened cost reports as they were received from the Medicare Fiscal Intermediary. There is a single record for each Medicare Cost Report submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary. This file is no longer updated.

Price: $660.00

4. TEFRA Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1982 and Before October 1, 1983

The TEFRA Minimum Data Set contains cost, statistical, financial, and other information from the Medicare Hospital Cost Report (HCFA Form 2552–83) for the Hospital Fiscal Periods beginning on or after October 1, 1982 and before October 1, 1983. This dataset includes capital-related cost (fixed/moveable) information used in the early analyses of prospective capital payment. The majority of these cost reports have been settled by the Medicare Fiscal Intermediary. This file is no longer updated.

Price: $660.00

5. PPS–I Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1983 and Before October 1, 1984

The PPS–I Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552–84). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. The majority of these cost reports have been settled by the Medicare Fiscal Intermediary. This file is no longer updated.

Price: $660.00

6. PPS–II Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1984 and before October 1, 1985

The PPS–II Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552–85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: $660.00

7. PPS–III Minimum Data Set, Cost Reporting Periods beginning on or after October 1, 1985 and before October 1, 1986

The PPS–III Minimum Data Set contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552–85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: $660.00

8. PPS–IV Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1986 and Before October 1, 1987

The PPS–IV Minimum Data Set, contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552–85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: $660.00

9. PPS–V Minimum Data Set, Cost Reporting Periods Beginning On or After October 1, 1987 and Before October 1, 1988

The PPS–V Minimum Data Set, contains cost, statistical, financial, and other information from the Medicare hospital cost report (HCFA Form 2552–85). The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: $660.00

10. PPS–VI Minimum Data Set

The PPS–VI Minimum Data Set contains cost, statistical, financial, and other information from the Medicare Hospital Cost Report (Form HCFA 2552–85) for the Hospital Fiscal Periods beginning on or after October 1, 1988 and before January 1, 1989 and (Form HCFA 2552–89) for the Hospital Fiscal Periods beginning on or after January 1, 1989 and before October 1, 1989. The dataset includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This dataset is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: $660.00

11. PPS–VII Minimum Data Set

The PPS–VII Minimum Data Set contains cost, statistical, financial and other information from the Medicare Hospital Cost Report (Form HCFA 2552–85) for the Hospital Fiscal Periods beginning on or after October 1, 1989 and before January 1, 1990) and (Form HCFA 2552–89) for the Hospital Fiscal Periods beginning on or after January 1, 1990 and before October 1, 1990. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated by the end of each calendar quarter and is available on the last day of the following month.

Price: $660.00

12. PPS–VI Capital Data Set

The PPS–VI Capital Data Set contains selected data for capital-related costs, interest expense and related information

and complete balance sheet data from the Medicare Hospital Cost Report (Form 2552–85) for the Hospital Fiscal Periods beginning on or after October 1, 1988 and before January 1, 1989 and (Form 2552–89) for the Hospital Fiscal Periods beginning on or after January 1, 1989 and before October 1, 1989. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated at the close of each calendar quarter and is available on the last day of the following month.

Price: $660.00

13. PPS–VII Capital Data Set

The PPS–VII Capital Data Set contains selected data for capital related costs, interest expense and related information and complete balance sheet data from the Medicare Hospital Cost Report (Form 2552–85) for the Hospital Fiscal Periods beginning on or after October 1, 1989 and before October 1, 1990. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare Certified Hospital by the Medicare Fiscal Intermediary to HCFA. This data set is updated at the close of each calendar quarter and is available on the last day of the following month.

Price: $660.00

14. Provider-Specific File

This file is a component of the PRICER program used in an intermediary's system to compute individual DRG payments. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration process and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements. Beginning with December 1991, the individual records were enlarged to include elements related to the capital prospective payment system.

Periods Available: December 1987, 1988, 1989, 1990, and 1991 updates

Price: $460.00

15. HCFA Medicare Case-Mix Index File (3½" Diskette)

This file contains the hospital provider number and the Medicare case-mix index as published in each year's update of the Medicare Hospital Prospective Payment System. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases.

Periods Available: FY 1985 through FY 1991

Price: $130.00

16. Table 5 DRG (3½" Diskette)

This file contains a listing of DRGs, DRG narrative description, relative weight, geometric mean, length of stay, and day outlier trim points as published in the **Federal Register**.

Periods Available: FY 1993 PPS Update

Price: $130.00

17. AOR/BOR File (3½" Diskette)

This diskette contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are "Before Outliers Removed" and the AOR is "After Outliers Removed." (This refers to statistical outliers, not payment outliers.)

Periods Available: FY 1993 PPS Update

Price: $130.00

For further information concerning these data tapes, contact Mary R. White at (410) 597–3671.

In addition, certain other data, such as area wage data and data used to construct the Puerto Rico standardized amounts, are available in hard copy format. Commenters interested in examining hard copy data should contact Lana Price at (410) 966–4535.

We realize that commenters may be interested in obtaining data other than those we have discussed above. These commenters should direct their requests to Lana Price at the number provided above.

Finally, in lieu of obtaining data through the mail, certain data may also be available for inspection at the central office of the Health Care Financing Administration in Baltimore, Maryland. Commenters interested in obtaining more information about this alternative for reviewing data should also contact Lana Price.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the "Dates" section of this preamble and respond to those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5) of the Act that our final rule for FY 1993 be published by September 1, 1992, we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR chapter IV is amended as follows:

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

SUBCHAPTER B—MEDICARE PROGRAMS

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

I. Part 412 is amended as follows:

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

Authority: Sections 1102, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395hh, and 1395ww).

Subpart A—General Provisions

B. Subpart A is amended as follows:

1. Section 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services, organ acquisition costs incurred by hospitals

with approved organ transplantation centers, and direct costs of medical education) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(b) *Summary of content.* This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems, and sets forth the general basis of these systems. Subpart B of this part sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification. Subpart C of this part sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems. Subpart D of this part sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined. Subpart E of this part describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first four years of the prospective payment system. Subpart F of this part sets forth the methodology for determining additional payments for outlier cases. Subpart G of this part sets forth rules for special treatment of certain facilities under the prospective payment system for inpatient operating costs. Subpart H of this part describes the types, amounts, and methods of payment to hospitals under the prospective payment system for inpatient operating costs. Subpart K of this part describes how the prospective payment system for inpatient operating costs is implemented for hospitals located in Puerto Rico. Subpart L of this part sets forth the procedures and criteria concerning application from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation. Subpart M of this part describes how the prospective payment system for inpatient capital-related costs is implemented effective with cost reporting periods beginning on or after October 1, 1991.

2. Section 412.2 is amended as follows:

a. Paragraphs (a), (b)(1), and the introductory text of paragraph (b)(2) are revised;

b. Paragraphs (d) and (e) are redesignated as paragraphs (e) and (f), and a new paragraph (d) is added;

c. The introductory text of newly redesignated paragraph (e) and newly redesignated paragraphs (e)(1) and (e)(2) are revised;

d. The introductory text of newly redesignated paragraph (f) and newly redesignated paragraphs (f)(2), (f)(3), and (f)(6) are revised;

e. Newly redesignated paragraph (f)(7) is redesignated as paragraph (f)(8), and a new paragraph (f)(7) is added.

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in § 412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that have an atypically long length of stay or are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph (b)(2) of this section include the following:

* * * * *

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

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

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§ 413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in § 413.85 of this chapter.

* * * * *

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment rates for inpatient operating costs and inpatient capital-related costs, hospitals receive payments for the following:

* * * * *

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in § 412.105 for inpatient operating costs and in § 412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in § 412.115.

* * * * *

(6) Serving a disproportionate share of low-income patients, as provided in § 412.106 for inpatient operating costs and § 412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in § 413.86 of this chapter.

* * * * *

§ 412.4 [Amended]

3. In § 412.4, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; and in paragraph (d)(1), the term "prospective payment rate" is changed to read "prospective payment rates", and the phrase "subparts D and E" is revised to read "subparts D, E, and M" wherever it appears.

4. Section 412.6 is revised to read as follows:

§ 412.6 Cost reporting periods subject to the prospective payment systems.

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient

capital-related costs effective with the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective payment system for inpatient operating costs, the reasonable costs of services funished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* HCFA recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

5. Section 412.8 is revised to read as follows:

§ 412.8 Publication of schedules for determining prospective payment rates.

(a) *Initial prospective payment rates*—(1) *For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30, 1984) were determined in accordance with documents published in the Federal Register on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published in the Federal Register on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) for cost reporting periods beginning after September 30, 1984, HCFA publishes an annual document setting forth the methodology and data used, including the percentage increase factor, to determine prospective payment rates for inpatient operating costs and (for cost reporting periods beginning after September 30, 1991) for inpatient capital-related costs applicable to discharges occurring during the Federal fiscal year beginning on or after October 1 of that year.

(2) HCFA proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a Federal Register document published for public comment not later than the May 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(3) HCFA publishes a Federal Register document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

§ 412.10 [Amended]

6. In § 412.10(a), the phrase "DRG changes will be effective" is revised to read "DRG changes are effective".

C. Subpart B is amended as follows:

1. The heading of subpart B is revised to read as follows:

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.20 [Amended]

2. In § 412.20, including the heading, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears. In § 412.20(b)(1), remove the phrase ", and § 412.32 " and add the word "and" before "§ 412.29.".

3. In § 412.22, in paragraph (a), the phrase "A hospital will be excluded from the prospective payment system" is revised to read "A hospital is excluded from the prospective payment systems"; in paragraph (b), the phrase "will be subject to the ceiling" is revised to read "are subject to the ceiling" and the phrase "and § 412.32" is removed; and a new paragraph (d) is added to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire costs reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

4. In § 412.23, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; paragraph (b)(8) is revised; and paragraph (c) is removed and reserved to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) * * *

(8) A hospital that seeks exclusion as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated such a population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 13 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

* * * * *

5. In § 412.25, the term "prospective payment system" is revised to read "prospective payment systems" wherever it appears; the introductory text of paragraph (a) is revised; a new paragraph (a)(13) is added; in paragraph (b), the phrase "will remain the same" is revised to read "remains the same"; and a new paragraph (c) is added to read as follows:

§ 412.25 Excluded distinct part hospital units: Common requirements.

(a) Basis for exclusion. In order to be excluded from the prospective payment systems, a distinct part psychiatric or rehabilitation unit must meet the following requirements:

* * * * *

(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

* * * * *

(c) *Changes in the status of hospital units.* For purposes of exclusion from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any

changes in the status of a unit are made only at the start of a cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of the hospital's next cost reporting period.

§ 412.27 [Amended]

6. In the introductory text of § 412.27, the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.29 [Amended]

7. In the introductory text of § 412.29, the term "prospective payment system" is revised to read "prospective payment systems".

8. In § 412.30, paragraph (a) is revised and, in paragraph (c), the term "prospective payment system" is revised to read "prospective payment systems" to read as follows:

§ 412.30 Exclusion of new distinct part rehabilitation units and expansion of units already excluded.

(a) *New units.* (1) A hospital that seeks exclusion of a new rehabilitation unit may provide a written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2) instead of showing that the unit has treated such a population during the hospital's most recent 12-month cost reporting period.

(2) If a hospital that is currently participating in Medicare has not previously sought exclusion for any rehabilitation unit and has obtained approval for added bed capacity under State licensure and under its Medicare certification, it may identify the new beds as a new rehabilitation unit for the first full 12-month cost reporting period during which the beds are used to furnish inpatient care. A unit of a currently participating hospital that includes some beds that were previously licensed and certified and some new beds is recognized as a new rehabilitation unit only if more than one-half of the beds are new.

(3) If a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period that occurs after it becomes a Medicare participating hospital. The written certification described in paragraph (a)(1) of this section also is effective for any cost reporting period of not less than 1 month and not more than 13 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(4) For purposes of paragraph (a) of this section, a hospital that has undergone a change of ownership or leasing as defined in § 489.18 of this chapter is not considered to have participated previously in the Medicare program.

* * * * *

§ 412.32 [Removed]

9. Section 412.32 is removed.

D. Subpart C is amended as follows:

1. The heading for subpart C is revised to read as follows:

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.40 [Amended]

2. In § 412.40(a), the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.42 [Amended]

3. In § 412.42, the term "prospective payment system" is revised to read "prospective payment systems" in paragraph (a) and in the introductory text of paragraph (b).

§ 412.46 [Amended]

4. In § 412.46, in paragraph (d)(1), the phrase "The PRO will review" is revised to read "The PRO reviews"; in paragraph (e)(1), the phrase "the Medicare claim will be appropriately changed" is revised to read "the Medicare claim is appropriately changed"; and in paragraph (e)(2), the phrase "the PRO will change the coding and assign the appropriate DRG" is revised to read "the PRO changes the coding and assigns the appropriate DRG".

§ 412.48 [Amended]

5. In § 412.48(c), the term "prospective payment system" is revised to read "prospective payment systems".

§ 412.50 [Amended]

6. In § 412.50(a), the phrase "The applicable payments made under the prospective payment system, as described in subpart H" is revised to read "The applicable payments made under the prospective payment systems, as described in subparts H and M".

§ 412.52 [Amended]

7. In § 412.52, the term "prospective payment system" is revised to read "prospective payment systems".

E. Subpart D is amended as follows:

1. The heading for subpart D is revised to read as follows:

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

§ 412.60 [Amended]

2. In § 412.60, in paragraphs (a) and (c) introductory text, the phrase "HCFA will establish" is revised to read "HCFA establishes"; in paragraph (b), the phrase "HCFA will assign" is revised to read "HCFA assigns"; in paragraph (c)(1), the phrase "The classification of a particular discharge, will, as appropriate, be based," is revised to read "The classification of a particular discharge is based, as appropriate,"; in paragraphs (c)(2) and (c)(3), the phrase "will be" is revised to read "is"; and in paragraph (c)(3), the phrase "will provide" is revised to read "provides".

3. In § 412.62, the section heading is revised; paragraph (a) is revised; in paragraph (b), the heading is revised, and the phrase "HCFA will determine" is revised to read "HCFA determines"; in paragraph (c) introductory text, the phrase "HCFA will update" is revised to read "HCFA updates"; in paragraph (d) introductory text, the phrase "HCFA will standardize" is revised to read "HCFA standardizes"; in paragraph (e) introductory text, the phrase "HCFA will compute" is revised to read "HCFA computes"; and the heading and the introductory text of paragraph (j) are revised to read as follows:

§ 412.62 Federal rates for inpatient operating costs for fiscal year 1984.

(a) *General rule.* HCFA determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under Subpart B of this part, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region, for which payment may be made under Medicare Part A. Such rates are determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b) through (k) of this section.

(b) *Determining allowable individual hospital inpatient operating costs.*

* * * * *

(j) *Computing Federal rates for inpatient operating costs for urban and rural hospitals in the United States and*

in each region. For each discharge classified within a DRG, HCFA establishes a national prospective payment rate for inpatient operating costs and a regional prospective payment rate for inpatient operating costs for each region, as follows:

* * * * *

4. Section 412.63 is amended by revising the section heading, paragraph (a)(1), the introductory text of paragraph (o) and paragraph (p)(1); by revising in paragraph (a)(2) the phrase "Each such rate will be" to read "Each such rate is"; by revising in paragraph (b)(2)(ii) the phrase "will receive the lower" to read "receives the lower"; and by revising in paragraph (n)(1) the phrase "HCFA will adjust" to read "HCFA adjusts" to read as follows:

§ 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

(a) *General rule.* (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.

* * * * *

(o) Computing Federal rates for inpatient operating costs for large urban, other urban, and rural hospitals. For each discharge classified within a DRG, HCFA establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate for inpatient operating costs, for each region, as follows:

* * * * *

(p) *Adjusting for different area wage levels.* (1) HCFA adjusts the proportion (as estimated by HCFA from time to time) of Federal rates for inpatient operating costs computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs.

* * * * *

F. Subpart E is amended as follows:

1. The heading for subpart E is revised to read as follows:

Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

2. Section 412.70 is revised to read as follows:

§ 412.70 General description.

For discharges occurring on or after April 1, 1988 and before October 1, 1993, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

3. Section 412.71 is amended by revising the section heading; by revising paragraph (c)(1) introductory text; by revising the phrase "will decide" to read "decides" in paragraph (c)(2); and by revising the phrase "will use" to read "uses" in paragraph (d) to read as follows:

§ 412.71 Determination of base-year inpatient operating costs.

* * * * *

(c) *Hospital's request for adjustment of base-year inpatient operating costs.* (1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

* * * * *

§ 412.73 [Amended]

4. In § 412.73, paragraph (d)(1) is amended by revising the phrase "HCFA will adjust" to read "HCFA adjusts" and by revising the phrase "will be based on a factor" to read "is based on a factor "; in paragraph (d)(2), by revising the phrase "HCFA will adjust" to read "HCFA adjusts" and in paragraph (e) by revising the phrase "cost per discharge will be multiplied" to read "cost per discharge is multiplied".

§ 412.74 [Removed]

5. Section 412.74 is removed.

6. Section 412.75 is amended by revising the section heading; in paragraph (b), by revising the phrase "consdered to be a discharge" to read "considered to be a discharge" and by combining the concluding paragraph with paragraph (b); and in paragraph (e), by revising the phrase "cost per discharge will be multiplied" to read "cost per discharge is multiplied" to read as follows:

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

* * * * *

§ 412.76 [Amended]

6. Section 412.76 is amended by revising the phrase "costs will be adjusted" to read "costs are adjusted" and by revising the phrase "HCFA will recover" to read "HCFA recovers".

G. Subpart F is amended as follows:

1. In § 412.80, the introductory text of paragraph (a)(1)(ii) is republished; paragraphs (a)(1)(ii) (A) and (c) are revised; and in paragraph (a)(2), the phrase "HCFA will provide cost outlier payments" is revised to read "HCFA provides cost outlier payments" to read as follows:

§ 412.80 General provisions.

(a) *Basic rule.* (1) * * *

(ii) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a cost-to-charge ratio as described in § 412.84(h), exceed the greater of the following:

(A) A fixed dollar amount (adjusted for geographic variation in costs) as specified by HCFA.

* * * * *

(c) *Relation to hospitals that incur indirect costs for graduate medical education programs and that serve a disproportionate share of low-income patients.* The outlier payment amounts are included in total DRG revenue for purposes of determining payments for hospitals that incur indirect costs for graduate medical education programs under § 412.105 and to hospitals that serve a disproportionate share of low-income patients under §412.106.

2. In § 412.82, paragraph (c) is revised; paragraph (d) is removed; and paragraph (e) is redesignated as paragraph (d) to read as follows:

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

* * * * *

(c) Except as provided in § 412.86, the per diem payment made under paragraph (a) of this section is derived by taking 55 percent of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under Subpart D of this part by the arithmetic mean length-to-stay for that DRG.

* * * * *

§ 412.84 [Amended]

3. In § 412.84(d), the phrase "through this review will be denied" is revised to read "through this review are denied" and the phrase "these services will be recovered" is revised to read "these services are recovered".

H. Subpart G is amended as follows:

1. The heading of subpart G is revised to read as follows:

Subpart G—Special Treatment of Certain Facilities under the Prospective Payment System for Inpatient Operating Costs

2. Section 412.90 is revised to read as follows:

§ 412.90 General rules.

(a) *Sole community hospitals.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

(b) *Referral center.* HCFA may make an adjustment to the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in § 412.96.

(c) *Christian Science Sanatoria.* HCFA adjusts the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital is a Christian Science sanatorium. Such a santorium's prospective payment rates are determined in accordance with § 412.98.

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* HCFA pays for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in § 412.100.

(e) *Hospitals that are located in urban areas and that are reclassified as rural.* HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals reclassified as rural, as defined in § 412.62(f). The criteria for this adjustment are set forth in § 412.102.

(f) *Hospitals that have a high percentage of ESRD beneficiary discharges.* HCFA makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) *Hospitals that incur indirect costs for graduate medical education programs.* HCFA makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, HCFA makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

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

3. In § 412.92, in paragraphs (b)(1)(iv) and (b)(1)(v), the phrase "will review" is revised to read "reviews"; in paragraph (b)(3), the phrase "will remain" is revised to read "remains"; in paragraph (b)(5), the phrase "will be" is revised to read "is"; and the heading of paragraph (d), and paragraphs (e)(3) introductory text and (e)(3)(i)(B) are revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.*

* * * * *

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease.*

* * * * *

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted propsective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under Subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) * * *

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

* * * * *

4. In § 412.96, the reference "§ 412.118(b)" in paragraph (b)(1) introductory text is revised to read "§ 412.105(b)"; the reference "§ 412.118" in paragraph (c)(1)(ii) is revised to read "§ 412.105"; and paragraph (d) is revised to read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(d) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with § 412.63, as adjusted by the hospital's area wage index.

* * * * *

5. In § 412.98, paragraphs (a) and (b) are revised to read as follows:

§ 412.98 Special treatment: Christian Science Sanatoria

(a) *General rule.* If a Christian Science Sanatorium is not excluded from the prospective payment systems under subpart B of this part, HCFA pays, for inpatient hospital services furnished to be beneficiary by that sanatorium, a predetermined fixed amount per discharge based on the sanatorium's historical inpatient operating costs per discharge.

(b) *Prospective payment rates.* For cost reporting periods beginning on or after October 1, 1983, the sanatorium's prospective payment rate for inpatient operating costs equals the amount that would constitute the sanatorium's target amount under § 413.40(c)(4) of this chapter if the institution were subject to the rate of increase ceiling specified in § 413.40 of this chapter instead of the propsective payment systems. This amount is not adjusted for the DRG weighting factor.

* * * * *

6. In § 412.100, paragraphs (a)(1) and (a)(2) are revised to read as follows:

§ 412.100 Special treatment: Renal transplantation centers.

(a) *Adjustments for renal transplantation centers.*

(1) HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§ 405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

* * * * *

§ 412.102 [Amended]

7. In the introductory text of § 412.102, the phrase "rural Federal payment amount" is revised to "rural Federal payment amount for operating costs".

§ 412.104 [Amended]

8. In § 412.104, in paragraph (a), the phrase "will provide" is revised to read "provides"; in the introductory text of paragraph (b) and in paragraph (b)(4) the phrase "will be" is revised to read "is"; and in paragraph (b)(5), the phrase "will be equal to" is revised to read "equals".

9. In § 412.105, the section heading and the introductory text to the section are revised; the introductory text of paragraph (a) is reprinted; and paragraphs (a)(2) and (e) are revised to read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

HCFA makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) *Basic data.* HCFA determines the following for each hospital:

* * * * *

(2) The hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs including outlier payments for inpatient operating costs determined under subpart F of this part, but excluding additional payments made under the provisions of this subpart.

* * * * *

(e) *Determination of payment amount.* Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.

* * * * *

10. In § 412.106, the reference "§ 412.118(b)" in paragraph (a)(1)(i) is revised to read "§ 412.105(b)"; the reference "§ 412.118" in paragraph (a)(2)(ii) is revised to read "412.105"; in paragraphs (d)(2)(i)(B)(*1*) and (*2*) the date "January 1, 1993" is revised to read "October 1, 1993"; and paragraphs (a)(2) and (d)(1) are revised to read as follows:

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

(a) *General considerations.*

* * * * *

(2) The payment adjustment is applied to the hospital's total DRG revenues for inpatient operating costs.

(i) A hospital's total DRG revenues for inpatient operating costs are determined on the basis of DRG-adjusted prospective payment rates for inpatient operating costs or, for transition period payments under subpart B of this part, on the basis of the Federal portion of the hospital's payment rates.

(ii) For purposes of this section, total DRG revenues for inpatient operating costs include outlier payments for inpatient operating costs under subpart F of this part, but exclude additional payments made under this subpart.

* * * * *

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

* * * * *

10. In § 412.108, paragraph (a)(1)(i) the reference "§ 412.118(b)" is revised to read "§ 412.105(b)"; in paragraph (d)(3)(i)(B) the term "reimbursed" is revised to read "paid"; and paragraphs (c) and (d)(3) introductory text are revised to read as follows:

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

* * * * *

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

* * * * *

(d) *Additional payments to hospitals experiencing a significant volume decrease.*

* * * * *

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under Subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indierect medical education costs as determinèd under § 412.105).

* * * * *

I. Subpart H is amended as follows:

1. The heading of subpart H is revised to read as follows:

Subpart H—Payments to Hospitals under the Prospective Payment Systems

§ 412.110 [Amended]

2. In § 412.110, the phrase "prospective payment system" is revised to read "prospective payment systems".

3. In § 412.112, the introductory text of the section and paragraph (a) are revised to read as follows:

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs for each discharge as determined in accordance with subparts D, E, and G of this part.

* * * * *

4. In § 412.113, paragraph (a)(2)(i) introductory text is republished and paragraph (a)(2)(i)(E) is revised to read as follows:

§ 412.113 Other payments.

(a) *Capital-related costs.** * *

(2) *Reduction to capital-related payments.* (i) Except for sole community hospitals as defined in § 412.92, the amount of capital-related payments for cost reporting periods beginning before October 1, 1991 (including a return on equity capital as provided under

§ 413.157 of this chapter) is reduced by—

* * * * *

(E) Ten percent for payments attributable to portions of cost-reporting periods occurring on or after October 1, 1991 and before the beginning of the hospital's first cost-reporting period beginning on or after October 1, 1991.

* * * * *

§ 412.115 [Amended]

5. In § 412.115, in paragraph (a), the phrase "An additional payment will be made" is revised to read "An additional payment is made".

§ 412.120 [Amended]

6. In § 412.120 in paragrpah (a), the phrase "payments otherwise payable to a hospital will be reduced" is revised to read "payments otherwise payable to a hospital are reduced"; and in the introductory text of paragraph (b) the phrase "the Medicare payment will be determined" is revised to read "the Medicare payment is determined".

§ 412.130 [Amended]

7. In § 412.130, in paragraphs (b)(1) and (b)(2), the phrase "prospective payment system" is revised to read "prospective payment systems".

J. Subpart K is amended as follows:

1. The heading of supart K is revised to read as follows:

Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

2. Section 412.200 is revised to read as follows:

§ 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for § 412.60, which deals with DRG classification and weighting factors, the provisions of subparts D and E of this part, which describe the methodology used to determine prospective payment rates for inpatient operating costs for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for inpatient operating costs for these hospitals is set forth in § 412.204 through 412.212.

3. Section 412.204 is revised to read as follows:

§ 412.204 Payments to hospitals located in Puerto Rico.

Payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(a) 75 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(b) 25 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

4. In § 412.208, paragraphs (a) and (b), and the heading of paragraph (h) are revised to read as follows:

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* HCFA determines the Puerto Rico adjusted DRG prospective payment for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system for inpatient operating costs, HCFA determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

* * * * *

(h) *Computing Puerto Rico rates established under the prospective payment system for inpatient operating costs for urban and rural hospitals.*

* * * * *

§ 412.210 [Amended]

5. In § 412.210, in paragraphs (a)(1), (b)(3) and the introductory text of paragraph (d), the phrase "for inpatient operating costs" is inserted after the phrase "prospective payment rate".

§ 412.212 [Amended]

6. In § 412.212, paragraph (a), the phrase "national prospective payment rate" is revised to read "national prospective payment rate for inpatient operating costs".

§ 412.220 [Amended]

7. In § 412.220, introductory text for the section, the phrase "prospective payment system," is revised to read "prospective payment system for inpatient operating costs."

Subpart L—The Medicare Geographic Classification Review Board

L. Subpart L is amended as follows:

1. Section 412.230 is amended as follows:

a. The heading is revised;

b. Paragraphs (a)(1) and (a)(3) are revised;

c. New paragraphs (a)(4)(v) and (a)(5) are added;

d. In the heading of paragraph (d) and in paragraphs (d)(1) and (d)(3) introductory text, the phrase "standardized amount" is revised to read "standardized amount for inpatient operating costs";

e. In paragraph (d)(3)(ii), the phrase "prospective payment sytem rates for inpatient hospital services" is revised to read "prospective payment rates for inpatient operating costs";

f. Paragraph (e)(1) is revised;

g. Paragraph (e)(2) introductory text is republished and paragraph (e)(2)(i) is revised;

h. Paragraph (e)(2)(ii) introductory text is republished and paragraph (e)(2)(ii)(A) is revised.

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General*—(1) *Purpose.* An individual hospital may seek redesignation from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, wage index value, or both. An individual hospital may not be redesignated to more than one area.

* * * * *

(3) *Proximity.* Except as provided in paragraph (a)(4) of this section, to be redesignated to another rural area or an urban area, a hospital must demonstrate a close proximity to the adjacent area to which it seeks redesignation by meeting the criteria in paragraph (b) of this section, and submitting data requested under paragraph (c) of this section.

(4) *Special rules for sole community hospitals and rural referral centers.*

* * * * *

(v) A hospital that applies for redesignation under this section may not also apply for redesignation in the same fiscal year under paragraph (a)(2) or (a)(3) of this section.

(5) *Application of criteria.* In applying the numeric criteria contained in §§ 412.230(b)(1) and (2), (d)(2), (e)(1)(iii), and (e)(1)(iv)(A) and (B), rounding of numbers to meet the mileage or

qualifying percentage standard is not permitted.

* * * * *

(e) *Use of urban or other rural area's wage index—*

(1) *Criteria for use of adjacent area's wage index.* To use an adjacent area's wage index, a hospital must demonstrate the following:

(i) The hospital's incurred wage costs are comparable to hospital wage costs in an adjacent urban or other rural area;

(ii) The hospital has the necessary geographic relationship as specified in paragraphs (a) and (b) of this section;

(iii) The hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; and

(iv) One of the following conditions apply:

(A) The hospital's average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the adjacent area to which it seeks redesignation; or

(B) The hospital's average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wage of hospitals in the adjacent area to which it seeks redesignation.

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate data as follows:

(i) For hospital-specific data, the hospital must provide data from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(ii) For data of other hospitals, the hospital must provide data concerning both of the following:

(A) The average hourly wage in the adjacent area, which is taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification and;

* * * * *

4. § 421.232, paragraph (c) is revised; paragraphs (d)(2) introductory text and (d)(2)(ii) are republished; and paragraphs (d)(2)(i) introductory text and (d)(2)(ii)(A) are revised to read as follows:

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

* * * * *

(c) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

* * * * *

(d) * * *

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For hospital-specific data, the hospitals must provide data from the HCFA wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(ii) For data for other hospitals, the hospitals must provide the following:

(A) The average hourly wage in the adjacent area, which is taken from the HCFA hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

* * * * *

5. In § 412.234, paragraph (b) is revised, and in the heading of paragraph (c) the phrase "inpatient operating costs" is inserted after the phrase "standardized amount" to read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

* * * * *

(b) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

* * * * *

6. In § 412.273, the introductory text of paragraph (a), paragraph (a)(1) and paragraph (b) are revised; and paragraph (c) is added to read as follows:

§ 412.273 Withdrawing an application.

(a) *Timing of a withdrawal.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application if the request for withdrawal is submittd to the MGCRB during the following time periods:

(1) At any time before the MGCRB issues a decision on the application; or

* * * * *

(b) *Written request only.* A request to withdraw an application must be made in writing to the MGCRB by all hospitals that are party to the application.

(c) *Appeal of the MGCRB's denial of a hospital's request for withdrawal.* (1) A hospital may appeal the MGCRB's denial of its request for withdrawal of an application to the Administrator within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

3. In § 412.278, paragraphs (f)(1) and (f)(3) are revised; a new heading for paragraph (f) and a new paragraph (g) are added to read as follows:

§ 412.278 Administrator's review.

* * * * *

(f) *Administrator's decision.* (1) The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and comments submitted under paragraphs (b)(2), (b)(3), (b)(4), (c)(2), and (c)(3) of this section.

* * * * *

(3) The Administrator's decision issued under §§ 412.278(a) or (c) is the final Departmental decision, unless it is amended under § 412.278 (g). The final Departmental decision is not subject to judicial review.

(g) *Amendment of Administrator decision.* (1) Hospital's request for amendment. The hospital may request the Administrator to amend the decision for the limited purpose of correcting mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The following procedure is followed:

(i) The hospital's request for amendment must be received by the Administrator within 10 days after the date the Administrator issues a decision. The request for amendment must be in writing, with a copy to HCFA.

(ii) The Administrator promptly reviews the hospital's request and amends the decision, if necessary, within 5 days following receipt of the hospital's request for amendment.

(2) *Discretionary review by the Administrator.* Within 15 days following the issuance of the Administrator's decision, the Administrator, at his or her discretion, may amend the decision to correct mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The Administrator's amended decision is final and is not subject to judicial review.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

M. Subpart M is amended as follows:

1. In §412.300, paragraph (b) is revised to read as follows:

§ 412.300 Scope of subpart and definition.

* * * * *

(b) *Definition.* For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years.

The following hospitals are not new hospitals:

(1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A hospital that closes and subsequently reopens.

(3) A hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.

(4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment system.

2. In § 412.302, the introductory text of paragraph (b) is revised; paragraphs (b)(3)(iii) and (b)(7) are added; paragraphs (c)(1)(ii), (c)(1)(iv), (c)(1)(v), (c)(1)(vii)(B) are revised; the introductory text of paragraph (c)(2)(i) is republished; and paragraph (c)(2)(i)(B) is revised to read as follows:

§ 412.302 Introduction to capital costs.

* * * * *

(b) *Old capital costs.* Except as provided in paragraph (c) of this section with respect to capital obligations that qualify for recognition as old capital, old capital costs are allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before December 31, 1990. However, for a new hospital as defined in § 412.300(b), old capital costs are defined as those allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period under § 412.328(a)(2). Old capital costs include the following:

* * * * *

(3) * * *

(iii) If an entire hospital is leased without assumption of the hospital's asset costs after December 31, 1990, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for old capital costs in the base year or the last cost reporting period these costs were recognized under this subpart, whichever is later.

* * * * *

(7) If a hospital had nonreimbursable costs applicable to an old capital asset as of December 31, 1990 that subsequently become allowable inpatient capital-related costs, the allowable costs for such an asset that are attributable to inpatient hospital services are recognized as old capital costs if a portion of the asset was in use for inpatient hospital care on December 31, 1990.

* * * * *

(c) *Obligated capital costs.* (1) * * *

(ii) *Moveable equipment.* Moveable equipment is recognized as old capital only if all of the conditions specified in paragraph (c)(1)(i)(B) through (D) of this section are met and one of the following conditions is met:

(A) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for the lease or purchase of the item of equipment on or before December 31, 1990.

(B) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for financing the acquisition of the equipment, on or before December 31, 1990; or before December 31, 1990; the item of equipment costs at least $100,000; and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990.

* * * * *

(iv) *Extension of deadline.* HCFA may extend the deadline in paragraph (c)(1)(i)(B) of this section, under which an asset must be put in use for patient care before October 1, 1994, to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

(A) The hospital must submit its request for an extended deadline with documentation of the extraordinary circumstances by the later of January 1, 1993 or within 180 days of the extraordinary circumstance.

(B) The intermediary reviews the request and verifies the hospital's documentation, and forwards the request to HCFA within 60 days. Within 90 days, HCFA notifies the intermediary of its decision and, if an extension is granted, of the revised deadline for putting the asset in use for patient care service.

(v) *Notification to intermediary.* The hospital must submit to its intermediary the binding agreement and supporting documents that relate to the obligated capital expenditure by the later of October 1, 1992 or within 90 days after the start of the hospital's first cost reporting period beginning on or after October 1, 1991.

* * * * *

(vii) *Determining old capital costs.*

* * * * *

(B) The intermediary advises the hospital of its determination within 12 months of the receipt of the hospital's notification under paragraph (c)(1)(v) of this section.

* * * * *

(2) *Lengthy certificate-of-need process.* (i) If a hospital does not meet the criteria under paragraph (c)(1)(i) or paragraph (c)(1)(ii) of this section, but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs:

* * * * *

(B) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990. If the hospital received conditional approval on or before September 30, 1990, the hospital's intermediary assesses the nature of the conditions. The hospital will be considered to have received approval for the project as of September 30, 1990 if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

* * * * *

In § 412.328, paragraph (a)(3) is added; paragraphs (b)(2), (b)(3), (c)(1), (f)(1)(i), and (f)(1)(iii) are revised; the introductory text of paragraph (f)(3) is republished; a new paragraph (f)(3)(iv) is added; paragraph (f)(4) is redesignated as paragraph (f)(5); and a new paragraph (f)(4) is added to read as follows:

§ 412.328 Determining and updating the hospital-specific rate.

(a) *Base-year cost reporting period.*

* * * * *

(3) *Other hospitals.* For other than a new hospital as defined in § 412.300(b), if a hospital does not have a 12-month cost reporting period ending on or

before December 31, 1990, the hospital-specific rate is based on the hospital's old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) *Base-year costs per discharge.*

* * * * *

(2) *Discharges.* For the purpose of determining a hospital's base period capital costs per discharge a discharge, includes discharges as defined in § 412.4(a) and transfers as defined in § 412.4(b)(2), adjusted by the transfer adjustment factor that is determined under paragraph (b)(3) of this section.

(3) *Transfer adjustment factor.* (i) For base year cost reporting periods ending on or before December 31, 1990, HCFA uses the base year MEDPAR data received as of June 30, 1991 to develop an adjustment to discharges to account for transfers. HCFA divides the length of stay for each transfer case by the geometric mean length of stay for the DRG (but in no case using a number greater than 1.0) and assigns each nontransfer case a value of 1.0. To determine the transfer adjustment factor, HCFA adds together the adjusted discharges and divides the result by total discharges including transfers.

(ii) For base year cost reporting periods ending after December 31, 1990 but beginning before October 1, 1991, HCFA determines a transfer adjustment factor as described in paragraph (b)(3)(i) of this section for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the approved base year.

(iii) For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer adjustment factor in place of HCFA as described in paragraph (b)(3)(i) of this section based on the most recent billing data available as of the date of the final determination of the hospital specific rate.

(c) *Case-mix adjustment*—(1) *Determining transfer-adjusted case mix value. Step 1:* For base year cost reporting periods ending on or before December 31, 1990, HCFA uses the base year MEDPAR data received as on June 30, 1991 to determine the hospital's transfer-adjusted case-mix value. For base year cost reporting periods ending after December 31, 1990 and beginning before October 1, 1991, HCFA determines a transfer-adjusted case-mix value for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the base year. For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer-adjusted case-mix value based on the most recent billing data available as of the date of the final determination of the hospital-specific rate. HCFA or the intermediary, as appropriate, multiplies the DRG weight for each case by one of the following factors:

* * * * *

(f) *Redetermination of hospital-specific rate—*

(1) *General.* (i) Upon request by a hospital, the intermediary redetermines the hospital-specific rate to reflect an increase in old capital costs as determined in a cost reporting period subsequent to the base year. An increase in Medicare old capital cost per discharge that is related solely to a decline in utilization is not recognized as an increase in old capital costs for purposes of this section. New capital costs are excluded from the redetermination of the hospital-specific rate.

* * * * *

(iii) The hospital must request a redetermination in writing no later than the date the cost report must be filed with the hospital's intermediary for the first cost reporting period beginning on or after October 1, 1991 or the cost reporting period that will serve as the new base period whichever is later. The hospital's redetermination request must include the cost report for the new base period and an estimate of the revised hospital-specific rate indicating that the new rate exceeds the hospital's current hospital-specific rate.

* * * * *

(3) *Redetermined hospital-specific rate.* The intermediary redetermines the hospital-specific rate based on the old capital costs that are determined under paragraph (f)(2) of this section for the new base period. The intermediary—

* * * * *

(iv) If the intermediary determines, after audit, that the requested redetermination will result in a lower hospital-specific rate, it advises the hospital of its determination and provides the hospital the opportunity to withdraw its request within 60 days of the intermediary notice.

(4) *Withdrawing a request.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital of its determination and promptly notifies the hospital that it may withdraw its request within 60 days of the intermediary notice.

* * * * *

4. A new § 412.331 is added to read as follows:

§ 412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *Hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under § 413.134(k) of this chapter, the intermediary determines a revised hospital-specific rate applicable to the combined facility under § 412.328, which is effective beginning with the date of merger or consolidation. The following rules apply to the revised hospital-specific rate and payment determination:

(1) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge weighted hospital-specific rate.

(2) *Payment determination.* The discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate to establish the appropriate payment methodology under § 412.336 and for payment purposes under §§ 412.340 or 412.344. The revised payment methodology is effective as of the date of merger or consolidation.

(3) *Old capital cost determination.* The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments.

(b) *Hospital dissolution.* If a hospital separates into two or more hospitals that are subject to capital payments under this subpart after the base year, the intermediary determines new hospital-specific rates for each separate hospital under the provisions of § 412.328 effective as of the date of the dissolution. The new hospital-specific rates are determined as follows:

(1) *Hospital-specific rate*—(i) *Adequate base year data.* The intermediary determines whether the base year capital-related cost data and necessary statistical records are adequate to reconstruct the cost and other data required under § 412.328 from the former hospital's financial records to determine the hospital-specific rates for each facility. If the data are adequate, the intermediary uses the former hospital's base period to determine the

hospital-specific rate for each separate hospital.

(ii) *Inadequate original base year data.* If the intermediary determines that the base period data for the former hospital is inadequate to establish separate hospital-specific rates, the intermediary establishes a new base period for each hospital. The new base period is each hospital's first 12-month or longer cost reporting periods covering at least 12 months) immediately following separation of the hospitals. The intermediary determines the hospital-specific rate for each hospital using the new base period under § 412.328.

(2) *Payment determinations.* The intermediary applies the payment methodology provisions of § 412.336. The revised payment determination is effective as of the date of the hospital's dissolution.

(3) *Old capital cost determination.* In determining the old capital costs for each hospital, the amount recognized as old capital is limited to the allowable capital-related costs attributable to assets that were in use for patient care as of December 31, 1990, and the hospitals are subject to all other transition period rules of this subpart.

5. Section 412.348(e)(2) is revised to read as follows:

§ 412.348 Exception payments during transition period.

* * * * *

(e) * * *

(2) A hospital must apply to its HCFA Regional Office by the later of October 1, 1992 or within 180 days of the extrordinary circumstance causing the unanticipated expenditures for a determination by the HCFA Administrator of whether the hospital is eligible for an additional payment based on the nature of the circumstances and the amount of financial loss documented by the hospital.

* * * * *

II. Part 413 is amended as follows:

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

Authority: Sections 1102, 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 13951(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Pub. L. 100–360 as amended by sec. 608(d)(3) of Pub. L. 100–485 (42 U.S.C. 1395ww (note)); and sec. 101(c) of Pub. L. 101–234 (42 U.S.C. 1395ww (note))

Subpart A—Introduction and General Rules

B. Subpart A is amended as follows:

1. In § 413.1, paragraph (d)(2) introductory text and paragraph (d)(2)(i) are revised to read as follows:

§ 413.1 Introduction.

* * * * *

(d) *Payment for inpatient hospital services.*

* * * * *

(2) Payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of hospital inpatient services for cost reporting periods beginning on or after October 1, 1983, and for inpatient services for capital-related costs for cost reporting periods beginning on or after October 1, 1991 are determined prospectively on a per discharge basis under part 412 of this chapter except as follows:

(i) Payment for capital-related costs for cost reporting periods beginning before October 1, 1991, medical education, and kidney acquisition costs, and the costs of certain anesthesia services, is described in § 412.113 of this chapter.

* * * * *

2. In § 413.5, the introductory text of paragraph (c) is revised to read as follows:

§ 413.5 Cost reimbursement: General.

* * * * *

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital (in the case of certain proprietary providers). With respect to allowable costs some items of inclusion and exclusion are:

* * * * *

Subpart B—Accounting Records and Reports

C. Subpart B is amended as follows:

§ 413.24 [Amended]

In § 413.24(f)(3)(iii), the term "prospective payment system" is revised to read "prospective payment systems".

Subpart C—Limits on Cost Reimbursement

D. Subpart C is amended as follows:

In § 413.40, paragraph (a)(2)(i) introductory text is republished; paragraphs (a)(2)(i)(B), (c)(2), (f)(1)(i), and (g)(3)(iii) are revised; and a sentence is added at the end of paragraph (b)(1) to read as follows:

§ 413.40 Ceiling on rate of hospital cost increases.

(a) * * *

(2) *Applicability.* (i) This section is not applicable to—

* * * * *

(B) Hospitals that are paid under the prospective payment systems for inpatient hospital services in accordance with section 1886(d) and (g) of the Act and part 412 of this chapter.

* * * * *

(b) *Cost reporting periods subject to the rate of increase ceiling.* (1) * * * When the operational structure of a hospital or distinct unit changes (that is, a freestanding rehabilitation hospital becomes a distinct-part unit or vice versa) the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.

(c) * * *

(2) *Cost determined on a per case basis.* Costs subject to the ceiling as described in paragraph (c)(1) of this section are determined on a per discharge basis. For purposes of this subpart, a patient is considered discharged on the earliest of the following dates:

(i) The date the patient has exhausted Medicare Part A inpatient hospital benefits (including the election to use lifetime reserve days) during his or her spell of illness.

(ii) The date the patient is formally released as specified in § 412.4(a)(1) of this chapter;

(iii) The date the patient is transferred to another facility.

(iv) The date the patient dies.

* * * * *

(f) *Exemptions—(1)* * * *

(i) *New hospitals.* A new hospital is exempt from the rate-of-increase ceiling imposed under this section. The exemption begins when the hospital accepts its first patient and ends at the end of the first cost reporting period ending at least two years after the hospital accepts its first patient. The first 12-month cost reporting period beginning at least one year after the hospital accepts its first patient is the base year in accordance with paragraph (b) of this section. For purposes of this section, a new hospital is a provider of hospital inpatient services that—

(A) Has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than two full years; and

(B) Has not previously provided the type of hospital inpatient services for

which HCFA granted it approval to participate in the Medicare program.

* * * * *

(g) *Adjustments*—

* * * * *

(3) * * *

(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 certain adjustments. These adjustments include, but are not limited to, adjustments under paragraphs (g)(3)(ii) (A), (B), (C), (E), and (F) of this section.

* * * * *

Subpart E—Payments to Providers

E. Subpart E is amended as follows:

§ 413.64 [Amended]

In § 413.64, in paragraphs (h)(1)(i) and (h)(1)(ii), the term "prospective payment system" is revised to read "prospective payment systems".

Subpart F—Specific Categories of Costs

F. Subpart F is amended as follows:

Section 413.86 is amended by adding paragraph (h)(6) to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(h) * * *

(6) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section. On or after July 1, 1993 only the results of steps I and II of the United States Medical Licensing Examination shall be accepted for purposes of making this determination.

* * * * *

Subpart G—Capital Related Costs

G. Subpart G is amended as follows:

§ 413.134 [Amended]

1. In § 413.134, in paragraph (f)(2)(iii)(D), the reference "§ 412.340(a)(2)" is revised to read "§ 412.344(a)(2)".

§ 413.157 [Amended]

2. In § 413.157, paragraph (c)(5) is removed.

(Catalog of Federal Domestic Assistance Program No. 93.733, Medicare—Hospital Insurance; No. 93.744, Medicare—Supplementary Medicare Insurance)

Dated: April 30, 1992.

William Toby,

Acting Administrator, Health Care Financing Administration.

Approved: May 22, 1992.

Louis W. Sullivan,

Secretary.

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

Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges On or After October 1, 1992 and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1992

I. Summary and Background

In this addendum, we are making changes in the amounts and factors for determining prospective payment rates for Medicare inpatient operating costs and Medicare inpatient capital-related costs. 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, 1992, 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, for cost reporting periods ending on or before March 31, 1993, 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 for Medicare inpatient operating costs. The changes, to be applied prospectively, will affect the calculation of the Federal rates. In section III we discuss changes we are making in the determination of the prospective payment rates for Medicare inpatient capital-related costs. Section IV 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 proposed rule are presented at the end of this addendum in section V.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 1993

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs 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, 1992. As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and weighting factors for discharges in FY 1993.

In summary, the proposed standardized amounts set forth in Tables 1a, 1b, and 1c of section V of this addendum were—

- Updated by 2.75 percent for urban hospitals (that is, the market basket percentage increase of 4.3 percent minus 1.55 percent); and 3.75 percent for rural hospitals (that is, the market basket percentage increase of 4.3 percent minus 0.55 percent);
- Adjusted by removing the FY 1992 outlier offsets and applying the revised urban and rural outlier offsets;
- Adjusted to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1992 budget neutrality factor and applying a revised factor; and
- Adjusted to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by removing the FY 1992 budget neutrality adjustment factors and applying revised budget neutrality adjustment factors to the urban and rural standardized amounts.

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 interm 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 required that Medicare target amounts be determined for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates (52 FR 33043, 33066).

The standardized amounts are based on per discharge averages of adjusted hospital costs 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 the cost data the affects 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 FY 1993 were made. That is, the standardization adjustments reflected in the FY 1993 standardized amounts are the same as those reflected in the FY 1992 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

Section 1886(d)(3) of the Act requires the Secretary to compute three average standardized amounts for discharges occurring in a fiscal year: One for hospitals located in rural areas; one for hospitals located in large urban areas; and one for hospitals located in other urban areas. In addition, under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge 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 1886(d)(2)(D) of the Act defines 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 population estimates published by the Bureau of the Census, the current 49 large urban areas continue to meet the criteria to be defined as large urban areas for FY 1993. These areas are identified by an asterisk in Tables 4a and 4c. No additional areas have been identified. Therefore, we are making no change in these areas for purposes of this proposed rule. If new population estimates are published by the Bureau of Census by June 30, 1992, we will include any resulting changes in the list of large urban areas in the final rule.

Table 1a contains the three national standardized amounts that would continue to be applicable to most hospitals. Table 1b sets forth the 27 regional standardized amounts that would 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 would be applicable to most hospitals in Puerto Rico.

The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to 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)(VIII) of the Act (as added by sections 4002 (a) and (c) of Public Law 101–508) specifies the following update factors for the standardized amounts for FY 1993:

- The market basket percentage increase minus 1.55 percentage points (that is, 2.75 percent) for hospitals located in urban areas.
- The market basket percentage increase minus 0.55 percentage points (that is, 3.75 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 FY 1993 is 4.3 percent.

Although the update factor for FY 1993 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, 1992 on our initial recommendation of update factors for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act), as well as our responses to ProPAC's recommendation concerning the update factor, is set forth as Appendix D to this proposed rule.

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 FY 1992 based on determinations by the Medicare Geographic Classification Review Board (MGCRB). 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. (See section I.A.1 of the preamble for a further explanation.)

Section 1886(d)(8)(D) of the Act specifies two budget neutrality objectives that must be met. First, the FY 1993 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. We note that some rural referral centers have been reclassified for purposes of the standardized amount. The budget neutrality adjustment for geographic reclassifications does not include the cost of paying the rural referral centers the other urban standardized amount since they are already paid on this basis. Rather, the budget neutrality adjustment includes only the difference between the payments to these hospitals after reclassification and payments as a rural referral center before reclassification (for example, higher disproportionate share payments or the difference between large urban and other urban rates, as applicable). Once the rural referral center triennial reviews are implemented beginning October 1, 1992 (see section V.B., above), it is likely that several of these hospitals will no longer be eligible for rural referral center status. At that point, it would be appropriate to include the cost of paying the hospitals the other urban standardized amount in the budget neutrality adjustment factor. Therefore, in calculating the final FY 1993 budget neutrality adjustment factor, we would identify those hospitals that are likely to lose their rural referral center status and determine the cost of paying them the urban standardized amount for the portion of FY 1993 that we estimate they would no longer qualify as a rural referral center. We would include this cost in the budget neutrality adjustment factor. The following adjustment factors, necessary to achieve the requisite budget neutrality constraints, were applied to the proposed standardized amounts:

Urban	Rural
.987245	.999457

The adjustment factors are applied to the standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment factors. We note that the proposed FY 1993 adjustments reflect wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 30, 1992. The effects of any additional reclassification changes resulting from appeals and review of the MGCRB's decisions for FY 1993 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act.

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 FY 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 II.C of the preamble, 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)(3)(E) of the Act that the updated wage index be implemented in a budget neutral manner, we compared aggregate payments using the FY 1992 relative weights and the wage index effective October 1, 1991 to aggregate payments using the proposed FY 1993 relative weights and wage index. The same methodology was used for the FY 1992 budget neutrality adjustment. (See the discussion in the August 30, 1991 final rule (56 FR 43246).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 1.000007. We applied this budget neutrality adjustment factor to the standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment.

In addition, we are proposing to continue to apply the same FY 1993 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1992, 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 the discussion in the September 4, 1990 final rule (55 FR 36073).)

c. *Retroactive Budget Neutrality Adjustment to Reflect FY 1992 Midyear Wage Index Corrections.* In the September 4, 1990 final rule (55 FR 36042), we set forth under § 412.63(l) (redesignated at § 412.63(p)) our policy for making mid-year 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 mid-year corrections are made under the provisions of § 412.63(l), 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) of the Act (to account for the effect on payments of the mid-year corrections), are not made until the beginning of the next fiscal year.

To account for the effect that mid-year corrections in the wage index for FY 1992 had on program payments for that year, we have computed a retroactive budget neutrality adjustment factor of .999586. This adjustment was computed by comparing FY 1992 aggregate

payments before the wage data corrections were made with aggregate payments after the revised wage index values were implemented. This adjustment has been applied to the FY 1993 standardized amounts after removing the effects of the FY 1992 budget neutrality adjustment for mid-year wage corrections.

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 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.

In the August 30, 1991 final rule, we set the outlier thresholds so as to result in estimated operating outlier payments equal to 5.1 percent of total operating 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 1992, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 32 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 $44,000 ($40,100 for hospitals that have not yet entered the prospective payment system for inpatient capital-related costs). The outlier adjustments for FY 1992 that were effective for discharges on or after October 1, 1991 were .944047 for the urban rates, .979202 for the rural rates, and .949722 for the capital Federal rate.

As discussed in section V.A of the preamble, we are proposing to establish outlier thresholds that would be applicable to both inpatient operating costs and inpatient capital-related costs. The proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1993 are as follows:

Urban standardized amount	Rural standardized amount	Capital federal rate
.944828	.978085	.9490

We would apply the proposed outlier adjustment factors after removing the effects of the FY 1992 outlier adjustment factors on the standardized amounts and the capital Federal rate.

We are proposing to continue to set the outlier thresholds so as to result in estimated outlier payments equal to 5.1 percent of total prospective payments. The model that we use to determine the outlier thresholds necessary to target our desired outlier payment percentage for FY 1993 uses the FY 1991 MEDPAR file and the most recent available information on hospital-specific payment parameters (such as the cost-to-charge ratios). This information is based on the December 31, 1991 update of the provider-specific file used in the PRICER program.

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 would be made by the intermediaries in determining the prospectus 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 prospectus 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 III of the preamble, 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 1993, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Table of cost-of-living adjustment factors, Alaska and Hawaii Hospitals

Alaska—All areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Weighting Factors

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed weighting factors for each DRG that are intended to reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs.

Table 5 of section V of this addendum contains the weighting factors that we propose to use for discharges occurring in FY 1993. These factors have been recalibrated as explained in section II.C of the preamble.

D. Calculation of Prospective Payment Rates for FY 1993

General Formula for Calculation of Prospective Payment Rates for FY 1993

Prospective payment rate for all hospitals located outside Puerto Rico except sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent, small rural hospitals = Federal rate.

Prospective payment rate for sole community hospitals and, for cost reporting periods ending on or before March 31, 1993, Medicare-dependent,

small rural hospitals = 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, 1992 and before October 1, 1993, except for sole community hospitals, Medicare-dependent, small rural hospitals (for cost reporting periods ending on or before March 31, 1993), 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. 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, 1992, rural hospitals in regions I, II, III, and IV and urban and large urban hospitals in regions 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 V 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 V of this addendum).

Step 3—For examples 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 V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community Hospitals)

Section 1886(d)(5)(D)(i) of the Act provides that 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 for cost reporting periods beginning or after April 1, 1990 and ending on or before March 31, 1993 using 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 1993 Cost Reporting Periods.* For cost reporting periods beginning on or after October 1, 1992, we are proposing to increase the hospital-specific rates by 4.3 percent (the hospital market basket percentage increase) for sole community hospitals located in all areas. The update, which is effective for cost reporting periods beginning in FY 1993, is not applicable to Medicare-dependent small rural hospitals since the provision ends with cost reporting periods ending after March 31, 1993.) Section 1886(b)(3)(C)(ii) of the Act (as amended by section 4002(c)(2)(A)(ii) of Pub. L. 101-508) provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(ii) of the Act, which, for cost reporting periods beginning in FY 1993, is the market basket rate of increase.

b. *Calculation of Hospital-Specific Rate.* For sole community hospital cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993, the applicable hospital-specific rate would be calculated by multiplying a hospital's hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 4.3 percent). In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 1.000007) as discussed in section II.A.4.b of this addendum. This resulting rate would be used in determining under which rate a sole community hospital is paid for its cost reporting period beginning on or after October 1, 1992, 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, 1992 and before October 1, 1993

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 V 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 V 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 weighing factor corresponding to the appropriate DRG weight (see Table 5, section V to 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 V 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 weighing factor corresponding to the appropriate DRG weight (see Table 5, section V 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. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1993

The prospective payment system for hospital inpatient capital-related costs was implemental for cost reporting periods beginning on or after October 1,

1991. Effective with that cost reporting period, hospital inpatient capital related costs are paid during a 10-year transition period extending through FY 2001 on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of the historical costs for capital as described below.

The basic methodology for determining Federal capital prospective rates is set forth at § § 412.308–412.352 of the regulations. Below we discuss the manner in which we propose to change the factors used for determining the Federal rate and the hospital-specific rate. The rate changes would be effective for discharges occurring on or after October 1, 1992.

The FY 1992 standard Federal payment rate for capital-related costs under the prospective payment system was computed by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per discharge. The standard Federal rate is updated each year for increases in capital-related costs as provided in § 412.308(c)(1). Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of total capital payments under the Federal rate. For FY 1992 through FY 2001, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated additional payments made for exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that estimated aggregate payments after any changes resulting from the annual DRG reclassification and the recalibration of DRG weights and in the geographic adjustment factor are budget neutral. For FY 1992 through FY 1995, § 412.352 requires that the Federal rate is also adjusted by a budget neutrality factor, so that estimated aggregate payments for inpatient hospital capital costs will equal 90 percent of the estimated payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year.

The hospital-specific rate for each hospital was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment reduction factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. The hospital-specific rate is updated each year for inflation and for changes in the exceptions payment adjustment factor and the budget neutrality adjustment factor.

To determine the appropriate budget neutrality adjustment factors and the exceptions reduction factor, we developed a dynamic model of Medicare inpatient capital- related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. The model and its application are more fully described in Appendix B.

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for inpatient operating costs, hospitals located in Puerto Rico are paid under a special payment formula. These hospitals are paid a blended rate that takes into account their geographical designation and is comprised of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals in the prospective payment system for inpatient capital-related costs. Accordingly, for capital-related costs we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national rate for capital-related costs. Hospitals in Puerto Rico are paid based on 75 percent of the Puerto Rico rate and 25 percent of the Federal rate.

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

1. Standard Federal Rate Update

Section 412.308(c)(1)(i) provides that for FY 1993 through FY 1995, the standard Federal rate is updated on the basis of a lagged two-year moving average of actual increases in Medicare inpatient capital-related costs per discharge. The two-year moving average is based on the actual increase, adjusted for case-mix index change, in Medicare inpatient capital-related costs per case for the fiscal years three and four years before the fiscal year in question. For FY 1993, the increase is based on the increase in Medicare inpatient capital-related costs per case between FY 1988 and FY 1990. These are the most recent fiscal years for which cost report data are available. To determine the amount of the increase, we apportioned a hospital's costs and discharges to each fiscal year based on the number of months in the hospital's cost reporting period that occurred during the applicable fiscal year. Thus, an individual hospital may have more than one cost report included in the calculation.

We are proposing that the FY 1993 update for the Federal rate will be 3.76%. The following chart shows how this figure was computed:

CAPITAL PER CASE INCREASE FROM COST REPORT DATA

FY	Number of cost reports	Average capital cost per case	Percent increase	Observed case mix increase (percent)	Adjustment to case mix increase (percent)
1988	6356	$485.75			
1989	6282	518.90	6.83	2.52	
1990	5155	547.23	5.46	0.85	1.22

FY	Adjusted case mix (percent)	Case mix adjusted increase	Average two year increase (percent)
1989	2.52	4.20	
1990	2.08	3.31	3.76

This computation was based on incomplete cost report data from FY 1990. As the above chart suggests, some hospital cost reports are not yet included in the Hospital Cost Report Information System (HCRIS). We expect

data from those cost reports to become available on HCRIS before we publish the final rule. We will therefore recalculate the FY 1993 update factor on the basis of complete FY 1990 cost report data for the final rule. We note that the proposed FY 1993 update factor is 2.21 percentage points lower than the update factor of 5.97 percent which we projected from the capital acquisitions model for FY 1993.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 20 percent for cost reporting periods beginning in FY 1993 for hospitals paid under the fully prospective methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments under the Federal rate for outlier cases, determined as a proportion of inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that 5.1 percent of estimated inpatient operating payments are paid as outlier payments. The inpatient capital-related outlier reduction factor is then set according to the estimated inpatient capital-related outlier payments that would be made if hospitals were all paid according to 100 percent of the Federal rate. It is appropriate, for purposes of calculating the outlier thresholds and the outlier reduction factor, to model all hospitals as if paid 100 percent of the Federal rate. This is because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

For FY 1992, we estimated that outlier payments would equal 5.03 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of .9497 to the Federal rate. Based on the proposed thresholds as set forth in section VI of the preamble, we estimate that outlier payments will equal 5.10 percent of inpatient capital-related payments based on the Federal rate in FY 1993. We are therefore proposing an outlier adjustment factor of 0.9490 to the Federal rate. The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore the net change in the outlier adjustment to the Federal rate for FY 1993 is 0.9490/.9497 or 0.9993. Thus, the higher outlier payment percentage will reduce the FY 1993 Federal rate by .07 percent (1—0.9993) compared with the FY 1992 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Weight and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that estimated aggregate payments for the fiscal year based on any changes resulting from the annual reclassification and recalibration of the DRG weights and in the geographic adjustment factor equal estimated aggregate payments that would have been made on the basis of the Federal rate without such changes. We used the actuarial model described in Appendix B to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the geographic adjustment factor. We also used the model to estimate aggregate payments that would have been made on the basis of the Federal rate as a result of those changes. We used these figures to compute the adjustment in DRG weights and in the geographic adjustment factor. For FY 1993, we are estimating that a budget neutrality factor of 0.9906 is necessary for this purpose. We note that this factor accounts only for changes due to DRG classification changes and recalibration and in the geographic adjustment factor. It does not account for changes in payments due to changes in the disproportionate share and indirect medical education adjustment factors. It incorporates the effects on the geographic adjustment factor of FY 1993 geographic reclassification decisions made by the MGCRB compared to FY 1992 decisions.

4. Budget Neutrality Factor to Assure Aggregate Payments Equal 90 Percent of Reasonable Cost Payments

As amended by section 4001(b) of Public Law 101–508, section 1886(g)(1)(A) of the Act requires that aggregate payments made each year in FY 1992 through FY 1995 for hospital inpatient services be reduced in a manner that results in savings equivalent to 10 percent of what HCFA estimates would have been payable on a reasonable cost basis for inpatient capital-related costs in that year. The Conference Committee report accompanying Public Law 101–508 indicated that, prior to the fiscal year, the Secretary may estimate the budget neutrality adjustment based on the best available information (H.R. Conf. Rep. No. 964, 101st Cong., 2nd Sess. 691 (1990)). In keeping with the legislation, no retroactive increase or decrease is made if aggregate payments are greater than or less than 90 percent of actual Medicare inpatient capital-related costs for that year.

Section 412.352 of the regulations provides that HCFA determines an adjustment to the hospital-specific rate and the Federal rate proportionately, so that the estimated payments for capital in each year from FY 1992 through FY 1995 will equal 90 percent of what would have been payable that year on a reasonable cost basis. The effect of this provision is that the savings required under section 1886(g)(1)(A) of the Act are realized entirely through a reduction in payment for capital costs in FY 1992 through FY 1995.

For FY 1992, we determined that a budget neutrality factor of 0.9602 was required, so that aggregate payments for inpatient capital-related costs would equal 90 percent of what would have been payable on a reasonable cost basis in that year. As we explain in Appendix B, there was practically no capital data available for use in setting the capital budget neutrality factor for FY 1992. We now have available some data that can be used directly in the determination of the budget neutrality factor. For FY 1993, we are using an actuarial model that integrates the available data with results from the FY 1992 capital acquisition model for items for which data are still missing. On the basis of the integrated model, we now estimate that capital-PPS payments for FY 1992 will equal approximately 92.09 percent of what we estimate would have been payable on a reasonable cost basis for inpatient capital-related costs in FY 1992. In other words, we now estimate that capital-PPS payments for FY 1992 will exceed the 90 percent budget neutrality target by approximately 2.09 percentage points.

We believe that there are at least two reasons for the difference between our estimate in the final rule for FY 1992 and the estimate based on the most recent data. One reason is that more hospitals appear to be qualifying as high cost hospitals receiving payment under the hold-harmless methodology than we originally estimated. In the preamble to the final rule, we estimated that 29 percent of hospitals subject to the capital-PPS system would qualify for hold-harmless payments. On the basis of the data now available, our actuarial

model estimates that about 36 percent of hospitals are qualifying for hold-harmless payments in FY 1992. Another reason is that exceptions payments appear to be higher than we previously estimated. On the basis of the data now available, the actuarial model estimates that more hospitals will receive exceptions payments, and that they will receive higher payments, than we anticipated on the basis of our original model simulations for FY 1992. Since the budget neutrality and exceptions reduction factors interact, the revised estimate of exceptions payments for FY 1992 has an effect on the determination of the budget neutrality factor.

While we do not retroactively adjust budget neutrality factors for previous years to account for revisions in our estimates, we do employ the information obtained through our monitoring efforts to refine the budget neutrality adjustment for subsequent years. Thus, we have used the most recently available data to establish the proposed budget neutrality adjustment for FY 1993. For FY 1993, we are proposing a budget neutrality factor of 0.9564 to realize the required expenditure level. The budget neutrality factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. The net adjustment to the FY 1993 Federal rate would therefore be .9564/.9602 or .9960. We will continue to integrate newly available data with the results from the model used in FY 1992, and we will recalculate the budget neutrality factor on the basis of all the data available at the time we publish the final rule.

5. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated additional payments for exceptions under § 412.348 determined as a proportion of total payments under the hospital-specific rate and Federal rate. The model developed for determining the budget neutrality adjustment factor is also used to estimate payments under the exceptions payment process and to determine the exceptions payment adjustment factor.

For FY 1992, we estimated that exceptions payments would equal 1.87 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of .9813 (1–0.0187) in determining the Federal rate. For FY 1993, we estimate that exceptions payments will equal 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we propose to apply an exceptions reduction factor of 0.9610 to determine the FY 1993 Federal rate. The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. The net adjustment to the FY 1993 Federal rate is therefore .9610/.9813, or .9793.

6. Standard Federal Rate for FY 1993

For FY 1992, the Federal rate was $415.59. With the changes we are proposing to the factors used to establish the Federal rate, we are proposing that the FY 1993 Federal rate will be $416.36. The changes are calculated as follows:

- The FY 1993 update factor would be 1.0376.
- The FY 1993 outlier adjustment factor would be 0.9490.
- The FY 1993 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the geographic adjustment factor would be 0.9906.
- The FY 1993 budget neutrality adjustment factor that is applied to the standard Federal payment rate and the hospital-specific rate to assure that aggregate payments equal 90 percent of payments that would have been made on a reasonable cost basis would be 0.9564.
- The FY 1993 exceptions payments adjustment factor would be 0.9610.

Since the Federal rate has 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, we propose to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factors for changes in the DRG relative weights and the geographic adjustment factor.

We are providing below a comparison of the proposed rate calculation that accounts for changes in the Federal rate from FY 1992. At each step, dollar amounts are shown to illustrate the cumulative effect on the Federal rate of each adjustment factor, and the difference in the effect of each adjustment factor between the final FY 1992 rate and the proposed rate for FY 1993. The cumulative percent change column shows the difference, to that point in the table, between the rate in FY 1992 and the proposed rate for FY 1993.

The 1993 update increases the Federal rate 3.76 percent compared to the rate in FY 1992 while the geographic and DRG budget neutrality factor decrease the Federal rate by 0.94 percent. The exceptions reduction factor decreases the proposed Federal rate by 2.07 percent compared to the exceptions reduction for FY 1992. The budget neutrality adjustment factor reduces the proposed FY 1993 rate by 0.40 percent compared to the budget neutrality reduction in FY 1992. The combined effect of all the proposed changes is to increase the proposed Federal rate by 0.19 percent compared to the Federal rate for FY 1992.

COMPARISON OF FEDERAL RATE CALCULATION FROM FY 92 FINAL RULE TO FY 93 PROPOSED RULE

	Cost per discharge	Percent change from FY 1992 rate	Cumulative percent change from FY 1992 rate
FY 89 cost per discharge	$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters	464.42		
93 update factor:			
FY 92	464.42		
FY 93: 1.0376	481.88	+3.76	+3.76
GAF/DRG budget neutrality factor:			
FY 92: 1.0000	464.42		
FY 93: 0.9906	477.35	−0.94	+2.78
Outlier reduction factor:			
FY 92: 0.9497	441.06		
FY 93: 0.9490	453.01	−0.07	+2.71

COMPARISON OF FEDERAL RATE CALCULATION FROM FY 92 FINAL RULE TO FY 93 PROPOSED RULE—Continued

	Cost per discharge	Percent change from FY 1992 rate	Cumulative percent change from FY 1992 rate
Exceptions reduction factor:			
FY 92: 0.9813	432.81		
FY 93: 0.9610	435.34	−2.07	+0.58
Budget neutrality reduction factor:			
FY 92: 0.9602	415.59		
FY 93: 0.9564	416.36	−0.40	+0.19
Net change:			
FY 92 rate	415.59		
FY 93 rate	416.36	+0.19	

We have refined our proposed budget neutrality and exceptions reduction factors for FY 1993 on the basis of the most recent data at our disposal. We have not retroactively adjusted the Federal rate for FY 1992 in determining the proposed rate for FY 1993. We are providing a chart that demonstrates how our proposed FY 1993 Federal rate differs from the projection we made when we published the final rule for the capital prospective payment system on August 30, 1991. At that time, we projected that the Federal rate for FY 1993 would be $430.17. This projection was based on an anticipated update factor of 1.0579, and expected exceptions reduction and budget neutrality factors of 0.9605 and 0.9582, respectively. Our proposed FY 1993 Federal rate of $416.36 is 3.21 percent lower than our August 1991 projection. As the chart shows, there are two major reasons for the difference between the projection and our current proposal. First, our projection did not include the budget neutrality factor for changes in DRG weights and in the geographic adjustment factor. Application of this factor in determining the proposed rate for FY 1993 accounts for a 0.94 percent reduction. The other reason is that the update factor used to compute the proposed rate is 2.21 percentage points lower than the update factor we used in our projection. This accounts for a 2.09 percent reduction in the proposed rate for FY 1993 compared with the projected rate. As we discuss in section III.A.1 of this Addendum, the update factor for FY 1993 is the average of the actual increases in Medicare inpatient capital-related costs per case between FY 1988 and FY 1990. The average capital cost per case for FY 1990 is lower than we originally anticipated. However, the FY 1990 average we have employed in developing the proposed FY 1993 Federal rate is based upon as yet incomplete cost report data for FY 1990. We expect to have complete FY 1990 cost report data available before we publish the final rule. We will therefore recalculate the FY 1993 update factor on the basis of complete FY 1990 data for the final rule. Also, we note that although the proposed Federal rate is only .19 percent higher than the FY 1992 rate, total payments per case under the capital prospective payment system are projected to increase 7.57 percent.

COMPARISON OF FEDERAL RATE CALCULATION AUGUST 1991 PROJECTION AND FY 1993 RATE

	Cost per discharge	Percent change from projected rate	Cumulative percent change from projected rate
FY 89 cost per discharge	$527.22		
FY 89 cost per discharge updated to FY 92, adjusted for transfers and payment parameters	464.42		
Update factor:			
Projection: 1.0597	492.15		
Proposed FY 1993: 1.0376	481.88	−2.09	−2.09
GAF/DRG budget neutrality adjustment factor:			
Projection: -----	492.15		
Proposed FY 1993: 0.9906	477.35	−0.94	−3.01
Outlier adjustment factor:			
Projection: 0.9497	467.39		
Proposed FY 1993: 0.9490	453.01	−0.07	−3.08
Exceptions reduction factor:			
Projection: 0.9605	448.93		
Proposed FY 1993: 0.9610	435.34	+0.05	−3.03
Budget neutrality factor:			
Projection: 0.9582	430.17		
Proposed FY 1993: 0.9564	416.36	−0.19	−3.21
Net change:			
Projected Federal Rate:	430.17		
FY 1993 Proposed Federal Rate:	416.36	−3.21	

7. Special Rate for Puerto Rico Hospitals

For FY 1992, the special rate for Puerto Rico hospitals was $319.68. With the changes we are proposing to the factors used to determine the rate, we are proposing that the FY 1993 special rate for Puerto Rico will be $320.27.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate each year be determined by adjusting

the FY 1992 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 1993, we are proposing that the hospital-specific rate be updated by a factor of 1.0376.

2. Exceptions Payment Adjustment Factor

For FY 1992 through FY 2001, the updated hospital-specific rate is reduced by an adjustment factor equal to the estimated additional payments for capital-related costs for exceptions under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 1993, we estimate that exceptions payments will be 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore propose that the updated hospital-specific rate be reduced by a factor of 0.9610. The exceptions reductions factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1993 hospital-specific rate is therefore .9610/.9813 or .9793.

3. Budget Neutrality Adjustment Factor

For FY 1992 through FY 1995, the updated hospital specific rate is adjusted by a budget neutrality adjustment factor determined under § 412.352 of the regulations so that estimated aggregate payments under the capital prospective payment system will equal 90 percent of what would have been payable on a reasonable cost basis. (The budget neutrality adjustment for changes in the DRG relative weights and in the geographic adjustment factor is not applied to the hospital-specific rate.) For FY 1993, we are proposing a budget neutrality factor of 0.9564. The budget neutrality factor is not built permanently into the rates; that is, the factor is not applied cumulatively in determining the hospital-specific rate. The net adjustment to the FY 1993 hospital-specific rate is therefore .9564/.9602 or .9960.

4. Net change to Hospital-Specific Rate

We are providing a chart below to show the proposed net change to the hospital-specific rate. The chart shows the factors for FY 1992 and FY 1993 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1992 to FY 1993 is 1.0121, which represents an increase of 1.21 percent to the hospital-specific rate. The proposed FY 1993 hospital-specific rate for each hospital can be determined by multiplying the FY 1992 hospital-specific rate by the cumulative net adjustment of 1.0121.

PROPOSED FY 1993 UPDATE AND ADJUSTMENTS TO HOSPITAL—SPECIFIC RATES

		Net adjustment	Percent change
Update factor:			
FY 92			
FY 93	1.0376	1.0376	+3.76
Exceptions payment adjustment factor:			
FY 92	0.9813		
FY 93	0.9610	0.9793	−2.07
Budget neutrality factor:			
FY 92	0.9602		
FY 93	0.9564	0.9960	−0.40
Cumulative adjustments:			
FY 92	0.9422		
FY 93	0.9537	1.0121	+1.21

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1993

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two alternative payment methodologies: The fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate is determined by adjusting:

- For outliers by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and,
- For the payment adjustment factors applicable to the hospital (that is, the hospital's geographic adjustment factor, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, where appropriate). If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor) × (Large Urban Add-on, if applicable) × (for hospitals located in Alaska and Hawaii, COLA adjustment) × (1 + Disproportionate Share Adjustment Factor + Indirect Medical Education Adjustment Factor, if applicable).

The result is termed the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total

Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost-reporting period beginning on or after October 1, 1993 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis throughout the transition period.

Payment for each discharge under the fully prospective methodology is the sum of:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 1993 are 20 percent of the adjusted Federal rate and 80 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that will be 20 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1993. Thus, a fully prospective hospital will receive 20 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1993. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The proposed rules to establish outlier thresholds for FY 1993 are published in section V.A of the preamble to this proposed rule. For FY 1993, we are proposing that a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the larger of 2.0 times the prospective payment rate for the case or $34,500. We are also proposing that a case qualifies as a day outlier for FY 1993 if the length of stay is greater than the geometric mean length of stay for the DRG plus the lesser of three standard deviations of the length of stay or 23 days.

During the capital prospective payment system transition period, any hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The minimum payment levels for portions of cost reporting periods occurring in FY 1993 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent and urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and,
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

New hospitals are exempted from the capital prospective payment system for their first two years of operation and are paid 85 percent of their reasonable costs during that period. As discussed in section VI.A. of the preamble, we are proposing to clarify that a new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even though the hold-harmless payments may extend beyond the normal transition period.

IV. Proposed 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.

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—

- Fifty percent of the difference between the inpatient operating cost per discharge and the target amount; or
- Five percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage. For cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993, 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 1993, the hospital's target amount for its reporting period that began in FY 1992 is increased by the market basket percentage increase for FY 1993. The most recent forecasted market basket increase for FY 1993 for hospitals and units excluded from the prospective payment system is 4.5 percent. Therefore, the applicable percentage increase is also 4.5 percent.

V. Tables

This section contains the tables referred to throughout the preamble to this proposed 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, 1d, 3C, 4a, 4b, 4c, 5, 6a, 6b, 6c, 6d, 6e, 6f, 6g, 6h, 7A, 7B, 8a, 8b, and 9 are presented below. The tables presented below are as follows:

Table 1a—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1b—Regional Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1c—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1d—Capital Standard Federal Payment Rate
Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1990
Table 4a—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4b—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4c—Wage Index and Capital Geographic Adjustment Factor (GAF) 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 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 91 MEDPAR Update 12/91 GROUPER V9.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 91 MEDPAR Update 12/91 GROUPER V10.0
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—1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban		Other urban		Rural	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2594.12	1068.75	2553.05	1051.84	2626.19	846.11

TABLE 1B.—REGIONAL ADJUSTED OPERATING 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)	2724.24	1116.00	2681.11	1098.33	2911.62	1004.15
2. Middle Atlantic (PA, NJ, NY)	2447.49	1057.28	2408.74	1040.54	2788.46	949.28
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2612.60	975.75	2571.24	960.30	2665.64	823.15
4. East North Central (IL, IN, MI, OH, WI)	2755.66	1154.48	2712.04	1136.20	2699.32	914.86
5. East South Central (AL, KY, MS, TN)	2507.38	883.52	2467.68	869.54	2641.93	767.60
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	2613.35	1051.92	2571.98	1035.27	2567.76	820.06
7. West South Central (AR, LA, OK, TX)	2598.31	969.14	257.17	953.80	2462.59	754.17
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2506.45	1038.08	2466.77	1021.65	2490.33	867.40
9. Pacific (AK, CA, HI, OR, WA)	2438.08	1,185.79	2399.49	1167.02	2422.06	977.17

TABLE 1C.—ADJUSTED OPERATING 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	2333.14	485.24	2296.20	477.56	1790.07	385.90
National	2587.30	1006.27				

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	416.36
Puerto Rico	320.27

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PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.2775	010065	01.2063	010130	01.1185	030012	01.2290	030086	01.1894
010004	00.9132	010066	00.9436	010131	01.2511	030013	01.2429	030087	01.6015
010005	01.1192	010068	01.2064	010134	00.8435	030014	01.4006	030088	01.2872
010006	01.3435	010069	01.1523	010136	00.9504	030016	01.2747	030089	01.2291
010007	01.1001	010072	01.1109	010137	01.2242	030017	01.3580	030091	00.8278
010008	01.0040	010073	00.8996	010138	00.9187	030018	01.5921	030092	01.4527
010009	01.0231	010078	01.1838	010139	01.5177	030019	01.2839	030093	01.2457
010010	01.1173	010079	01.1452	010143	01.1228	030022	01.3881	030094	01.2766
010011	01.3551	010080	00.9592	010144	01.3789	030023	01.2050	030898	00.5181
010012	01.1931	010081	01.8040	010145	01.2057	030024	01.6287	030899	00.5200
010015	01.0675	010083	01.0991	010146	01.0427	030025	01.0787	040001	01.0683
010016	01.0742	010084	01.2935	010148	00.9513	030027	01.0654	040002	01.1373
010018	00.9098	010085	01.2727	010149	01.3690	030030	01.6618	040003	01.0324
010019	01.1735	010086	00.9632	010150	01.0031	030033	01.3712	040004	01.2185
010020	01.0072	010087	01.5119	010152	01.2610	030034	01.0249	040005	01.0502
010021	01.2132	010089	01.0956	010153	00.9070	030035	01.2448	040007	01.5284
010022	00.9360	010090	01.4736	010155	01.1117	030036	01.2282	040008	01.0195
010023	01.2700	010091	01.0218	010898	00.5196	030037	01.8874	040010	01.1381
010024	01.2319	010092	01.3452	010899	00.5200	030038	01.4584	040011	00.9208
010025	01.2143	010094	01.1822	020001	01.4754	030040	00.9766	040013	00.9658
010027	00.8636	010095	01.0234	020002	01.1956	030041	00.9497	040014	01.1036
010029	01.4907	010096	00.9042	020004	01.0918	030043	01.1944	040015	01.0686
010031	01.2842	010097	01.0094	020005	00.9051	030044	01.1142	040016	01.4734
010032	00.8913	010098	01.0222	020006	01.0468	030046	00.9643	040017	01.2387
010033	01.9377	010099	01.0824	020007	00.8787	030047	00.9250	040018	01.2086
010034	01.0469	010100	01.1729	020008	01.0333	030049	00.9363	040019	01.1872
010035	01.1685	010101	01.0592	020009	00.8031	030051	01.0265	040020	01.4510
010036	01.1452	010102	00.9106	020010	00.9000	030054	00.9012	040021	01.2032
010038	01.2322	010103	01.5427	020011	00.9370	030055	01.1982	040022	01.6969
010039	01.5834	010104	01.5701	020012	01.1503	030059	01.3750	040024	01.0838
010040	01.2840	010108	01.1551	020013	00.8702	030060	01.1305	040025	00.9924
010043	00.9584	010109	01.0717	020014	00.9537	030061	01.4277	040026	01.4369
010044	00.9788	010110	00.9124	020017	01.3518	030062	01.2495	040027	01.2740
010045	01.0010	010112	01.1436	020018	00.8783	030064	01.5417	040028	00.9902
010046	01.3147	010113	01.5935	020019	00.9422	030065	01.4484	040029	01.0888
010047	00.9028	010114	01.1846	020021	00.9005	030067	01.0552	040030	00.9164
010049	01.0790	010115	00.8953	020024	01.0287	030068	01.0087	040031	00.9815
010050	00.9491	010117	01.1050	020025	01.0213	030069	01.2789	040032	00.9272
010051	00.8287	010118	01.1373	020026	01.2160	030071	00.9640	040035	00.9102
010052	00.9674	010119	01.1974	020027	00.8182	030072	00.8799	040036	01.2323
010053	01.0179	010120	00.9855	030001	01.3617	030073	01.0323	040037	01.1350
010054	01.1925	010121	01.1050	030002	01.7349	030074	01.0497	040039	01.0616
010055	01.3289	010122	00.9577	030003	01.3318	030075	00.9453	040040	00.9931
010056	01.2851	010123	01.2930	030004	00.9855	030076	01.0423	040041	01.1299
010057	01.0122	010124	01.2847	030006	01.5760	030078	01.0864	040042	01.3037
010058	00.9253	010125	01.0912	030007	01.2757	030079	00.7815	040044	00.9218
010059	00.9964	010126	01.0751	030008	01.8925	030080	01.5166	040045	00.9477
010061	00.9627	010127	01.5091	030009	01.2164	030083	01.3440	040047	01.0546
010062	00.9473	010128	00.8857	030010	01.4319	030084	01.1458	040048	01.2052
010064	01.6492	010129	01.0542	030011	01.3722	030085	01.3881	040050	01.1061

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 2 OF 3

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040051	01.0291	050009	01.6032	050075	01.2735	050137	01.2678	050212	01.1063
040053	01.0340	050013	02.1233	050076	01.4847	050138	01.7065	050213	01.3622
040054	00.9467	050014	01.0837	050077	01.6442	050139	01.2130	050214	01.5456
040055	01.3270	050015	01.4664	050078	01.3218	050140	01.2963	050215	01.4141
040058	00.9101	050016	01.1859	050079	01.5001	050143	01.4018	050217	01.2034
040060	00.9745	050017	02.0086	050080	01.2194	050144	01.4952	050219	01.3608
040062	01.3459	050018	01.2656	050081	01.6186	050145	01.2839	050220	01.2477
040063	01.4385	050019	00.8019	050082	01.4811	050146	01.3042	050222	01.5161
040064	00.9033	050021	01.2692	050084	01.4887	050147	00.7626	050224	01.6179
040066	01.0287	050022	01.5469	050087	01.7340	050148	01.1279	050225	01.3268
040067	01.0078	050024	01.3713	050088	01.1475	050149	01.3523	050226	01.4244
040069	01.0531	050025	01.6700	050089	01.3437	050150	01.2418	050228	01.2684
040070	00.9627	050026	01.4750	050090	01.2347	050152	01.3937	050230	01.3319
040071	01.4115	050028	01.2694	050091	01.2234	050153	01.6399	050231	01.4916
040072	01.0749	050029	01.3282	050092	00.9544	050154	01.2079	050232	01.8523
040074	01.1782	050030	01.2953	050093	01.5279	050155	01.0988	050233	01.2233
040075	01.1030	050032	01.2800	050095	01.8435	050158	01.6873	050234	01.2788
040076	01.0457	050033	01.3889	050096	01.0950	050159	01.3846	050235	01.4955
040077	00.9271	050034	01.3112	050097	01.4334	050161	01.5247	050236	01.3804
040078	01.2381	050036	01.7073	050099	01.6580	050166	01.0544	050238	01.5048
040080	01.0666	050038	01.4042	050100	01.8096	050167	01.3769	050239	01.4072
040081	00.8585	050039	01.6455	050101	01.3540	050168	01.6897	050240	01.4357
040082	01.2073	050040	01.1085	050102	01.2835	050169	01.4897	050241	01.2873
040084	01.1230	050041	01.2975	050103	01.4970	050170	01.3975	050242	01.3914
040085	01.1277	050042	01.2151	050104	01.3516	050172	01.3293	050243	01.4666
040088	01.2199	050043	01.5635	050107	01.3445	050173	01.2464	050245	01.4073
040090	00.9564	050045	01.2640	050108	01.4279	050174	01.5976	050248	01.1128
040091	01.1591	050046	01.1789	050109	02.0895	050175	01.4123	050251	01.1629
040093	01.0163	050047	01.6959	050110	01.1486	050177	01.2383	050254	01.1301
040095	00.8770	050049	01.5293	050111	01.2768	050179	01.2320	050256	01.6689
040100	01.1257	050051	01.1437	050112	01.4440	050180	01.4036	050257	01.1402
040105	01.0186	050053	01.2884	050113	01.1630	050181	01.2676	050258	01.2463
040106	01.1743	050054	01.2674	050114	01.4689	050183	01.1229	050260	00.9182
040107	01.0535	050055	01.2658	050115	01.4645	050186	01.3243	050261	01.1815
040109	01.1405	050056	01.3653	050116	01.4446	050188	01.3669	050262	01.7402
040114	01.7018	050057	01.4435	050117	01.3078	050189	00.9111	050263	01.2485
040115	01.0638	050058	01.4070	050118	01.1611	050191	01.3797	050264	01.4181
040116	01.3735	050060	01.4525	050121	01.2749	050192	01.1773	050267	01.5090
040118	01.1913	050061	01.2547	050122	01.4136	050193	01.3451	050269	01.0991
040119	01.1378	050063	01.3386	050124	01.2015	050194	01.3375	050270	01.3084
040122	01.0989	050065	01.5143	050125	01.2916	050195	01.5291	050272	01.3138
040124	01.0802	050066	01.2789	050126	01.3895	050196	01.2749	050274	00.9718
040126	00.9696	050067	01.2796	050127	01.2513	050197	01.9148	050276	01.1388
040132	01.4616	050068	01.1265	050128	01.4923	050199	01.2346	050277	01.4033
040898	00.5196	050069	01.5878	050129	01.5417	050201	00.9045	050278	01.4025
040899	00.5200	050070	01.1970	050131	01.2596	050204	01.4017	050279	01.2145
050002	01.2967	050071	01.3146	050132	01.3999	050205	01.2219	050280	01.4567
050006	01.2959	050072	01.2163	050133	01.1862	050207	01.2349	050281	01.2718
050007	01.4748	050073	01.2151	050135	01.3006	050208	01.1981	050282	01.2748
050008	01.3865	050074	01.0344	050136	01.2961	050211	01.3124	050283	01.4291

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050286	01.0244	050369	01.2706	050448	01.0819	050539	01.1954	050609	01.2933
050289	01.6764	050373	01.3800	050449	01.2931	050541	01.4811	050613	01.0819
050290	01.4731	050376	01.3023	050450	00.8056	050542	01.1247	050615	01.3968
050291	01.1747	050377	00.9904	050451	00.9648	050543	01.3982	050616	01.3301
050292	01.1348	050378	01.1644	050454	01.6526	050545	00.9304	050618	01.1719
050293	01.3058	050379	01.1386	050455	01.8496	050546	01.1350	050619	01.3693
050295	01.3292	050380	01.6015	050456	01.3863	050547	00.9116	050622	01.0777
050296	01.1106	050382	01.4337	050457	01.8000	050549	01.7832	050623	01.1558
050298	01.2188	050385	01.3214	050458	00.9333	050550	01.1040	050624	01.2654
050299	01.2423	050387	00.9417	050459	01.2557	050551	01.2649	050625	01.4642
050300	01.2945	050388	00.9504	050464	01.7938	050552	01.0653	050630	01.2453
050301	01.1870	050390	01.2280	050467	01.2370	050557	01.5074	050633	01.2234
050302	01.2706	050391	01.4178	050468	01.6302	050559	01.2590	050635	01.2962
050305	01.4602	050392	00.9559	050469	01.0978	050560	01.2621	050636	01.2819
050307	01.4068	050393	01.5017	050470	01.1291	050561	01.1587	050637	01.1627
050308	01.5480	050394	01.4718	050471	01.7540	050564	01.3160	050638	01.0131
050309	01.2966	050396	01.5810	050476	01.2644	050565	01.1196	050641	01.1309
050310	01.2352	050397	00.8738	050477	01.3904	050566	01.0216	050643	00.8934
050312	01.7651	050401	01.1898	050478	01.0005	050567	01.6121	050644	01.0971
050313	01.1686	050404	01.0481	050481	01.4764	050568	01.3153	050649	01.1482
050315	01.2833	050406	01.0903	050482	01.0299	050569	01.2062	050651	01.2751
050317	01.2069	050407	01.0341	050483	01.2493	050570	01.6957	050655	00.7803
050320	01.3202	050410	00.8314	050485	01.7390	050571	01.4054	050660	01.1220
050324	01.8365	050411	01.3054	050486	01.4141	050573	01.6318	050661	00.8980
050325	01.2841	050414	01.2608	050488	01.1990	050575	01.2308	050662	00.9940
050327	01.6173	050417	01.1647	050489	01.0803	050577	01.3060	050663	01.1048
050328	01.2477	050418	01.3164	050491	01.4395	050578	01.4097	050666	00.9618
050329	01.2414	050419	01.2788	050492	01.2545	050579	01.4477	050667	01.0151
050331	01.2894	050420	01.3644	050494	01.0906	050580	01.2579	050668	01.1684
050333	01.0028	050421	01.3308	050496	01.7941	050581	01.3583	050669	00.7493
050334	01.4687	050423	01.0499	050497	00.7612	050583	01.7159	050670	01.2287
050335	01.2418	050424	01.6884	050498	01.1462	050584	01.2776	050671	01.1525
050336	01.2370	050425	01.3100	050502	01.6770	050585	01.3653	050672	00.6859
050337	01.2174	050426	01.3732	050503	01.2981	050586	01.3371	050674	01.1831
050342	01.3071	050427	00.9738	050506	01.4730	050587	01.2359	050675	01.5231
050343	01.0348	050430	00.9661	050510	01.2897	050588	01.2718	050676	00.9970
050345	01.3605	050431	01.0448	050512	01.2454	050589	01.3564	050677	01.2951
050348	01.7029	050432	01.6131	050515	01.3163	050590	01.3075	050678	01.1900
050349	01.0077	050433	01.1511	050516	01.3388	050591	01.1238	050680	01.1784
050350	01.4095	050434	01.1019	050517	01.3989	050592	01.2864	050682	00.9421
050351	01.4804	050435	01.2896	050522	01.3364	050593	01.2619	050684	01.2152
050352	01.2587	050436	01.0104	050523	01.2422	050594	01.9607	050685	01.1468
050353	01.6574	050438	01.4773	050526	01.3684	050597	01.3571	050686	01.2813
050355	00.9837	050440	01.2045	050527	01.2051	050598	01.3543	050688	01.1468
050357	01.8126	050441	01.7390	050528	01.2075	050599	01.6492	050689	01.3497
050359	01.1197	050442	00.8510	050530	00.9026	050601	01.3017	050690	01.1960
050360	01.4326	050443	00.9028	050531	01.2815	050603	01.4267	050691	00.9533
050363	01.3267	050444	01.2352	050534	01.4063	050604	01.4106	050693	01.2499
050366	01.2918	050446	00.8811	050535	01.3038	050607	01.2276	050694	01.1491
050367	01.2376	050447	01.0390	050537	01.2255	050608	01.1783	050695	01.2229

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 4 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050696	01.7667	060062	00.9905	070028	01.4866	100021	01.3539	100079	01.1933
050898	00.5184	060063	01.1643	070029	01.2278	100022	01.6030	100080	01.5876
050899	00.5200	060064	01.3938	070030	01.2712	100023	01.3257	100081	01.0850
060001	01.4473	060065	01.3389	070031	01.3064	100024	01.2561	100082	01.3652
060003	01.2174	060066	00.9210	070033	01.3594	100025	01.5092	100083	01.3256
060004	01.0625	060068	01.1589	070034	01.2937	100026	01.4216	100084	01.3015
060005	01.7634	060070	01.1378	070035	01.3635	100027	00.8915	100085	01.3420
060006	01.1687	060071	01.0907	070036	01.3354	100028	01.2884	100086	01.2972
060007	01.1705	060072	00.9116	070038	00.6890	100029	01.3160	100087	01.7275
060008	01.0566	060073	01.0022	070898	00.5192	100030	01.2433	100088	01.5126
060009	01.3422	060074	00.8741	070899	00.5200	100032	01.7739	100089	01.2576
060010	01.5323	060075	01.2877	080001	01.5986	100034	01.6068	100090	01.3009
060011	01.2398	060076	01.3972	080002	01.1482	100035	01.4708	100092	01.3309
060012	01.4429	060085	00.8856	080003	01.2470	100038	01.6027	100093	01.5400
060013	01.1587	060087	01.4029	080004	01.2425	100039	01.6078	100098	01.0255
060014	01.6576	060088	01.1095	080005	01.1641	100040	01.6453	100099	01.2760
060015	01.4507	060090	00.9544	080006	01.1587	100042	01.2676	100100	01.2561
060016	01.1624	060096	01.0348	080007	01.2412	100043	01.3730	100102	01.2052
060018	01.1716	060100	01.3752	080898	00.5196	100044	01.4116	100103	01.0123
060020	01.4510	060101	01.3241	080899	00.5200	100045	01.3840	100105	01.3779
060022	01.5650	060102	04.0098	090001	01.4324	100046	01.3314	100106	01.1455
060023	01.4318	060103	01.3942	090002	01.1968	100047	01.5519	100107	01.2547
060024	01.5904	060104	01.2421	090003	01.4211	100048	00.9518	100108	01.1039
060026	01.3897	070001	01.7935	090004	01.5339	100049	01.3471	100109	01.2356
060027	01.4832	070002	01.7754	090005	01.2647	100050	01.2169	100110	01.3936
060028	01.3114	070003	01.1715	090006	01.3010	100051	01.2891	100112	00.9398
060029	01.0063	070004	01.1316	090007	01.2671	100052	01.3159	100113	01.9434
060030	01.3033	070005	01.2877	090008	01.3742	100053	01.2670	100114	01.4608
060031	01.4095	070006	01.2630	090009	01.2280	100054	01.3836	100117	01.2908
060032	01.3503	070007	01.3738	090010	00.9452	100055	01.3523	100118	01.1757
060033	01.1385	070008	01.2364	090011	01.8691	100056	01.5729	100121	01.1084
060034	01.3380	070009	01.2975	090898	00.5247	100057	01.3440	100122	01.3107
060036	01.1230	070010	01.4696	090899	00.5200	100059	01.5216	100124	01.3007
060037	01.0147	070011	01.1991	100001	01.3999	100060	01.7630	100125	01.1734
060038	01.1302	070012	01.2447	100002	01.4195	100061	01.4898	100126	01.4681
060041	01.0393	070013	01.3400	100004	01.0160	100062	01.6713	100127	01.5839
060042	00.9514	070014	01.2508	100005	00.9181	100063	01.3037	100128	02.2774
060043	00.9036	070015	01.2474	100006	01.6073	100065	01.2895	100129	01.3777
060044	01.2120	070016	01.2964	100007	01.8771	100067	01.3848	100130	01.1884
060046	01.1247	070017	01.2853	100008	01.7168	100068	01.4241	100131	01.2148
060047	01.1706	070018	01.3011	100009	01.4227	100069	01.3902	100132	01.2970
060049	01.0782	070019	01.1736	100010	01.3955	100070	01.3118	100134	00.9987
060050	01.2190	070020	01.3966	100012	01.5492	100071	01.3919	100135	01.5116
060052	01.0024	070021	01.2052	100014	01.3253	100072	01.1614	100137	01.1324
060053	01.0392	070022	01.6674	100015	01.4018	100073	01.8211	100138	00.9728
060054	01.3065	070023	01.2590	100016	01.0734	100074	01.2326	100139	01.0604
060056	00.9142	070024	01.1946	100017	01.6853	100075	01.7370	100140	01.1142
060057	01.0967	070025	01.6569	100018	01.3501	100076	01.2951	100142	01.1543
060058	00.8810	070026	01.2481	100019	01.4850	100077	01.3021	100143	01.2479
060060	01.0164	070027	01.2134	100020	01.3049	100078	01.1487	100144	01.2115

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100145	01.3976	100218	00.8935	100277	01.0002	110051	01.0654	110115	01.5804
100146	01.0737	100219	01.3945	100278	00.6969	110052	00.9595	110117	01.0814
100147	01.0807	100220	01.6886	100279	01.2692	110054	01.2231	110118	01.0345
100150	01.4351	100221	01.5400	100898	00.5185	110055	00.8784	110120	01.0454
100151	01.7286	100222	01.2188	100899	00.5200	110056	00.9984	110121	01.1181
100152	01.2548	100223	01.4274	110001	01.1514	110059	01.3499	110122	01.3054
100154	01.5992	100224	01.3180	110002	01.2126	110061	00.9985	110123	00.8407
100156	01.0467	100225	01.3578	110003	01.2787	110062	00.9273	110124	01.0725
100157	01.4911	100226	01.3231	110004	01.2388	110063	01.0321	110125	01.1430
100159	01.0496	100227	00.9950	110005	01.4177	110064	01.2389	110127	00.9568
100160	01.1839	100228	01.2705	110006	01.2823	110065	01.0074	110128	01.1580
100161	01.5007	100229	01.4521	110007	01.3635	110066	01.2479	110129	01.5818
100162	01.3001	100230	01.2808	110008	01.1223	110069	01.1940	110130	00.9843
100164	00.9880	100231	01.7172	110009	01.0997	110070	00.9516	110132	01.1278
100165	01.1703	100232	01.3095	110010	01.9836	110071	01.0340	110133	00.8938
100166	01.4899	100234	01.3452	110011	01.1478	110072	01.0001	110134	00.8857
100167	01.3349	100235	01.3245	110013	00.9991	110073	01.2378	110135	01.1668
100168	01.2989	100236	01.3256	110014	01.0282	110074	01.2521	110136	01.0652
100169	01.7901	100237	02.0925	110015	01.0553	110075	01.2141	110140	00.8749
100170	01.4164	100238	01.4005	110016	01.2323	110076	01.3575	110141	00.8966
100172	01.3735	100239	01.4278	110017	00.9219	110078	01.5955	110142	01.1064
100173	01.5659	100240	00.8747	110018	01.1568	110079	01.2925	110143	01.2768
100174	01.3582	100241	00.9983	110020	01.1523	110080	01.0696	110144	01.2225
100175	01.0843	100242	01.3139	110023	01.1944	110082	02.0548	110146	00.9286
100176	01.9514	100243	01.3886	110024	01.3733	110083	01.4758	110149	01.0948
100177	01.3284	100244	01.3431	110025	01.2896	110085	01.1683	110150	01.2360
100179	01.7186	100246	01.3684	110026	01.0925	110086	01.0764	110151	00.9851
100180	01.4036	100248	01.6913	110027	01.0390	110087	01.2570	110152	01.0209
100181	01.3168	100249	01.2949	110028	01.5457	110088	00.9019	110153	01.0076
100183	01.3387	100252	01.3774	110029	01.2975	110089	01.1032	110154	00.9383
100185	01.2200	100253	01.3636	110030	01.1894	110091	01.2712	110155	01.0529
100186	01.3615	100254	01.6109	110031	01.3160	110092	01.0649	110156	00.9185
100187	01.3159	100255	01.3767	110032	01.1149	110093	00.9367	110157	01.0762
100189	01.3613	100256	01.7268	110033	01.3365	110094	01.0202	110161	01.2659
100191	01.3664	100258	01.6919	110034	01.3826	110095	01.3300	110162	00.8024
100194	01.2544	100259	01.4074	110035	01.3233	110096	01.1470	110163	01.3459
100196	01.2477	100260	01.4020	110036	01.6187	110097	01.1070	110164	01.3095
100199	01.1715	100262	01.3357	110037	01.0781	110098	01.0151	110165	01.1870
100200	01.3521	100263	01.4525	110038	01.3267	110100	01.0974	110166	01.3463
100203	01.0816	100264	01.3878	110039	01.3182	110101	01.0193	110168	01.6421
100204	01.5665	100265	01.2780	110040	00.9111	110103	00.9414	110169	00.7656
100206	01.3603	100266	01.3124	110041	01.0631	110104	01.1317	110171	01.3361
100207	01.3851	100267	01.2256	110042	01.0593	110105	01.1648	110172	01.1566
100208	01.5129	100268	01.2607	110043	01.5546	110107	01.6075	110174	00.8708
100209	01.5320	100269	01.4203	110044	01.1330	110108	00.9009	110176	01.1209
100210	01.6637	100270	00.9083	110045	01.0170	110109	01.1164	110177	01.3922
100211	01.2674	100271	01.5639	110046	01.1779	110111	01.1600	110178	01.1896
100212	01.6383	100273	01.1320	110048	01.1276	110112	00.9343	110179	01.1987
100213	01.6177	100275	01.2894	110049	01.0904	110113	00.9223	110181	00.9519
100217	01.1787	100276	01.3800	110050	01.0831	110114	01.1558	110183	01.3344

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 6 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
110184	01.2003	130005	01.3730	140013	01.3847	140077	01.2273	140138	01.0748
110185	00.9921	130006	01.6776	140014	01.0454	140079	01.2482	140139	01.0728
110186	01.2747	130007	01.4902	140015	01.2315	140080	01.8216	140140	01.0426
110187	01.1391	130008	00.8848	140016	00.9992	140081	01.1374	140141	00.9698
110188	01.3436	130009	00.9932	140018	01.3817	140082	01.2590	140143	01.0528
110189	01.1006	130010	00.9362	140019	00.9139	140083	01.2650	140144	00.9633
110190	01.1052	130011	01.3106	140024	00.9709	140084	01.1859	140145	01.0480
110191	01.1501	130012	01.0191	140025	01.1061	140086	01.0968	140146	00.9265
110192	01.3316	130013	01.2650	140026	01.1448	140087	01.3291	140147	01.1786
110193	01.2024	130014	01.2539	140027	01.0764	140088	01.4716	140148	01.5280
110194	00.9175	130015	01.0129	140029	01.3221	140089	01.2468	140150	01.3500
110195	01.1101	130016	00.8789	140030	01.5148	140090	01.3547	140151	01.0620
110198	01.3031	130017	00.9921	140031	01.0301	140091	01.6510	140152	01.0214
110200	01.7448	130018	01.5557	140032	01.2728	140093	01.2369	140154	01.2605
110201	01.2760	130019	01.1236	140033	01.1999	140094	01.2425	140155	01.2017
110202	00.9783	130021	00.8857	140034	01.1019	140095	01.2257	140158	01.4258
110203	01.0440	130022	01.1573	140035	01.0121	140097	00.9048	140159	01.1728
110204	00.9001	130024	01.1213	140036	01.1263	140098	01.3902	140160	01.1383
110205	00.9699	130025	01.0614	140037	00.9639	140100	01.2560	140161	01.1267
110206	02.5579	130026	01.1397	140038	01.0459	140101	01.0441	140162	01.4821
110207	00.9171	130027	00.8704	140039	00.9937	140102	00.9953	140164	01.2575
110208	00.9302	130028	01.2769	140040	01.2346	140103	01.3222	140165	01.0683
110898	00.5196	130029	00.9896	140041	01.0551	140105	01.2932	140166	01.2615
110899	00.5200	130030	00.9719	140042	01.0330	140107	00.9112	140167	01.0718
120001	01.6744	130031	00.9746	140043	01.1795	140108	01.1909	140168	01.1887
120002	01.1395	130034	00.9033	140045	00.9506	140109	01.1301	140170	00.9658
120003	01.0859	130035	00.9414	140046	01.1915	140110	01.2297	140171	00.8721
120004	01.2360	130036	01.1817	140047	01.0355	140112	01.0422	140172	01.5130
120005	01.2139	130037	01.3858	140048	01.2248	140113	01.3763	140173	01.0039
120006	01.2061	130039	01.1447	140049	01.3639	140114	01.2527	140174	01.3784
120007	01.5725	130040	01.0515	140051	01.2854	140115	01.1906	140176	01.2093
120009	00.8843	130043	00.9901	140052	01.2107	140116	01.2328	140177	01.2467
120010	01.5601	130044	00.9167	140053	01.7314	140117	01.2833	140179	01.2840
120011	01.2146	130045	00.9461	140054	01.3480	140118	01.4737	140180	01.4660
120012	00.9295	130048	01.0410	140055	00.9674	140119	01.6353	140181	01.3033
120014	01.1543	130049	01.1747	140058	01.0839	140120	01.1694	140182	01.3101
120015	00.9384	130051	00.9799	140059	01.0949	140121	00.9718	140184	01.1422
120016	00.9362	130054	00.9280	140061	01.0748	140122	01.3824	140185	01.4099
120018	01.0064	130056	01.0417	140062	01.2415	140123	01.1906	140186	01.2111
120019	01.1990	130058	00.9293	140063	01.3225	140124	01.1130	140187	01.4419
120021	00.9305	140001	01.2689	140064	01.1511	140125	01.2390	140188	00.9627
120022	01.4982	140002	01.2618	140065	01.3256	140126	01.6426	140189	01.1626
120025	00.9026	140003	00.9576	140066	01.2128	140127	01.2685	140190	01.1883
120026	01.2761	140004	00.9865	140067	01.6926	140128	01.1235	140191	01.4355
120027	01.3496	140005	00.9421	140068	01.2049	140129	01.0379	140192	01.1390
120898	00.5183	140007	01.2627	140069	01.0681	140130	01.1289	140193	00.9868
120899	00.5200	140008	01.3957	140070	01.2140	140132	01.5673	140197	01.2873
130001	01.1231	140010	01.3454	140072	01.1220	140133	01.3392	140199	01.0066
130002	01.3127	140011	01.0797	140074	01.1306	140135	01.1999	140200	01.4280
130003	01.2337	140012	01.2217	140075	01.3858	140137	00.9743	140202	01.2196

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140203	01.1337	140898	00.5181	150053	01.0470	150112	01.1982	160040	01.3666
140205	00.9551	140899	00.5200	150054	01.0497	150113	01.2270	160041	01.1382
140206	01.1013	150001	01.0866	150056	01.6901	150114	01.0611	160043	00.9578
140207	01.2690	150002	01.3312	150057	02.2253	150115	01.2867	160044	01.2367
140208	01.4229	150003	01.6251	150058	01.5508	150122	01.0794	160045	01.6074
140209	01.5752	150004	01.3044	150059	01.2186	150123	00.9503	160046	01.0336
140210	01.0445	150005	01.2138	150060	01.1671	150124	01.1739	160047	01.4127
140211	01.1326	150006	01.2403	150061	01.1838	150125	01.3873	160048	01.0440
140212	01.2870	150007	01.1829	150062	01.0910	150126	01.5358	160049	00.8982
140213	01.1873	150008	01.3416	150063	01.1227	150127	01.1294	160050	01.0342
140215	01.0482	150009	01.2908	150064	01.0567	150128	01.1622	160051	01.2973
140217	01.2319	150010	01.1783	150065	01.1089	150129	01.2726	160052	00.9844
140218	00.9885	150011	01.2436	150066	01.1213	150130	01.1040	160054	01.0653
140220	01.1372	150012	01.5638	150067	01.0741	150132	01.3831	160055	01.0042
140223	01.5118	150013	01.2096	150069	01.2334	150133	01.2568	160056	01.0445
140224	01.3121	150014	01.3494	150070	01.0998	150134	01.1592	160057	01.3591
140226	00.9456	150015	01.2179	150071	01.1540	150135	00.8683	160058	01.6085
140228	01.5306	150017	01.6638	150072	01.2506	150136	01.0943	160059	01.2371
140229	00.9738	150018	01.2399	150073	01.0332	150898	00.5281	160060	01.0625
140230	00.9463	150019	01.1710	150074	01.4884	150899	00.5200	160061	00.9922
140231	01.5672	150020	01.1315	150075	01.2291	160001	01.1459	160062	00.9161
140233	01.6464	150021	01.6037	150076	01.0504	160002	01.2211	160063	01.1777
140234	01.1276	150022	01.1080	150077	01.1840	160003	01.0661	160064	01.5250
140236	00.9992	150023	01.3798	150078	01.0674	160005	01.0823	160065	01.1123
140239	01.5783	150024	01.1862	150079	01.1606	160007	00.9661	160066	01.0640
140240	01.2534	150025	01.5246	150082	01.3845	160008	01.0831	160067	01.2509
140242	01.4056	150026	01.1850	150084	01.6722	160009	01.1237	160068	01.0595
140245	01.0278	150027	00.9988	150085	00.9949	160012	01.1698	160069	01.3451
140246	01.0286	150029	01.2366	150086	01.2449	160013	01.2526	160070	01.1470
140250	01.2315	150030	01.1538	150088	01.1321	160014	00.9603	160071	01.1085
140251	01.2873	150031	01.0737	150089	01.2705	160016	01.2805	160072	01.0487
140252	01.2874	150032	01.6708	150090	01.2714	160018	00.9803	160073	00.9101
140253	01.2978	150033	01.5674	150091	01.2142	160020	01.0945	160074	01.0358
140258	01.3986	150034	01.2955	150092	01.1656	160021	01.1472	160075	01.0646
140271	01.0257	150035	01.4004	150094	01.0387	160023	01.0519	160076	00.9608
140275	01.1750	150036	00.9985	150095	01.1019	160024	01.4478	160077	01.1110
140276	02.0314	150037	01.2045	150096	00.9955	160025	01.8087	160079	01.2838
140280	01.1492	150038	01.2351	150097	01.0369	160026	01.0294	160080	01.1229
140281	01.5020	150039	00.9896	150098	01.0412	160027	01.1317	160081	01.0832
140285	01.2689	150042	01.1886	150099	01.2931	160028	01.2531	160082	01.6677
140286	01.1101	150043	01.0538	150100	01.5883	160029	01.4546	160083	01.5479
140288	01.5924	150044	01.2313	150101	01.0645	160030	01.3108	160085	01.1158
140289	01.2836	150045	01.1570	150102	01.1126	160031	01.0375	160086	01.0256
140290	01.3853	150046	01.4045	150103	01.1413	160032	01.0543	160088	01.0229
140291	01.2536	150047	01.6539	150104	01.1703	160033	01.3345	160089	01.2044
140292	01.1840	150048	01.1880	150105	01.1906	160034	01.0049	160090	01.0593
140294	01.0794	150049	01.0822	150106	01.0667	160035	00.9184	160091	01.1440
140295	03.2098	150050	01.1867	150109	01.2663	160036	01.0409	160092	00.9561
140297	01.4023	150051	01.2354	150110	00.8906	160037	01.0126	160093	01.1058
140299	00.8975	150052	01.0362	150111	01.0951	160039	01.0469	160094	01.1664

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 8 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160095	01.0190	170007	01.1100	170064	01.1682	170123	01.6619	180018	01.1547
160097	01.1524	170008	01.0001	170066	00.9297	170124	00.9698	180019	01.1754
160098	00.9580	170009	01.1566	170067	01.0338	170125	00.9370	180020	01.0113
160099	01.0951	170010	01.1290	170068	01.2346	170126	00.9533	180021	00.8962
160101	01.1564	170011	01.3507	170069	00.8681	170128	00.9943	180023	00.8405
160102	01.4309	170012	01.4250	170070	01.0500	170131	01.1240	180024	01.1986
160103	00.9021	170013	01.1995	170072	00.9415	170133	01.1704	180025	01.1341
160104	01.1303	170014	01.0569	170073	01.1247	170134	00.9724	180026	01.1069
160106	01.0243	170015	01.0876	170074	01.1620	170137	01.1588	180027	01.1579
160107	01.1143	170016	01.5492	170075	00.8509	170139	00.9596	180028	00.9895
160108	01.1360	170017	01.1652	170076	01.1261	170140	01.0344	180029	01.2787
160109	00.9435	170018	01.1002	170077	00.9625	170142	01.2568	180030	01.1421
160110	01.5132	170019	01.1755	170079	00.9817	170143	01.0926	180031	01.0028
160111	01.1020	170020	01.2224	170080	00.9468	170144	01.4924	180032	00.9845
160112	01.3806	170021	00.8705	170081	01.1629	170145	01.1424	180033	01.0804
160113	01.0430	170022	01.1900	170082	00.9078	170146	01.3142	180034	01.0138
160114	00.9986	170023	01.3026	170084	00.9100	170147	01.2109	180035	01.4403
160115	01.0069	170024	01.1041	170085	00.9514	170148	01.3324	180036	01.1042
160116	01.1581	170025	01.4256	170086	01.6350	170150	01.1269	180037	01.2745
160117	01.3205	170026	00.9911	170087	01.3417	170151	01.0010	180038	01.3231
160118	00.9801	170027	01.1585	170088	00.9295	170152	00.9193	180040	01.9484
160119	00.8656	170030	00.9718	170089	01.0006	170159	00.9105	180041	01.0778
160120	01.0034	170031	00.8776	170090	00.9957	170160	00.9690	180042	01.0364
160122	01.2228	170032	01.0526	170092	00.8563	170164	01.0938	180043	01.0120
160123	01.0963	170033	01.2046	170093	01.0164	170166	01.0144	180044	01.0752
160124	01.1753	170034	00.9560	170094	01.0047	170168	00.8770	180045	01.1536
160126	01.1345	170035	00.8789	170095	01.1818	170170	00.8537	180046	01.0595
160129	01.1714	170036	00.9473	170097	00.9439	170171	01.1421	180047	01.0280
160130	01.2586	170037	01.1591	170098	01.0287	170172	01.0228	180048	01.2029
160131	01.1591	170038	00.9980	170099	01.3981	170173	00.8276	180049	01.3388
160133	01.1978	170039	01.1149	170100	00.8458	170174	00.9455	180050	01.3006
160134	00.8912	170040	01.4044	170101	00.9893	170175	01.2206	180051	01.1949
160135	01.0161	170041	01.0247	170102	00.9798	170176	01.4126	180053	01.1655
160138	01.1636	170043	01.0621	170103	01.2120	170898	00.5196	180054	01.0952
160140	01.0666	170044	01.2601	170104	01.4366	170899	00.5200	180055	01.0618
160141	00.9225	170045	01.0048	170105	00.9795	180001	01.1551	180056	01.0465
160142	01.1504	170049	01.3084	170106	00.8874	180002	01.1152	180058	00.9059
160143	01.1120	170050	00.9449	170108	00.9018	180004	01.1859	180059	00.9006
160145	00.9883	170051	00.9698	170109	01.0129	180005	01.0705	180060	00.9007
160146	01.3139	170052	01.0973	170110	00.9777	180006	00.9389	180062	00.8038
160147	01.2251	170053	00.8526	170112	00.9233	180007	01.4146	180063	01.0271
160151	01.1450	170054	01.0881	170113	01.0559	180009	01.1756	180064	01.0549
160152	01.0275	170055	01.0842	170114	01.0692	180010	01.7058	180065	00.9945
160153	01.5606	170056	00.9901	170115	01.0858	180011	01.0951	180066	01.1690
160898	00.5196	170057	01.0262	170116	01.1130	180012	01.2606	180067	01.8854
160899	00.5200	170058	01.0342	170117	00.9549	180013	01.3258	180069	01.0757
170001	01.1790	170060	01.0250	170119	00.9609	180014	01.5681	180070	01.0676
170003	01.1970	170061	00.9598	170120	01.2157	180015	01.1107	180072	01.0910
170004	01.0552	170062	00.8460	170121	00.7845	180016	01.2027	180075	00.9465
170006	01.2423	170063	00.9227	170122	01.8009	180017	01.2178	180078	01.0110

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180079	01.0158	190009	01.0869	190098	01.3473	190175	01.8435	200026	00.9964
180080	01.1259	190010	00.9124	190099	01.1842	190176	01.4020	200027	01.0818
180081	01.3845	190011	01.0651	190102	01.4314	190177	01.4911	200028	01.0334
180085	01.3268	190013	01.2197	190103	00.9018	190178	00.9785	200031	01.2848
180087	00.9848	190014	00.9872	190106	01.1609	190182	01.0160	200032	01.2705
180088	01.6284	190015	01.1929	190109	01.0862	190183	01.0784	200033	01.6831
180092	01.1040	190017	01.2233	190110	00.9627	190184	00.9008	200034	01.1733
180093	01.3912	190018	01.1515	190111	01.5638	190185	01.2377	200037	01.1608
180094	00.9914	190019	01.4994	190112	01.2865	190186	00.9504	200038	00.9959
180095	00.9731	190020	01.1497	190113	01.2819	190187	00.6374	200039	01.3038
180099	00.9826	190023	00.6808	190114	00.9300	190189	01.0927	200040	01.0448
180101	01.2639	190025	01.2591	190115	01.2984	190190	00.9928	200041	01.1624
180102	01.3959	190026	01.3084	190116	01.2175	190191	01.2145	200043	00.6671
180103	01.7911	190027	01.3961	190118	00.9955	190193	01.1726	200044	01.1561
180104	01.3908	190029	01.2525	190120	00.8999	190194	01.1263	200050	01.1164
180105	00.9756	190033	00.9577	190122	01.1389	190196	00.8327	200051	00.9915
180106	00.9030	190034	01.2263	190124	01.4427	190197	01.1954	200052	01.0318
180108	00.9008	190035	01.3867	190125	01.3857	190198	01.1925	200055	01.0359
180115	00.9735	190036	01.6053	190127	01.4642	190199	01.2482	200062	00.9688
180116	01.2722	190037	00.9829	190128	00.8335	190200	01.5711	200063	01.2191
180117	01.2493	190039	01.4224	190130	00.9213	190201	01.2052	200066	01.1383
180118	01.0100	190040	01.3537	190131	01.2685	190202	01.4030	200898	00.5196
180120	00.9155	190041	01.5700	190132	01.0487	190203	01.6192	200899	00.5200
180121	01.0528	190043	01.0344	190133	01.0881	190204	01.4483	210001	01.3113
180122	00.9433	190044	01.0859	190134	00.9965	190205	01.3582	210002	01.8102
180123	01.4493	190045	01.2702	190135	01.3406	190206	01.4580	210003	01.3679
180124	01.3235	190046	01.4276	190136	01.0275	190207	01.1789	210004	01.2692
180125	01.0289	190047	01.1513	190138	00.7591	190208	00.8650	210005	01.2031
180126	01.0195	190048	00.9815	190140	00.9931	190211	00.9095	210006	01.0709
180127	01.1529	190049	00.9832	190142	00.9274	190212	00.8972	210007	01.4240
180128	01.1070	190050	01.0377	190144	01.1443	190213	00.7898	210008	01.2671
180129	01.0511	190053	01.0173	190145	00.9276	200001	01.3061	210009	01.6115
180130	01.3826	190054	01.3866	190146	01.4486	200002	01.0690	210010	01.1401
180132	01.3115	190059	00.9473	190147	00.9627	200003	01.0446	210011	01.2918
180133	01.2250	190060	01.2367	190148	00.9486	200006	01.0578	210012	01.4686
180134	01.0809	190064	01.4478	190149	00.9899	200007	01.0300	210013	01.2990
180136	01.2741	190065	01.4534	190151	01.0827	200008	01.2206	210015	01.2112
180137	01.7549	190071	00.8912	190152	01.4163	200009	01.6701	210016	01.7479
180138	01.2003	190075	01.4406	190155	00.9153	200012	01.1630	210017	01.1426
180139	01.0273	190077	00.8830	190156	00.8454	200013	01.1053	210018	01.2121
180898	00.5196	190078	01.1669	190158	01.2932	200015	01.2727	210019	01.3329
180899	00.5200	190079	01.2161	190160	01.1167	200016	01.0312	210021	01.2554
190001	00.8958	190081	00.8791	190161	00.8674	200017	01.3041	210022	01.3115
190002	01.5643	190083	00.8729	190162	01.2630	200018	01.1012	210023	01.2724
190003	01.3795	190086	01.2142	190164	01.0565	200019	01.2165	210024	01.2451
190004	01.1471	190088	01.3358	190165	01.0670	200020	01.0701	210025	01.2536
190005	01.3164	190089	01.0645	190166	01.0047	200021	01.1376	210026	01.3391
190006	01.0955	190090	01.1977	190167	01.2954	200023	00.7971	210027	01.1947
190007	01.0465	190092	01.1615	190170	01.0008	200024	01.1752	210028	01.0626
190008	01.4282	190095	01.0355	190173	01.4337	200025	01.1447	210029	01.3446

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 10 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
210030	01.0595	220036	01.4834	220105	01.1695	230032	01.6964	230104	01.5790
210031	01.4051	220038	01.2598	220106	01.1035	230034	01.1744	230105	01.4711
210032	01.1903	220041	01.1661	220107	01.1500	230035	01.1663	230106	01.1156
210033	01.1204	220042	01.1514	220108	01.1383	230036	01.2841	230107	01.0171
210034	01.1897	220045	01.1892	220110	01.9168	230037	01.2656	230108	01.1981
210035	01.1484	220046	01.3591	220111	01.1722	230038	01.5726	230110	01.2223
210036	01.2133	220048	01.1725	220114	01.0710	230039	01.2712	230111	01.0475
210037	01.1863	220049	01.1742	220115	01.2616	230040	01.3120	230113	01.0260
210038	01.3598	220050	00.9942	220116	01.7618	230041	01.1222	230114	00.7155
210039	01.2021	220051	01.2208	220118	01.9112	230042	01.0850	230115	01.0244
210040	01.3506	220052	01.2323	220119	01.3504	230046	01.7675	230116	00.9016
210043	01.1926	220053	01.2760	220120	00.9899	230047	01.2111	230117	01.7995
210044	01.1942	220055	01.1789	220123	00.9522	230053	01.4494	230118	01.2659
210045	00.9678	220057	01.1936	220126	01.2209	230054	01.6021	230119	01.1895
210046	01.1195	220058	01.0118	220128	01.1053	230055	01.1461	230120	01.0485
210048	01.1631	220060	01.1394	220131	01.1600	230056	00.9740	230121	01.1978
210049	01.1574	220062	00.6459	220133	00.8163	230058	01.1574	230122	01.3594
210051	01.2987	220063	01.1314	220135	01.1216	230059	01.4275	230124	01.1282
210054	01.2530	220064	01.1833	220153	01.0615	230060	01.1550	230125	01.3778
210055	01.1864	220065	01.1802	220154	00.9829	230062	01.1155	230128	01.3803
210056	01.3710	220066	01.2842	220156	01.2133	230063	01.2606	230129	01.8959
210057	01.2377	220067	01.2460	220162	01.4154	230065	01.4452	230130	01.5703
210058	01.7027	220068	00.6142	220163	01.9473	230066	01.3047	230132	01.3326
210059	01.3246	220070	01.1430	220171	01.6249	230068	01.3382	230133	01.1317
210060	01.0387	220071	01.8364	220173	00.4926	230069	01.0842	230134	01.3096
220001	01.1455	220073	01.2169	220175	01.0281	230070	01.3124	230135	01.2971
220002	01.3339	220074	01.1303	220897	05.1063	230071	00.6451	230137	01.0688
220003	01.1052	220075	00.7598	220898	00.5184	230072	01.1754	230138	00.8920
220004	01.3526	220076	01.1903	220899	00.5200	230075	01.3006	230140	01.5311
220006	01.2667	220077	01.5935	230001	01.1380	230076	01.2008	230141	01.5159
220008	01.1517	220079	01.1113	230002	01.2264	230077	02.1412	230142	01.2211
220010	01.1987	220080	01.1914	230003	01.1340	230078	01.3494	230143	01.2287
220011	01.1745	220081	00.9630	230004	01.6977	230080	01.2467	230144	01.2039
220012	01.1783	220082	01.2163	230005	01.2082	230081	01.1805	230145	01.1011
220015	01.1955	220083	01.1173	230006	00.9902	230082	01.1693	230146	01.2209
220016	01.1822	220084	01.1402	230007	01.0874	230085	01.1510	230147	01.5170
220017	01.2453	220086	01.5508	230012	00.7936	230086	00.9502	230149	01.0323
220019	01.0963	220088	01.4854	230013	01.2781	230087	01.1035	230150	01.5858
220020	01.1486	220089	01.2671	230014	00.9354	230089	01.3413	230151	01.3966
220021	01.2272	220090	01.1744	230015	01.3998	230090	01.1216	230153	01.0639
220023	01.2625	220092	01.1877	230017	01.5254	230092	01.2605	230154	01.1036
220024	01.1928	220094	01.2019	230019	01.5578	230093	01.1906	230155	01.0427
220025	01.0177	220095	01.1789	230020	01.5718	230095	01.1450	230156	01.6121
220026	01.2698	220097	01.0091	230021	01.5158	230096	01.0844	230157	01.3851
220028	01.3958	220098	01.2938	230022	01.2618	230097	01.5015	230159	01.3519
220029	01.1196	220099	01.1297	230024	01.4667	230098	00.7519	230162	00.9358
220030	01.0752	220100	01.2618	230027	01.0804	230099	01.2163	230165	01.7048
220031	01.7694	220101	01.3756	230029	01.4894	230100	01.1905	230167	01.1934
220033	01.2295	220102	00.7887	230030	01.1748	230101	01.0476	230169	01.3184
220035	01.1757	220104	01.2410	230031	01.3672	230103	01.0029	230171	01.1818

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230172	01.1439	230270	01.2648	240056	01.3087	240116	00.9400	240180	00.9663
230173	01.4271	230273	01.4985	240057	01.7572	240117	01.1206	240183	01.1108
230174	01.2172	230275	00.7450	240058	00.9789	240119	00.8942	240184	01.0688
230175	01.0197	230276	01.0169	240059	01.1062	240121	00.9326	240187	01.2038
230176	01.1364	230277	01.1445	240061	01.4214	240122	01.0927	240192	00.9223
230178	01.1632	230278	01.3676	240063	01.5106	240123	01.1280	240193	01.0907
230179	00.8224	230898	00.5183	240064	01.2170	240124	01.0059	240196	01.3415
230180	01.1261	230899	00.5200	240065	00.9885	240125	00.9411	240200	00.8882
230184	01.1551	240001	01.5525	240068	01.3442	240127	01.0744	240201	01.0099
230186	01.0102	240002	01.6772	240069	01.1868	240128	01.1689	240205	00.8630
230188	01.1156	240003	01.2518	240071	01.1145	240129	00.9582	240206	00.8691
230189	00.9079	240004	01.4701	240072	00.9980	240130	01.0139	240207	01.1578
230190	00.9770	240005	00.9336	240073	01.0056	240132	01.2876	240210	01.2426
230191	00.9704	240006	01.1714	240075	01.2335	240133	01.1273	240211	01.3121
230193	01.2994	240007	01.1036	240076	01.1225	240134	01.0280	240898	00.5196
230194	01.2165	240008	01.0298	240077	01.0165	240135	00.8382	240899	00.5200
230195	01.3589	240009	01.0648	240078	01.3835	240136	00.8750	250001	01.5232
230197	01.2297	240010	01.8442	240079	01.0763	240137	01.1870	250002	00.8101
230199	01.1807	240011	01.0432	240080	01.3625	240138	00.8505	250003	00.9667
230201	00.9735	240013	01.2242	240082	01.2115	240139	00.9802	250004	01.4368
230204	01.2494	240014	01.1907	240083	01.2346	240140	00.8291	250005	00.9593
230205	01.1088	240016	01.3556	240084	01.2279	240141	01.0038	250006	00.9742
230207	01.2858	240017	01.1897	240085	00.8600	240142	01.0587	250007	01.1598
230208	01.0809	240018	01.2133	240086	01.0710	240143	00.9457	250008	00.8814
230211	00.9529	240019	01.3203	240087	01.0587	240144	00.9873	250009	01.0987
230212	01.0931	240020	01.2205	240088	01.4423	240145	00.9044	250010	01.0838
230213	01.0755	240021	01.0521	240089	01.0096	240146	00.9948	250012	00.9682
230216	01.3168	240022	01.0970	240090	01.0258	240148	00.9883	250015	00.9488
230217	01.0783	240023	01.0387	240091	00.9892	240150	00.9497	250016	00.8825
230219	01.0066	240025	01.1940	240093	01.2884	240152	00.9568	250017	00.9838
230221	01.2415	240027	01.0591	240094	00.9901	240153	00.9823	250018	01.0221
230222	01.3525	240028	01.1189	240096	01.0569	240154	00.9760	250019	01.2674
230223	01.2882	240029	01.1722	240097	01.0456	240155	00.9647	250020	01.0198
230227	01.3220	240030	01.3210	240098	00.9286	240156	01.0383	250021	00.8865
230228	01.1907	240031	00.9693	240099	00.9673	240157	01.0822	250023	00.8288
230230	01.3387	240036	01.4856	240100	01.3045	240158	00.9253	250024	00.9312
230232	01.0412	240037	01.0452	240101	01.2128	240160	00.9687	250025	01.0173
230235	00.9852	240038	01.4651	240102	01.0642	240161	00.9851	250027	00.9818
230236	01.3334	240040	01.2753	240103	01.1615	240162	01.0599	250029	00.9028
230237	01.0843	240041	01.2215	240104	01.2225	240163	00.9641	250030	00.8954
230239	01.1589	240043	01.1198	240105	00.8978	240166	01.1833	250031	01.2566
230241	01.2039	240044	01.1645	240106	01.3231	240167	00.8225	250032	01.2148
230244	01.3639	240045	01.1042	240107	00.9717	240169	00.9676	250033	01.0404
230253	01.1020	240047	01.3852	240108	00.9372	240170	01.0514	250034	01.4456
230254	01.2612	240048	01.2586	240109	00.9743	240171	01.0979	250035	00.8393
230257	00.9134	240049	01.6408	240110	01.0183	240172	01.0974	250036	00.9640
230259	01.0826	240050	01.1178	240111	01.0075	240173	00.9721	250037	00.8906
230264	01.3921	240051	00.8773	240112	01.0110	240175	00.8058	250038	00.9200
230266	01.2378	240052	01.2165	240114	01.0988	240176	00.8777	250039	01.0136
230269	01.2346	240053	01.4558	240115	01.5158	240179	00.9654	250040	01.2040

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 12 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
250042	01.1247	250107	00.9221	260025	01.3034	260094	01.0703	260180	01.5535
250043	00.8894	250109	00.9893	260026	00.9651	260095	01.3633	260182	01.0287
250044	01.0552	250112	00.9511	260027	01.5425	260096	01.4339	260183	01.4370
250045	01.1668	250113	00.9415	260029	01.1546	260097	01.2057	260186	01.1359
250046	01.0486	250117	01.0837	260030	01.1216	260100	01.1322	260188	01.1762
250047	00.9340	250119	00.9708	260031	01.4522	260102	00.9714	260189	00.9424
250048	01.3314	250120	01.0690	260032	01.6089	260103	01.3151	260190	01.1465
250049	00.9234	250122	01.2673	260033	01.2708	260104	01.5977	260191	01.2650
250050	01.1677	250123	01.1464	260034	01.0357	260105	01.9034	260193	01.1966
250051	00.8826	250124	00.8807	260035	01.0585	260107	01.3031	260195	01.1117
250057	01.0908	250125	01.2574	260036	01.0804	260108	01.6492	260197	01.2138
250058	01.1705	250126	00.9941	260037	01.2423	260109	00.9966	260198	01.2956
250059	01.0072	250127	00.8579	260039	01.2908	260110	01.6325	260200	01.1599
250060	00.7996	250128	00.9747	260040	01.4929	260111	00.9736	260202	01.3720
250061	00.9222	250129	01.1868	260042	01.1057	260112	01.4293	260898	00.5196
250062	00.9936	250131	00.9698	260044	01.0713	260113	01.1681	260899	00.5200
250063	00.8533	250134	00.9456	260047	01.3360	260115	01.0318	270002	01.2270
250065	00.9489	250136	00.7368	260048	01.3619	260116	01.2017	270003	01.2098
250066	00.9400	250137	00.9566	260049	00.9763	260119	01.1452	270004	01.6612
250067	01.0130	250138	01.3143	260050	01.0855	260120	01.1723	270006	00.8631
250068	00.8491	250139	00.9025	260051	01.2067	260122	01.2244	270007	00.9652
250069	01.2286	250140	00.8086	260052	01.1861	260123	00.9744	270009	01.0743
250071	01.0417	250141	01.1842	260053	01.0727	260127	01.1439	270011	01.1330
250072	01.2247	250142	00.7975	260054	01.3405	260128	01.0267	270012	01.3864
250073	00.9908	250143	00.9179	260055	01.1987	260129	01.0761	270013	01.2741
250076	00.9144	250898	00.5196	260057	01.1632	260131	01.3532	270014	01.6195
250077	00.9350	250899	00.5200	260059	01.0663	260134	01.2830	270016	00.8960
250078	01.3812	260001	01.5577	260061	01.1121	260137	01.2215	270017	01.1889
250079	00.8564	260002	01.3321	260062	01.1662	260138	01.7838	270019	00.9810
250081	01.2362	260003	00.9550	260063	01.1717	260141	02.0284	270021	01.0869
250082	01.2527	260004	01.0372	260064	01.3788	260142	01.2001	270023	01.3086
250083	00.8969	260005	01.3762	260065	01.6091	260143	01.1463	270024	01.0474
250084	01.1993	260006	01.3910	260066	01.0367	260146	01.3530	270026	00.9351
250085	01.0011	260007	01.2516	260067	00.9155	260147	01.0368	270027	01.0342
250086	00.9265	260008	01.1950	260068	01.7711	260148	01.0130	270028	01.0321
250088	01.0125	260009	01.2595	260070	01.0646	260158	01.1349	270029	01.0902
250089	00.9991	260011	01.5395	260073	00.9690	260159	01.1081	270030	00.9306
250091	01.0209	260012	01.0014	260074	01.1946	260160	01.1247	270031	00.8980
250093	01.1545	260013	01.1559	260077	01.3789	260162	00.9993	270032	01.1308
250094	01.2687	260014	01.6183	260078	01.1076	260163	01.2092	270033	00.8281
250095	01.0474	260015	01.1773	260079	01.0051	260164	01.0634	270035	01.0465
250096	01.2004	260016	01.2397	260080	01.1189	260165	00.9847	270036	00.9939
250097	01.1793	260017	01.2127	260081	01.4034	260166	01.2306	270039	00.9223
250098	00.8454	260018	00.9508	260082	01.1552	260172	01.0171	270040	01.0091
250099	01.2073	260019	01.0171	260085	01.4329	260173	01.0752	270041	00.9219
250100	01.1534	260020	01.6072	260086	01.0521	260175	01.1399	270044	01.1112
250101	00.8876	260021	01.2811	260089	01.0811	260176	01.4735	270046	00.9506
250102	01.4386	260022	01.3859	260090	01.4633	260177	01.3011	270047	00.9894
250104	01.3161	260023	01.2742	260091	01.5472	260178	01.4137	270048	01.1184
250105	00.9118	260024	01.0645	260092	01.1313	260179	01.5396	270049	01.5723

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
270050	01.0273	280035	00.9089	280101	01.1410	300012	01.2570	310038	01.6843
270051	01.1926	280037	00.9509	280102	00.8717	300013	01.1550	310039	01.2894
270052	01.0362	280038	01.0367	280104	00.9342	300014	01.3527	310040	01.2168
270053	00.9047	280039	01.0744	280105	01.2156	300015	01.0436	310041	01.2510
270055	00.6659	280040	01.5595	280106	01.0083	300016	01.2320	310042	01.1616
270057	01.1058	280041	00.9190	280107	01.0819	300017	01.2088	310043	01.2161
270058	00.9452	280042	00.9747	280108	01.0518	300018	01.2214	310044	01.2521
270059	00.8462	280043	01.1654	280109	00.8804	300019	01.2676	310045	01.2755
270060	00.9531	280045	01.1419	280110	01.0000	300020	01.1544	310047	01.2516
270063	00.8769	280046	01.0118	280111	01.2032	300021	01.1592	310048	01.2203
270067	00.9483	280047	01.1742	280114	00.9031	300022	01.1210	310049	01.2629
270068	00.8818	280048	01.0600	280115	00.9720	300023	01.2302	310050	01.1893
270072	00.8396	280049	01.0295	280117	01.0834	300024	01.2501	310051	01.2856
270073	01.2127	280050	00.9943	280118	01.0149	300028	01.1837	310052	01.1775
270074	00.8435	280051	00.9726	280119	00.9112	300029	01.2917	310054	01.2728
270075	00.9801	280052	01.0246	280123	00.9142	300033	01.0722	310056	01.1821
270076	00.8445	280054	01.1529	280898	00.5196	300034	01.7367	310057	01.2180
270079	00.9275	280055	00.9712	280899	00.5200	300898	00.5184	310058	01.1870
270080	01.1140	280056	00.9864	290001	01.5986	300899	00.5200	310060	01.1997
270081	00.9450	280057	01.0220	290002	00.9212	310001	01.6470	310061	01.1438
270082	00.9089	280058	01.2269	290003	01.6323	310002	01.8101	310062	01.1324
270083	00.9860	280060	01.4556	290005	01.1866	310003	01.2132	310063	01.3011
270084	00.9454	280061	01.2919	290006	01.0913	310005	01.2349	310064	01.2180
270898	00.5196	280062	01.1201	290007	01.6965	310006	01.1505	310067	01.2214
270899	00.5200	280064	01.0728	290008	01.2587	310008	01.3104	310069	01.1427
280001	01.1190	280065	01.1489	290009	01.5486	310009	01.1767	310070	01.2537
280003	01.8229	280066	01.1383	290010	01.0460	310010	01.2271	310071	00.7389
280005	01.4465	280068	00.9241	290011	01.0057	310011	01.2111	310072	01.2944
280009	01.4844	280070	00.9732	290012	01.3113	310012	01.5171	310073	01.4065
280011	00.9785	280073	00.9619	290013	01.0262	310013	01.2608	310074	01.3116
280012	01.1932	280074	01.1614	290014	00.9873	310014	01.5553	310075	01.2311
280013	01.8684	280075	01.2969	290015	01.0883	310015	01.5652	310076	01.3200
280014	00.9879	280076	00.9738	290016	01.1385	310016	01.2372	310077	01.5553
280015	01.0124	280077	01.2694	290018	01.0100	310017	01.3242	310078	01.2838
280017	01.1679	280078	00.9470	290019	01.2020	310018	01.2066	310081	01.1943
280018	00.9331	280079	00.9695	290020	01.0154	310019	01.6371	310083	01.2864
280020	01.4313	280080	01.0701	290021	01.5421	310020	01.1915	310084	01.2258
280021	01.1310	280081	01.4459	290022	01.6838	310021	01.2565	310085	01.2156
280022	01.0302	280082	01.5157	290027	00.9537	310022	01.2040	310086	01.1730
280023	01.3601	280083	00.9744	290029	00.8077	310024	01.2143	310087	01.1772
280024	00.8327	280084	00.9565	290032	01.4516	310025	01.1681	310088	01.2537
280025	00.9912	280085	00.9390	300001	01.2916	310026	01.2210	310090	01.2506
280026	01.0498	280088	01.6279	300003	01.8715	310027	01.2737	310091	01.2295
280028	00.8837	280089	01.0383	300005	01.3500	310028	01.1943	310092	01.3354
280029	00.9921	280090	00.9305	300006	01.1124	310029	01.8039	310093	01.0835
280030	01.7687	280091	01.0150	300007	01.0971	310031	02.7260	310096	01.7146
280031	01.1181	280092	01.0050	300008	01.2337	310032	01.2523	310105	01.0982
280032	01.1713	280094	01.1244	300009	01.2216	310034	01.1488	310108	01.3596
280033	00.9317	280097	00.8690	300010	01.2422	310036	01.1980	310110	01.2075
280034	01.2760	280098	01.0111	300011	01.2197	310037	01.2095	310111	01.2361

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 14 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
310112	01.2250	320072	00.9134	330058	01.3208	330135	01.1965	330204	01.2380
310113	01.2184	320074	01.0652	330059	01.4801	330136	01.2484	330205	01.1031
310115	01.1824	320076	01.1177	330061	01.3001	330140	01.6347	330208	01.1778
310116	01.2468	320079	01.0741	330062	01.0854	330141	01.2493	330209	01.2043
310118	01.2034	320898	00.5182	330064	01.2793	330142	01.3154	330211	01.2315
310119	01.5134	320899	00.5200	330065	01.2031	330144	01.0114	330212	01.2419
310120	01.0530	330001	01.1573	330066	01.2180	330148	01.0180	330213	01.1492
310121	01.0509	330002	01.4178	330067	01.3155	330151	01.1101	330214	01.7238
310898	00.5196	330003	01.3324	330072	01.3231	330152	01.3930	330215	01.1806
310899	00.5200	330004	01.3470	330073	01.1239	330153	01.3069	330218	01.2610
320001	01.4284	330005	01.6610	330074	01.2555	330154	01.4019	330219	01.5511
320002	01.2439	330006	01.3761	330075	01.0668	330155	01.1711	330221	01.2897
320003	01.1377	330007	01.3450	330078	01.3561	330157	01.3175	330222	01.2118
320004	01.1801	330008	01.2121	330079	01.1011	330158	01.3176	330223	01.1131
320005	01.2406	330009	01.3057	330080	01.2468	330159	01.3015	330224	01.2673
320006	01.1917	330010	01.1917	330082	01.2226	330160	01.4422	330225	01.1777
320009	01.3541	330011	01.1983	330084	00.9693	330161	01.0632	330226	01.2963
320011	00.9576	330012	01.5868	330085	01.3317	330162	01.2347	330229	01.1835
320012	00.9723	330013	02.0354	330086	01.2771	330163	01.1747	330230	01.4634
320013	01.0995	330014	01.3753	330088	01.0898	330164	01.3840	330231	01.2070
320014	00.9425	330015	01.0378	330090	01.7305	330166	00.9395	330232	01.2588
320016	01.2059	330016	00.9929	330091	01.3645	330167	01.5236	330233	01.5082
320017	01.2024	330019	01.3490	330092	00.9851	330168	00.9973	330234	01.8912
320018	01.2379	330020	00.9973	330094	01.3163	330169	01.3720	330235	01.2159
320019	01.3548	330022	01.0130	330095	01.2609	330171	01.3071	330236	01.3588
320021	01.6425	330023	01.2037	330096	01.1434	330174	00.7840	330238	01.1054
320022	01.2361	330024	01.6899	330097	01.1778	330175	01.0509	330239	01.1781
320023	01.1024	330025	01.1024	330100	00.6818	330176	00.8622	330240	01.3464
320030	01.0346	330027	01.4414	330101	01.6693	330177	01.0661	330241	01.7347
320031	00.9630	330028	01.3333	330102	01.2881	330179	00.9373	330242	01.2878
320032	00.9273	330029	01.1491	330103	01.1723	330180	01.2218	330244	01.0712
320033	01.0914	330030	01.1599	330104	01.3349	330181	01.2606	330245	01.3033
320035	01.0746	330033	01.1312	330106	01.5402	330182	02.2759	330246	01.1755
320037	01.2472	330034	01.0865	330107	01.2411	330183	01.4307	330247	00.6007
320038	01.2286	330036	01.1991	330108	01.2375	330184	01.2489	330249	01.2008
320046	01.0954	330037	01.0772	330110	01.1247	330185	01.1842	330250	01.2449
320048	01.2192	330038	01.1795	330111	01.1248	330186	01.0038	330252	00.9331
320056	00.9297	330039	00.9000	330114	00.9981	330188	01.2024	330254	00.9861
320057	01.0692	330041	01.3702	330115	01.2552	330189	00.8786	330258	01.3215
320058	00.8835	330043	01.2826	330116	01.0029	330191	01.2538	330259	01.3093
320059	01.0758	330044	01.2064	330118	01.5864	330193	01.3665	330261	01.2056
320060	00.9179	330045	01.3000	330119	01.5770	330194	01.7174	330263	01.0711
320061	01.2195	330046	01.5833	330121	01.0150	330195	01.6558	330264	01.2189
320062	00.8963	330047	01.2797	330122	01.2778	330196	01.3766	330265	01.2850
320063	01.2780	330048	01.2461	330125	01.7622	330197	01.0220	330267	01.2425
320065	01.1644	330049	01.3134	330126	01.2213	330198	01.3368	330268	01.1279
320067	00.8660	330053	01.0524	330127	01.2255	330199	01.2794	330270	01.8929
320068	00.8698	330055	01.3943	330128	01.3995	330201	01.5020	330273	01.1870
320069	01.0449	330056	01.4090	330132	01.1159	330202	01.2672	330275	01.2072
320070	00.9930	330057	01.5815	330133	01.2817	330203	01.4149	330276	01.1970

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330277	01.1660	330397	01.4297	340052	00.9654	340124	01.0989	350015	01.5061
330279	01.2536	330398	01.3045	340053	01.5704	340125	01.4481	350016	00.9585
330281	00.5865	330399	01.3740	340054	00.9833	340126	01.2820	350017	01.2579
330285	01.7031	330898	00.5184	340055	01.1548	340127	01.2081	350018	01.0418
330286	01.3267	330899	00.5200	340060	01.1856	340129	01.1142	350019	01.5266
330288	01.0133	340001	01.2404	340061	01.6078	340130	01.3899	350020	01.3499
330290	01.6685	340002	01.7820	340063	01.0115	340131	01.3413	350021	01.0395
330293	01.1313	340003	01.1435	340064	01.1032	340132	01.3657	350023	00.9263
330304	01.1989	340004	01.3954	340065	01.2402	340133	01.2113	350024	01.0001
330306	01.3801	340005	01.2246	340067	01.1056	340135	01.0416	350025	00.9635
330307	01.1486	340006	01.1648	340068	01.2634	340136	00.9614	350027	00.9697
330308	01.2473	340007	01.1116	340069	01.7376	340137	01.2062	350029	00.9776
330309	01.2865	340008	01.2217	340070	01.2945	340138	01.1089	350030	01.0582
330314	01.2773	340009	01.2648	340071	01.0871	340141	01.5315	350031	00.9810
330315	01.1910	340010	01.3128	340072	01.0476	340142	01.1637	350032	01.3053
330316	01.2799	340011	01.0781	340073	01.3482	340143	01.3666	350033	00.9688
330327	00.9488	340012	01.0743	340075	01.1893	340144	01.2602	350034	00.9727
330331	01.2008	340013	01.1872	340076	01.0244	340145	01.1963	350035	00.8449
330332	01.2653	340014	01.6284	340080	01.1014	340146	01.0203	350036	00.9076
330333	01.3160	340015	01.2257	340084	01.0221	340147	01.2785	350038	00.9526
330336	01.2640	340016	01.2028	340085	01.2491	340148	01.3089	350039	00.8935
330338	01.1680	340017	01.2031	340087	01.0862	340151	01.1634	350041	00.9930
330339	00.8648	340018	01.2122	340088	01.0764	340153	01.9198	350042	00.9265
330340	01.1330	340019	01.0662	340089	01.0124	340154	00.9284	350043	01.5744
330350	01.9215	340020	01.2519	340090	01.1315	340155	01.4968	350044	00.8569
330351	01.0933	340021	01.2154	340091	01.6586	340156	00.8534	350047	01.1519
330353	01.2130	340022	01.1558	340093	01.0479	340158	01.0492	350049	01.0615
330354	01.1772	340023	01.2726	340094	01.3398	340159	01.2119	350050	01.0010
330357	01.3776	340024	01.2260	340096	01.2097	340160	01.0407	350051	00.9505
330359	00.9417	340025	01.0940	340097	01.0062	340162	01.2649	350053	00.8922
330362	00.6534	340027	01.1217	340098	01.6183	340164	01.3377	350055	00.9727
330363	00.6845	340028	01.3877	340099	01.1457	340166	01.3225	350056	00.8603
330366	00.7261	340030	01.7523	340100	01.0956	340167	00.5762	350058	00.9942
330367	00.5681	340031	01.0756	340101	01.0643	340168	00.5300	350060	00.9168
330368	00.6233	340032	01.2943	340104	01.0020	340898	00.5196	350061	01.0142
330369	00.6711	340034	01.2779	340105	01.3302	340899	00.5200	350063	00.7953
330371	00.6549	340035	01.0914	340106	01.1064	350001	01.1026	350064	00.8623
330372	01.2421	340036	01.0860	340107	01.2896	350002	01.6352	350065	00.9920
330373	00.6816	340037	01.2507	340109	01.2934	350003	01.1400	350066	00.9984
330381	01.3074	340038	01.2043	340111	01.1799	350004	01.8644	350067	01.0656
330383	01.3691	340039	01.2345	340112	00.9991	350005	01.1970	350898	00.5196
330385	01.1783	340040	01.7078	340113	01.9433	350006	01.3887	350899	00.5200
330386	01.2131	340041	01.2337	340114	01.3841	350007	01.0270	360001	01.2226
330387	00.8627	340042	01.1508	340115	01.4469	350008	01.0426	360002	01.1431
330389	01.8356	340044	01.0107	340116	01.7276	350009	01.1669	360003	01.5658
330390	01.2295	340045	00.9733	340119	01.2190	350010	01.0820	360006	01.7152
330393	01.6495	340047	01.7790	340120	01.0632	350011	01.7312	360007	01.1430
330394	01.3833	340049	00.5900	340121	00.9440	350012	00.9732	360008	01.1916
330395	01.3378	340050	01.2034	340122	01.0351	350013	01.0990	360009	01.3037
330396	01.2310	340051	01.2232	340123	01.1902	350014	01.0561	360010	01.1657

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 16 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360011	01.2688	360067	01.1867	360123	01.1541	360185	01.1675	370023	01.3168
360012	01.2752	360068	01.4362	360124	01.2262	360186	01.1421	370025	01.3078
360013	01.0955	360069	01.0220	360125	01.0834	360187	01.3223	370026	01.3150
360014	01.1706	360070	01.3931	360126	01.2638	360188	00.9713	370028	01.6151
360015	01.4453	360071	01.2778	360127	01.0096	360189	01.0678	370029	01.2316
360016	01.4757	360072	01.1552	360128	01.0577	360192	01.2764	370030	01.2154
360017	01.7331	360074	01.3209	360129	01.0458	360193	01.2620	370032	01.3419
360018	01.3610	360075	01.4143	360130	01.0978	360194	01.0610	370033	01.2163
360019	01.1733	360076	01.2496	360131	01.2720	360195	01.1878	370034	01.1203
360020	01.2371	360077	01.4009	360132	01.1771	360197	01.1574	370035	01.5034
360021	01.2068	360078	01.2626	360133	01.3116	360200	01.2136	370036	01.1071
360024	01.2680	360079	01.6158	360134	01.5310	360203	01.1235	370037	01.5263
360025	01.2149	360080	01.2318	360135	01.1111	360204	01.1589	370038	01.0466
360026	01.1206	360081	01.3380	360136	01.0682	360210	01.1832	370039	01.2295
360027	01.4854	360082	01.3197	360137	01.5089	360211	01.1732	370040	01.0386
360028	01.3210	360083	01.2142	360139	01.1094	360212	01.4171	370041	01.0290
360029	01.1008	360084	01.4097	360140	01.0636	360213	01.0868	370042	00.8924
360030	01.1580	360085	01.6471	360141	01.4140	360218	01.3151	370043	00.9567
360031	01.2664	360086	01.3438	360142	00.9764	360230	01.2837	370045	01.0610
360032	01.1208	360087	01.3144	360143	01.2275	360231	01.1283	370046	01.0292
360034	01.0871	360088	01.1562	360144	01.2815	360232	01.1302	370047	01.2496
360035	01.4566	360089	01.1092	360145	01.4933	360234	01.2226	370048	01.2086
360036	01.1737	360090	01.1715	360147	01.2190	360236	01.2094	370049	01.2973
360037	01.8243	360091	01.3100	360148	01.1922	360238	00.8448	370050	00.8128
360038	01.4361	360092	01.1705	360149	01.0874	360239	01.2025	370051	00.9928
360039	01.2386	360093	01.1582	360150	01.2049	360240	00.5398	370054	01.2477
360040	01.2696	360094	01.2112	360151	01.2795	360241	00.6501	370056	01.4626
360041	01.2336	360095	01.2971	360152	01.4982	360242	01.5486	370057	01.0892
360042	01.0928	360096	01.1068	360153	01.1558	360243	00.8675	370059	01.2355
360044	01.0952	360098	01.3126	360154	01.0467	360898	00.5184	370060	01.0403
360045	01.5106	360099	01.0472	360155	01.2083	360899	00.5200	370063	01.1848
360046	01.1347	360100	01.2812	360156	01.1294	370001	01.6642	370064	00.9081
360047	01.1163	360101	01.6002	360159	01.1421	370002	01.1794	370065	01.1247
360048	01.7040	360102	01.2254	360161	01.2217	370004	01.2024	370069	01.0062
360049	01.2535	360103	01.3331	360162	01.2163	370005	00.9222	370071	01.0033
360050	01.2657	360104	00.8994	360163	01.6517	370006	01.2095	370072	00.9691
360051	01.4826	360106	01.1571	360164	00.9676	370007	01.1043	370076	01.1094
360052	01.5898	360107	01.2097	360165	01.0692	370008	01.2174	370077	01.2691
360054	01.2958	360108	01.0245	360166	01.0386	370011	00.9363	370078	01.5444
360055	01.1928	360109	01.0346	360169	01.0041	370012	00.9154	370079	00.9236
360056	01.2931	360112	01.5994	360170	01.1506	370013	01.4040	370080	00.9516
360057	00.9648	360113	01.2367	360172	01.3331	370014	01.1488	370082	00.9993
360058	01.0989	360114	01.0518	360174	01.1534	370015	01.1305	370083	00.9966
360059	01.4730	360115	01.2371	360175	01.1481	370016	01.2488	370084	00.8518
360061	01.0460	360116	01.0292	360176	01.1409	370017	00.9915	370085	00.8918
360062	01.6356	360118	01.2455	360177	01.2651	370018	01.1807	370086	01.0963
360063	01.0518	360119	01.2274	360178	01.2657	370019	01.1326	370089	01.2445
360064	01.4481	360120	00.7106	360179	01.2516	370020	01.2644	370091	01.5312
360065	01.1965	360121	01.1784	360180	02.1048	370021	00.9578	370092	01.0342
360066	01.2309	360122	01.2276	360184	00.7063	370022	01.3427	370093	01.6203

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370094	01.2715	370185	00.6561	380061	01.6147	390026	01.2350	390081	01.2352
370095	00.9090	370186	00.9633	380062	00.9570	390027	01.7235	390083	01.1265
370097	01.2381	370189	00.9887	380063	01.2625	390028	01.6767	390084	01.1541
370099	01.1431	370190	01.1516	380064	01.3335	390029	01.6407	390086	01.0814
370100	01.0537	370898	00.5196	380065	01.0716	390030	01.1468	390088	01.3309
370103	00.9131	370899	00.5200	380066	01.0928	390031	01.1583	390090	01.7817
370105	01.9054	380001	01.3151	380068	01.0711	390032	01.2088	390091	01.1120
370106	01.3381	380002	01.2177	380069	01.1473	390035	01.2520	390092	01.2343
370108	01.0380	380003	01.1390	380070	01.0594	390036	01.2100	390093	01.2071
370110	00.9936	380004	01.8286	380071	01.2608	390037	01.2077	390095	01.2471
370112	00.9185	380005	01.2014	380072	00.9347	390039	01.0619	390096	01.2292
370113	01.1029	380006	01.1538	380075	01.3688	390040	00.9668	390097	01.3045
370114	01.5388	380007	01.7708	380078	01.1849	390041	01.2209	390098	01.5699
370117	01.2894	380008	01.0588	380081	01.0504	390042	01.2514	390100	01.7315
370121	01.1767	380009	01.6300	380082	01.2725	390043	01.0833	390101	01.2256
370122	00.9285	380010	01.1575	380083	01.1657	390044	01.5320	390102	01.2754
370123	01.1545	380011	01.1304	380084	01.2489	390045	01.2951	390103	01.0748
370125	00.9826	380013	01.2429	380087	00.9822	390046	01.4190	390104	01.0872
370126	01.0998	380014	01.3119	380088	00.9352	390047	01.4521	390106	01.0622
370131	00.9898	380017	01.7205	380089	01.2930	390048	01.1036	390107	01.1651
370133	01.1934	380018	01.8699	380090	01.3293	390049	01.5208	390108	01.3281
370138	01.1798	380019	01.2783	380091	01.1712	390050	01.8703	390109	01.2110
370139	01.0055	380020	01.3416	380094	01.1617	390051	02.0862	390110	01.3263
370140	01.0515	380021	01.2306	380096	01.1107	390052	01.1418	390111	01.7098
370141	01.4378	380022	01.2313	380898	00.5196	390054	01.1087	390112	01.1746
370146	01.0256	380023	01.2936	380899	00.5200	390055	01.6827	390113	01.2433
370148	01.2664	380024	01.2845	390001	01.2147	390056	01.0945	390114	01.0307
370149	01.2092	380025	01.2444	390002	01.1796	390057	01.2598	390115	01.2881
370153	01.1017	380026	01.4077	390003	01.1478	390058	01.3234	390116	01.1831
370154	01.0267	380027	01.2087	390004	01.2445	390059	01.3136	390117	01.1725
370156	01.0215	380029	01.1339	390005	01.0950	390060	01.1532	390118	01.1642
370157	00.9246	380030	00.8953	390006	01.6596	390061	01.2365	390119	01.3159
370158	01.0516	380031	01.0127	390007	01.1734	390062	01.1893	390121	01.1893
370159	01.1527	380033	01.6735	390008	01.1211	390063	01.6161	390122	01.0338
370161	01.1942	380035	01.1923	390009	01.4950	390064	01.4105	390123	01.2058
370163	00.8659	380036	01.0970	390010	01.1663	390065	01.2463	390125	01.2138
370165	01.1719	380037	01.2176	390011	01.1975	390066	01.2665	390126	01.2151
370166	01.1703	380038	01.2342	390012	01.1928	390067	01.5075	390127	01.1053
370169	00.9926	380039	01.3115	390013	01.1584	390068	01.2521	390128	01.1815
370170	00.8072	380040	01.3432	390014	00.8148	390069	01.2566	390130	01.0679
370171	00.9418	380042	01.1141	390015	01.1150	390070	01.1840	390131	01.2017
370172	00.9121	380047	01.5505	390016	01.1720	390071	01.1242	390132	01.1387
370173	01.0665	380048	01.0019	390017	01.1567	390072	00.9962	390133	01.4034
370174	01.0009	380050	01.3308	390018	01.2169	390073	01.4684	390135	01.2273
370176	01.2772	380051	01.4272	390019	01.1097	390074	01.2196	390136	01.1659
370177	00.9315	380052	01.1700	390021	01.0653	390075	01.2995	390137	01.1604
370178	01.0072	380055	01.1809	390022	01.2727	390076	01.2453	390138	01.2456
370179	01.0859	380056	01.0445	390023	01.2386	390078	01.0561	390139	01.4407
370180	01.0029	380059	00.9126	390024	00.7858	390079	01.6580	390142	01.7079
370183	01.0819	380060	01.3229	390025	00.8127	390080	01.1670	390143	03.1916

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 18 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390145	01.2077	390200	01.0849	390899	00.5200	400114	01.0792	420039	01.1107
390146	01.1874	390201	01.3200	400001	01.1881	400115	01.0219	420040	01.3040
390147	01.1797	390203	01.2850	400002	01.2619	400117	01.1646	420042	01.0843
390148	01.1450	390204	01.2733	400003	01.1298	400118	01.1589	420043	01.1479
390149	01.2549	390205	01.2314	400004	01.1206	400120	01.3046	420044	01.1473
390150	01.2004	390206	01.2467	400005	01.1140	400121	01.0225	420048	01.1359
390151	01.2469	390209	00.9586	400006	01.1571	400898	00.5196	420049	01.0901
390152	01.0106	390211	01.1450	400007	01.0914	400899	00.5200	420051	01.5358
390153	01.2124	390213	01.0178	400008	01.1094	410001	01.2630	420053	01.1017
390154	01.1162	390215	01.1778	400009	00.9779	410002	01.2355	420054	01.1395
390155	01.2803	390217	01.1410	400010	00.9458	410004	01.4273	420055	01.0400
390156	01.3738	390219	01.1903	400011	01.1151	410005	01.2999	420056	01.0084
390157	01.1784	390220	01.1172	400012	01.0291	410006	01.1826	420057	01.0795
390158	01.2512	390222	01.1946	400013	01.0254	410007	01.5217	420059	01.0485
390159	01.3086	390223	01.5740	400014	01.3307	410008	01.2004	420061	01.2556
390160	01.1731	390224	00.9522	400015	01.0703	410009	01.3363	420062	01.2827
390161	01.0764	390225	01.2679	400016	01.2595	410010	01.0407	420064	01.0795
390162	01.2337	390226	01.6080	400017	01.1041	410011	01.1912	420065	01.3002
390163	01.1978	390228	01.1861	400018	01.2617	410012	01.5811	420066	01.0041
390164	01.8624	390229	01.4254	400019	01.3508	410013	01.1469	420067	01.1186
390165	01.0746	390231	01.3033	400021	01.2994	410898	00.5196	420068	01.1797
390166	01.1072	390232	01.0853	400022	01.2823	410899	00.5200	420069	01.0023
390167	01.2338	390233	01.2849	400024	01.0325	420002	01.3240	420070	01.2608
390168	01.1900	390235	01.8288	400026	00.9313	420004	01.9427	420071	01.3698
390169	01.2273	390236	01.1930	400027	01.0911	420005	01.1073	420072	00.9958
390170	01.6154	390237	01.4891	400028	01.0395	420006	01.5351	420073	01.2805
390171	01.0817	390238	01.0094	400029	01.0170	420007	01.4119	420074	00.9684
390172	01.1806	390242	01.2194	400031	01.0524	420009	01.2345	420075	01.0698
390173	01.1219	390244	00.8730	400032	01.1264	420010	01.0809	420076	01.2665
390174	01.5807	390245	01.3427	400037	00.5692	420011	01.0845	420078	01.5720
390176	01.2013	390246	01.2164	400038	00.9750	420014	01.1106	420079	01.5496
390178	01.3262	390247	01.1041	400044	01.2408	420015	01.2475	420080	01.1496
390179	01.2269	390249	00.9808	400048	01.1459	420016	01.2167	420081	00.7876
390180	01.3859	390252	00.9369	400061	01.7371	420018	01.6236	420082	01.3718
390181	01.0733	390256	01.6516	400079	01.1457	420019	01.1733	420083	01.1968
390183	01.1363	390258	01.2932	400087	01.2501	420020	01.1773	420084	00.8455
390184	01.1014	390260	01.2395	400088	00.7437	420022	00.9983	420085	01.2552
390185	01.1590	390261	01.8236	400089	01.0861	420023	01.2449	420086	01.3713
390186	01.1075	390262	01.6794	400094	00.9166	420026	01.8136	420087	01.5173
390187	01.1026	390263	01.4378	400098	01.2250	420027	01.3422	420088	01.1821
390189	01.1099	390265	01.2528	400102	01.0973	420028	01.0602	420089	01.2615
390191	01.0642	390266	01.1168	400103	01.4186	420029	01.8435	420898	00.5313
390192	01.0709	390267	01.2177	400104	01.2728	420030	01.1602	420899	00.5200
390193	01.1893	390268	01.2218	400105	01.2768	420031	00.9776	430004	01.0589
390194	01.0999	390270	01.2963	400106	01.1445	420032	00.8787	430005	01.3206
390195	01.5444	390272	00.6242	400109	01.4987	420033	01.1668	430007	01.1418
390196	01.2926	390275	00.5310	400110	01.1753	420035	00.8405	430008	01.2122
390197	01.2815	390277	01.6310	400111	01.2148	420036	01.2587	430009	01.0996
390198	01.2482	390278	00.8910	400112	01.2234	420037	01.2765	430010	01.0968
390199	01.2215	390898	00.5192	400113	01.1732	420038	01.2094	430011	01.3505

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
430012	01.3084	430087	01.0579	440063	01.4083	440149	01.1662	450016	01.6544
430013	01.2454	430088	00.9421	440064	01.0954	440150	01.2932	450018	01.6503
430014	01.1890	440001	00.9710	440065	01.1440	440151	01.1714	450019	02.8940
430015	01.0293	440002	01.5655	440067	01.1697	440152	01.5694	450020	01.0557
430016	01.6953	440003	01.1090	440068	01.1621	440153	00.9806	450021	01.7629
430017	01.0846	440006	01.3970	440069	01.0935	440154	00.7147	450023	01.4166
430018	00.9456	440007	01.0231	440070	00.9308	440156	01.4041	450024	01.2536
430022	00.9458	440008	00.9625	440071	01.3170	440157	01.0081	450025	01.4466
430023	00.9379	440009	01.0308	440072	01.3583	440159	01.2140	450027	01.1954
430024	01.0137	440010	00.9318	440073	01.2856	440160	01.0405	450028	01.4483
430025	01.0095	440011	01.2254	440074	00.8608	440161	01.5762	450029	01.3719
430026	00.8653	440012	01.3384	440078	01.0116	440162	01.0043	450031	01.1900
430027	01.6561	440014	00.8858	440079	00.8498	440166	01.2763	450032	01.2096
430028	01.1055	440015	01.4816	440081	01.1415	440168	01.0281	450033	01.6006
430029	00.9983	440016	00.9602	440082	01.8158	440170	01.3334	450034	01.4963
430031	00.9975	440017	01.4762	440083	01.2483	440173	01.4729	450035	01.4695
430033	00.9929	440018	01.2990	440084	01.0829	440174	00.9087	450037	01.4597
430034	01.0588	440019	01.4703	440087	01.0207	440175	01.1648	450039	01.1511
430036	01.0453	440020	01.2235	440090	01.0396	440176	01.2756	450040	01.6108
430037	00.9834	440022	01.0825	440091	01.3860	440177	00.9367	450041	00.9472
430038	01.0461	440023	00.9773	440095	01.0953	440178	01.1921	450042	01.6229
430039	01.0090	440024	01.1467	440100	01.0999	440180	01.0619	450043	01.4104
430040	00.9203	440025	01.1475	440102	01.0619	440181	00.9828	450044	01.4927
430041	00.9454	440026	01.2751	440103	01.2865	440182	00.9364	450046	01.3798
430042	00.9998	440029	01.2259	440104	01.4334	440183	01.4240	450047	00.9998
430043	01.1914	440030	01.0524	440105	01.3087	440184	01.2448	450050	01.2859
430044	00.9388	440031	01.0529	440109	01.0668	440185	01.0517	450051	01.6291
430047	01.0810	440032	00.9562	440110	01.0901	440186	01.1522	450052	01.0289
430048	01.1315	440033	01.0851	440111	01.2744	440187	01.0761	450053	01.1015
430049	00.9209	440034	01.3879	440114	01.0018	440189	01.4806	450054	01.6246
430051	00.9773	440035	01.1765	440115	01.1553	440192	00.9532	450055	01.0724
430054	00.9451	440038	00.9218	440120	01.4563	440193	01.0727	450056	01.6171
430056	00.8748	440039	01.5765	440121	01.0677	440194	01.2600	450057	01.1806
430057	00.9685	440040	00.9040	440125	01.4404	440196	00.9973	450058	01.5082
430060	00.9537	440041	00.8864	440128	00.9216	440197	01.3314	450059	01.2849
430062	00.8516	440046	01.0325	440130	01.1082	440200	01.0815	450060	01.3500
430064	01.0446	440047	00.9206	440131	01.1177	440203	00.9772	450063	00.9432
430065	00.9423	440048	01.5953	440132	01.0465	440205	00.9808	450064	01.4579
430066	01.0643	440049	01.6157	440133	01.4522	440898	00.5197	450065	01.1445
430073	01.1110	440050	01.1505	440135	01.3829	440899	00.5200	450068	01.6470
430076	01.0211	440051	00.9205	440136	01.2873	450002	01.3864	450070	01.1262
430077	01.4148	440052	01.1596	440137	01.0606	450004	01.0625	450072	01.1843
430079	01.0445	440053	01.1735	440141	00.9095	450005	01.0307	450073	01.1778
430080	00.8204	440054	00.9849	440142	01.0573	450007	01.3619	450074	01.1898
430081	01.0074	440056	00.9662	440143	01.0382	450008	01.2429	450076	01.2325
430082	00.8879	440057	00.9621	440144	01.1350	450010	01.2689	450077	00.9726
430083	00.8287	440058	01.1529	440145	00.9853	450011	01.5573	450078	00.9892
430084	01.0482	440059	01.1398	440146	01.3775	450012	01.2168	450079	01.4361
430085	00.9199	440060	01.2190	440147	00.7335	450014	01.1106	450080	01.1779
430086	00.8609	440061	01.1074	440148	01.1368	450015	01.5125	450081	01.1803

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 20 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450082	00.9878	450155	01.0332	450237	01.5126	450355	01.0741	450489	01.0442
450083	01.5443	450157	01.0099	450239	01.1959	450358	01.9532	450497	01.1356
450085	00.9962	450160	01.0575	450241	00.9517	450362	00.9684	450498	01.0658
450087	01.3390	450162	01.3390	450243	00.9273	450365	00.9715	450508	01.4049
450090	01.1553	450163	01.1193	450246	00.9979	450366	01.6461	450514	01.1396
450092	01.2944	450164	00.9439	450249	00.9346	450369	01.1674	450517	00.9377
450094	01.3856	450165	00.9336	450253	01.0849	450370	01.1883	450518	01.3356
450096	01.4924	450166	00.8618	450258	01.1207	450371	01.1062	450523	01.4825
450097	01.4141	450169	00.8653	450259	01.2308	450372	01.3072	450530	01.3099
450098	01.1252	450170	01.0904	450264	00.8503	450373	01.1546	450534	00.9543
450099	01.2202	450175	01.1666	450268	01.2098	450374	00.8612	450535	01.2194
450101	01.3902	450176	01.2832	450269	00.9470	450376	01.4562	450537	01.3913
450102	01.6896	450177	01.0842	450270	01.1608	450378	01.2775	450538	01.2977
450104	01.2474	450178	01.0815	450271	01.1922	450379	01.5759	450539	01.2685
450107	01.4183	450179	01.0164	450272	01.3403	450381	00.8646	450544	01.2497
450108	00.9694	450181	00.9942	450276	00.9661	450388	01.6205	450545	01.1671
450109	00.9858	450183	00.9973	450278	00.9057	450389	01.2353	450546	01.3580
450110	01.2155	450184	01.4658	450280	01.3054	450393	01.2800	450547	00.9746
450111	01.1778	450185	01.0386	450283	01.1518	450395	01.0896	450550	01.0319
450112	01.2127	450187	01.1771	450286	01.0898	450399	01.0396	450551	01.0391
450113	01.2878	450188	00.9746	450288	01.1503	450400	01.0660	450557	01.0538
450115	01.0680	450190	01.2664	450289	01.3791	450403	01.2092	450558	01.7882
450118	01.4149	450191	01.1072	450292	01.2671	450410	01.0659	450559	00.8825
450119	01.2371	450192	01.0919	450293	00.9699	450411	01.0600	450561	01.5047
450121	01.3651	450193	02.1479	450296	01.2220	450417	01.0292	450563	01.2059
450123	01.0641	450194	01.1301	450297	01.0674	450418	01.3690	450565	01.2924
450124	01.4506	450195	01.4354	450299	01.3529	450419	01.2510	450570	01.0008
450126	01.3166	450196	01.2475	450303	00.9489	450422	00.7494	450571	01.4405
450127	01.0078	450197	01.2008	450306	01.0477	450423	01.3512	450573	01.0363
450128	01.1509	450200	01.2921	450307	00.9572	450424	01.2682	450574	01.0282
450130	01.4644	450201	00.9786	450309	01.0480	450429	00.9324	450575	00.9963
450131	01.2453	450203	01.1729	450315	01.2300	450431	01.4965	450578	00.9630
450132	01.4508	450207	01.0764	450320	01.2982	450438	01.0520	450580	01.1800
450133	01.4421	450209	01.3398	450321	00.8811	450446	00.8813	450583	01.0112
450135	01.5677	450210	01.2090	450322	00.9604	450447	01.2796	450584	01.1850
450137	01.3428	450211	01.2599	450324	01.5257	450450	01.0934	450586	01.1113
450140	00.9070	450213	01.4222	450325	01.1884	450451	01.0167	450587	01.2652
450142	01.2794	450214	01.3077	450327	00.9930	450457	01.6592	450591	01.2213
450143	01.0147	450217	00.8757	450330	01.0889	450460	00.9727	450596	01.2305
450144	01.1266	450218	00.9962	450334	01.0795	450462	01.5850	450597	01.0431
450145	00.9544	450219	01.1150	450337	01.1764	450464	00.9097	450603	00.9690
450146	01.0182	450221	00.9934	450340	01.3527	450465	01.1069	450604	01.2344
450147	01.3537	450222	01.6862	450341	00.9360	450467	01.0530	450605	01.2340
450148	01.3152	450224	01.1254	450346	01.3103	450469	01.2746	450607	00.8981
450149	01.4288	450229	01.3541	450347	01.2278	450473	01.0949	450609	00.8539
450150	01.0242	450231	01.5950	450348	00.9811	450475	01.1409	450610	01.3881
450151	01.0793	450233	01.0909	450349	01.1467	450476	01.0202	450614	01.0266
450152	01.4122	450234	00.9314	450351	01.2655	450484	01.5207	450615	00.9538
450153	01.5918	450235	01.0319	450352	01.2257	450486	00.9499	450617	01.3736
450154	01.1277	450236	01.1188	450353	01.1381	450488	01.2127	450620	01.0614

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450623	01.1476	450697	01.4699	450770	00.9889	470005	01.1979	490046	01.3389
450626	00.9651	450698	00.9552	450771	01.4111	470006	01.2789	490047	01.1653
450628	00.9503	450700	00.9175	450773	01.1124	470008	01.2208	490048	01.3225
450630	01.6511	450702	01.2760	450775	01.1776	470010	01.0254	490050	01.3135
450631	01.6362	450703	01.2785	450898	00.5185	470011	01.1556	490052	01.4038
450632	00.9847	450704	01.2962	450899	00.5200	470012	01.2596	490053	01.2112
450633	01.5711	450705	00.8149	460001	01.5910	470013	01.1287	490054	01.0658
450634	01.3409	450706	01.2481	460003	01.4113	470015	01.2089	490057	01.3419
450637	01.3098	450709	01.1947	460004	01.7064	470018	01.1678	490059	01.4007
450638	01.4733	450711	01.6225	460005	01.2454	470020	01.0006	490060	01.0770
450639	01.5158	450712	00.7194	460006	01.3458	470023	01.2311	490063	01.5852
450641	00.8841	450713	01.2517	460007	01.3776	470024	01.1076	490066	01.1116
450643	01.1766	450715	01.3764	460008	01.3143	490001	01.1323	490067	01.2715
450644	01.6030	450716	01.2263	460009	01.7463	490002	01.0317	490069	01.3486
450646	01.4840	450717	01.2375	460010	01.9660	490003	00.6395	490071	01.2856
450647	01.9627	450718	01.1224	460011	01.3179	490004	01.2101	490073	01.2196
450648	01.1252	450723	01.2326	460013	01.4278	490005	01.4001	490074	01.2449
450649	01.0717	450724	01.1880	460014	01.0621	490006	01.1376	490075	01.2375
450651	01.8199	450725	00.9321	460015	01.2529	490007	01.9148	490077	01.1729
450652	00.9619	450726	00.8599	460016	00.9745	490008	01.1116	490079	01.2313
450653	01.2314	450727	00.9686	460017	01.2250	490009	01.6351	490083	00.7805
450654	00.9789	450728	00.9472	460018	00.9533	490010	01.1770	490084	01.1388
450656	01.2664	450729	00.9489	460019	01.0058	490011	01.2672	490085	01.2258
450658	00.9588	450730	01.4029	460020	00.9427	490012	01.0014	490088	01.1191
450659	01.4433	450732	01.1608	460021	01.2977	490013	01.1187	490089	01.0411
450660	01.6517	450733	01.3195	460022	00.9521	490014	01.5709	490090	01.1363
450661	01.2154	450734	01.2375	460023	01.1429	490015	01.4681	490091	01.1587
450662	01.4387	450735	00.8265	460024	01.0117	490017	01.2780	490092	01.1211
450665	00.9758	450737	00.8791	460025	00.8553	490018	01.0967	490093	01.2491
450666	01.2175	450742	01.3395	460026	00.9581	490019	01.1426	490094	01.0887
450668	01.5190	450743	01.4476	460027	00.9403	490020	01.0785	490095	01.2782
450669	01.3242	450745	00.8077	460029	00.9543	490021	01.3897	490097	01.1425
450670	01.2277	450746	00.9051	460030	01.0972	490022	01.2225	490098	01.2686
450672	01.5931	450747	01.3162	460032	00.9703	490023	01.1895	490099	00.9336
450673	01.0162	450749	01.0372	460033	00.9958	490024	01.6477	490100	01.2993
450674	00.8367	450750	00.9804	460035	00.9104	490027	01.0316	490101	01.1101
450675	01.3391	450751	01.3373	460036	00.9599	490028	01.2898	490104	00.8736
450677	01.3364	450753	00.9048	460037	00.9599	490030	01.3082	490105	00.7261
450678	01.4938	450754	00.8722	460039	00.9527	490031	01.0667	490106	00.7954
450681	01.5216	450755	01.0120	460041	01.2414	490032	01.6436	490107	01.2615
450682	01.2870	450757	00.9510	460042	01.3789	490033	01.2261	490108	00.8624
450683	01.3102	450758	01.4096	460043	01.2982	490035	01.2400	490109	00.8145
450684	01.3007	450759	01.1331	460044	01.1330	490037	01.1340	490110	01.2088
450685	01.2243	450760	01.3684	460046	00.9837	490038	01.2384	490111	01.1740
450686	01.3796	450761	00.9382	460047	01.6109	490040	01.3770	490112	01.5107
450688	01.3271	450763	01.0496	460898	00.5196	490041	01.1789	490113	01.2435
450690	01.3170	450765	01.0945	460899	00.5200	490042	01.2832	490114	01.0200
450691	01.1673	450766	01.6135	470001	01.1564	490043	01.1755	490115	01.1474
450694	01.2216	450768	01.0823	470003	01.9130	490044	01.2678	490116	01.1893
450696	01.0664	450769	00.9555	470004	01.1646	490045	01.1589	490117	01.0684

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 22 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
490118	01.7073	500051	01.6277	500127	01.0519	510058	01.2105	520034	01.1832
490119	01.3397	500052	01.2199	500129	01.6858	510059	01.4222	520035	01.2521
490120	01.3092	500053	01.2526	500132	00.8248	510060	01.1601	520037	01.5960
490122	01.2075	500054	01.8276	500134	00.7403	510061	01.0490	520038	01.2987
490123	01.1363	500055	00.9629	500135	01.1288	510062	01.1464	520039	01.0154
490124	01.2094	500057	01.2672	500137	00.8291	510063	01.0619	520040	01.4174
490126	01.1955	500058	01.3159	500138	07.0911	510065	00.9937	520041	01.1147
490127	01.0650	500059	01.1346	500139	01.3462	510066	01.1450	520042	01.0127
490129	01.1401	500060	01.1839	500140	01.0335	510067	01.2778	520044	01.3333
490130	01.2281	500061	01.1698	500141	01.2346	510068	01.1025	520045	01.6380
490131	00.9497	500062	00.9586	500143	00.6451	510070	01.1906	520047	00.9704
490898	00.5185	500064	01.5577	500898	00.5185	510071	01.2567	520048	01.3229
490899	00.5200	500065	01.2726	500899	00.5200	510072	01.0244	520049	01.8077
500001	01.3037	500068	01.1644	510001	01.6416	510076	00.9725	520051	02.0414
500002	01.4095	500069	01.0012	510002	01.2824	510077	01.1417	520053	01.0585
500003	01.2861	500071	01.4032	510004	00.9408	510080	00.9917	520054	01.1941
500005	01.7196	500072	01.1949	510005	00.9523	510081	01.0073	520056	01.2993
500007	01.3095	500073	00.9418	510006	01.2044	510082	01.0169	520057	01.1415
500008	01.8947	500074	01.1165	510007	01.3741	510084	00.9481	520058	01.1071
500009	01.3186	500075	01.1767	510008	01.1726	510085	01.2046	520059	01.2641
500011	01.2218	500076	01.3138	510009	01.0303	510086	01.0422	520060	01.2323
500012	01.4964	500077	01.2247	510012	01.0428	510087	00.7675	520062	01.1789
500014	01.6630	500078	01.2940	510013	01.1459	520002	01.2749	520063	01.1924
500015	01.2843	500079	01.2506	510015	00.9063	520003	01.1504	520064	01.5197
500016	01.3652	500080	00.9168	510016	01.0076	520004	01.2442	520066	01.2357
500019	01.2405	500084	01.0035	510018	01.1304	520006	01.0229	520068	01.0682
500021	01.3708	500085	01.0518	510020	01.0968	520007	01.0810	520069	01.1981
500023	01.1643	500086	01.3255	510022	01.6247	520008	01.2004	520070	01.3171
500024	01.3348	500088	01.3065	510023	01.0375	520009	01.4767	520071	01.1762
500025	01.9312	500089	01.0160	510024	01.3137	520010	01.0967	520074	01.1135
500026	01.2537	500090	00.9145	510025	00.9025	520011	01.0892	520075	01.3924
500027	01.5794	500092	01.0780	510026	00.9758	520012	00.9264	520076	01.1606
500028	00.9881	500093	01.1705	510027	01.0050	520013	01.2887	520077	01.0289
500029	00.8975	500094	00.9211	510028	01.0652	520014	01.1740	520078	01.3122
500030	01.3448	500096	01.0582	510029	01.2433	520015	01.1644	520081	01.2238
500031	01.2319	500097	01.1723	510030	01.1212	520016	00.9844	520082	01.2813
500033	01.1501	500098	00.8613	510031	01.2711	520017	01.1666	520083	01.4987
500034	00.9200	500101	00.8910	510033	01.2111	520018	00.9703	520084	01.0795
500035	01.3931	500102	00.9656	510035	01.0599	520019	01.2357	520087	01.4852
500036	01.2762	500104	01.2425	510036	01.1241	520021	01.1840	520088	01.2179
500037	01.1511	500106	00.9918	510038	01.0047	520024	00.9820	520089	01.4068
500039	01.2991	500107	01.0965	510039	01.2755	520025	01.1231	520090	01.1483
500041	01.2065	500108	01.6490	510040	00.9642	520026	01.0953	520091	01.2251
500042	01.3023	500110	01.2181	510043	00.9995	520027	01.1398	520092	01.1655
500043	01.1726	500118	01.1796	510046	01.2532	520028	01.3676	520094	01.1628
500044	01.9039	500119	01.2504	510047	01.1249	520029	00.9306	520095	01.3054
500045	01.1537	500122	01.2079	510048	01.1308	520030	01.5238	520096	01.4423
500048	00.9342	500123	01.0362	510050	01.2260	520031	01.1646	520097	01.2966
500049	01.2301	500124	01.3282	510053	01.0018	520032	01.1415	520098	01.6714
500050	01.2771	500125	00.9528	510055	01.1619	520033	01.2564	520100	01.2286

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
520101	01.1672	520177	01.5263						
520102	01.1975	520178	01.1647						
520103	01.3449	520180	00.6036						
520104	00.9950	520898	00.5196						
520107	01.2338	520899	00.5200						
520109	01.0785	530001	01.2428						
520110	00.9839	530002	01.1366						
520111	01.0896	530003	00.9530						
520112	01.1200	530004	00.9961						
520113	01.2130	530005	01.0865						
520114	01.0570	530006	01.0919						
520115	01.2976	530007	01.0376						
520116	01.1964	530008	01.1465						
520117	01.0751	530009	00.9901						
520118	00.9407	530010	01.2515						
520120	01.0842	530011	01.1264						
520121	00.9647	530012	01.6027						
520122	01.0401	530014	01.1252						
520123	01.0392	530015	01.1345						
520124	01.1529	530016	01.1563						
520130	01.0705	530017	00.9896						
520131	01.0713	530018	01.0646						
520132	01.1558	530019	00.9882						
520134	01.1471	530022	01.1225						
520135	01.0616	530023	00.9090						
520136	01.4677	530024	00.9669						
520138	01.8363	530025	01.2490						
520139	01.1935	530026	01.0612						
520140	01.4028	530027	00.8697						
520141	01.0957	530029	00.9020						
520142	00.9897	530031	00.9951						
520144	01.0093	530032	01.2519						
520145	01.0206	530898	00.5183						
520146	01.1614								
520148	01.1000								
520149	01.0489								
520151	01.0610								
520152	01.1404								
520153	01.0141								
520154	01.1121								
520156	01.0848								
520157	01.0066								
520159	00.9077								
520160	01.7466								
520161	01.0675								
520170	01.3002								
520171	00.9938								
520173	01.0598								
520174	01.4641								
520176	00.8365								

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH DECEMBER 1991

BILLING CODE 4120-01-C

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOP (GAF) FOR URBAN AREAS

[Areas that Qualify as Large Urban Areas Are Designated with an Asterisk]

Urban area (constituent counties or county equivalents)	Wage index	GAF
Abilene, TX	0.9429	0.9605
Taylor, TX		
Aguadilla, PR	0.4568	0.5848
Aquada, PR		
Aguadilla, PR		
Isabella, PR		
Moca, PR		
Akron, OH	0.8921	0.9248
Portage, OH		
Summit, OH		
Albany, GA	0.8050	0.8620
Dougherty, GA		
Lee, GA		
Albany-Schenectady-Troy, NY	0.8956	0.9273
Albany, NY		
Greene, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Albuquerque, NM	1.0123	1.0084
Bernalillo, NM		
Alexandria, LA	0.8275	0.8784
Rapides, LA		
Allentown-Bethlehem-Easton, PA-NJ	0.8797	0.9160
Warren, NJ		
Carbon, PA		
Lehigh, PA		
Northampton, PA		
Altoona, PA	0.9238	0.9472
Blair, PA		
Amarillo, TX	0.8739	0.9118
Potter, TX		
Randall, TX		
*Anaheim-Santa Ana, CA	1.1756	1.1172
Orange, CA		
Anchorage, AK	1.4176	1.2699
Anchorage, AK		
Anderson, IN	0.9583	0.9713
Madison, IN		
Anderson, SC	0.7258	0.8029
Anderson, SC		
Ann Arbor, MI	1.1384	1.0928
Washtenaw, MI		
Anniston, AL	0.7931	0.8532
Calhoun, AL		
Appleton-Oshkosh-Neenah, WI	0.9223	0.9461
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
Arecibo, PR	0.3953	0.5296
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
Quebradillas, PR		
Asheville, NC	0.8739	0.9118
Buncombe, NC		
Athens, GA	0.7773	0.8415
Clarke, GA		
Jackson, GA		
Madison, GA		
Oconee, GA		
*Atlanta, GA	0.9596	0.9722
Barrow, GA		
Butts, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
De Kalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
Atlantic City, NJ	1.0609	1.0413
Atlantic City, NJ		
Cape May, NJ		
Augusta, GA-SC	0.9401	0.9586
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Aurora-Elgin, IL	0.9463	0.9629
Kane, IL		
Kendall, IL		
Austin, TX	0.9599	0.9724
Hays, TX		
Travis, TX		
Williamson, TX		
Bakersfield, CA	1.0868	1.0587
Kern, CA		
*Baltimore, MD	1.0156	1.0107
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Annes, MD		
Bangor, ME	0.9064	0.9349
Penobscot, ME		
Baton Rouge, LA	0.9089	0.9367
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
Battle Creek, MI	0.9099	0.9374
Calhoun, MI		
Beaumont-Port Arthur, TX	0.9604	0.9727
Hardin, TX		
Jefferson, TX		
Orange, TX		
Beaver County, PA	1.0165	1.0113
Beaver, PA		
Bellingham, WA	1.0497	1.0338
Whatcom, WA		
Benton Harbor, MI	0.8091	0.8650
Berrien, MI		
*Bergen-Passaic, NJ	0.8565	0.8994
Bergen, NJ		
Passaic, NJ		
Billings, MT	0.9325	0.9533
Yellowstone, MT		
Biloxi-Gulfport, MS	0.8062	0.8628
Hancock, MS		
Harrison, MS		
Binghamton, NY	0.9260	0.9487
Broome, NY		
Tioga, NY		
Birmingham, AL	0.8769	0.9140
Blount, AL		
Jefferson, AL		
Saint Clair, AL		
Shelby, AL		
Walker, AL		
Bismarck, ND	0.8881	0.9219
Burleigh, ND		
Morton, ND		
Bloomington, IN	0.7757	0.8404
Monroe, IN		
Bloomington-Normal, IL	0.8658	0.9060
McLean, IL		
Boise City, ID	0.9757	0.9833
Ada, ID		
*Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1809	1.1206
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Boulder-Longmont, CO	0.9689	0.9786
Boulder, CO		
Bradenton, FL	0.8730	0.9112
Manatee, FL		
Brazoria, TX	0.8947	0.9266
Brazoria, TX		
Bremerton, WA	1.0365	1.0249
Kitsap, WA		
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1905	1.1268
Fairfield, CT		
Brownsville-Harlingen, TX	0.8601	0.9019
Cameron, TX		
Bryan-College Station, TX	0.9489	0.9647
Brazos, TX		
Buffalo, NY	0.8908	0.9239
Erie, NY		
Burlington, NC	0.7936	0.8536
Alamance, NC		
Burlington, VT	0.9358	0.9556
Chittenden, VT		
Grand Isle, VT		
Caguas, PR	0.4588	0.5865
Caguas, PR		
Gurabo, PR		
San Lorenz, PR		
Aguas Buenas, PR		
Cayey, PR		
Cidra, PR		
Canton, OH	0.8453	0.8913
Carroll, OH		
Stark, OH		
Casper, WY	0.8891	0.9227
Natrona, WY		
Cedar Rapids, IA	0.7532	0.8236
Linn, IA		
Champaign-Urbana-Rantoul, IL	0.8745	0.9123
Champaign, IL		
Charleston, SC	0.8331	0.8825
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
Charleston, WV	0.9692	0.9788
Kanawha, WV		
Putnam, WV		
*Charlotte-Gastonia-Rock Hill, NC-SC	0.9486	0.9645

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) 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	GAF
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
Charlottesville, VA	0.9615	0.9735
Albermarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
Chattanooga, TN-GA	0.9198	0.9444
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
Sequatchie, TN		
Cheyenne, WY	0.7777	0.8418
Laramie, WY		
*Chicago, IL	1.0518	1.0352
Cook, IL		
Du Page, IL		
McHenry, IL		
Chico, CA	1.0981	1.0662
Butte, CA		
*Cincinnati, OH-KY-IN	0.0921	0.9877
Dearborn, IN		
Boone, KY		
Campbell, KY		
Kenton, KY		
Clermont, OH		
Hamilton, OH		
Warren, OH		
Clarksville-Hopkinsville, TN-KY	0.7319	0.8076
Christian, KY		
Montgomery, TN		
*Cleveland, OH	1.0739	1.0500
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Medina, OH		
Colorado Springs, CO	0.9816	0.9874
El Paso, CO		
Columbia, MO	0.9506	0.9659
Boone, MO		
Columbia, SC	0.8940	0.9261
Lexington, SC		
Richland, SC		
Columbus, GA-AL	0.7371	0.8115
Russell, AL		
Chattanoochee, GA		
Muscogee, GA		
*Columbus, OH	0.9673	0.9775
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
Union, OH		
Corpus Christi, TX	0.8594	0.9014
Neuces, TX		
San Patricio, TX		
Cumberland, MD-WV	0.8188	0.8721
Allegeny, MD		
Mineral, WV		
*Dallas, TX	0.9638	0.9751
Collins, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Kaufman, TX		
Rockwall, TX		
Danville, VA	0.7826	0.8455
Danville City, VA		
Pittsylvania, VA		
Davenport-Rock Island-Moline, IA-IL	0.8471	0.8926
Scott, IA		
Henry, IL		
Rock Island, IL		
Dayton-Springfield, OH	0.9646	0.9756
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
Daytona Beach, FL	0.8906	0.9237
Volusia, FL		
Decatur, AL	0.7487	0.8202
Lawrence, AL		
Morgen, AL		
Decatur, IL	0.8286	0.8792
Macon, IL		
*Denver, CO	1.0762	1.0516
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
Des Moines, IA	0.9171	0.9425
Dallas, IA		
Polk, IA		
Warren, IA		
*Detroit, MI	1.0827	1.0559
Lapeer, MI		
Livingston, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
Saint Clair, MI		
Wayne, MI		
Dothan, AL	0.7569	0.8264
Dale, AL		
Houston, AL		
Dubuque, IA	0.8374	0.8856
Dubuque, IA		
Duluth, MN-WI	0.9517	0.9667
St. Louis, MN		
Douglas, WI		
Eau Claire, WI	0.8481	0.8933
Chippewa, WI		
Eau Claire, WI		
El Paso, TX	0.8714	0.9100
El Paso, TX		
Elkhart-Goshen, IN	0.8872	0.9213
Elkhart, IN		
Elmira, NY	0.8852	0.9199
Chemung, NY		
Enid, OK	0.8912	0.9242
Garfield, OK		
Erie, PA	0.9155	0.9413
Erie, PA		
Eugene-Springfield, OR	1.0164	1.0112
Lane, OR		
Evansville, IN-KY	0.9276	0.9498
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
Fargo-Moorhead, ND-MN	0.9707	0.9798
Clay, MN		
Cass, ND		
Fayetteville, NC	0.8296	0.8799
Cumberland, NC		
Fayetteville-Springdale, AR	0.7990	0.8576
Washington, AR		
Flint, MI	1.1544	1.1033
Genesee, MI		
Florence, AL	0.7717	0.8374
Colbert, AL		
Lauderdale, AL		
Florence, SC	0.8429	0.8896
Florence, SC		
Fort Collins-Loveland, CO	1.0238	1.0162
Larimor, CO		
*Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0356	1.0242
Lee, FL		
Fort Myers-Cape Coral, FL	0.9799	0.9862
Martin, FL		
Fort Pierce, FL	1.1041	1.0702
Martin, FL		
St. Lucie, FL		
Fort Smith, AR-OK	0.7931	0.8532
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
Fort Walton Beach, FL	0.8941	0.9262
Okaloosa, FL		
Fort Wayne, IN	0.8901	0.934
Allen, IN		
De Kalb, IN		
Whitley, IN		
*Fort Worth-Arlington, TX	0.9747	0.9826
Johnson, TX		
Parker, TX		
Tarrant, TX		
Fresno, CA	1.0737	1.0499
Fresno, CA		
Gadsden, AL	0.8199	0.8729
Etowah, AL		
Gainesville, FL	0.8798	0.9160
Alachua, FL		
Bradford, FL		
Galveston-Texas City, TX	0.9428	0.9605
Galveston, TX		
Gary-Hammond, IN	0.9596	0.9722
Lake, IN		
Porter, IN		
Glens Falls, NY	0.9231	0.9467
Warren, NY		
Washington, NY		
Grand Forks, ND	0.9577	0.9708
Grand Forks, ND		
Grand Rapids, MI	0.9883	0.9920
Kent, MI		
Ottawa, MI		
Great Falls, MT	0.9992	0.9995
Cascade, MT		
Greeley, CO	0.9358	0.9556
Weld, CO		
Green Bay, WI	0.9585	0.9714
Brown, WI		
Greensboro-Winston-Salem-High Point, NC	0.9165	0.9120
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
Greenville-Spartanburg, SC	0.8923	0.9249

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) 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	GAF
Greensville, SC		
Pickens, SC		
Spartanburg, SC		
Hagerstown, MD	0.9157	0.9415
Washington, MD		
Hamilton-Middletown, OH	0.9153	0.9412
Butler, OH		
Harrisburg-Lebanon-Carlisle, PA	0.9919	0.9944
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
*Hartford-Middletown-New Britain-Bristol, CT	1.1910	1.1272
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
Hickory, NC	0.8666	0.9066
Alexander, NC		
Burke, NC		
Catawba, NC		
Honolulu, HI	1.1580	1.1057
Honolulu, HI		
Houma-Thibodaux, LA	0.7344	0.8095
Lafourche, LA		
Terrebonne, LA		
*Houston, TX	0.9935	0.9955
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
Huntington-Ashland, WV-KY-OH	0.9438	0.9612
Boyd, KY		
Carter, KY		
Greenup, KY		
Lasrence, OH		
Cabell, WV		
Wayne, WV		
Huntsville, AL	0.8835	0.9187
Madison, AL		
*Indianapolis, IN	0.9663	0.9768
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
Iowa City, IA	0.9528	0.9674
Johnson, IA		
Jackson, MI	0.8826	0.9180
Jackson, MI		
Jackson, MS	0.7733	0.8386
Hinds, MS		
Madison, MS		
Rankin, MS		
Jackson, TN	0.8329	0.8823
Madison, TN		
Jacksonville, FL	0.9051	0.9340
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
Jacksonville, NC	0.7936	0.8536
Onslow, NC		
Jamestown-Dunkirk, NY	0.6634	0.7550
Chatauqua, NY		
Janesville-Beloit, WI	0.8447	0.8909
Rock, WI		
Jersey City, NJ	1.1276	1.0857
Hudson, NJ		
Johnson City-Kingsport-Bristol, TN-VA	0.8668	0.9067
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
Johnstown, PA	0.8613	0.9026
Cambria, PA		
Somerset, PA		
Joliet, IL	1.0509	1.0346
Grundy, IL		
Will, IL		
Joplin, MO	0.7957	0.8551
Jasper, MO		
Newton, MO		
Kalamazoo, MI	1.1709	1.1141
Kalamazoo, MI		
Kankakee, IL	0.8489	0.8939
Kankakee, IL		
*Kansas City, KS-MO	0.9588	0.9716
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
Kenosha, WI	0.8855	0.9201
Kenosha, WI		
Killeen-Temple, TX	1.1295	1.0870
Bell, TX		
Coryell, TX		
Knoxville, TN	0.8693	0.9085
Anderson, TN		
Blount, TN		
Grainger, TN		
Jefferson, TN		
Knox, TN		
Sevier, TN		
Union, TN		
Kokomo, IN	0.9603	0.9726
Howard, IN		
Tipton, IN		
LaCrosse, WI	0.8956	0.9273
LaCrosse, WI		
Lafayette, LA	0.8227	0.8749
Lafayette, LA		
St. Martin, LA		
Lafayette, IN	0.8432	0.8898
Tippecanoe, IN		
Lake Charles, LA	0.8374	0.8856
Calcasieu, LA		
Lake County, IL	0.9408	0.9591
Lake, IL		
Lakeland-Winter Haven, FL	0.7659	0.8331
Polk, FL		
Lancaster, PA	0.9278	0.9500
Lancaster, PA		
Lansing-East Lansing, MI	1.0222	1.0151
Clinton, MI		
Eaton, MI		
Ingham, MI		
Laredo, TX	0.7278	0.8045
Webb, TX		
Las Cruces, NM	0.7909	0.8516
Dona Ana, NM		
Las Vegas, NV	1.0631	1.0428
Clark, NV		
Lawrence, KS	0.7504	0.8215
Douglas, KS		
Lawton, OK	0.8388	0.8866
Comanche, OK		
Lewiston-Auburn, ME	0.8457	0.8916
Androscoggin, ME		
Lexington-Fayette, KY	0.8446	0.8908
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Scott, KY		
Woodford, KY		
Lima, OH	0.8453	0.8913
Allen, OH		
Auglaize, OH		
Lincoln, NE	0.8956	0.9273
Lancaster, NE		
Little Rock-North Little Rock, AR	0.8420	0.8889
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
Longview-Marshall, TX	0.8691	0.9084
Gregg, TX		
Harrison, TX		
Lorain-Elyria, OH	0.8896	0.9230
Lorain, OH		
*Los Angeles-Long Beach, CA	1.2359	1.1561
Los Angeles, CA		
Louisville, KY-IN	0.9092	0.9369
Clark, IN		
Floyd, IN		
Harrison, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
Shelby, KY		
Lubbock, TX	0.8790	0.9155
Lubbock, TX		
Lynchburg, VA	0.8544	0.8978
Amherst, VA		
Campbell, VA		
Lynchburg City, VA		
Macon-Warner Robins, GA	0.8804	0.9165
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Madison, WI	1.0311	1.0212
Dane, WI		
Manchester-Nashua, NH	1.0130	1.0089
Hillsborough, NH		
Merrimack, NH		
Mansfield, OH	0.8392	0.8869
Richland, OH		
Mayaguez, PR	0.4771	0.6024
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
San German, PR		
McAllen-Edinburg-Mission, TX	0.7715	0.8372
Hidalgo, TX		
Medford, OR	1.0045	1.0031
Jackson, OR		
Melbourne-Titusville, FL	0.8730	0.9112

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) 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	GAF
Brevard, FL		
Memphis, TN-AR-MS	0.9060	0.9346
Crittenden, AR		
De Soto, MS		
Shelby, TN		
Tipton, TN		
Merced, CA	1.0315	1.0215
Merced, CA		
*Miami-Hialeah, FL	0.9955	0.9969
Dade, FL		
*Middlesex-Somerset-Hunterdon, NJ	1.0409	1.0278
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
Midland, TX	1.0377	1.0257
Midland, TX		
*Milwaukee, WI	0.9719	0.9807
Milwaukee, WI		
Ozaukee, WI,		
Washington, WI		
Waukesha, WI		
*Minneapolis-St. Paul, MN-WI	1.0818	1.0553
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Washington, MN		
Wright, MN		
St. Croix, WI		
Mobile, AL	0.8244	0.8761
Baldwin, AL		
Mobile, AL		
Modesto, CA	1.1388	1.0931
Stanislaus, CA		
Monmouth-Ocean, NJ	0.9912	0.9940
Monmouth, NJ		
Ocean, NJ		
Monroe, LA	0.7864	0.8483
Ouachita, LA		
Montgomery, AL	0.7738	0.8389
Autauga, AL		
Elmore, AL		
Montgomery, AL		
Muncie, IN	0.8068	0.8633
Delaware, IN		
Muskegon, MI	0.9853	0.9899
Muskegon, MI		
Naples, FL	1.0324	1.0221
Collier, FL		
Nashville, TN	0.9397	0.9583
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
*Nassau-Suffolk, NY	1.2154	1.1429
Nassau, NY		
Suffolk, NY		
New Bedford-Fall River-Attleboro, MA	1.1713	1.1144
Bristol, MA		
New Haven-Waterbury-Meriden, CT	1.2095	1.1391
New Haven, CT		
New London-Norwich, CT	1.1571	1.1051
New London, CT		
*New Orleans, LA	0.8908	0.9239
Jefferson, LA		
Orleans, LA		
St. Bernard, LA		
St. Charles, LA		
St. John The Baptist, LA		
St. Tammany, LA		
*New York, NY	1.3460	1.2257
Bronx, NY		
Kings, NY		
New York City, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
*Newark, NJ	1.0906	1.0612
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Niagara Falls, NY	0.7560	0.8257
Niagara, NY		
*Norfolk-Virginia Beach-Newport News, VA	0.8515	0.8958
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	1.4529	1.2915
Alameda, CA		
Contra Costa, CA		
Ocala, FL	0.8614	0.9029
Marion, FL		
Odessa, TX	1.0839	1.0567
Ector, TX		
Oklahoma City, OK	0.9145	0.9406
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
Olympia, WA	1.1002	1.0676
Thurston, WA		
Omaha, NE-IA	0.8989	0.9296
Pottawattamie, IA		
Douglas, NE		
Sarpy, NE		
Washington, NE		
Orange County, NY	1.0121	1.0083
Orange, NY		
*Orlando, FL	0.9621	0.9739
Orange, FL		
Osceola, FL		
Seminole, FL		
Owensboro, KY	0.8151	0.8694
Daviess, KY		
Oxnard-Ventura, CA	1.1792	1.1195
Ventura, CA		
Panama City, FL	0.8632	0.9042
Bay, FL		
Parkersburg-Marietta, WV-OH	0.8540	0.8976
Washington, OH		
Wood, WV		
Pascagoula, MS	0.8771	0.9141
Jackson, MS		
Pensacola, FL	0.8623	0.9035
Escambia, FL		
Santa Rosa, FL		
Peoria, IL	0.8710	0.9098
Peoria, IL		
Tazewell, IL		
Woodford, IL		
*Philadelphia, PA-NJ	1.0952	1.0643
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
*Phoenix, AZ	1.0429	1.0292
Maricopa, AZ		
Pine Bluff, AR	0.6979	0.7817
Jefferson, AR		
*Pittsburgh, PA	1.0127	1.0087
Allegheny, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
Pittsfield, MA	1.0782	1.0529
Berkshire, MA		
Ponce, PR	0.4601	0.5877
Juana Diaz, PR		
Ponce, PR		
*Portland, ME	0.9257	0.9485
Cumberland, ME		
Sagadahoc, ME		
York, ME		
*Portland, OR	1.1576	1.1054
Clackamas, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Portsmouth-Dover-Rochester, NH	1.0027	1.0018
Rockingham, NH		
Strafford, NH		
Poughkeepsie, NY	0.9369	0.9563
Dutchess, NY		
*Providence-Pawtucket-Woonsocket, RI	1.0380	1.0259
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
Provo-Orem, UT	1.0230	1.0157
Utah, UT		
Pueblo, CO	0.8722	0.9106
Pueblo, CO		
Racine, WI	0.8488	0.8938
Racine, WI		
Raleigh-Durham, NC	0.9465	0.9630
Durham, NC		
Franklin, NC		
Orange, NC		
Wake, NC		
Rapid City, SD	0.8400	0.8875
Pennington, SD		
Reading, PA	1.0271	1.0185
Berks, PA		
Redding, CA	1.0549	1.0373

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) 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	GAF
Shasta, CA		
Reno, NV	1.1618	1.1082
Washoe, NV		
Richland-Kennewick, WA	0.9402	0.9587
Benton, WA		
Franklin, WA		
Richmond-Petersburg, VA	0.9417	0.9597
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	1.1107	1.0745
Riverside, CA		
San Bernardino, CA		
Roanoke, VA	0.8284	0.8790
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
Rochester, MN	1.1030	1.0694
Olmsted, MN		
*Rochester, NY	0.9710	0.9800
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
Rockford, IL	0.9283	0.9503
Boone, IL		
Winnebago, IL		
*Sacramento, CA	1.2253	1.1493
Eldorado, CA		
Placer, CA		
Sacramento, CA		
Yolo, CA		
Saginaw-Bay City-Midland, MI	1.0484	1.0329
Bay, MI		
Midland, MI		
Saginaw, MI		
St. Cloud, MN	0.8919	0.9246
Benton, MN		
Sherburne, MN		
Stearns, MN		
St. Joseph, MO	0.9414	0.9595
Buchanan, MO		
*St. Louis, MO-IL	0.9388	0.9577
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	0.9837	0.9888
Marion, OR		
Polk, OR		
Salinas-Seaside-Monterey, CA	1.3041	1.1994
Monterey, CA		
*Salt Lake City-Ogden, UT	0.9932	0.9953
Davis, UT		
Salt Lake, UT		
Weber, UT		
San Angelo, TX	0.8139	0.8685
Tom Green, TX		
*San Antonio, TX	0.8452	0.8912
Bexar, TX		
Comal, TX		
Guadalupe, TX		
*San Diego, CA	1.1934	1.1287
San Diego, CA		
*San Francisco, CA	1.4447	1.2665
Marin, CA		
San Francisco, CA		
San Mateo, CA		
*San Jose, CA	1.4900	1.3140
Santa Clara, CA		
*San Juan, PR	0.4987	0.6210
Barcelona, PR		
Bayoman, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trojillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Santa Barbara-Santa Maria-Lompoc, CA	1.1805	1.1203
Santa Barbara, CA		
Santa Cruz, CA	1.1618	1.1212
Santa Cruz, CA		
Santa Fe, NM	0.9162	0.9416
Los Alamos, NM		
Santa Fe, NM		
Santa Rosa-Petaluma, CA	1.2957	1.1941
Sonoma, CA		
Sarasota, FL	0.9781	0.9850
Sarasota, FL		
Savannah, GA	0.8327	0.8822
Chatham, GA		
Effingham, GA		
Scranton-Wilkes Barre, PA	0.8959	0.9275
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Monroe, PA		
Wyoming, PA		
*Seattle, WA	1.0871	1.0589
King, WA		
Snohomish, WA		
Sharon, PA	0.8914	0.9243
Mercer, PA		
Sheboygan, WI	0.8872	0.9213
Sheboygan, WI		
Sherman-Denison, TX	0.9089	0.9367
Grayson, TX		
Shreveport, LA	0.9299	0.9514
Bossier, LA		
Caddo, LA		
Sioux City, IA-NE	0.8504	0.8950
Woodbury, IA		
Dakota, NE		
Sioux Falls, SD	0.8833	0.9185
Minnehaha, SD		
South Bend-Mishawaka, IN	1.0067	1.0046
St. Joseph, IN		
Spokane, WA	1.0691	1.0468
Spokane, WA		
Springfield, IL	0.9295	0.9512
Menard, IL		
Sangamon, IL		
Springfield, MO	0.8082	0.8643
Christian, MO		
Greene, MO		
Springfield, MA	0.9589	0.9717
Hampden, MA		
Hampshire, MA		
State College, PA	0.9901	0.9932
Centre, PA		
Steubenville-Weirton, OH-WV	0.8712	0.9099
Jefferson, OH		
Brooke, WV		
Hancock, WV		
Stockton, CA	1.1789	1.1193
San Joaquin, CA		
Syracuse, NY	0.9917	0.9943
Madison, NY		
Onondaga, NY		
Oswego, NY		
Tacoma, WA	0.9868	0.9909
Pierce, WA		
Tallahassee, FL	0.9220	0.9459
Gadsden, FL		
Leon, FL		
*Tampa-St. Petersburg-Clearwater, FL	0.9186	0.9437
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
Terre Haute, IN	0.8758	0.9132
Clay, IN		
Vigo, IN		
Texarkana-TX-Texarkana, AR	0.7906	0.8514
Miller, AR		
Bowie, TX		
Toledo, OH	0.8714	0.9100
Fulton, OH		
Lucas, OH		
Wood, OH		
Topeka, KS	0.9302	0.9517
Shawnee, KS		
Trenton, NJ	1.0038	1.0026
Mercer, NJ		
Tuscon, AZ	0.9620	0.9738
Pima, AZ		
Tulsa, OK	0.8532	0.8970
Creeks, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
Tuscaloosa, AL	0.8521	0.8962
Tuscaloosa, AL		
Tyler, TX	0.9838	0.9889
Smith, TX		
Utica-Rome, NY	0.8402	0.8876
Herkimer, NY		
Oneida, NY		
Vallejo-Fairfield-Napa, CA	1.2917	1.1916

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) 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	GAF
Napa, CA		
Salano, CA		
Vancouver, WA	1.0712	1.0482
Clark, WA		
Victoria, TX	0.8994	0.9300
Victoria, TX		
Vineland-Millville-Bridgeton, NJ	0.9649	0.9758
Cumberland, NJ		
Visalia-Tulare-Porterville, CA	1.0392	1.0267
Tulare, CA		
Waco, TX	0.7814	0.8446
McLennan, TX		
*Washington, DC-MD-VA	1.0941	1.0635
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Loudoun, VA		
Manassas City, VA		
Manassis Park City, VA		
Prince William, VA		
Stafford, VA		
Waterloo-Cedar Falls, IA	0.8642	0.9049
Black Hawk, IA		
Bremer, IA		
Wausau, WI	0.9748	0.9827
Marathon, WI		
West Palm Beach-Boca Raton-Delray Beach, FL	1.0291	1.0198
Palm Beach, FL		
Wheeling, WV-OH	0.6926	0.7776
Belmont, OH		
Marshall, WV		
Ohio, WV		
Wichita, KS	0.9809	0.9869
Butler, KS		
Harvey, KS		
Sedgwick, KS		
Wichita Falls, TX	0.8172	0.8709
Wichita, TX		
Williamsport, PA	0.8864	0.9207
Lycoming, PA		
Wilmington, DE-NJ-MD	1.0884	1.0597
New Castle, DE		
Cecil, MD		
Salem, NJ		
Wilmington, NC	0.8712	0.9099
New Hanover, NC		
Worcester-Fitchburg-Leominster, MA	0.9694	0.9789
Worcester, MA		
Yakima, WA	1.0111	1.0076
Yakima, WA		
York, PA	0.8613	0.9028
Adams, PA		
York, PA		
Youngstown-Warren, OH	0.9866	0.9908
Mahoning, OH		
Trumbull, OH		
Yuba City, CA	1.0142	1.0097
Sutter, CA		
Yuba, Ca		
Yuma, AZ	0.8747	0.9124
Yuma, AZ		

TABLE 4a.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) 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	GAF
Yuba, Ca		
Yuma, AZ	0.8747	0.9124
Yuma, AZ		

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7121	0.7925
Alaska	1.3498	1.2280
Arizona	0.8747	0.9124
Arkansas	0.6966	0.7807
California	1.0142	1.0097
Colorado	0.8415	0.8885
Connecticut	1.1905	1.1268
Delaware	0.8572	0.8999
Florida	0.8730	0.9112
Georgia	0.7773	0.8415
Hawaii	0.9618	0.9737
Idaho	0.9105	0.9378
Illinois	0.7700	0.8361
Indiana	0.7806	0.8440
Iowa	0.7532	0.8236
Kansas	0.7446	0.8171
Kentucky	0.7793	0.8430
Louisiana	0.7384	0.8125
Maine	0.8328	0.8822
Maryland	0.8061	0.8628
Massachusetts	1.1713	1.1144
Michigan	0.8826	0.9180
Minnesota	0.8309	0.8809
Mississippi	0.6957	0.7800
Missouri	0.7249	0.8023
Montana	0.8255	0.8769
Nebraska	0.6995	0.7829
Nevada	0.9702	0.9795
New Hampshire	0.9547	0.9688
New Jersey [1]		
New Mexico	0.8318	0.8815
New York	0.8402	0.8876
North Carolina	0.7936	0.8536
North Dakota	0.7719	0.8375
Ohio	0.8453	0.8913
Oklahoma	0.7400	0.8137
Oregon	0.9607	0.9729
Pennsylvania	0.8613	0.9028
Puerto Rico	0.4333	0.5640
Rhode Island [1]		
South Carolina	0.7650	0.8324
South Dakota	0.7168	0.7961
Tennessee	0.7340	0.8091
Texas	0.7591	0.8280
Utah	0.9044	0.9335
Vermont	0.9706	0.9798
Virginia	0.7826	0.8455
Washington	0.9635	0.9749
West Virginia	0.8488	0.8938
Wisconsin	0.8447	0.8906
Wyoming	0.8457	0.8916

[1] All counties within the State are classified urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area reclassified to—	Wage index	GAF
Abilene, TX	0.9429	0.9605
Aguadilla, PR	0.4568	0.5848
Akron, OH	0.8921	0.9248
Albany, GA	0.7897	0.8507
Albany-Schenectady-Troy, NY	0.8956	0.9273
Albany-Schenectady-Troy, NY (Rural Vermont Hospitals)	0.9706	0.9798
Albuquerque, NM	0.9942	0.9960
Alexandria, LA	0.8050	0.8620
Allentown-Bethlehem-Easton, PA-NJ	0.8797	0.9160
Altoona, PA	0.9238	0.9472
Amarillo, TX	0.8739	0.9118
Anaheim-Santa Ana, CA	1.1545	1.1034
Anchorage, AK	1.4000	1.2591
Ann Arbor, MI	1.1063	1.0716
Appleton-Oshkosh-Neenah, WI	0.8698	0.9089
Asheville, NC	0.8472	0.8927
Athens, GA	0.7773	0.8415
Atlanta, GA	0.9461	0.9628
Augusta, GA-SC	0.9401	0.9586
Aurora-Elgin, IL	0.8874	0.9215
Baltimore, MD	1.0156	1.0107
Bangor, ME	0.8801	0.9163
Baton Rouge, LA	0.9089	0.9367
Battle Creek, MI	0.9099	0.9374
Beaver County, PA	0.9451	0.9621
Benton Harbor, MI	0.8826	0.9180
Billings, MT	0.9049	0.9339
Biloxi-Gulfport, MS	0.7804	0.8438
Binghamton, NY	0.8868	0.9210
Birmingham, AL	0.8769	0.9140
Bismarck, ND	0.8681	0.9219
Bloomington, IN	0.7806	0.8440
Boise City, ID	0.9558	0.9695
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1574	1.1053
Boston-Lawrence-Salem-Lowell-Brockton, MA (Rural Massachusetts Hospitals)	1.1713	1.1144
Brazoria, TX	0.8792	0.9156
Bremerton, WA	1.0365	1.0249
Buffalo, NY	0.8789	0.9154
Burlington, VT	0.9018	0.9317
Burlington, VT (Rural Vermont Hospitals)	0.9706	0.9798
Caguas, PR	0.4588	0.5865
Canton, OH	0.8453	0.8913
Casper, WY	0.8773	0.9143
*Champaign-Urbana-Rantoul, IL	0.8745	0.9123
Charleston, SC	0.8171	0.8708
Charleston, WV	0.9692	0.9788
Charlotte-Gastonia-Rock Hill, NC-SC	0.9300	0.9515
Charlottesville, VA	0.9374	0.9567
Chattanooga, TN-GA	0.8878	0.9217
Cheyenne, WY	0.7499	0.8211
Chicago, IL	1.0518	1.0352
Chico, CA	1.0826	1.0559
Cincinnati, OH-KY-IN	0.9821	0.9877
Cleveland, OH	1.0475	1.0323
Columbia, MO	0.9269	0.9493
Columbia, SC	0.8748	0.9125
Columbus, GA-AL	0.7371	0.8115
Columbus, OH	0.9518	0.9667
Corpus Christi, TX	0.9638	0.9751
Dallas, TX	0.9638	0.9751
Davenport-Rock Island-Moline, IA-IL	0.8346	0.8835
Dayton-Springfield, OH	0.9646	0.9756
Daytona Beach, FL	0.8906	0.9237
Decatur, AL	0.7331	0.8085
Denver, CO	1.0762	1.0516
Des Moines, IA	0.9032	0.9327

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Detroit, MI	1.0708	1.0480
Dothan, AL	0.7569	0.8264
Dubuque, IA	0.8121	0.8672
Dubuque, IA (Rural Wisconsin Hospitals)	0.8447	0.8909
Duluth, MN-WI	0.9394	0.9581
Eau Claire, WI	0.8481	0.8933
El Paso, TX	0.8714	0.9100
Elkhart-Goshen, IN	0.8872	0.9213
Elmira, NY	0.8659	0.9061
Erie, PA	0.9155	0.9413
Eugene-Springfield, OR	1.0164	1.0112
Evansville, IN-KY	0.8959	0.9275
Fargo-Moorhead, ND-MN	0.9316	0.9526
Fayetteville, NC	0.7936	0.8536
Fayetteville-Springdale, AR	0.7990	0.8576
Flint, MI	1.1208	1.0812
Florence, AL	0.7717	0.8374
Florence, SC	0.8429	0.8896
Fort Collins-Loveland, CO	1.0031	1.0021
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0228	1.0156
Fort Myers-Cape Coral, FL	0.9799	0.9862
Fort Pierce, FL	1.0260	1.0177
Fort Smith, AR	0.7931	0.8532
Fort Walton Beach, FL	0.8941	0.9262
Fort Wayne, IN	0.8658	0.9060
Fort Worth-Arlington, TX	0.9747	0.9826
Fresno, CA	1.0624	1.0423
Galveston-Texas City, TX	0.9428	0.9605
Gary-Hammond, IN	0.9022	0.9319
Glens Falls, NY	0.8989	0.9296
Grand Forks, ND	0.9209	0.9451
Grand Rapids, MI	0.9883	0.9920
Great Falls, MT	0.9262	0.9489
Greeley, CO	0.8956	0.9273
Green Bay, WI	0.9278	0.9500
Greensboro-Winston-Salem-High Point, NC	0.8959	0.9275
Greenville-Spartanburg, SC	0.8768	0.9139
Hagerstown, MD	0.8758	0.9132
Hamilton-Middletown, OH	0.8435	0.8900
Harrisburg-Lebanon-Carlisle, PA	0.9390	0.9578
Hartford-Middletown-New Britain-Bristol, CT	1.1808	1.1205
Hickory, NC	0.8424	0.8892
Honolulu, HI	1.1580	1.1057
Houston, TX	0.9935	0.9955
Huntington-Ashland, WV-KY-OH	0.9255	0.9484
Huntsville, AL	0.8480	0.8932
Indianapolis, IN	0.9551	0.9690
Iowa City, IA	0.9327	0.9534
Jackson, MI	0.8826	0.9180
Jackson, MS	0.7593	0.8281
Jackson, TN	0.8073	0.8636
Jacksonville, FL	0.9051	0.9340
Johnson City-Kingsport-Bristol, TN-VA	0.8668	0.9067
Johnstown, PA	0.8613	0.9028
Joliet, IL	1.0211	1.0144
Joplin, MO	0.7838	0.8464
Kalamazoo, MI	1.1194	1.0803
Kansas City, KS-MO	0.9588	0.9716
Knoxville, TN	0.8693	0.9085
Kokomo, IN	0.9002	0.9305
LaCrosse, WI	0.8749	0.9125
Lafayette, LA	0.8227	0.8749
Lafayette, IN	0.8432	0.8898
Lake Charles, LA	0.8374	0.8856
Lancaster, PA	0.9096	0.9372
Lansing-East Lansing, MI	1.0046	1.0031
Las Vegas, NV	1.0489	1.0332
Lawrence, KS	0.7504	0.8215
Lawton, OK	0.8277	0.8785
Lewiston-Auburn, ME	0.8457	0.8916
Lexington-Fayette, KY	0.8323	0.8819
Lincoln, NE	0.8462	0.8919
Little Rock-North Little Rock, AR	0.8208	0.8735
Longview-Marshall, TX	0.8520	0.8961
Lorain-Elyria, OH	0.8896	0.9230
Los Angeles-Long Beach, CA	1.2359	1.1561
Louisville, KY-IN	0.8969	0.9282
Lubbock, TX	0.8790	0.9155
Lynchburg, VA	0.8389	0.8867
Macon-Warner Robins, GA	0.8622	0.9035
Madison, WI	0.9791	0.9856
Manchester-Nashua, NH	1.0130	1.0089
Mansfield, OH	0.8453	0.8913
Medford, OR	0.9884	0.9920
Memphis, TN-AR-MS	0.8772	0.9142
Merced, CA	1.0315	1.0215
Miami-Hialeah, FL	0.9955	0.9969
Middlesex-Somerset-Hunterdon, NJ	0.9928	0.9951
Midland, TX	1.0377	1.0257
Milwaukee, WI	0.9603	0.9726
Minneapolis-St. Paul, MN-WI	1.0818	1.0553
Mobile, AL	0.8244	0.8761
Modesto, CA	1.1388	1.0931
Monroe, LA	0.7864	0.8483
Montgomery, AL	0.7738	0.8389
Muncie, IN	0.7955	0.8550
Nashville, TN	0.9397	0.9583
New London-Norwich, CT	1.1095	1.0738
New Orleans, LA	0.8908	0.9239
New York, NY	1.3460	1.2257
Newark, NJ	1.0699	1.0474
Norfolk-Virginia Beach-Newport News, VA	0.8515	0.8958
Oakland, CA	1.4529	1.2915
Odessa, TX	1.0839	1.0567
Oklahoma City, OK	0.9145	0.9406
Olympia, WA	1.0390	1.0265
Omaha, NE-IA	0.8989	0.9296
Orange County, NY	1.0121	1.0083
Orlando, FL	0.9446	0.9617
Owensboro, KY	0.8151	0.8694
Oxnard-Ventura, CA	1.1792	1.1195
Panama City, FL	0.8632	0.9042
Parkersburg-Marietta, WV-OH	0.8540	0.8976
Pascagoula, MS	0.8771	0.9141
Peoria, IL	0.8710	0.9098
Philadelphia, PA-NJ	1.0801	1.0542
Phoenix, AZ	1.0429	1.0292
Pine Bluff, AR	0.6979	0.7817
Pittsburgh, PA	0.9960	0.9973
Pittsfield, MA	1.0119	1.0081
Portland, ME	0.9095	0.9371
Portland, OR	1.1421	1.0953
Portsmouth-Dover-Rochester, NH	1.0027	1.0018
Poughkeepsie, NY	0.9369	0.9563
Providence-Pawtucket-Woonsocket, RI	1.0063	1.0043
Provo-Orem, UT	1.0001	1.0001
Pueblo, CO	0.8519	0.8960
Raleigh-Durham, NC	0.9197	0.9443
Rapid City, SD	0.8284	0.8790
Redding, CA	1.0406	1.0276
Reno, NV	1.1438	1.0964
Roanoke, VA	0.8284	0.8790
Rochester, NY	0.9564	0.9699
Rockford, IL	0.9095	0.9371
Sacramento, CA	1.2253	1.1493
Saginaw-Bay City-Midland, MI	1.0211	1.0144
St. Cloud, MN	0.8919	0.9246
St. Louis, MO-IL	0.9248	0.9479
Salem, OR	0.9837	0.9888
Salinas-Seaside-Monterey, CA	1.2899	1.1904
Salt Lake City-Ogden, UT	0.9932	0.9953
San Angelo, TX	0.8139	0.8685
San Antonio, TX	0.8452	0.8912
San Diego, CA	1.1934	1.1287
San Francisco, CA	1.4447	1.2865
San Jose, CA	1.4721	1.3032
San Juan, PR	0.4987	0.6210
Santa Barbara-Santa Maria-Lompoc, CA	1.1636	1.1093
Santa Fe, NM	0.8856	0.9202
Santa Rosa-Petaluma, CA	1.2957	1.1941
Sarasota, FL	0.9446	0.9617
Scranton-Wilkes Barre, PA	0.8856	0.9202
Seattle, WA	1.0719	1.0487
Sharon, PA	0.8914	0.9243
Sheboygan, WI	0.8723	0.9107
Sherman-Denison, TX	0.8934	0.9257
Shreveport, LA	0.9299	0.9514
Sioux City, IA-NE	0.8323	0.8819
Sioux Falls, SD	0.8833	0.9185
South Bend-Mishawaka, IN	0.9686	0.9784
Spokane, WA	1.0691	1.0468
Springfield, IL	0.9193	0.9440
Springfield, MO	0.7915	0.8520
State College, PA	0.9328	0.9535
Steubenville-Weirton, OH-WV	0.8340	0.8831
Stockton, CA	1.1789	1.1193
Syracuse, NY	0.9514	0.9665
Tacoma, WA	0.9868	0.9909
Tallahassee, FL	0.8853	0.9200
Tampa-St. Petersburg-Clearwater, FL	0.9188	0.9437
Terre Haute, IN	0.8651	0.9055
Texarkana, TX-Texarkana, AR	0.7906	0.8514
Toledo, OH	0.8714	0.9100
Toledo, OH (Rural Michigan Hospitals)	0.8826	0.9180
Topeka, KS	0.9302	0.9517
Tucson, AZ	0.9620	0.9738
Tulsa, OK	0.8398	0.8873
Tyler, TX	0.9330	0.9536
Vallejo-Fairfield-Napa, CA	1.2722	1.1792
Vancouver, WA	1.0124	1.0085
Victoria, TX	0.8839	0.9190
Waco, TX	0.7814	0.8446
Washington, DC-MD-VA	1.0941	1.0635
Waterloo-Cedar Falls, IA	0.8642	0.9049
Wausau, WI	0.9069	0.9353
West Palm Beach-Boca Raton-Delray Beach, FL	1.0291	1.0198
Wichita, KS	0.9563	0.9699
Wichita Falls, TX	0.8172	0.8709
Williamsport, PA	0.8707	0.9095
Wilmington, NC	0.8299	0.8801
Worcester-Fitchburg-Leominster, MA	0.9694	0.9789
Yakima, WA	0.9866	0.9990
Youngstown-Warren, OH	0.9507	0.9660
Rural California	0.9983	0.9988
Rural Connecticut	1.1581	1.1057
Rural Georgia	0.7773	0.8415
Rural Illinois	0.7700	0.8361
Rural Indiana	0.7806	0.8440
Rural Iowa	0.7532	0.8236
Rural Kansas	0.7446	0.8171
Rural Kentucky	0.7793	0.8430
Rural Louisiana	0.7384	0.8125
Rural Massachusetts	1.1509	1.1010
Rural Michigan	0.8826	0.9180
Rural Minnesota	0.8309	0.8809
Rural Missouri	0.7249	0.8023
Rural New Hampshire	0.9706	0.9798
Rural North Carolina	0.7936	0.8536

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Rural Ohio	0.8453	0.8913
Rural Oklahoma	0.7400	0.8137
Rural Pennsylvania	0.8613	0.9028
Rural South Dakota	0.7168	0.7961
Rural Texas	0.7591	0.8280
Rural Utah	0.9044	0.9335

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Rural Virginia	0.7826	0.8455
Rural Washington	0.9429	0.9605
Rural Washington (Rural Oregon Hospitals)	0.9607	0.9729
Rural West Virginia	0.8488	0.8938
Rural Wisconsin	0.8447	0.8909

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to—	Wage index	GAF
Rural Wyoming	0.8289	0.8794

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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		CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.2349	11.3	34
2	01	SURG		CRANIOTOMY FOR TRAUMA AGE >17	3.1227	10.7	34
3	01	SURG	*	CRANIOTOMY AGE 0-17	2.9677	12.7	36
4	01	SURG		SPINAL PROCEDURES	2.3569	8.8	32
5	01	SURG		EXTRACRANIAL VASCULAR PROCEDURES	1.5593	5.2	28
6	01	SURG		CARPAL TUNNEL RELEASE	.5510	2.0	22
7	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC	2.5891	11.0	34
8	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	.8055	3.0	26
9	01	MED		SPINAL DISORDERS & INJURIES	1.2840	6.5	30
10	01	MED		NERVOUS SYSTEM NEOPLASMS WITH CC	1.2879	7.4	30
11	01	MED		NERVOUS SYSTEM NEOPLASMS W/O CC	.7738	4.3	27
12	01	MED		DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9516	6.9	30
13	01	MED		MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.8409	6.6	30
14	01	MED		SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.2178	7.0	30
15	01	MED		TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.6704	4.1	27
16	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1154	6.6	30
17	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6477	4.4	27
18	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC	.9168	5.8	29
19	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6016	4.0	27
20	01	MED		NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.9823	8.6	32
21	01	MED		VIRAL MENINGITIS	1.4613	7.2	30
22	01	MED		HYPERTENSIVE ENCEPHALOPATHY	.7290	4.2	27
23	01	MED		NONTRAUMATIC STUPOR & COMA	.8233	4.2	27
24	01	MED		SEIZURE & HEADACHE AGE >17 WITH CC	.9715	5.2	28
25	01	MED		SEIZURE & HEADACHE AGE >17 W/O CC	.5330	3.4	26
26	01	MED		SEIZURE & HEADACHE AGE 0-17	1.0701	3.9	27
27	01	MED		TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3670	4.3	27
28	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC	1.2128	5.9	29
29	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.5965	3.3	26
30	01	MED	*	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3599	2.0	17
31	01	MED		CONCUSSION AGE >17 WITH CC	.7696	4.4	27
32	01	MED		CONCUSSION AGE >17 W/O CC	.4474	2.7	25
33	01	MED	*	CONCUSSION AGE 0-17	.2498	1.6	9
34	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	1.1432	5.9	29
35	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5662	3.6	27

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG		RETINAL PROCEDURES	.6268	1.9	11
37	02	SURG		ORBITAL PROCEDURES	.7899	2.8	26
38	02	SURG		PRIMARY IRIS PROCEDURES	.3607	2.1	16
39	02	SURG		LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.4866	1.5	8
40	02	SURG		EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.5181	2.0	25
41	02	SURG	*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3719	1.6	7
42	02	SURG		INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.5991	1.9	14
43	02	MED		HYPHEMA	.4101	3.7	27
44	02	MED		ACUTE MAJOR EYE INFECTIONS	.5793	5.2	28
45	02	MED		NEUROLOGICAL EYE DISORDERS	.6015	3.5	26
46	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W CC	.7207	4.3	27
47	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4203	2.9	26
48	02	MED	*	OTHER DISORDERS OF THE EYE AGE 0-17	.4086	2.9	26
49	03	SURG		MAJOR HEAD & NECK PROCEDURES	1.6364	5.0	28
50	03	SURG		SIALOADENECTOMY	.6683	2.0	13
51	03	SURG		SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6320	2.1	19
52	03	SURG		CLEFT LIP & PALATE REPAIR	.7808	2.2	18
53	03	SURG		SINUS & MASTOID PROCEDURES AGE >17	.7264	2.0	24
54	03	SURG	*	SINUS & MASTOID PROCEDURES AGE 0-17	.7006	3.2	22
55	03	SURG		MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.5480	1.7	15
56	03	SURG		RHINOPLASTY	.6144	1.9	17
57	03	SURG		T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8995	3.3	26
58	03	SURG	*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3150	1.5	4
59	03	SURG		TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.4367	1.5	10
60	03	SURG	*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2660	1.5	4
61	03	SURG		MYRINGOTOMY W TUBE INSERTION AGE >17	.8791	2.6	26
62	03	SURG	*	MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3142	1.3	5
63	03	SURG		OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.0570	3.7	27
64	03	MED		EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.0975	5.1	28
65	03	MED		DYSEQUILIBRIUM	.4944	3.3	23
66	03	MED		EPISTAXIS	.4898	3.3	25
67	03	MED		EPIGLOTTITIS	.8271	4.1	27
68	03	MED		OTITIS MEDIA & URI AGE >17 WITH CC	.7223	4.7	28
69	03	MED		OTITIS MEDIA & URI AGE >17 W/O CC	.5038	3.6	22
70	03	MED		OTITIS MEDIA & URI AGE 0-17	.6458	3.3	26

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TABLE 5

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED		LARYNGOTRACHEITIS	.7794	4.1	27
72	03	MED		NASAL TRAUMA & DEFORMITY	.5800	3.2	26
73	03	MED		OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7460	4.1	27
74	03	MED	*	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	.3485	2.1	20
75	04	SURG		MAJOR CHEST PROCEDURES	3.0434	11.1	34
76	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3930	10.6	34
77	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1306	5.2	28
78	04	MED		PULMONARY EMBOLISM	1.4381	8.4	31
79	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC	1.7150	8.8	32
80	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	.9485	6.3	29
81	04	MED	*	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.1219	6.1	29
82	04	MED		RESPIRATORY NEOPLASMS	1.1901	6.3	29
83	04	MED		MAJOR CHEST TRAUMA WITH CC	.9477	6.0	29
84	04	MED		MAJOR CHEST TRAUMA W/O CC	.4799	3.4	26
85	04	MED		PLEURAL EFFUSION WITH CC	1.1723	6.7	30
86	04	MED		PLEURAL EFFUSION W/O CC	.6630	4.0	27
87	04	MED		PULMONARY EDEMA & RESPIRATORY FAILURE	1.3585	5.8	29
88	04	MED		CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9950	5.8	29
89	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.1478	6.9	30
90	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.7080	5.2	28
91	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.9381	4.8	28
92	04	MED		INTERSTITIAL LUNG DISEASE WITH CC	1.1660	6.6	30
93	04	MED		INTERSTITIAL LUNG DISEASE W/O CC	.7374	4.7	28
94	04	MED		PNEUMOTHORAX WITH CC	1.2701	7.0	30
95	04	MED		PNEUMOTHORAX W/O CC	.5978	4.3	27
96	04	MED		BRONCHITIS & ASTHMA AGE >17 WITH CC	.9355	5.8	29
97	04	MED		BRONCHITIS & ASTHMA AGE >17 W/O CC	.6222	4.3	24
98	04	MED		BRONCHITIS & ASTHMA AGE 0-17	.9254	4.6	28
99	04	MED		RESPIRATORY SIGNS & SYMPTOMS WITH CC	.7598	3.8	27
100	04	MED		RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5063	2.5	17
101	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC	.8956	4.9	28
102	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5385	3.3	26
103	05	SURG		HEART TRANSPLANT	12.0076	23.5	46
104	05	SURG		CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.7901	17.1	40
105	05	SURG		CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.8509	11.9	35

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.6949	13.3	36
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.2763	10.2	33
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.9112	12.3	35
109			NO LONGER VALID	.0000	.0	0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES WITH CC	4.0937	9.9	33
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.3178	7.3	30
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	2.0008	4.5	28
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.7699	13.9	37
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6038	8.9	32
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	3.6230	11.2	34
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GEN PROC C	2.4759	5.3	28
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.2405	3.7	27
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6001	2.5	26
119	05	SURG	VEIN LIGATION & STRIPPING	.9692	3.5	26
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9968	7.2	30
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	1.6191	7.8	31
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE	1.1639	5.7	29
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4089	2.9	26
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.2107	4.2	27
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	.7652	2.2	22
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.8616	15.5	39
127	05	MED	HEART FAILURE & SHOCK	1.0159	5.9	29
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7910	7.2	30
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.2912	2.4	25
130	05	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	.9149	6.1	29
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5909	4.7	28
132	05	MED	ATHEROSCLEROSIS WITH CC	.7632	4.0	27
133	05	MED	ATHEROSCLEROSIS W/O CC	.5347	2.9	24
134	05	MED	HYPERTENSION	.5686	3.8	27
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 WITH CC	.8716	4.7	28
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	.5352	3.1	25
137	05	MED	* CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.6422	3.3	26
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC	.8142	4.3	27
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5067	2.9	21
140	05	MED	ANGINA PECTORIS	.6266	3.6	24

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.7030	4.2	27
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5087	3.1	22
143	05	MED	CHEST PAIN	.5202	2.7	18
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0691	5.0	28
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6304	3.1	26
146	06	SURG	RECTAL RESECTION WITH CC	2.5585	11.9	35
147	06	SURG	RECTAL RESECTION W/O CC	1.5519	8.3	31
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	3.1528	13.0	36
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5106	8.3	28
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.5671	11.3	34
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2025	6.3	29
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.7859	8.8	32
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0483	6.5	25
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 WITH CC	4.0735	14.0	37
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 W/O CC	1.4849	7.2	30
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8524	6.0	29
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	.9639	4.5	27
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5020	2.4	17
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 WITH CC	1.0840	4.7	28
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	.6226	2.7	19
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 WITH CC	.7862	3.2	26
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.4684	1.8	11
163	06	SURG	HERNIA PROCEDURES AGE 0-17	.4646	2.1	10
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.1773	9.5	32
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2206	6.4	25
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.3383	5.9	29
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.7550	3.6	15
168	03	SURG	MOUTH PROCEDURES WITH CC	1.0037	3.5	26
169	03	SURG	MOUTH PROCEDURES W/O CC	.5928	2.1	19
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7235	10.6	34
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1181	5.0	28
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.2967	7.0	30
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6455	3.5	27
174	06	MED	G.I. HEMORRHAGE WITH CC	.9841	5.3	28
175	06	MED	G.I. HEMORRHAGE W/O CC	.5567	3.6	22

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED		COMPLICATED PEPTIC ULCER	1.0421	5.8	29
177	06	MED		UNCOMPLICATED PEPTIC ULCER WITH CC	.7987	5.0	28
178	06	MED		UNCOMPLICATED PEPTIC ULCER W/O CC	.5766	3.7	22
179	06	MED		INFLAMMATORY BOWEL DISEASE	1.1102	7.0	30
180	06	MED		G.I. OBSTRUCTION WITH CC	.9312	5.7	29
181	06	MED		G.I. OBSTRUCTION W/O CC	.5059	3.8	25
182	06	MED		ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 WITH CC	.7744	4.8	28
183	06	MED		ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	.5350	3.4	24
184	06	MED		ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.4682	2.8	17
185	03	MED		DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	.7998	4.5	27
186	03	MED	*	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	.4181	2.9	23
187	03	MED		DENTAL EXTRACTIONS & RESTORATIONS	.5799	2.6	26
188	06	MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 WITH CC	.9995	5.2	28
189	06	MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.4833	2.8	26
190	06	MED		OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.6676	4.2	27
191	07	SURG		PANCREAS, LIVER & SHUNT PROCEDURES WITH CC.	4.4563	15.1	38
192	07	SURG		PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7402	7.7	31
193	07	SURG		BILIARY TRACT PROC W CC EXCEPT ONLY CHOLECYST W OR W/O CDE .D.E	3.0458	13.6	37
194	07	SURG		BILIARY TRACT PROC W/O CC EXCEPT ONLY CHOLECYST W OR W/O C.D.E	1.6456	7.9	31
195	07	SURG		CHOLECYSTECTOMY W C.D.E. WITH CC	2.2861	10.4	33
196	07	SURG		CHOLECYSTECTOMY W C.D.E. W/O CC	1.4276	7.3	30
197	07	SURG		CHOLECYSTECTOMY W/O C.D.E. WITH CC	1.7014	6.2	29
198	07	SURG		CHOLECYSTECTOMY W/O C.D.E. W/O CC	.8839	2.7	26
199	07	SURG		HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3390	10.9	34
200	07	SURG		HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.6811	8.9	32
201	07	SURG		OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.5417	10.0	33
202	07	MED		CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3029	6.9	30
203	07	MED		MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.2203	6.8	30
204	07	MED		DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1201	6.0	29
205	07	MED		DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA WITH CC	1.2281	6.5	30
206	07	MED		DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6172	3.6	27
207	07	MED		DISORDERS OF THE BILIARY TRACT WITH CC	.9866	5.3	28
208	07	MED		DISORDERS OF THE BILIARY TRACT W/O CC	.5603	3.1	26
209	08	SURG		MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - LOWER EXTREMITY	2.3848	9.4	32
210	08	SURG		HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC	1.9186	10.7	34

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TABLE 5

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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	1.3438	8.3	31
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.0490	4.2	27
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7656	9.2	32
214	08	SURG	BACK & NECK PROCEDURES WITH CC	1.8748	8.1	31
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.0972	5.1	28
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.0448	10.0	33
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.0412	13.5	37
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 WITH CC	1.4242	6.8	30
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	.9017	4.2	26
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	.9398	5.3	28
221	08	SURG	KNEE PROCEDURES WITH CC	1.7993	7.3	30
222	08	SURG	KNEE PROCEDURES W/O CC	.9709	3.7	27
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	.8124	3.0	22
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	.6573	2.4	14
225	08	SURG	FOOT PROCEDURES	.8255	3.3	26
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3386	5.8	29
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6847	2.8	24
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	.8083	2.5	25
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5567	1.9	14
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.9269	3.9	27
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	1.1114	3.9	27
232	08	SURG	ARTHROSCOPY	1.1827	3.6	27
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC	1.8439	8.2	31
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	.9044	3.9	27
235	08	MED	FRACTURES OF FEMUR	1.0150	6.8	30
236	08	MED	FRACTURES OF HIP & PELVIS	.8161	6.2	29
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5525	4.2	27
238	08	MED	OSTEOMYELITIS	1.5507	10.2	33
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0448	7.4	30
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.1342	6.8	30
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5842	4.3	27
242	08	MED	SEPTIC ARTHRITIS	1.1927	7.8	31
243	08	MED	MEDICAL BACK PROBLEMS	.6867	5.0	28
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7422	5.2	28
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5120	3.8	27

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED		NON-SPECIFIC ARTHROPATHIES	.5713	4.2	27
247	08	MED		SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	.5676	3.6	27
248	08	MED		TENDONITIS, MYOSITIS & BURSITIS	.6765	4.5	27
249	08	MED		AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.7006	4.1	27
250	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 WITH CC	.7053	4.5	28
251	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	.4428	2.6	25
252	08	MED	*	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.3555	1.8	15
253	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 WITH CC	.7786	5.5	29
254	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	.4249	3.4	26
255	08	MED	*	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4717	2.9	26
256	08	MED		OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	.6544	3.7	27
257	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY WITH CC	.9025	4.2	23
258	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7070	3.2	14
259	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC	.8855	3.6	27
260	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.5736	2.2	12
261	09	SURG		BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	.7220	2.2	14
262	09	SURG		BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.5432	2.1	23
263	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS WITH CC	2.5340	14.2	37
264	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.2745	8.2	31
265	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.3952	5.9	29
266	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	.7069	3.0	26
267	09	SURG		PERIANAL & PILONIDAL PROCEDURES	.6361	2.8	26
268	09	SURG		SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	.7640	2.6	26
269	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE WITH CC	1.7053	8.0	31
270	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE W/O CC	.6458	2.8	26
271	09	MED		SKIN ULCERS	1.2022	8.4	31
272	09	MED		MAJOR SKIN DISORDERS WITH CC	1.0535	7.1	30
273	09	MED		MAJOR SKIN DISORDERS W/O CC	.6648	5.2	28
274	09	MED		MALIGNANT BREAST DISORDERS WITH CC	1.1607	6.7	30
275	09	MED		MALIGNANT BREAST DISORDERS W/O CC	.6015	3.1	26
276	09	MED		NON-MALIGANT BREAST DISORDERS	.6157	4.0	27
277	09	MED		CELLULITIS AGE >17 WITH CC	.9103	6.8	30
278	09	MED		CELLULITIS AGE >17 W/O CC	.6015	5.1	28
279	09	MED	*	CELLULITIS AGE 0-17	.7492	4.2	24
280	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC	.6833	4.6	28

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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	.4271	3.1	26
282	09	MED	*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.3482	2.2	19
283	09	MED		MINOR SKIN DISORDERS WITH CC	.7606	5.2	28
284	09	MED		MINOR SKIN DISORDERS W/O CC	.4514	3.4	26
285	10	SURG		AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.7319	14.5	38
286	10	SURG		ADRENAL & PITUITARY PROCEDURES	2.4111	9.0	32
287	10	SURG		SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.1723	12.5	35
288	10	SURG		O.R. PROCEDURES FOR OBESITY	2.0959	7.0	30
289	10	SURG		PARATHYROID PROCEDURES	1.0320	3.7	27
290	10	SURG		THYROID PROCEDURES	.7500	2.6	16
291	10	SURG		THYROGLOSSAL PROCEDURES	.4939	1.7	9
292	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.8505	11.9	35
293	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1593	5.2	28
294	10	MED		DIABETES AGE >35	.7508	5.6	29
295	10	MED		DIABETES AGE 0-35	.7769	4.3	27
296	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.9433	5.9	29
297	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5319	3.9	27
298	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.5779	2.8	26
299	10	MED		INBORN ERRORS OF METABOLISM	.8209	4.5	27
300	10	MED		ENDOCRINE DISORDERS WITH CC	1.1212	6.8	30
301	10	MED		ENDOCRINE DISORDERS W/O CC	.5818	3.9	27
302	11	SURG		KIDNEY TRANSPLANT	3.9177	13.5	37
303	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6685	10.9	34
304	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.3986	9.8	33
305	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1708	5.0	28
306	11	SURG		PROSTATECTOMY WITH CC	1.2840	6.5	30
307	11	SURG		PROSTATECTOMY W/O CC	.6947	3.7	20
308	11	SURG		MINOR BLADDER PROCEDURES WITH CC	1.4432	6.0	29
309	11	SURG		MINOR BLADDER PROCEDURES W/O CC	.7402	2.9	26
310	11	SURG		TRANSURETHRAL PROCEDURES WITH CC	.8938	3.8	27
311	11	SURG		TRANSURETHRAL PROCEDURES W/O CC	.5215	2.1	14
312	11	SURG		URETHRAL PROCEDURES, AGE >17 WITH CC	.8169	3.7	27
313	11	SURG		URETHRAL PROCEDURES, AGE >17 W/O CC	.4667	2.1	17
314	11	SURG	*	URETHRAL PROCEDURES, AGE 0-17	.4398	2.3	25
315	11	SURG		OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0508	6.6	30

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED		RENAL FAILURE	1.2942	6.2	29
317	11	MED		ADMIT FOR RENAL DIALYSIS	.5108	2.8	26
318	11	MED		KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.1258	5.9	29
319	11	MED		KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5104	2.5	25
320	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	.9857	6.5	29
321	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.6299	4.8	27
322	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6850	4.9	28
323	11	MED		URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY	.7416	3.1	26
324	11	MED		URINARY STONES W/O CC	.3903	2.1	13
325	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	.6579	4.2	27
326	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4182	2.8	22
327	11	MED	*	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.5604	3.1	26
328	11	MED		URETHRAL STRICTURE AGE >17 WITH CC	.6434	3.6	27
329	11	MED		URETHRAL STRICTURE AGE >17 W/O CC	.4147	2.1	18
330	11	MED	*	URETHRAL STRICTURE AGE 0-17	.2835	1.6	9
331	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	.9797	5.3	28
332	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5376	3.0	26
333	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.9568	5.2	28
334	12	SURG		MAJOR MALE PELVIC PROCEDURES W CC	1.7876	8.2	27
335	12	SURG		MAJOR MALE PELVIC PROCEDURES W/O CC	1.3796	6.9	19
336	12	SURG		TRANSURETHRAL PROSTATECTOMY WITH CC	.8905	4.7	25
337	12	SURG		TRANSURETHRAL PROSTATECTOMY W/O CC	.6141	3.5	12
338	12	SURG		TESTES PROCEDURES, FOR MALIGNANCY	.7881	2.8	26
339	12	SURG		TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.7077	2.7	26
340	12	SURG	*	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.4409	2.4	13
341	12	SURG		PENIS PROCEDURES	.9716	3.3	25
342	12	SURG		CIRCUMCISION AGE >17	.5888	2.5	25
343	12	SURG	*	CIRCUMCISION AGE 0-17	.3852	1.7	6
344	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0639	3.9	27
345	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.7572	3.2	26
346	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	.9977	5.7	29
347	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5218	2.9	26
348	12	MED		BENIGN PROSTATIC HYPERTROPHY WITH CC	.6888	4.0	27
349	12	MED		BENIGN PROSTATIC HYPERTROPHY W/O CC	.4034	2.3	20
350	12	MED		INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6739	4.8	28

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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
351	12	MED	*	STERILIZATION, MALE	.3390	1.3	5
352	12	MED		OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5853	3.2	26
353	13	SURG		PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.9325	9.3	32
354	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.3856	6.8	30
355	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.8607	4.7	12
356	13	SURG		FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7087	3.8	15
357	13	SURG		UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.3204	10.0	33
358	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.1154	5.6	22
359	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.7796	4.2	11
360	13	SURG		VAGINA, CERVIX & VULVA PROCEDURES	.8119	4.0	27
361	13	SURG		LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.9995	3.6	27
362	13	SURG	*	ENDOSCOPIC TUBAL INTERRUPTION	.5066	1.4	5
363	13	SURG		D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6328	3.0	25
364	13	SURG		D&C, CONIZATION EXCEPT FOR MALIGNANCY	.5703	2.6	26
365	13	SURG		OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7333	7.1	30
366	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.2102	6.4	29
367	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.4966	2.7	26
368	13	MED		INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8830	5.8	29
369	13	MED		MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5461	3.2	26
370	14	SURG		CESAREAN SECTION W CC	.8892	5.2	24
371	14	SURG		CESAREAN SECTION W/O CC	.6447	4.0	11
372	14	MED		VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4679	2.9	19
373	14	MED		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3189	2.1	8
374	14	SURG		VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6246	2.8	23
375	14	SURG	*	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6933	4.4	27
376	14	MED		POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3194	2.2	15
377	14	SURG		POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	.8445	3.6	27
378	14	MED		ECTOPIC PREGNANCY	.7802	3.3	14
379	14	MED		THREATENED ABORTION	.2845	2.0	20
380	14	MED		ABORTION W/O D&C	.3497	1.9	20
381	14	SURG		ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.4250	1.7	13
382	14	MED		FALSE LABOR	.1520	1.3	5
383	14	MED		OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3924	3.2	26
384	14	MED		OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.2893	2.0	19
385	15	MED	*	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2439	1.8	25

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

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
386	15	MED	*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.7098	17.9	41
387	15	MED	*	PREMATURITY W MAJOR PROBLEMS	1.8578	13.3	36
388	15	MED	*	PREMATURITY W/O MAJOR PROBLEMS	1.1767	8.6	32
389	15	MED	*	FULL TERM NEONATE W MAJOR PROBLEMS	1.4253	4.7	28
390	15	MED		NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3104	4.2	27
391	15	MED	*	NORMAL NEWBORN	.2255	3.1	11
392	16	SURG		SPLENECTOMY AGE >17	3.1580	11.1	34
393	16	SURG	*	SPLENECTOMY AGE 0-17	1.5463	9.1	32
394	16	SURG		OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.5947	5.6	29
395	16	MED		RED BLOOD CELL DISORDERS AGE >17	.7907	4.6	28
396	16	MED		RED BLOOD CELL DISORDERS AGE 0-17	.6899	2.0	24
397	16	MED		COAGULATION DISORDERS	1.1954	5.3	28
398	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.2163	6.4	29
399	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6832	4.0	27
400	17	SURG		LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.5529	8.9	32
401	17	SURG		LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.4112	10.4	33
402	17	SURG		LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	.8693	3.5	27
403	17	MED		LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6775	8.1	31
404	17	MED		LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.7522	4.0	27
405	17	MED	*	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0583	4.9	28
406	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7902	10.9	34
407	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.2024	5.0	28
408	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.3730	5.0	28
409	17	MED		RADIOTHERAPY	.9920	6.1	29
410	17	MED		CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	.6140	2.8	20
411	17	MED		HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4698	2.5	25
412	17	MED		HISTORY OF MALIGNANCY W ENDOSCOPY	.4072	1.9	17
413	17	MED		OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.3256	7.3	30
414	17	MED		OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.6849	4.0	27
415	18	SURG		O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.4971	14.5	37
416	18	MED		SEPTECEMIA AGE >17	1.5203	7.4	30
417	18	MED		SEPTECEMIA AGE 0-17	.8950	4.5	27
418	18	MED		POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9709	6.4	29
419	18	MED		FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9519	5.7	29
420	18	MED		FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6570	4.4	27

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LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED		VIRAL ILLNESS AGE >17	.6849	4.3	27
422	18	MED		VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.7356	4.8	28
423	18	MED		OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.5481	7.7	31
424	19	SURG		O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.3554	13.5	36
425	19	MED		ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.7086	4.5	27
426	19	MED		DEPRESSIVE NEUROSES	.6031	5.1	28
427	19	MED		NEUROSES EXCEPT DEPRESSIVE	.6348	5.1	28
428	19	MED		DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7701	6.5	29
429	19	MED		ORGANIC DISTURBANCES & MENTAL RETARDATION	.9448	7.6	31
430	19	MED		PSYCHOSES	.9030	8.5	32
431	19	MED		CHILDHOOD MENTAL DISORDERS	.6180	5.1	28
432	19	MED		OTHER MENTAL DISORDER DIAGNOSES	.7081	4.5	27
433	20	MED		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3596	2.9	26
434	20	MED		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC	.7590	5.4	28
435	20	MED		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC	.4876	4.4	27
436	20	MED		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	1.0080	15.0	38
437	20	MED		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	1.1011	14.2	37
438				NO LONGER VALID	.0000	.0	0
439	21	SURG		SKIN GRAFTS FOR INJURIES	1.2262	5.5	29
440	21	SURG		WOUND DEBRIDEMENTS FOR INJURIES	1.8295	8.1	31
441	21	SURG		HAND PROCEDURES FOR INJURIES	.7437	2.4	25
442	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES WITH CC	1.9129	5.9	29
443	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.7604	2.6	26
444	21	MED		TRAUMATIC INJURY AGE > 17 W CC	.7648	5.2	28
445	21	MED		TRAUMATIC INJURY AGE > 17 W/O CC	.4685	3.4	26
446	21	MED	*	TRAUMATIC INJURY AGE 0-17	.4877	2.4	22
447	21	MED		ALLERGIC REACTIONS AGE >17	.4905	2.5	24
448	21	MED	*	ALLERGIC REACTIONS AGE 0-17	.3529	2.9	17
449	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC	.7899	4.0	27
450	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4374	2.3	22
451	21	MED	*	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.5277	2.1	17
452	21	MED		COMPLICATIONS OF TREATMENT WITH CC	.8540	4.2	27
453	21	MED		COMPLICATIONS OF TREATMENT W/O CC	.4220	2.7	23
454	21	MED		OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC	.8886	4.3	27
455	21	MED		OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC	.4160	2.4	21

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22	MED	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.7210	4.4	27
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	2.0868	3.8	27
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.8990	16.0	39
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	1.9178	10.1	33
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0043	6.2	29
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	.9111	2.7	26
462	23	MED	REHABILITATION	1.7740	13.7	37
463	23	MED	SIGNS & SYMPTOMS W CC	.7333	4.8	28
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4618	3.1	26
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.3474	1.8	17
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.5332	2.4	25
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4384	2.7	26
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.2644	12.6	36
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	0
470		**	UNGROUPABLE	.0000	.0	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.9172	11.9	35
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	11.6267	16.0	39
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4700	9.7	33
474	04		NO LONGER VALID	.0000	.0	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.5025	9.4	32
476			PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1952	13.5	36
477			NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.4306	5.9	29
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.1789	6.8	30
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.2851	4.1	27
480		SURG	LIVER TRANSPLANT	21.8488	28.1	51
481		SURG	BONE MARROW TRANSPLANT	15.5389	41.0	64
482		SURG	TRACHEOSTOMY W MOUTH, LARYNX OR PHARYNX DISORDER	3.4816	13.6	37
483		SURG	TRACHEOSTOMY EXCEPT FOR MOUTH, LARYNX OR PHARYNX DISORDER	16.2645	42.5	66
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.8212	14.9	38
485	24	SURG	LIMB REATTACH., HIP AND FEMUR PROCS FOR MULTI SIGN TRAUMA	3.1328	12.9	36
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.7689	10.6	34
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.8656	7.5	31
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	3.5333	14.9	38
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8532	9.0	32
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1221	5.4	28

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TABLE 5

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - UPPER EXTREMITY	1.5760	5.3	28
492	17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	2.9124	8.6	32

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TABLE 6a.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
008.00	Intestinal infection due to unspecified E. coli	N	06	182, 183, 184
008.01	Intestinal infection due to enteropathogenic E. coli	N	06	182, 183, 184
008.02	Intestinal infection due to enterotoxigenic E. coli	N	06	182, 183, 184
008.03	Intestinal infection due to enteroinvasive E. coli	N	06	182, 183, 184
008.04	Intestinal infection due to enterohemorrhagic E. coli	N	06	182, 183, 184
008.09	Intestinal infection due to other intestinal E. coli infections	N	06	182, 183, 184
008.43	Intestinal infection due to Campylobacter	N	06	182, 183, 184
008.44	Intestinal infection due to Yersinia enterocolitica	N	06	182, 183, 184
008.45	Intestinal infection due to Clostridium difficile	N	06	182, 183, 184
008.46	Intestinal infection due to other anaerobes	N	06	182, 183, 184
008.47	Intestinal infection due to other gram-negative bacteria	N	06	182, 183, 184
008.61	Enteritis due to Rotavirus	N	06	182, 183, 184
008.62	Enteritis due to Adenovirus	N	06	182, 183, 184
008.63	Enteritis due to Norwalk virus	N	06	182, 183, 184
008.64	Enteritis due to other small round viruses [SRV's]	N	06	182, 183, 184
008.65	Enteritis due to Calcivirus	N	06	182, 183, 184
008.66	Enteritis due to Astrovirus	N	06	182, 183, 184
008.67	Enteritis due to Enterovirus not elsewhere classified	N	06	182, 183, 184
008.69	Enteritis due to other viruses	N	06	182, 183, 184
041.00	Bacterial infection due to unspecified Streptococcus	N	18	423
041.01	Bacterial infection due to Streptococcus, Group A	N	18	423
041.02	Bacterial infection due to Streptococcus, Group B	N	18	423
041.03	Bacterial infection due to Streptococcus, Group C	N	18	423
041.04	Bacterial infection due to Streptococcus, Group D	N	18	423
041.05	Bacterial infection due to Streptococcus, Group G	N	18	423
041.09	Bacterial infection due to other Streptococcus	N	18	423
041.10	Bacterial infection due to unspecified Staphylococcus	N	18	423
041.11	Bacterial infection due to Staphylococcus aureus	N	18	423
041.19	Bacterial infection due to other Staphylococcus	N	18	423
041.81	Bacterial infection due to Mycoplasma	N	18	423
041.82	Bacterial infection due to Bacillus fragilis	N	18	423
041.83	Bacterial infection due to Clostridium perfringens	N	18	423
041.84	Bacterial infection due to other anaerobes	N	18	423
041.85	Bacterial infection due to other gram-negative organisms	N	18	423
041.89	Bacterial infection due to other specified bacteria	N	18	423
099.40	Unspecified nongonococcal urethritis [NGU]	N	12	423
			13	358, 359, 368
099.41	Venereal urethritis due to Chlamydia trachomatis	N	12	350
			13	358, 359, 368
099.49	Venereal urethritis due to other specified organism	N	12	350
			13	358, 359, 368
099.50	Chlamydia trachomatis infection of unspecified site	N	12	350
		13	358, 359, 368	
099.51	Chlamydia trachomatis infection of pharynx	N	03	68, 69, 70
099.52	Chlamydia trachomatis infection of anus and rectum	N	06	188, 189, 190
099.53	Chlamydia trachomatis infection of lower genitourinary sites	N	12	350
			13	358, 359, 368
099.54	Chlamydia trachomatis infection of other genitourinary sites	N	11	320, 321, 322
099.55	Chlamydia trachomatis infection of unspecified genitourinary site	N	12	350
			13	358, 359, 368
099.56	Chlamydia trachomatis infection of peritoneum	N	06	188, 189, 190
099.59	Chlamydia trachomatis infection of other specified site	N	12	350
			13	358, 359, 368
112.84	Candidiasis of the esophagus	Y	06	182, 183, 184
			15	387, 389
			25	489
112.85	Candidiasis of the intestine	Y	06	182, 183, 184
			15	387, 389
			25	489
320.81	Meningitis due to anaerobic bacteria	Y	01	20
			15	387, 389
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified	Y	01	20
			15	387, 389
320.89	Meningitis due to other specified bacteria	Y	01	20
			15	387, 389
346.00	Classical migraine without mention of intractable migraine	N	01	24, 25, 26
346.01	Classical migraine with intractable migraine, so stated	N	01	24, 25, 26
346.10	Common migraine without mention of intractable migraine	N	01	24, 25, 26
346.11	Common migraine with intractable migraine, so stated	N	01	24, 25, 26
346.20	Variants of migraine without mention of intractable migraine	N	01	24, 25, 26
346.21	Variants of migraine with intractable migraine, so stated	N	01	24, 25, 26
346.80	Other forms of migraine without mention of intractable migraine	N	01	24, 25, 26
346.81	Other forms of migraine with intractable migraine, so stated	N	01	24, 25, 26
346.90	Migraine, unspecified, without mention of intractable migraine	N	01	24, 25, 26
346.91	Migraine, unspecified, with intractable migraine, so stated	N	01	24, 25, 26
371.82	Corneal disorder due to contact lens	N	02	46, 47, 48
437.7	Transient global amnesia	N	01	16, 17

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
440.20	Atherosclerosis of arteries of the extremities, unspecified	N	05	130, 131
440.21	Atherosclerosis of arteries of the extremities with intermittent claudication	N	05	130, 131
440.22	Atherosclerosis of arteries of the extremities with rest pain	N	05	130, 131
482.30	Pneumonia due to unspecified Streptococcus	Y	04	89, 90, 91
			15	[1] 387, 389
			25	489
482.31	Pneumonia due to Streptococcus, Group A	Y	04	89, 90, 91
			15	[1] 387, 389
	D	25	489	
482.32	Pneumonia due to Streptococcus, Group B	Y	04	89, 90, 91
			15	[1] 387, 389
			25	489
482.32	Pneumonia due to Streptococcus, Group B	Y	04	89, 90, 91
			15	[1] 387, 389
			25	489
482.39	Pneumonia due to other Streptococcus	Y	04	89, 90, 91
			15	[1] 387, 389
			25	489
482.81	Pneumonia due to anaerobes	Y	04	79, 80, 81
			15	[1] 387, 389
			25	489
482.82	Pneumonia due to Escherichia coli [E. coli]	Y	04	79, 80, 81
			15	[1] 387, 389
			25	489
482.83	Pneumonia due to other gram-negative bacteria	Y	04	79, 80, 81
			15	[1] 387, 389
			25	489
482.89	Pneumonia due to other specified bacteria	Y	04	79, 80, 81
			15	[1] 387, 389
			25	489
483.0	Pneumonia due to Mycoplasma pneumoniae	Y	04	89, 90, 91
			15	[1] 387, 389
483.8	Pneumonia due to other specified organism	Y	04	89, 90, 91
			15	[1] 387, 389
524.00	Unspecified anomaly of jaw size	N	03	185, 186, 187
			—	482
524.01	Maxillary hyperplasia	N	03	185, 186, 187
			—	482
524.02	Mandibular hyperplasia	N	03	185, 186, 187
			—	482
524.03	Maxillary hypoplasia	N	03	185, 186, 187
			—	482
524.04	Mandibular hypoplasia	N	03	185, 186, 187
			—	482
524.05	Macrogenia	N	03	185, 186, 187
			—	482
524.06	Microgenia	N	03	185, 186, 187
			—	482
524.09	Other specified anomaly of jaw size	N	03	185, 186, 187
			—	482
524.10	Unspecified anomaly of relationship of jaw to cranial base	N	03	185, 186, 187
			—	482
524.11	Maxillary asymmetry	N	03	185, 186, 197
			—	482
524.12	Other jaw asymmetry	N	03	185, 186, 187
			—	482
524.19	Other specified anomaly of relationship of jaw to cranial base	N	03	185, 186, 187
			—	482
524.70	Unspecified alveolar anomaly	N	03	185, 186, 187
			—	482
524.71	Alveolar maxillary hyperplasia	N	03	185, 186, 187
			—	482
524.72	Alveolar mandibular hyperplasia	N	03	185, 186, 187
			—	482
524.73	Alveolar maxillary hypoplasia	N	03	185, 186, 187
			—	482
524.74	Alveolar mandibular hypoplasia	N	03	185, 186, 187
			—	482
524.79	Other specified alveolar anomaly	N	03	185, 186, 187
			—	482
596.51	Hypertonicity of bladder	N	11	331, 332, 333
596.52	Low bladder compliance	N	11	331, 332, 333
596.53	Paralysis of bladder	N	11	331, 332, 333
596.54	Neurogenic bladder, not otherwise specified	N	11	331, 332, 333
596.55	Detrusor sphincter dyssynergia	N	11	331, 332, 333
596.59	Other functional disorder of bladder	N	11	331, 332, 333
599.81	Urethral hypermobility	N	11	331, 332, 333
599.82	Intrinsic (urethral) sphincter deficiency [ISD]	N	11	331, 332, 333
599.83	Urethral instability	N	11	331, 332, 333

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
599.84	Other specified disorders of urethra	N	11	331, 332, 333
599.89	Other specified disorders of urinary tract	N	11	331, 332, 333
659.60	Other advanced maternal age, unspecified as to episode of care or not applicable	N	14	370, 371, 372, 373, 374, 375
659.61	Other advanced maternal age, delivered, with or without mention of antepartum condition	N	14	370, 371, 372, 373, 374, 375
659.63	Other advanced maternal age, antepartum condition or complication	N	14	383, 384
692.72	Acute dermatitis due to solar radiation	N	09	283, 284
692.73	Actinic reticuloid and actinic granuloma	N	09	283, 284
692.74	Other chronic dermatitis due to solar radiation	N	09	283, 284
692.82	Dermatitis due to other radiation	N	09	283, 284
692.83	Dermatitis due to metals	N	09	283, 284
710.5	Eosinophilia myalgia syndrome	Y	09	240, 241
738.10	Unspecified acquired deformity of head	N	08	256
738.11	Zygomatic hyperplasia	N	08	256
738.12	Zygomatic hypoplasia	N	08	256
738.19	Other specified acquired deformity of head	N	08	256
780.01	Coma	Y	01	23
			15	[1] 387, 389
780.02	Transient alteration of awareness	N	01	23
780.09	Other alteration of consciousness	N	01	23
780.57	Other and unspecified sleep apnea	N	01	34,35
788.30	Unspecified urinary incontinence	N	11	325, 326, 327
788.31	Urge incontinence	N	11	325, 326, 327
788.32	Stress incontinence, male	N	11	325, 326, 327
788.33	Mixed incontinence, urge and stress	N	11	325, 326, 327
788.34	Incontinence without sensory awareness	N	11	325, 326, 327
788.35	Post-void dribbling	N	11	325, 326, 327
788.36	Nocturnal enuresis	N	11	325, 326, 327
788.37	Continuous leakage	N	11	325, 326, 327
788.39	Other urinary incontinence	N	11	325, 326, 327
864.05	Injury to liver without mention of open wound into cavity, unspecified laceration	Y	07	205, 206
			24	[2] 487
864.15	Injury to liver with open wound into cavity, unspecified laceration	Y	07	205, 206
			24	[2] 487
V07.4	[Need for] prophylactic postmenopausal hormone replacement therapy	N	23	467
V25.43	[Encounter for] surveillance of implantable subdermal contraceptive	N	23	467
V25.5	[Encounter for] insertion of implantable subdermal contraceptive	N	23	467
V29.0	Observation and evaluation of newborns and infants for suspected infectious condition not found.	N	15	[3] 391
			23	467
V29.1	Observation and evaluation of newborns and infants for suspected neurological condition not found.	N	15	[3] 391
			23	467
V29.8	Observation and evaluation of newborns and infants for other specified suspected condition not found.	N	15	[3] 391
			23	467
V29.9	Observation and evaluation of newborns and infants for unspecified suspected condition not found.	N	15	[3] 391
			23	467

[1] Diagnosis code is classified as a "major problem" in these DRGs.
[2] Diagnosis code is assigned to the "Significant Abdominal Trauma" body site category.
[3] Diagnosis code is considered in this classification only if it is a secondary diagnosis.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
02.96	Insertion of sphenoidal electrodes	N		
66.01	Salpingotomy	Y	13	354, 355, 357, 358, and 359.
66.02	Salpingostomy	Y	13	354, 355, 357, 358, and 359.
68.9	Other and unspecified hysterectomy	Y	13	354, 355, 357, 358, and 359.
			14	375
81.97	Revision of joint replacement of upper extremity	Y	08, 21, and 24.	233, 234, 442, 443, and 486.

TABLE 6C.—INVALID DIAGNOSIS CODES [1]

Diagnosis code	Description	CC	MDC	DRG
008.0	Intestinal infection due to Escherichia coli [E. coli]	N	06	182, 183, and 184.
008.6	Enteritis due to specified virus	N	06	182, 183, and 184.
041.0	Bacterial infection due to Streptococcus	N	18	423.
041.1	Bacterial infection due to Staphylococcus	N	18	423.
041.8	Other specified bacterial infections	N	18	423.

TABLE 6C.—INVALID DIAGNOSIS CODES [1]—Continued

Diagnosis code	Description	CC	MDC	DRG
099.4	Other nongonococcal urethritis	N	12	350.
		13	358, 359, and 368.	
320.8	Meningitis due to other specified bacteria	Y	01 and 15	20, 387, and 389.[2]
346.0	Classical migraine	N	01	24, 25, and 26.
346.1	Common migraine	N	01	24, 25, and 26.
346.2	Variants of migraine	N	01	24, 25, and 26.
346.8	Other forms of migraine	N	01	24, 25, and 26.
346.9	Migraine, unspecified	N	01	24, 25, and 26.
440.2	Atherosclerosis of arteries of the extremities	N	05	130, 131.
482.3	Pneumonia due to Streptococcus	Y	04	89, 90, and 91.
482.8	Pneumonia due to other specified bacteria	Y	04	79, 80, and 81.
483	Pneumonia due to other specified organism	Y	04	89, 90, and 91.
524.0	Major anomalies of jaw size	N	03	185, 186, and 187.
524.1	Anomalies of relationship of jaw to cranial base	N	03	185, 186, and 187.
596.5	Other functional disorders of bladder	N	11	331, 332, and 333.
599.8	Other specified disorders of urethra and urinary tract	N	11	331, 332, and 333.
738.1	Other acquired deformity of head	N	08	256.
780.0	Coma and stupor	Y	01	23.
788.3	Incontinence of urine	N	11	325, 326, and 327.

[1] See Table 6a for new diagnosis codes (4- or 5-digits) that will be considered valid by the FY 1993 GROUPER.
[2] Diagnosis code is classified as a "major problem" in these DRGs.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
46.12	Permanent magnetic colostomy	Y	06, 17, 21, and 24.	148, 149, 400, 406, 407, 442, 443, and 486.
69.11	Removal of intraligamentous ectopic pregnancy	Y	13 and 14	354, 355, 357, 358, 359, and 375.
89.49	Artificial pacemaker slew rate check	N		

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
079.8	Other specified viral and Chlamydial infections	N	18	421, 422.
079.9	Unspecified viral and Chlamydial infection	N	18	421, 422.
200.00	Reticulosarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, and 404.
200.10	Lymphosarcoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
200.20	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
200.80	Other named variants, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.00	Hodgkin's paragranuloma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.10	Hodgkin's granuloma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.20	Hodgkins sarcoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404
201.40	Lymphocytic-histiocytic predominance, unspecified site, extranodal and solid organ sites.		17	400, 401, 402, 403, and 404.
201.50	Nodular sclerosis, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.60	Mixed cellularity, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.70	Lymphocytic depletion, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
201.90	Hodgkin's disease, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.00	Nodular lymphoma, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.10	Mycosis fungoides, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.20	Sezary's disease, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.30	Malignant histiocytosis, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.40	Leukemic reticuloendotheliosis, unspecified site, extranodal and solid organ sites.		17	400, 401, 402, 403, and 404.
202.50	Letterer-Siwe disease, unspecified site, extranodal and solid organ sites		17	406, 407, 408, 413, and 414.
202.60	Malignant mast cell tumors, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.80	Other lymphomas, unspecified site, extranodal and solid organ sites		17	400, 401, 402, 403, and 404.
202.90	Other and unspecified malignant neoplasms of lymphoid and histocytic tissue, unspecified site, extranodal and solid organ sites.		17	400, 401, 402, 403, and 404.
481	Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia]		04	89, 89, 91.
654.20	Previous cesarean delivery, unspecified as to episode of care or not applicable	N	14	469.
654.21	Previous cesarean delivery, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, and 375.
654.23	Previous cesarean delivery, antepartum condition or complication	N	14	383, 384.
665.10	Rupture of uterus during labor, unspecified as to episode of care or not applicable.		14	370, 371, 372, 373, 374, and 375.
665.11	Rupture of uterus during labor, delivered, with or without mention of antepartum condition.		14	370, 371, 372, 373, 374, and 375.
665.12	Rupture of uterus during labor, delivered, with mention of postpartum complication.		14	370, 371, 372, 373, 374, and 375.

Table 6E.—Revised Diagnosis Code Titles—Continued

Diagnosis code	Description	CC	MDC	DRG
665.14	Rupture of uterus during labor, postpartum condition or complication		14	376, 377.
692.79	Other dermatitis due to solar radiation	N	09	283, 284.
768.4	Fetal distress, unspecified as to time of onset, in liveborn infant	N	15	390.
785.2	Undiagnosed cardiac murmurs	N	05	135, 136, 137.
V30.00	Single liveborn, born in hospital, delivered without mention of cesarean delivery	N	15	391.
V30.01	Single liveborn, born in hospital, delivered by cesarean delivery	N	15	391.
V31.00	Twin, mate liveborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391.
V31.01	Twin, mate liveborn, born in hospital, delivered by cesarean delivery	N	15	391.
V32.00	Twin, mate stillborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391.
V32.01	Twin, mate stillborn, born in hospital, delivered by cesarean delivery	N	15	391.
V33.00	Twin, unspecified, born in hospital, delivered without mention of cesarean delivery.	N	15	391.
V33.01	Twin, unspecified, born in hospital, delivered by cesarean delivery	N	15	391.
V34.00	Other multiple, mates all liveborn, born in hospital, delivered without mention of cesarean.	N	15	391.
V34.01	Other multiple, mates all liveborn, born in hospital, delivered by cesarean delivery.	N	15	391.
V35.00	Other multiple, mates all stillborn, born in hospital, delivered without mention of cesarian delivery.	N	15	391.
V35.01	Other multiple, mates all stillborn, born in hospital, delivered by cesarean delivery.	N	15	391.
V36.00	Other multiple, mates live- and stillborn, born in hospital, delivered without mention of cesarean delivery.	N	15	391.
V36.01	Other multiple, mates live- and stillborn, born in hospital, delivered by cesarean delivery.	N	15	391.
V37.00	Other multiple, unspecified, born in hospital, delivered without mention of cesarean delivery.	N	15	391.
V37.01	Other multiple, unspecified, born in hospital, delivered by cesarean delivery	N	15	391.
V39.00	Liveborn infant, type of birth unspecified, born in hospital, delivered without mention of cesarean delivery.	N	15	391.
V39.01	Liveborn infant, type of birth unspecified, born in hospital, delivered by cesarean delivery.	N	15	391.
V73.8	Other specific viral and Chlamydial diseases	N	23	467.

Table 6F.—Revised Procedure Code Titles

Procedure code	Description	OR	MDC	DRG
04.01	Excision of acoustic neuroma	Y	01	1, 2, 3.
			03	63.
46.13	Permanent colostomy	Y	06	148, 149.
			17	400, 406, 407.
			21	442, 443.
			24	486.
54.91	Percutaneous abdominal drainage	N		
74.3	Removal of extratubal ectopic pregnancy	Y	14	375.
81.59	Revision of joint replacement of lower extremity, not elsewhere classified	Y	08	233, 234.
			21	21
			24	442, 443.
				486.

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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.

*00321	48289	4830	4838	*01126	48230	48231	48232
32081	4830	4838	*01121	48230	48231	48232	48239
32082	4838	*01113	48230	48231	48232	48239	48281
32089	*01105	48230	48231	48232	48239	48281	48282
*01100	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01151
48281	48282	48283	48289	4830	4838	*01143	48230
48282	48283	48289	4830	4838	*01135	48230	48231
48283	48289	4830	4838	*01130	48230	48231	48232
48289	4830	4838	*01122	48230	48231	48232	48239
4830	4838	*01114	48230	48231	48232	48239	48281
4838	*01106	48230	48231	48232	48239	48281	48282
*01101	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01152
48281	48282	48283	48289	4830	4838	*01144	48230
48282	48283	48289	4830	4838	*01136	48230	48231
48283	48289	4830	4838	*01131	48230	48231	48232
48289	4830	4838	*01123	48230	48231	48232	48239
4830	4838	*01115	48230	48231	48232	48239	48281
4838	*01110	48230	48231	48232	48239	48281	48282
*01102	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01153
48281	48282	48283	48289	4830	4838	*01145	48230
48282	48283	48289	4830	4838	*01140	48230	48231
48283	48289	4830	4838	*01132	48230	48231	48232
48289	4830	4838	*01124	48230	48231	48232	48239
4830	4838	*01116	48230	48231	48232	48239	48281
4838	*01111	48230	48231	48232	48239	48281	48282
*01103	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01154
48281	48282	48283	48289	4830	4838	*01146	48230
48282	48283	48289	4830	4838	*01141	48230	48231
48283	48289	4830	4838	*01133	48230	48231	48232
48289	4830	4838	*01125	48230	48231	48232	48239
4830	4838	*01120	48230	48231	48232	48239	48281
4838	*01112	48230	48231	48232	48239	48281	48282
*01104	48230	48231	48232	48239	48281	48282	48283
48230	48231	48232	48239	48281	48282	48283	48289
48231	48232	48239	48281	48282	48283	48289	4830
48232	48239	48281	48282	48283	48289	4830	4838
48239	48281	48282	48283	48289	4830	4838	*01155
48281	48282	48283	48289	4830	4838	*01150	48230
48282	48283	48289	4830	4838	*01142	48230	48231
48283	48289	4830	4838	*01134	48230	48231	48232

48239 48281 48282 48283 48289 4830 4838 *01206
48281 48282 48283 48289 4830 4838 *01201 48230
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48289 4830 4838 *01180 48230 48231 48232 48239
4830 4838 *01172 48230 48231 48232 48239 48281
4838 *01164 48230 48231 48232 48239 48281 48282
*01156 48230 48231 48232 48239 48281 48282 48283
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48231 48232 48239 48281 48282 48283 48289 4830
48232 48239 48281 48282 48283 48289 4830 4838
48239 48281 48282 48283 48289 4830 4838 *01210
48281 48282 48283 48289 4830 4838 *01202 48230
48282 48283 48289 4830 4838 *01194 48230 48231
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48231 48232 48239 48281 48282 48283 48289 4830
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48239 48281 48282 48283 48289 4830 4838 *01211
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48282 48283 48289 4830 4838 *01195 48230 48231
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4830 4838 *01174 48230 48231 48232 48239 48281
4838 *01166 48230 48231 48232 48239 48281 48282
*01161 48230 48231 48232 48239 48281 48282 48283
48230 48231 48232 48239 48281 48282 48283 48289
48231 48232 48239 48281 48282 48283 48289 4830
48232 48239 48281 48282 48283 48289 4830 4838
48239 48281 48282 48283 48289 4830 4838 *01212
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48282 48283 48289 4830 4838 *01196 48230 48231
48283 48281 4830 4838 *01191 48230 48231 48232
48289 4830 4838 *01183 48230 48231 48232 48239
4830 4838 *01175 48230 48231 48232 48239 48281
4838 *01170 48230 48231 48232 48239 48281 48282
*01162 48230 48231 48232 48239 48281 48282 48283
48230 48231 48232 48239 48281 48282 48283 48289
48231 48232 48239 48281 48282 48283 48289 4830
48232 48239 48281 48282 48283 48289 4830 4838
48239 48281 48282 48283 48289 4830 4838 *01213
48281 48282 48283 48289 4830 4838 *01205 48230
48282 48283 48289 4830 4838 *01200 48230 48231
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48289 4830 4838 *01184 48230 48231 48232 48239
4830 4838 *01176 48230 48231 48232 48239 48281
4838 *01171 48230 48231 48232 48239 48281 48282
*01163 48230 48231 48232 48239 48281 48282 48283
48230 48231 48232 48239 48281 48282 48283 48289
48231 48232 48239 48281 48282 48283 48289 4830
48232 48239 48281 48282 48283 48289 4830 4838
48239 48281 48282 48283 48289 4830 4838 *01214

48230 48231 32089 48232 48239 0380 6822 6804
48231 48232 *01301 48239 48281 0381 6823 6805
48232 48239 32081 48281 48282 0382 6825 6806
48239 48281 32082 48282 48283 0383 6826 6807
48281 48282 32089 48283 48289 03840 6827 6808
48282 48283 *01302 48289 4830 03841 6828 6809
48283 48289 32081 4830 4838 03842 6829 6820
48289 4830 32082 4838 *01796 03843 *04102 6821
4830 4838 32089 *01791 48230 03844 0380 6822
4838 *01283 *01303 48230 48231 03849 0381 6823
*01215 48230 32081 48231 48232 0388 0382 6825
48230 48231 32082 48232 48239 0389 0383 6826
48231 48232 32089 48239 48281 6800 03840 6827
48232 48239 *01304 48281 48282 6801 03841 6828
48239 48281 32081 48282 48283 6802 03842 6829
48281 48282 32082 48283 48289 6803 03843 *04104
48282 48283 32089 48289 4830 6804 03844 0380
48283 48289 *01305 4830 4838 6805 03849 0381
48289 4830 32081 4838 *0212 6806 0388 0382
4830 4838 32082 *01792 48230 6807 0389 0383
4838 *01284 32089 48230 48231 6808 6800 03840
*01216 48230 *01306 48231 48232 6809 6801 03841
48230 48231 32081 48232 48239 6820 6802 03842
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48281 48282 48283 48289 7882 5809 58189 5848
48282 48283 48289 4830 *59981 5810 5819 5849
48283 48289 4830 4838 5800 5811 5834 585
48289 4830 4838 *5198 5804 5812 5845 59010
4830 4838 *5088 48230 58081 5813 5846 59011
4838 *5070 48230 48231 58089 58181 5847 5902
*5061 48230 48231 48232 5809 58189 5848 5903
48230 48231 48232 48239 5810 5819 5849 59080
48231 48232 48239 48281 5811 5834 585 59081
48232 48239 48281 48282 5812 5845 59010 5909
48239 48281 48282 48283 5813 5846 59011 591
48281 48282 48283 48289 58181 5847 5902 5921
48282 48283 48289 4830 58189 5848 5903 5935
48283 48289 4830 4838 5819 5849 59080 5950
48289 4830 4838 *5199 5834 585 59081 5951
4830 4838 *5089 48230 5845 59010 5909 5952
4838 *5071 48230 48231 5846 59011 591 5954
*5062 48230 48231 48232 5847 5902 5921 59581
48230 48231 48232 48239 5848 5903 5935 59582
48231 48232 48239 48281 5849 59080 5950 59589
48232 48239 48281 48282 585 59081 5951 5959
48239 48281 48282 48283 59010 5909 5952 5961
48281 48282 48283 48289 59011 591 5954 5962
48282 48283 48289 4830 5902 5921 59581 5964
48283 48289 4830 4838 5903 5935 59582 5966
48289 4830 4838 *5722 59080 5950 59589 5967
4830 4838 *5171 78001 59081 5951 5959 5970
4838 *5078 48230 *59651 5909 5952 5961 5981
*5063 48230 48231 5960 591 5954 5962 5982
48230 48231 48232 5964 5921 59581 5964 5990
48231 48232 48239 5996 5935 59582 5966 5994
48232 48239 48281 7882 5950 59589 5967 5996
48239 48281 48282 *59652 5951 5959 5970 5997
48281 48282 48283 5960 5952 5961 5981 *59989
48282 48283 48289 5964 5954 5962 5982 5800
48283 48289 4830 5996 59581 5964 5990 5804
48289 4830 4838 7882 59582 5966 5994 58081
4830 4838 *5178 *59653 59589 5967 5996 58089
4838 *5080 48230 5960 5959 5970 5997 5809
*5064 48230 48231 5964 5961 5981 *59984 5810
48230 48231 48232 5996 5962 5982 5800 5811
48231 48232 48239 7882 5964 5990 5804 5812
48232 48239 48281 *59654 5966 5994 58081 5813
48239 48281 48282 5960 5967 5996 58089 58181
48281 48282 48283 5964 5970 5997 5809 58189
48282 48283 48289 5996 5981 *59983 5810 5819
48283 48289 4830 7882 5982 5800 5811 5834
48289 4830 4838 *59655 5990 5804 5812 5845
4830 4838 *51889 5960 5994 58081 5813 5846
4838 *5081 48230 5964 5996 58089 58181 5847
*5069 48230 48231 5996 5997 5809 58189 5848
48230 48231 48232 7882 *59982 5810 5819 5849
48231 48232 48239 *59659 5800 5811 5834 585
48232 48239 48281 5960 5804 5812 5845 59010
48239 48281 48282 5964 58081 5813 5846 59011

5902	430	*80025	*80061	*80095	*80131	*80165	*80301
5903	431	78001	78001	78001	78001	78001	78001
59080	4320	*80026	*80062	*80096	*80132	*80166	*80302
59081	4321	78001	78001	78001	78001	78001	78001
5909	436	*80029	*80063	*80099	*80133	*80169	*80303
591	78001	78001	78001	78001	78001	78001	78001
5921	*7802	*80030	*80064	*80100	*80134	*80170	*80304
5935	78001	78001	78001	78001	78001	78001	78001
5950	*7804	*80031	*80065	*80101	*80135	*80171	*80305
5951	78001	78001	78001	78001	78001	78001	78001
5952	*7809	*80032	*80066	*80102	*80136	*80172	*80306
5954	78001	78001	78001	78001	78001	78001	78001
59581	*7998	*80033	*80069	*80103	*80139	*80173	*80309
59582	78001	78001	78001	78001	78001	78001	78001
59589	*80000	*80034	*80070	*80104	*80140	*80174	*80310
5959	78001	78001	78001	78001	78001	78001	78001
5961	*80001	*80035	*80071	*80105	*80141	*80175	*80311
5962	78001	78001	78001	78001	78001	78001	78001
5964	*80002	*80036	*80072	*80106	*80142	*80176	*80312
5966	78001	78001	78001	78001	78001	78001	78001
5967	*80003	*80039	*80073	*80109	*80143	*80179	*80313
5970	78001	78001	78001	78001	78001	78001	78001
5981	*80004	*80040	*80074	*80110	*80144	*80180	*80314
5982	78001	78001	78001	78001	78001	78001	78001
5990	*80005	*80041	*80075	*80111	*80145	*80181	*80315
5994	78001	78001	78001	78001	78001	78001	78001
5996	*80006	*80042	*80076	*80112	*80146	*80182	*80316
5997	78001	78001	78001	78001	78001	78001	78001
*7105	*80009	*80043	*80079	*80113	*80149	*80183	*80319
7105	78001	78001	78001	78001	78001	78001	78001
*74861	*80010	*80044	*80080	*80114	*80150	*80184	*80320
48230	78001	78001	78001	78001	78001	78001	78001
48231	*80011	*80045	*80081	*80115	*80151	*80185	*80321
48232	78001	78001	78001	78001	78001	78001	78001
48239	*80012	*80046	*80082	*80116	*80152	*80186	*80322
48281	78001	78001	78001	78001	78001	78001	78001
48282	*80013	*80049	*80083	*80119	*80153	*80189	*80323
48283	78001	78001	78001	78001	78001	78001	78001
48289	*80014	*80050	*80084	*80120	*80154	*80190	*80324
4830	78001	78001	78001	78001	78001	78001	78001
4838	*80015	*80051	*80085	*80121	*80155	*80191	*80325
*78001	78001	78001	78001	78001	78001	78001	78001
430	*80016	*80052	*80086	*80122	*80156	*80192	*80326
431	78001	78001	78001	78001	78001	78001	78001
4320	*80019	*80053	*80089	*80123	*80159	*80193	*80329
4321	78001	78001	78001	78001	78001	78001	78001
436	*80020	*80054	*80090	*80124	*80160	*80194	*80330
78001	78001	78001	78001	78001	78001	78001	78001
*78002	*80021	*80055	*80091	*80125	*80161	*80195	*80331
430	78001	78001	78001	78001	78001	78001	78001
431	*80022	*80056	*80092	*80126	*80162	*80196	*80332
4320	78001	78001	78001	78001	78001	78001	78001
4321	*80023	*80059	*80093	*80129	*80163	*80199	*80333
436	78001	78001	78001	78001	78001	78001	78001
78001	*80024	*80060	*80094	*80130	*80164	*80300	*80334
*78009	78001	78001	78001	78001	78001	78001	78001

*80335 78001	*80371 78001	*80405 78001	*80441 78001	*80475 78001	*85103 78001	*85139 78001	*85173 78001
*80336 78001	*80372 78001	*80406 78001	*80442 78001	*80476 78001	*85104 78001	*85140 78001	*85174 78001
*80339 78001	*80373 78001	*80409 78001	*80443 78001	*80479 78001	*85105 78001	*85141 78001	*85175 78001
*80340 78001	*80374 78001	*80410 78001	*80444 78001	*80480 78001	*85106 78001	*85142 78001	*85176 78001
*80341 78001	*80375 78001	*80411 78001	*80445 78001	*80481 78001	*85109 78001	*85143 78001	*85179 78001
*80342 78001	*80376 78001	*80412 78001	*80446 78001	*80482 78001	*85110 78001	*85144 78001	*85180 78001
*80343 78001	*80379 78001	*80413 78001	*80449 78001	*80483 78001	*85111 78001	*85145 78001	*85181 78001
*80344 78001	*80380 78001	*80414 78001	*80450 78001	*80484 78001	*85112 78001	*85146 78001	*85182 78001
*80345 78001	*80381 78001	*80415 78001	*80451 78001	*80485 78001	*85113 78001	*85149 78001	*85183 78001
*80346 78001	*80382 78001	*80416 78001	*80452 78001	*80486 78001	*85114 78001	*85150 78001	*85184 78001
*80349 78001	*80383 78001	*80419 78001	*80453 78001	*80489 78001	*85115 78001	*85151 78001	*85185 78001
*80350 78001	*80384 78001	*80420 78001	*80454 78001	*80490 78001	*85116 78001	*85152 78001	*85186 78001
*80351 78001	*80385 78001	*80421 78001	*80455 78001	*80491 78001	*85119 78001	*85153 78001	*85189 78001
*80352 78001	*80386 78001	*80422 78001	*80456 78001	*80492 78001	*85120 78001	*85154 78001	*85190 78001
*80353 78001	*80389 78001	*80423 78001	*80459 78001	*80493 78001	*85121 78001	*85155 78001	*85191 78001
*80354 78001	*80390 78001	*80424 78001	*80460 78001	*80494 78001	*85122 78001	*85156 78001	*85192 78001
*80355 78001	*80391 78001	*80425 78001	*80461 78001	*80495 78001	*85123 78001	*85159 78001	*85193 78001
*80356 78001	*80392 78001	*80426 78001	*80462 78001	*80496 78001	*85124 78001	*85160 78001	*85194 78001
*80359 78001	*80393 78001	*80429 78001	*80463 78001	*8500 78001	*85125 78001	*85161 78001	*85195 78001
*80360 78001	*80394 78001	*80430 78001	*80464 78001	*8501 78001	*85126 78001	*85162 78001	*85196 78001
*80361 78001	*80395 78001	*80431 78001	*80465 78001	*8502 78001	*85129 78001	*85163 78001	*85199 78001
*80362 78001	*80396 78001	*80432 78001	*80466 78001	*8503 78001	*85130 78001	*85164 78001	*85200 78001
*80363 78001	*80399 78001	*80433 78001	*80469 78001	*8504 78001	*85131 78001	*85165 78001	*85201 78001
*80364 78001	*80400 78001	*80434 78001	*80470 78001	*8505 78001	*85132 78001	*85166 78001	*85202 78001
*80365 78001	*80401 78001	*80435 78001	*80471 78001	*8509 78001	*85133 78001	*85169 78001	*85203 78001
*80366 78001	*80402 78001	*80436 78001	*80472 78001	*85100 78001	*85134 78001	*85170 78001	*85204 78001
*80369 78001	*80403 78001	*80439 78001	*80473 78001	*85101 78001	*85135 78001	*85171 78001	*85205 78001
*80370 78001	*80404 78001	*80440 78001	*80474 78001	*85102 78001	*85136 78001	*85172 78001	*85206 78001

*85209	*85244	*85400	86402	86415	86405
78001	78001	78001	86403	*86809	86415
*85210	*85245	*85401	86404	86405	*9599
78001	78001	78001	86405	86415	86405
*85211	*85246	*85402	86409	*86810	86415
78001	78001	78001	86410	86405	
*85212	*85249	*85403	86411	86415	
78001	78001	78001	86412	*86813	
*85213	*85250	*85404	86413	86405	
78001	78001	78001	86414	86415	
*85214	*85251	*85405	86415	*86814	
78001	78001	78001	86419	86405	
*85215	*85252	*85406	*86409	86415	
78001	78001	78001	86405	*86819	
*85216	*85253	*85409	86415	86405	
78001	78001	78001	*86410	86415	
*85219	*85254	*85410	86405	*8690	
78001	78001	78001	86415	86405	
*85221	*85255	*85411	*86411	86415	
78001	78001	78001	86405	*8691	
*85222	*85256	*85412	86415	86405	
78001	78001	78001	*86412	86415	
*85223	*85259	*85413	86405	*8792	
78001	78001	78001	86415	86405	
*85224	*85300	*85414	*86413	86415	
78001	78001	78001	86405	*8793	
*85225	*85301	*85415	86415	86405	
78001	78001	78001	*86414	86415	
*85226	*85302	*85416	86405	*8794	
78001	78001	78001	86415	86405	
*85229	*85303	*85419	*86415	86415	
78001	78001	78001	86400	*8795	
*85230	*85304	*86380	86401	86405	
78001	78001	86405	86402	86415	
*85231	*85305	86415	86403	*8796	
78001	78001	*86399	86404	86405	
*85232	*85306	86405	86405	86415	
78001	78001	86415	86409	*8797	
*85233	*85309	*86400	86410	86405	
78001	78001	86405	86411	86415	
*85234	*85310	86415	86412	*8798	
78001	78001	*86401	86413	86405	
*85235	*85311	86405	86414	86415	
78001	78001	86415	86415	*8799	
*85236	*85312	*86402	86419	86405	
78001	78001	86405	*86419	86415	
*85239	*85313	86415	86405	*9290	
78001	78001	*86403	86415	86405	
*85240	*85314	86405	*86800	86415	
78001	78001	86415	86405	*9299	
*85241	*85315	*86404	86415	86405	
78001	78001	86405	*86803	86415	
*85242	*85316	86415	86405	*9588	
78001	78001	*86405	86415	86405	
*85243	*85319	86400	*86804	86415	
78001	78001	86401	86405	*9598	

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.

*00321	4828	4828	4828	4828	4828	4828	*01316
3208	483	483	483	483	483	483	3208
*01100	*01120	*01140	*01160	*01180	*01200	*01280	*01790
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01101	*01121	*01141	*01161	*01181	*01201	*01281	*01791
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01102	*01122	*01142	*01162	*01182	*01202	*01282	*01792
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01103	*01123	*01143	*01163	*01183	*01203	*01283	*01793
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01104	*01124	*01144	*01164	*01184	*01204	*01284	*01794
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01105	*01125	*01145	*01165	*01185	*01205	*01285	*01795
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01106	*01126	*01146	*01166	*01186	*01206	*01286	*01796
4823	4823	4823	4823	4823	4823	4823	4823
4828	4828	4828	4828	4828	4828	4828	4828
483	483	483	483	483	483	483	483
*01110	*01130	*01150	*01170	*01190	*01210	*01300	*0212
4823	4823	4823	4823	4823	4823	3208	4823
4828	4828	4828	4828	4828	4828	*01301	4828
483	483	483	483	483	483	3208	483
*01111	*01131	*01151	*01171	*01191	*01211	*01302	*0310
4823	4823	4823	4823	4823	4823	3208	4823
4828	4828	4828	4828	4828	4828	*01303	4828
483	483	483	483	483	483	3208	483
*01112	*01132	*01152	*01172	*01192	*01212	*01304	*0360
4823	4823	4823	4823	4823	4823	3208	3208
4828	4828	4828	4828	4828	4828	*01305	*0391
483	483	483	483	483	483	3208	4823
*01113	*01133	*01153	*01173	*01193	*01213	*01306	4828
4823	4823	4823	4823	4823	4823	3208	483
4828	4828	4828	4828	4828	4828	*01310	*0410
483	483	483	483	483	483	3208	0380
*01114	*01134	*01154	*01174	*01194	*01214	*01311	0381
4823	4823	4823	4823	4823	4823	3208	0382
4828	4828	4828	4828	4828	4828	*01312	0383
483	483	483	483	483	483	3208	03840
*01115	*01135	*01155	*01175	*01195	*01215	*01313	03841
4823	4823	4823	4823	4823	4823	3208	03842
4828	4828	4828	4828	4828	4828	*01314	03843
483	483	483	483	483	483	3208	03844
*01116	*01136	*01156	*01176	*01196	*01216	*01315	03849
4823	4823	4823	4823	4823	4823	3208	0388

0389	01103	01184	01344	01615	01725	01805	6825
6800	01104	01185	01345	01616	01726	01806	6826
6801	01105	01186	01346	01620	01730	01880	6827
6802	01106	01190	01350	01621	01731	01881	6828
6803	01110	01191	01351	01622	01732	01882	6829
6804	01111	01192	01352	01623	01733	01883	*0470
6805	01112	01193	01353	01624	01734	01884	3208
6806	01113	01194	01354	01625	01735	01885	*0471
6807	01114	01195	01355	01626	01736	01886	3208
6808	01115	01196	01356	01630	01740	01890	*0478
6809	01116	01200	01360	01631	01741	01891	3208
6820	01120	01201	01361	01632	01742	01892	*0479
6821	01121	01202	01362	01633	01743	01893	3208
6822	01122	01203	01363	01634	01744	01894	*0490
6823	01123	01204	01364	01635	01745	01895	3208
6825	01124	01205	01365	01636	01746	01896	*0491
6826	01125	01206	01366	01640	01750	0310	3208
6827	01126	01210	01380	01641	01751	0360	*0530
6828	01130	01211	01381	01642	01752	0361	3208
6829	01131	01212	01382	01643	01753	0362	*05472
*0411	01132	01213	01383	01644	01754	0363	3208
0380	01133	01214	01384	01645	01755	03640	*0700
0381	01134	01215	01385	01646	01756	03641	7800
0382	01135	01216	01386	01650	01760	03642	*0701
0383	01136	01300	01390	01651	01761	03643	7800
03840	01140	01301	01391	01652	01762	03681	*07020
03841	01141	01302	01392	01653	01763	03682	7800
03842	01142	01303	01393	01654	01764	03689	*07021
03843	01143	01304	01394	01655	01765	0369	7800
03844	01144	01305	01395	01656	01766	0380	*07030
03849	01145	01306	01396	01660	01770	0381	7800
0388	01146	01310	01400	01661	01771	0382	*07031
0389	01150	01311	01401	01662	01772	0383	7800
6800	01151	01312	01402	01663	01773	03840	*07041
6801	01152	01313	01403	01664	01774	03841	7800
6802	01153	01314	01404	01665	01775	03842	*07042
6803	01154	01315	01405	01666	01776	03843	7800
6804	01155	01316	01406	01670	01780	03844	*07043
6805	01156	01320	01480	01671	01781	03849	7800
6806	01160	01321	01482	01672	01782	0388	*07049
6807	01161	01322	01483	01673	01783	0389	7800
6808	01162	01323	01484	01674	01784	3570	*07051
6809	01163	01324	01485	01675	01785	6800	7800
6820	01164	01325	01486	01676	01786	6801	*07052
6821	01165	01326	01600	01690	01790	6802	7800
6822	01170	01330	01601	01691	01791	6803	*07053
6823	01171	01331	01602	01692	01792	6804	7800
6825	01172	01332	01603	01693	01793	6805	*07059
6826	01173	01333	01604	01694	01794	6806	7800
6827	01174	01334	01605	01695	01795	6807	*0706
6828	01175	01335	01606	01696	01796	6808	7800
6829	01176	01336	01610	01720	01800	6809	*0709
*0418	01180	01340	01611	01721	01801	6820	7800
01100	01181	01341	01612	01722	01802	6821	*0721
01101	01182	01342	01613	01723	01803	6822	3208
01102	01183	01343	01614	01724	01804	6823	*09042

3208	3208	7800	11501	7800	01113	01193	5080
*09181	*11515	*25071	11511	*431	01114	01194	5081
3208	4823	7800	11591	7800	01115	01195	5171
*0942	4828	*25080	3200	*4320	01116	01196	*4824
3208	483	3208	3201	7800	01120	01200	4823
*09889	*11591	7800	3202	*4321	01121	01201	4828
3208	3208	*25081	3203	7800	01122	01202	483
*0994	*11595	3208	3207	*4329	01123	01203	*4828
09040	4823	7800	3208	7800	01124	01204	01100
09041	4828	*25090	3209	*4800	01125	01205	01101
09042	483	3208	3210	4823	01126	01206	01102
09049	*1221	7800	3211	4828	01130	01210	01103
0930	4823	*25091	3212	483	01131	01211	01104
0931	4828	3208	3213	*4801	01132	01212	01105
09320	483	7800	3214	4823	01133	01213	01106
09321	*1300	*2510	3218	4828	01134	01214	01110
09322	3208	7800	3220	483	01135	01215	01111
09323	*1304	*2511	3221	*4802	01136	01216	01112
09324	4823	7800	3222	4823	01140	0310	01113
09381	4828	*2512	3229	4828	01141	11505	01114
09382	483	7800	3570	483	01142	11515	01115
09389	*1363	*2513	*3209	*4808	01143	1304	01116
0939	4823	7800	3208	4823	01144	1363	01120
0940	4828	*3200	*3210	4828	01145	481	01121
0941	483	3208	3208	483	01146	4820	01122
0942	*25000	*3201	*3211	*4809	01150	4821	01123
0943	7800	3208	3208	4823	01151	4822	01124
09481	*25001	*3202	*3212	4828	01152	4823	01125
09487	7800	3208	3208	483	01153	4824	01126
09489	*25010	*3203	*3213	*481	01154	4828	01130
0949	7800	3208	3208	4823	01155	4829	01131
0980	*25011	*3207	*3214	4828	01156	483	01132
09810	7800	3208	3208	483	01160	4841	01133
09811	*25020	*3208	*3218	*4820	01161	4843	01134
09812	7800	01300	3208	4823	01162	4845	01135
09813	*25021	01301	*3220	4828	01163	4846	01136
09814	7800	01302	3208	483	01164	4847	01140
09815	*25030	01303	*3221	*4821	01165	4848	01141
09816	7800	01304	3208	4823	01166	485	01142
09817	*25031	01305	*3222	4828	01170	486	01143
09819	7800	01306	3208	483	01171	4870	01144
5970	*25040	01310	*3229	*4822	01172	4950	01145
5990	7800	01311	3208	4823	01173	4951	01146
*10081	*25041	01312	*3488	4828	01174	4952	01150
3208	7800	01313	7800	483	01175	4953	01151
*11283	*25050	01314	*3489	*4823	01176	4954	01152
3208	7800	01315	7800	01100	01180	4955	01153
*1142	*25051	01316	*34989	01101	01181	4956	01154
3208	7800	0360	3208	01102	01182	4957	01155
*11501	*25060	0530	7800	01103	01183	4958	01156
3208	3208	05472	*3499	01104	01184	4959	01160
*11505	7800	0721	3208	01105	01185	5060	01161
4823	*25061	09042	7800	01106	01186	5061	01162
4828	3208	0942	*3570	01110	01190	5070	01163
483	7800	11283	3208	01111	01191	5071	01164
*11511	*25070	1142	*430	01112	01192	5078	01165

01166	485	01142	11515	4823	4823	4823	7800
01170	486	01143	1304	4828	4828	4828	*5965
01171	4870	01144	1363	483	483	483	5960
01172	4950	01145	481	*4848	*4958	*5069	5964
01173	4951	01146	4820	4823	4823	4823	5996
01174	4952	01150	4821	4828	4828	4828	7882
01175	4953	01151	4822	483	483	483	*5998
01176	4954	01152	4823	*485	*4959	*5070	5800
01180	4955	01153	4824	4823	4823	4823	5804
01181	4956	01154	4828	4828	4828	4828	58081
01182	4957	01155	4829	483	483	483	58089
01183	4958	01156	483	*486	*496	*5071	5809
01184	4959	01160	4841	4823	4823	4823	5810
01185	5060	01161	4843	4828	4828	4828	5811
01186	5061	01162	4845	483	483	483	5812
01190	5070	01163	4846	*4870	*500	*5078	5813
01191	5071	01164	4847	4823	4823	4823	58181
01192	5078	01165	4848	4828	4828	4828	58189
01193	5080	01166	485	483	483	483	5819
01194	5081	01170	486	*4871	*501	*5080	5834
01195	5171	01171	4870	4823	4823	4823	5845
01196	*4829	01172	4950	4828	4828	4828	5846
01200	4823	01173	4951	483	483	483	5847
01201	4828	01174	4952	*494	*502	*5081	5848
01202	483	01175	4953	4823	4823	4823	5849
01203	*483	01176	4954	4828	4828	4828	585
01204	01100	01180	4955	483	483	483	59010
01205	01101	01181	4956	*4950	*503	*5088	59011
01206	01102	01182	4957	4823	4823	4823	5902
01210	01103	01183	4958	4828	4828	4828	5903
01211	01104	01184	4959	483	483	483	59080
01212	01105	01185	5060	*4951	*504	*5089	59081
01213	01106	01186	5061	4823	4823	4823	5909
01214	01110	01190	5070	4828	4828	4828	591
01215	01111	01191	5071	483	483	483	5921
01216	01112	01192	5078	*4952	*505	*5171	5935
0310	01113	01193	5080	4823	4823	4823	5950
11505	01114	01194	5081	4828	4828	4828	5951
11515	01115	01195	5171	483	483	483	5952
1304	01116	01196	*4841	*4953	*5060	*5178	5954
1363	01120	01200	4823	4823	4823	4823	59581
481	01121	01201	4828	4828	4828	4828	59582
4820	01122	01202	483	483	483	483	59589
4821	01123	01203	*4843	*4954	*5061	*51889	5959
4822	01124	01204	4823	4823	4823	4823	5961
4823	01125	01205	4828	4828	4828	4828	5962
4824	01126	01206	483	483	483	483	5964
4828	01130	01210	*4845	*4955	*5062	*5198	5966
4829	01131	01211	4823	4823	4823	4823	5967
483	01132	01212	4828	4828	4828	4828	5970
4841	01133	01213	483	483	483	483	5981
4843	01134	01214	*4846	*4956	*5063	*5199	5982
4845	01135	01215	4823	4823	4823	4823	5990
4846	01136	01216	4828	4828	4828	4828	5994
4847	01140	0310	483	483	483	483	5996
4848	01141	11505	*4847	*4957	*5064	*5722	5997

*74861	7800	7800	7800	7800	7800	7800	7800
4823	*80023	*80059	*80093	*80129	*80163	*80199	*80333
4828	7800	7800	7800	7800	7800	7800	7800
483	*80024	*80060	*80094	*80130	*80164	*80300	*80334
*7800	7800	7800	7800	7800	7800	7800	7800
430	*80025	*80061	*80095	*80131	*80165	*80301	*80335
431	7800	7800	7800	7800	7800	7800	7800
4320	*80026	*80062	*80096	*80132	*80166	*80302	*80336
4321	7800	7800	7800	7800	7800	7800	7800
436	*80029	*80063	*80099	*80133	*80169	*80303	*80339
7800	7800	7800	7800	7800	7800	7800	7800
*7802	*80030	*80064	*80100	*80134	*80170	*80304	*80340
7800	7800	7800	7800	7800	7800	7800	7800
*7804	*80031	*80065	*80101	*80135	*80171	*80305	*80341
7800	7800	7800	7800	7800	7800	7800	7800
*7809	*80032	*80066	*80102	*80136	*80172	*80306	*80342
7800	7800	7800	7800	7800	7800	7800	7800
*7998	*80033	*80069	*80103	*80139	*80173	*80309	*80343
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*80000	*80034	*80070	*80104	*80140	*80174	*80310	*80344
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*80001	*80035	*80071	*80105	*80141	*80175	*80311	*80345
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*80002	*80036	*80072	*80106	*80142	*80176	*80312	*80346
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*80003	*80039	*80073	*80109	*80143	*80179	*80313	*80349
7800	7800	7800	7800	7800	7800	7800	7800
*80004	*80040	*80074	*80110	*80144	*80180	*80314	*80350
7800	7800	7800	7800	7800	7800	7800	7800
*80005	*80041	*80075	*80111	*80145	*80181	*80315	*80351
7800	7800	7800	7800	7800	7800	7800	7800
*80006	*80042	*80076	*80112	*80146	*80182	*80316	*80352
7800	7800	7800	7800	7800	7800	7800	7800
*80009	*80043	*80079	*80113	*80149	*80183	*80319	*80353
7800	7800	7800	7800	7800	7800	7800	7800
*80010	*80044	*80080	*80114	*80150	*80184	*80320	*80354
7800	7800	7800	7800	7800	7800	7800	7800
*80011	*80045	*80081	*80115	*80151	*80185	*80321	*80355
7800	7800	7800	7800	7800	7800	7800	7800
*80012	*80046	*80082	*80116	*80152	*80186	*80322	*80356
7800	7800	7800	7800	7800	7800	7800	7800
*80013	*80049	*80083	*80119	*80153	*80189	*80323	*80359
7800	7800	7800	7800	7800	7800	7800	7800
*80014	*80050	*80084	*80120	*80154	*80190	*80324	*80360
7800	7800	7800	7800	7800	7800	7800	7800
*80015	*80051	*80085	*80121	*80155	*80191	*80325	*80361
7800	7800	7800	7800	7800	7800	7800	7800
*80016	*80052	*80086	*80122	*80156	*80192	*80326	*80362
7800	7800	7800	7800	7800	7800	7800	7800
*80019	*80053	*80089	*80123	*80159	*80193	*80329	*80363
7800	7800	7800	7800	7800	7800	7800	7800
*80020	*80054	*80090	*80124	*80160	*80194	*80330	*80364
7800	7800	7800	7800	7800	7800	7800	7800
*80021	*80055	*80091	*80125	*80161	*80195	*80331	*80365
7800	7800	7800	7800	7800	7800	7800	7800
*80022	*80056	*80092	*80126	*80162	*80196	*80332	*80366

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7800	7800	7800	7800	7800	7800	7800	7800
*80370	*80404	*80440	*80474	*85102	*85136	*85172	*85206
7800	7800	7800	7800	7800	7800	7800	7800
*80371	*80405	*80441	*80475	*85103	*85139	*85173	*85209
7800	7800	7800	7800	7800	7800	7800	7800
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7800	7800	7800	7800	7800	7800	7800	7800
*80373	*80409	*80443	*80479	*85105	*85141	*85175	*85211
7800	7800	7800	7800	7800	7800	7800	7800
*80374	*80410	*80444	*80480	*85106	*85142	*85176	*85212
7800	7800	7800	7800	7800	7800	7800	7800
*80375	*80411	*80445	*80481	*85109	*85143	*85179	*85213
7800	7800	7800	7800	7800	7800	7800	7800
*80376	*80412	*80446	*80482	*85110	*85144	*85180	*85214
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*80380	*80414	*80450	*80484	*85112	*85146	*85182	*85216
7800	7800	7800	7800	7800	7800	7800	7800
*80381	*80415	*80451	*80485	*85113	*85149	*85183	*85219
7800	7800	7800	7800	7800	7800	7800	7800
*80382	*80416	*80452	*80486	*85114	*85150	*85184	*85221
7800	7800	7800	7800	7800	7800	7800	7800
*80383	*80419	*80453	*80489	*85115	*85151	*85185	*85222
7800	7800	7800	7800	7800	7800	7800	7800
*80384	*80420	*80454	*80490	*85116	*85152	*85186	*85223
7800	7800	7800	7800	7800	7800	7800	7800
*80385	*80421	*80455	*80491	*85119	*85153	*85189	*85224
7800	7800	7800	7800	7800	7800	7800	7800
*80386	*80422	*80456	*80492	*85120	*85154	*85190	*85225
7800	7800	7800	7800	7800	7800	7800	7800
*80389	*80423	*80459	*80493	*85121	*85155	*85191	*85226
7800	7800	7800	7800	7800	7800	7800	7800
*80390	*80424	*80460	*80494	*85122	*85156	*85192	*85229
7800	7800	7800	7800	7800	7800	7800	7800
*80391	*80425	*80461	*80495	*85123	*85159	*85193	*85230
7800	7800	7800	7800	7800	7800	7800	7800
*80392	*80426	*80462	*80496	*85124	*85160	*85194	*85231
7800	7800	7800	7800	7800	7800	7800	7800
*80393	*80429	*80463	*8500	*85125	*85161	*85195	*85232
7800	7800	7800	7800	7800	7800	7800	7800
*80394	*80430	*80464	*8501	*85126	*85162	*85196	*85233
7800	7800	7800	7800	7800	7800	7800	7800
*80395	*80431	*80465	*8502	*85129	*85163	*85199	*85234
7800	7800	7800	7800	7800	7800	7800	7800
*80396	*80432	*80466	*8503	*85130	*85164	*85200	*85235
7800	7800	7800	7800	7800	7800	7800	7800
*80399	*80433	*80469	*8504	*85131	*85165	*85201	*85236
7800	7800	7800	7800	7800	7800	7800	7800
*80400	*80434	*80470	*8505	*85132	*85166	*85202	*85239
7800	7800	7800	7800	7800	7800	7800	7800
*80401	*80435	*80471	*8509	*85133	*85169	*85203	*85240
7800	7800	7800	7800	7800	7800	7800	7800
*80402	*80436	*80472	*85100	*85134	*85170	*85204	*85241

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7800	7800
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7800	7800
*85244	*85400
7800	7800
*85245	*85401
7800	7800
*85246	*85402
7800	7800
*85249	*85403
7800	7800
*85250	*85404
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*85251	*85405
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*85314	
7800	
*85315	

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28268	15.7441	4	7	11	19	31
002	5716	14.9003	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5127	13.0521	3	5	9	16	27
005	52807	6.7496	2	3	5	8	13
006	854	3.3162	1	1	2	3	7
007	5742	21.2179	2	6	11	22	45
008	2699	4.5954	1	1	3	6	10
009	1678	10.5864	2	4	7	12	21
010	19835	10.8720	2	4	7	14	22
011	3528	6.4212	1	2	4	8	13
012	21359	10.4106	2	4	7	12	19
013	5571	8.5144	3	4	7	10	15
014	337593	9.9669	3	4	7	12	19
015	133891	5.4328	2	3	4	6	10
016	11011	9.3524	3	4	7	11	18
017	2962	5.7667	2	3	5	7	10
018	13605	7.9338	2	4	6	9	15
019	6848	5.4936	1	2	4	7	11
020	7404	12.4114	2	5	9	16	25
021	1006	9.6928	3	4	7	12	19
022	9691	5.5158	2	3	4	7	10
023	3067	6.2097	1	2	4	7	12
024	53265	7.3423	2	3	5	9	14
025	22480	4.4321	1	2	3	5	8
026	55	5.6727	1	2	3	7	14
027	2678	7.9623	1	2	4	10	18
028	7878	9.4439	2	3	6	11	19
029	3540	4.8621	1	2	3	6	10
030	2	1.0000	1	1	1	1	1
031	3572	6.6249	2	2	4	7	13
032	2583	3.6806	1	2	3	4	7
034	13461	8.8028	2	3	6	10	17
035	3768	5.2606	1	2	4	6	10
036	20229	2.3422	1	1	2	3	4
037	2665	4.4649	1	1	3	5	10
038	770	2.8208	1	1	2	3	5
039	9581	1.9363	1	1	1	2	3
040	3321	3.4192	1	1	2	4	7
042	20297	2.5528	1	1	2	3	5
043	201	5.6866	1	2	4	6	11
044	1962	6.2819	2	4	5	7	11
045	2588	4.4532	1	2	4	6	8
046	2876	6.2827	1	2	5	8	12
047	1859	4.4330	1	2	3	5	8
048	2	7.0000	5	5	9	9	9
049	2967	7.6923	2	3	5	9	16
050	4902	2.6391	1	1	2	3	4
051	524	2.8645	1	1	2	3	6
052	171	3.1462	1	1	2	3	6
053	6387	3.4481	1	1	2	3	8

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3589	2.7317	1	1	1	2	6
056	1090	2.7009	1	1	2	3	6
057	696	5.3750	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	183	2.1858	1	1	1	2	4
061	381	5.0919	1	1	2	6	12
063	4780	5.7492	1	2	4	7	12
064	4332	8.7652	1	2	5	11	20
065	32014	4.1498	1	2	3	5	8
066	7733	4.3419	1	2	3	5	8
067	425	5.1671	2	3	4	6	9
068	11536	5.9536	2	3	5	7	11
069	3729	4.3124	2	2	4	5	8
070	17	4.5294	1	2	3	5	9
071	132	5.0682	2	3	4	6	10
072	673	5.7281	1	2	3	5	9
073	6546	6.0053	1	2	4	7	12
074	2	11.0000	9	9	13	13	13
075	31763	13.7042	6	8	10	16	25
076	75079	14.3224	4	7	11	18	27
077	6545	7.5325	1	3	6	10	15
078	26477	10.0135	4	7	9	12	16
079	132677	11.6036	4	6	9	14	21
080	8940	7.7613	3	4	6	9	14
081	1	7.0000	7	7	7	7	7
082	58814	9.0936	2	4	7	12	19
083	7021	8.1493	2	4	6	10	15
084	1783	4.4577	1	2	3	6	8
085	16869	8.8759	2	4	7	11	17
086	1697	5.2787	1	2	4	7	10
087	61021	8.0394	2	4	6	10	15
088	161966	7.3437	3	4	6	9	13
089	368544	8.6408	3	5	7	10	15
090	45578	6.1821	3	4	5	7	10
091	44	6.1136	2	3	5	7	11
092	8321	8.5321	3	4	7	10	16
093	1327	5.8425	2	3	5	7	10
094	9350	9.3702	3	4	7	11	18
095	1287	5.3963	2	3	4	7	10
096	176236	7.0607	3	4	6	8	12
097	32075	5.1441	2	3	4	6	9
098	17	6.2941	2	3	5	6	10
099	30114	5.1423	1	2	4	6	10
100	11199	3.1203	1	2	2	4	6
101	18008	6.6578	2	3	5	8	13
102	3535	4.2795	1	2	3	5	8
103	238	32.1723	10	14	23	38	62
104	17372	20.2585	9	12	17	25	35
105	15979	14.4294	7	9	11	16	25
106	74580	15.2254	8	10	13	17	24
107	52388	11.7606	7	8	10	13	18

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
108	8815	15.1239	7	9	12	18	27
110	50710	13.4182	3	8	11	16	25
111	6320	8.4106	3	6	8	10	13
112	128899	6.0896	2	3	5	8	12
113	36405	18.7793	6	8	14	22	37
114	8076	12.4459	3	5	9	15	24
115	8203	13.8516	5	8	11	17	24
116	63412	7.2544	2	3	6	9	14
117	3265	5.5103	1	2	3	7	12
118	8177	3.9209	1	1	2	4	9
119	3204	6.2644	1	2	3	7	15
120	34531	12.1610	2	3	8	15	27
121	143327	9.6028	4	6	8	11	16
122	99268	6.8777	2	4	7	9	11
123	55036	5.2961	1	1	3	7	13
124	123627	5.7604	1	2	5	7	11
125	88564	3.1515	1	1	2	4	7
126	4203	20.4149	5	10	16	29	41
127	602239	7.7143	2	4	6	9	14
128	23149	8.4066	4	5	7	10	13
129	6227	4.7466	1	1	1	6	12
130	70683	8.0792	2	4	7	10	14
131	26293	5.9626	1	3	6	8	10
132	12691	5.5565	1	2	4	7	11
133	4152	3.9188	1	2	3	5	7
134	29006	4.9912	2	2	4	6	9
135	6404	6.6284	2	3	5	8	13
136	1428	4.3690	1	2	3	5	7
138	185487	5.8414	2	3	4	7	11
139	71704	3.6838	1	2	3	5	7
140	341502	4.4690	2	2	4	5	8
141	76370	5.6764	2	3	4	7	10
142	36764	3.9269	1	2	3	5	7
143	115719	3.3746	1	2	3	4	6
144	55652	7.0829	2	3	5	9	14
145	8435	4.1801	1	2	3	5	8
146	7565	13.7870	7	9	11	15	22
147	1620	8.9846	5	7	9	11	13
148	141393	15.8461	7	9	12	18	28
149	18120	9.0679	6	7	8	10	13
150	21587	13.8921	5	8	11	17	24
151	4781	7.7833	3	4	7	10	13
152	4551	10.6339	5	7	9	12	18
153	2048	7.0459	4	5	7	8	10
154	37035	17.9293	7	9	14	22	34
155	4178	8.6084	4	5	7	10	14
157	13128	6.5957	2	3	5	8	13
158	9959	3.0688	1	1	2	4	6
159	16227	6.3665	2	3	5	8	12
160	12821	3.3392	1	2	3	4	6
161	23791	4.6269	1	2	3	6	10

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
162	21101	2.2025	1	1	2	3	4
163	10	2.4000	1	2	2	3	4
164	4579	11.3872	5	7	9	13	19
165	1794	7.0284	4	5	7	9	11
166	2932	7.1538	3	4	6	9	13
167	2170	4.1253	2	3	4	5	7
168	1799	5.7943	1	2	3	7	12
169	1386	2.9129	1	1	2	3	6
170	12713	15.6310	3	7	11	19	31
171	1463	6.9412	1	3	6	9	13
172	31140	10.3381	2	4	7	13	21
173	3337	5.2517	1	2	4	7	11
174	165016	6.9276	2	4	5	8	13
175	22542	4.3682	2	3	4	5	7
176	12892	7.7026	2	4	6	9	14
177	14855	6.2788	2	3	5	8	11
178	6418	4.4483	2	3	4	5	8
179	8630	9.5102	3	4	7	11	18
180	69302	7.6203	2	4	6	9	14
181	22049	4.5862	2	3	4	6	8
182	256259	6.2255	2	3	5	7	11
183	78178	4.5400	1	2	4	5	8
184	50	3.6000	1	2	3	4	6
185	3831	6.3156	1	3	5	8	13
186	1	4.0000	4	4	4	4	4
187	997	3.9529	1	1	2	5	8
188	49808	7.3748	2	3	5	9	14
189	9043	3.8545	1	1	3	5	8
190	94	5.2447	2	3	4	7	10
191	10080	19.7739	6	10	15	24	39
192	985	9.6020	3	6	8	12	16
193	12295	16.5587	7	9	14	20	29
194	1416	9.7041	3	6	9	12	17
195	17110	12.2889	6	7	10	14	20
196	1856	8.2193	4	5	7	10	13
197	76376	8.4937	2	4	7	11	16
198	48653	3.6350	1	1	3	5	7
199	2829	14.2616	4	7	11	18	27
200	1923	13.5190	2	5	10	17	26
201	2997	14.3784	3	6	10	18	30
202	17745	9.6320	2	4	7	12	19
203	29497	9.7206	2	4	7	12	20
204	39199	8.0600	3	4	6	9	15
205	20814	9.1418	2	4	7	11	18
206	2413	5.0220	1	2	4	7	10
207	37528	7.0338	2	3	5	9	13
208	14008	4.0415	1	2	3	5	7
209	267627	10.5536	6	7	9	12	16
210	116591	12.9940	6	8	10	14	21
211	28911	9.4425	5	6	8	11	14
212	18	6.1111	2	2	3	7	9

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
213	5736	12.8313	3	6	9	16	25
214	41313	10.2321	4	5	8	12	19
215	37991	6.0864	3	4	5	7	10
216	7018	14.4741	3	6	11	18	29
217	16628	21.0197	4	7	14	27	45
218	18336	9.0046	3	4	7	11	17
219	17781	5.1599	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4858	10.7091	2	4	8	13	21
222	5229	5.2878	1	2	4	7	10
223	15713	4.0320	1	2	3	4	7
224	8728	2.8997	1	2	2	3	5
225	9993	5.2825	1	2	3	6	12
226	5452	8.9762	2	3	6	11	20
227	6465	3.8863	1	2	3	4	7
228	4327	3.7123	1	1	2	4	8
229	2505	2.6591	1	1	2	3	5
230	3230	6.4412	1	2	4	7	13
231	10173	6.5634	1	2	4	7	15
232	793	6.5523	1	2	3	7	17
233	5188	11.6795	3	5	9	15	23
234	3023	5.4016	1	2	4	7	11
235	6239	11.1856	2	4	7	12	23
236	38320	8.9097	2	4	7	10	17
237	1681	5.8257	2	3	4	7	10
238	6361	13.9027	4	6	10	17	28
239	59319	10.0120	3	5	7	12	19
240	10920	9.3950	3	4	7	11	18
241	3950	5.6463	2	3	4	7	11
242	2498	10.5096	3	5	8	13	22
243	103841	6.8288	2	3	5	9	13
244	11051	7.2525	2	3	5	9	14
245	5661	5.3374	1	2	4	6	10
246	1726	5.4177	2	3	4	7	10
247	9689	5.0799	1	2	4	6	10
248	6248	6.1908	2	3	5	7	12
249	8359	6.3973	1	2	4	8	13
250	3393	6.7781	2	3	5	8	12
251	3237	3.6256	1	1	2	4	7
253	16958	8.1943	2	3	6	9	16
254	12121	4.7225	1	2	3	6	9
255	2	2.5000	1	1	4	4	4
256	9233	5.4512	1	2	4	6	11
257	28219	5.1278	2	3	4	6	8
258	26390	3.6482	2	2	3	4	6
259	4004	5.9298	1	2	3	6	13
260	4979	2.5700	1	1	2	3	4
261	2941	2.8259	1	1	2	3	5
262	1302	3.5661	1	1	2	3	7
263	28743	20.2119	5	8	14	24	40
264	4186	11.3512	3	5	8	14	23

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
265	4915	9.6867	2	3	6	11	21
266	4167	4.3252	1	2	3	5	9
267	368	4.9837	1	1	3	5	11
268	1410	5.1723	1	1	2	5	9
269	10906	12.2327	2	4	9	15	25
270	5130	4.0310	1	2	3	5	9
271	19866	11.4729	3	5	8	13	21
272	6799	9.3836	3	5	7	11	18
273	2194	6.8090	2	3	5	8	14
274	3139	10.9341	2	4	7	12	21
275	401	5.7232	1	2	3	6	9
276	867	5.7151	1	2	4	7	11
277	70657	8.4681	3	5	7	10	15
278	25890	6.1614	3	4	5	7	11
279	6	7.0000	2	3	4	11	11
280	12914	6.7166	2	3	5	8	13
281	7188	4.1994	1	2	3	5	8
282	1	2.0000	2	2	2	2	2
283	5814	7.3003	2	3	5	8	14
284	2389	5.0682	1	2	4	6	9
285	4549	20.6736	5	9	15	25	40
286	1721	11.2702	5	6	8	13	22
287	6493	18.7138	4	7	12	21	38
288	507	10.4694	3	4	7	10	21
289	3955	5.6718	2	2	3	5	12
290	9577	3.4522	1	2	2	4	6
291	143	2.1049	1	1	2	2	4
292	5044	17.6921	4	7	13	21	35
293	505	7.4950	1	3	6	10	15
294	89720	7.2549	3	4	6	8	13
295	3262	5.8483	2	3	4	7	11
296	210976	8.3160	2	4	6	10	16
297	44441	5.1711	2	3	4	6	9
298	65	4.6308	1	2	2	5	8
299	877	6.5530	1	2	5	8	13
300	11785	9.3115	3	4	7	11	18
301	2074	5.2160	1	2	4	7	10
302	6613	15.9463	7	9	13	19	28
303	17481	13.2953	6	8	10	15	23
304	13876	13.3942	4	6	10	16	26
305	3517	6.4578	2	3	6	8	12
306	12341	8.8255	3	4	6	11	17
307	4325	4.5686	2	3	4	5	8
308	10288	9.0454	2	3	6	11	19
309	4383	3.9877	1	2	3	5	8
310	35212	5.6127	1	2	4	7	11
311	19528	2.6869	1	1	2	3	5
312	3102	5.5239	1	2	4	7	11
313	1818	2.7629	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	26943	12.2125	1	3	7	15	27

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
316	49068	9.1396	2	4	7	12	18
317	707	4.1782	1	2	3	4	8
318	6661	8.9922	2	3	6	11	19
319	884	3.7986	1	1	2	4	8
320	162684	8.3690	3	4	6	10	15
321	29134	5.8757	2	3	5	7	10
322	50	5.8400	2	3	5	7	10
323	20541	4.2749	1	2	3	5	9
324	13479	2.5819	1	1	2	3	5
325	9618	5.7660	2	3	4	7	11
326	3609	3.5658	1	2	3	4	7
327	9	7.0000	1	2	8	8	10
328	1257	4.9578	1	2	4	6	9
329	341	2.9003	1	1	2	4	5
331	29323	7.4644	2	3	6	9	15
332	5847	4.4404	1	2	3	5	9
333	311	7.5949	2	3	5	10	16
334	22366	9.1218	5	6	8	10	14
335	10820	7.2799	5	6	7	8	10
336	105208	5.7983	3	3	4	7	10
337	88453	3.8239	2	3	3	4	6
338	7449	5.2254	1	1	2	6	13
339	3230	4.6889	1	1	2	5	11
340	2	5.0000	3	3	7	7	7
341	12839	4.3806	1	2	3	5	8
342	410	3.8610	1	1	2	4	9
343	2	2.0000	1	1	3	3	3
344	4825	5.3988	1	2	4	6	10
345	2512	4.8949	1	2	3	5	10
346	7797	8.5775	2	3	6	10	17
347	963	4.3894	1	1	3	5	9
348	4269	5.7126	1	2	4	7	11
349	1634	3.1157	1	1	2	4	6
350	7998	5.8718	2	3	5	7	10
351	1	6.0000	6	6	6	6	6
352	770	4.8065	1	2	3	6	10
353	2321	11.4942	5	6	9	14	21
354	9467	8.2451	4	5	6	9	14
355	6005	4.9975	3	4	5	6	7
356	31595	4.3123	2	3	4	5	7
357	6815	12.4031	5	7	10	15	23
358	23005	6.5869	3	4	5	7	11
359	26844	4.4908	3	4	4	5	6
360	9626	5.2339	2	3	4	6	9
361	440	5.7500	1	2	4	6	14
363	5695	4.3392	1	2	3	4	8
364	2642	4.1862	1	1	2	5	8
365	3169	10.7349	3	4	7	13	23
366	5027	10.0072	2	3	7	13	21
367	873	3.9210	1	1	3	4	8
368	1482	7.3657	2	4	6	9	14

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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2518	4.594	1	2	3	6	9
370	612	6.363	3	4	5	7	10
371	685	4.419	3	3	4	5	6
372	409	3.807	1	2	3	4	6
373	2513	2.522	1	2	2	3	3
374	67	4.000	2	2	2	3	5
375	7	14.714	1	2	2	7	14
376	146	2.740	1	1	2	3	5
377	27	5.074	1	2	4	7	10
378	138	3.652	2	3	3	4	6
379	310	2.971	1	1	2	3	6
380	66	2.818	1	1	2	3	5
381	222	2.432	1	1	1	3	4
382	58	1.448	1	1	1	2	2
383	842	4.426	1	2	3	5	9
384	98	2.724	1	1	2	3	6
385	5	5.600	1	1	3	6	15
386	1	149.000	149	149	149	149	149
387	1	6.000	6	6	6	6	6
389	9	8.556	1	5	9	9	11
390	28	6.536	1	2	4	11	14
391	1	2.000	2	2	2	2	2
392	2443	14.079	5	7	10	18	27
394	1980	10.330	1	2	6	12	22
395	70959	6.446	2	3	5	8	13
396	13	3.154	1	1	2	2	5
397	12488	7.452	2	3	5	9	15
398	14632	8.302	3	4	6	10	15
399	1681	5.258	1	2	4	7	10
400	8031	13.330	3	5	9	17	28
401	6988	15.257	3	6	11	19	32
402	2355	5.211	1	2	3	7	11
403	27920	11.893	2	5	8	15	25
404	5327	5.685	1	2	4	7	12
405	5	3.000	1	1	3	3	6
406	3783	15.319	4	7	11	19	31
407	977	6.492	2	3	5	8	11
408	5196	8.535	1	2	5	10	20
409	7546	9.030	2	4	5	11	20
410	125087	3.621	1	2	3	5	6
411	165	3.655	1	1	2	5	7
412	142	2.775	1	1	2	3	6
413	9559	10.688	2	4	8	13	22
414	1738	6.013	1	2	4	8	13
415	29908	20.274	5	9	15	25	40
416	135915	10.339	2	5	8	13	19
417	42	5.500	2	3	4	7	8
418	14224	8.258	3	4	7	10	15
419	16976	7.428	2	4	6	9	14
420	3737	5.434	2	3	4	7	10
421	12184	5.583	2	3	4	7	10

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SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
422	103	6.078	2	3	5	7	11
423	7136	10.896	3	5	8	13	22
424	2826	22.561	3	8	15	27	45
425	17758	6.483	2	3	4	8	13
426	5935	7.293	2	3	5	9	15
427	1979	7.866	1	3	5	9	16
428	1111	10.632	2	3	6	13	25
429	30483	12.055	3	4	7	13	23
430	55787	12.278	3	5	9	16	25
431	243	11.337	1	3	6	9	15
432	534	7.140	1	2	4	8	15
433	5788	4.536	1	1	3	5	11
434	18195	7.815	2	3	5	9	15
435	12116	6.330	2	3	5	7	13
436	2439	17.926	5	10	19	26	28
437	10653	16.676	6	10	15	23	28
439	944	9.394	1	3	6	12	22
440	4601	12.955	2	4	8	16	28
441	845	3.741	1	1	2	4	8
442	11317	9.876	1	3	6	12	21
443	5848	3.719	1	1	2	5	8
444	3891	7.287	2	3	5	8	13
445	2178	4.368	1	2	3	5	8
447	3122	3.495	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29032	5.941	1	2	4	7	12
450	7484	3.318	1	1	2	4	7
451	7	147.571	1	3	5	10	11
452	17447	6.230	1	2	4	7	13
453	5851	3.570	1	2	3	4	7
454	4045	6.901	1	2	4	8	14
455	1100	3.295	1	1	2	4	6
456	173	9.035	1	2	4	10	21
457	122	9.115	1	1	4	11	20
458	1606	22.719	5	10	17	29	45
459	563	14.909	3	6	10	18	31
460	2377	9.176	2	4	7	12	19
461	5830	5.401	1	1	2	5	13
462	6530	17.789	5	8	15	23	33
463	9344	6.762	2	3	5	8	13
464	2953	4.149	1	2	3	5	8
465	533	3.079	1	1	1	3	6
466	3591	4.686	1	1	2	4	9
467	3376	6.102	1	1	2	5	10
468	72859	18.112	4	8	14	22	35
471	7574	14.050	7	9	11	16	23
472	178	29.315	1	9	23	42	62
473	8355	17.029	2	4	10	26	41
475	73010	13.666	2	6	11	18	27
476	10661	16.928	6	10	14	20	29
477	36161	10.349	1	3	7	13	21

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
478	102880	10.2410	2	4	7	13	21
479	17854	5.4843	1	2	5	7	10
480	75	40.4933	11	16	26	45	96
481	67	44.9552	23	31	39	50	72
482	6838	18.0759	6	9	13	21	34
483	32814	54.0528	17	27	43	67	99
484	289	22.9516	2	9	18	33	49
485	2511	16.4552	6	9	12	19	30
486	1730	16.9983	1	7	13	22	35
487	2846	11.1774	2	4	8	14	22
488	844	20.3140	5	9	15	25	39
489	4279	13.8995	3	5	9	16	28
490	1702	8.6710	1	3	5	10	19
491	6713	6.3799	3	4	5	8	11
492	1048	14.4637	3	4	6	24	34
	==========						
	10203666						

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28268	15.7441	4	7	11	19	31
002	5716	14.9003	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5127	13.0521	3	5	9	16	27
005	52807	6.7496	2	3	5	8	13
006	854	3.3162	1	1	2	3	7
007	5742	21.2179	2	6	11	22	45
008	2699	4.5954	1	1	3	6	10
009	1678	10.5864	2	4	7	12	21
010	19835	10.8720	2	4	7	14	22
011	3528	6.4212	1	2	4	8	13
012	21359	10.4106	2	4	7	12	19
013	5571	8.5144	3	4	7	10	15
014	337593	9.9669	3	4	7	12	19
015	133891	5.4328	2	3	4	6	10
016	11011	9.3524	3	4	7	11	18
017	2962	5.7667	2	3	5	7	10
018	13605	7.9338	2	4	6	9	15
019	6848	5.4936	1	2	4	7	11
020	7404	12.4114	2	5	9	16	25
021	1006	9.6928	3	4	7	12	19
022	9691	5.5158	2	3	4	7	10
023	3067	6.2097	1	2	4	7	12
024	53265	7.3423	2	3	5	9	14
025	22480	4.4321	1	2	3	5	8
026	55	5.6727	1	2	3	7	14
027	2678	7.9623	1	2	4	10	18
028	7878	9.4439	2	3	6	11	19
029	3540	4.8621	1	2	3	6	10
030	2	1.0000	1	1	1	1	1
031	3572	6.6249	2	2	4	7	13
032	2583	3.6806	1	2	3	4	7
034	13461	8.8028	2	3	6	10	17
035	3768	5.2606	1	2	4	6	10
036	20229	2.3422	1	1	2	3	4
037	2665	4.4649	1	1	3	5	10
038	770	2.8208	1	1	2	3	5
039	9581	1.9363	1	1	1	2	3
040	3321	3.4192	1	1	2	4	7
042	20297	2.5528	1	1	2	3	5
043	201	5.6866	1	2	4	6	11
044	1962	6.2819	2	4	5	7	11
045	2588	4.4532	1	2	4	6	8
046	2876	6.2827	1	2	5	8	12
047	1859	4.4330	1	2	3	5	8
048	2	7.0000	5	5	9	9	9
049	2967	7.6923	2	3	5	9	16
050	4902	2.6391	1	1	2	3	4
051	524	2.8645	1	1	2	3	6
052	171	3.1462	1	1	2	3	6
053	6387	3.4481	1	1	2	3	8

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3589	2.7317	1	1	1	2	6
056	1090	2.7009	1	1	2	3	6
057	696	5.3750	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	183	2.1858	1	1	1	2	4
061	381	5.0919	1	1	2	6	12
063	4780	5.7492	1	2	4	7	12
064	4332	8.7652	1	2	5	11	20
065	32014	4.1498	1	2	3	5	8
066	7733	4.3419	1	2	3	5	8
067	425	5.1671	2	3	4	6	9
068	11536	5.9536	2	3	5	7	11
069	3729	4.3124	2	2	4	5	8
070	17	4.5294	1	2	3	5	9
071	132	5.0682	2	3	4	6	10
072	873	5.7281	1	2	3	5	9
073	6546	6.0053	1	2	4	7	12
074	2	11.0000	9	9	13	13	13
075	31763	13.7042	6	8	10	16	25
076	75079	14.3224	4	7	11	18	27
077	6545	7.5325	1	3	6	10	15
078	26477	10.0135	4	7	9	12	16
079	132877	11.6036	4	6	9	14	21
080	8940	7.7613	3	4	6	9	14
081	1	7.0000	7	7	7	7	7
082	58814	9.0936	2	4	7	12	19
083	7021	8.1493	2	4	6	10	15
084	1783	4.4577	1	2	3	6	8
085	16869	8.8759	2	4	7	11	17
086	1697	5.2787	1	2	4	7	10
087	61021	8.0394	2	4	6	10	15
088	161966	7.3437	3	4	6	9	13
089	368544	8.6408	3	5	7	10	15
090	45578	6.1821	3	4	5	7	10
091	44	6.1136	2	3	5	7	11
092	8321	8.5321	3	4	7	10	16
093	1327	5.8425	2	3	5	7	10
094	9350	9.3702	3	4	7	11	18
095	1287	5.3963	2	3	4	7	10
096	176236	7.0607	3	4	6	8	12
097	32075	5.1441	2	3	4	6	9
098	17	6.2941	2	3	5	6	10
099	30114	5.1423	1	2	4	6	10
100	11199	3.1203	1	2	2	4	6
101	18008	6.6578	2	3	5	8	13
102	3535	4.2795	1	2	3	5	8
103	238	32.1723	10	14	23	38	62
104	17372	20.2585	9	12	17	25	35
105	15979	14.4294	7	9	11	16	25
106	74580	15.2254	8	10	13	17	24
107	52388	11.7606	7	8	10	13	18

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
108	8815	15.1239	7	9	12	18	27
110	50710	13.4182	3	8	11	16	25
111	6320	8.4106	3	6	8	10	13
112	128628	6.0864	2	3	5	8	12
113	38405	18.7783	6	8	14	22	37
114	8076	12.4459	3	5	9	15	24
115	8203	13.8516	5	8	11	17	24
116	64667	7.2072	2	3	5	9	14
117	3247	5.5079	1	2	3	7	12
118	8174	3.9172	1	1	2	4	9
119	3204	6.2644	1	2	3	7	15
120	33573	12.3955	2	3	8	16	27
121	143327	9.6028	4	6	8	11	16
122	99268	6.8777	2	4	7	9	11
123	55036	5.2961	1	1	3	7	13
124	123627	5.7604	1	2	5	7	11
125	88564	3.1515	1	1	2	4	7
126	4203	20.4149	5	10	16	29	41
127	602239	7.7143	2	4	6	9	14
128	23149	8.4066	4	5	7	10	13
129	6227	4.7466	1	1	1	6	12
130	70683	8.0792	2	4	7	10	14
131	26293	5.9626	1	3	6	8	10
132	12691	5.5565	1	2	4	7	11
133	4152	3.9188	1	2	3	5	7
134	29006	4.9812	2	2	4	6	9
135	6404	6.6284	2	3	5	8	13
136	1428	4.3690	1	2	3	5	7
138	185487	5.8414	2	3	4	7	11
139	71704	3.6838	1	2	3	5	7
140	341502	4.4890	2	2	4	5	8
141	76370	5.6764	2	3	4	7	10
142	36764	3.9269	1	2	3	5	7
143	115719	3.3748	1	2	3	4	6
144	55652	7.0829	2	3	5	9	14
145	8435	4.1801	1	2	3	5	8
146	7565	13.7870	7	9	11	15	22
147	1620	8.9846	5	7	9	11	13
148	141393	15.8461	7	9	12	18	28
149	18120	9.0679	6	7	8	10	13
150	21587	13.8921	5	8	11	17	24
151	4781	7.7833	3	4	7	10	13
152	4551	10.6339	5	7	9	12	18
153	2048	7.0459	4	5	7	8	10
154	37035	17.9283	7	9	14	22	34
155	4178	8.6084	4	5	7	10	14
157	13128	6.5957	2	3	5	8	13
158	9959	3.0688	1	1	2	4	6
159	16227	6.3665	2	3	5	8	12
160	12821	3.3392	1	2	3	4	6
161	23791	4.6269	1	2	3	6	10

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
162	21101	2.2025	1	1	2	3	4
163	10	2.4000	1	2	2	3	4
164	4579	11.3872	5	7	9	13	19
165	1794	7.0284	4	5	7	9	11
166	2932	7.1538	3	4	6	9	13
167	2170	4.1253	2	3	4	5	7
168	1799	5.7943	1	2	3	7	12
169	1366	2.9129	1	1	2	3	6
170	12713	15.6310	3	7	11	19	31
171	1463	6.9412	1	3	6	9	13
172	31140	10.3381	2	4	7	13	21
173	3337	5.2517	1	2	4	7	11
174	165016	6.9276	2	4	5	8	13
175	22542	4.3682	2	3	4	5	7
176	12892	7.7026	2	4	6	9	14
177	14855	6.2788	2	3	5	8	11
178	6418	4.4483	2	3	4	5	8
179	8630	9.5102	3	4	7	11	18
180	69302	7.6203	2	4	6	9	14
181	22049	4.5862	2	3	4	6	8
182	256259	6.2255	2	3	5	7	11
183	78176	4.5400	1	2	4	5	8
184	50	3.6000	1	2	3	4	6
185	3831	6.3156	1	3	5	8	13
186	1	4.0000	4	4	4	4	4
187	997	3.9529	1	1	2	5	8
188	49808	7.3748	2	3	5	9	14
189	9043	3.8545	1	1	3	5	8
190	94	5.2447	2	3	4	7	10
191	10080	19.7739	6	10	15	24	39
192	985	9.6020	3	6	8	12	16
193	12295	16.5587	7	9	14	20	29
194	1416	9.7041	3	6	9	12	17
195	17110	12.2889	6	7	10	14	20
196	1856	8.2193	4	5	7	10	13
197	76376	8.4937	2	4	7	11	16
198	48653	3.6350	1	1	3	5	7
199	2829	14.2616	4	7	11	18	27
200	1923	13.5190	2	5	10	17	28
201	2997	14.3784	3	6	10	18	30
202	17745	9.6320	2	4	7	12	19
203	29497	9.7206	2	4	7	12	20
204	39199	8.0600	3	4	6	9	15
205	20814	9.1418	2	4	7	11	18
206	2413	5.0220	1	2	4	7	10
207	37528	7.0338	2	3	5	9	13
208	14008	4.0415	1	2	3	5	7
209	267627	10.5536	6	7	9	12	16
210	116591	12.9940	6	8	10	14	21
211	28911	9.4425	5	6	8	11	14
212	18	6.1111	2	2	3	7	9

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
213	5738	12.8313	3	6	9	16	25
214	41313	10.2321	4	5	8	12	19
215	37991	6.0864	3	4	5	7	10
216	7018	14.4741	3	6	11	18	29
217	16628	21.0197	4	7	14	27	45
218	18336	9.0048	3	4	7	11	17
219	17781	5.1599	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4858	10.7091	2	4	8	13	21
222	5229	5.2878	1	2	4	7	10
223	15713	4.0320	1	2	3	4	7
224	8728	2.8997	1	2	2	3	5
225	9993	5.2825	1	2	3	6	12
226	5452	8.9762	2	3	6	11	20
227	8465	3.8863	1	2	3	4	7
228	4327	3.7123	1	1	2	4	8
229	2505	2.6591	1	1	2	3	5
230	3230	6.4412	1	2	4	7	13
231	10173	6.5634	1	2	4	7	15
232	793	6.5523	1	2	3	7	17
233	5188	11.6795	3	5	9	15	23
234	3023	5.4016	1	2	4	7	11
235	6239	11.1856	2	4	7	12	23
236	38320	8.9097	2	4	7	10	17
237	1681	5.8257	2	3	4	7	10
238	6361	13.9027	4	6	10	17	28
239	59319	10.0120	3	5	7	12	19
240	10920	9.3950	3	4	7	11	18
241	3950	5.6463	2	3	4	7	11
242	2498	10.5096	3	5	8	13	22
243	103841	6.8288	2	3	5	9	13
244	11051	7.2525	2	3	5	9	14
245	5661	5.3374	1	2	4	6	10
246	1726	5.4177	2	3	4	7	10
247	9689	5.0799	1	2	4	6	10
248	6248	6.1908	2	3	5	7	12
249	8359	6.3973	1	2	4	8	13
250	3393	6.7781	2	3	5	8	12
251	3237	3.6256	1	1	2	4	7
253	16958	8.1943	2	3	6	9	16
254	12121	4.7225	1	2	3	6	9
255	2	2.5000	1	1	4	4	4
256	9233	5.4512	1	2	4	6	11
257	28219	5.1278	2	3	4	6	9
258	26390	3.6482	2	2	3	4	6
259	4004	5.9298	1	2	3	6	13
260	4979	2.5700	1	1	2	3	4
261	2941	2.8259	1	1	2	3	5
262	1302	3.5661	1	1	2	3	7
263	28743	20.2119	5	8	14	24	40
264	4186	11.3512	3	5	8	14	23

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
265	4915	9.6867	2	3	6	11	21
266	4167	4.3252	1	2	3	5	9
267	368	4.9837	1	1	3	5	11
268	1410	5.1723	1	1	2	5	9
269	10906	12.2327	2	4	9	15	25
270	5130	4.0310	1	2	3	5	9
271	19866	11.4729	3	5	8	13	21
272	6799	9.3836	3	5	7	11	18
273	2194	6.8090	2	3	5	8	14
274	3139	10.9341	2	4	7	12	21
275	401	5.7232	1	2	3	6	9
276	867	5.7151	1	2	4	7	11
277	70657	8.4681	3	5	7	10	15
278	25890	6.1614	3	4	5	7	11
279	6	7.0000	2	3	4	11	11
280	12914	6.7166	2	3	5	8	13
281	7188	4.1994	1	2	3	5	8
282	1	2.0000	2	2	2	2	2
283	5814	7.3003	2	3	5	8	14
284	2389	5.0682	1	2	4	6	9
285	4549	20.6736	5	9	15	25	40
286	1721	11.2702	5	6	8	13	22
287	6493	18.7138	4	7	12	21	38
288	507	10.4694	3	4	7	10	21
289	3955	5.6718	2	2	3	5	12
290	9577	3.4522	1	2	2	4	6
291	143	2.1049	1	1	2	2	4
292	5044	17.6921	4	7	13	21	35
293	505	7.4950	1	3	6	10	15
294	89720	7.2549	3	4	6	8	13
295	3262	5.8483	2	3	4	7	11
296	210976	8.3160	2	4	6	10	16
297	44441	5.1711	2	3	4	6	9
298	65	4.6308	1	2	2	5	8
299	877	6.5530	1	2	5	8	13
300	11785	9.3115	3	4	7	11	18
301	2074	5.2160	1	2	4	7	10
302	6613	15.9463	7	9	13	19	28
303	17481	13.2953	6	8	10	15	23
304	13876	13.3942	4	6	10	16	26
305	3517	6.4578	2	3	6	8	12
306	12341	8.8255	3	4	6	11	17
307	4325	4.5686	2	3	4	5	8
308	10288	9.0454	2	3	6	11	19
309	4383	3.9877	1	2	3	5	8
310	35212	5.6127	1	2	4	7	11
311	19528	2.6869	1	1	2	3	5
312	3102	5.5239	1	2	4	7	11
313	1818	2.7629	1	1	2	3	5
314	1	8.0000	8	8	8	8	8
315	26943	12.2125	1	3	7	15	27

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
316	49066	9.1396	2	4	7	12	18
317	707	4.1782	1	2	3	4	8
318	6661	8.9922	2	3	6	11	19
319	884	3.7986	1	1	2	4	8
320	182684	8.3690	3	4	6	10	15
321	29134	5.8757	2	3	5	7	10
322	50	5.8400	2	3	5	7	10
323	20541	4.2749	1	2	3	5	9
324	13479	2.5819	1	1	2	3	5
325	9618	5.7660	2	3	4	7	11
326	3609	3.5658	1	2	3	4	7
327	9	7.0000	1	2	8	8	10
328	1257	4.9578	1	2	4	6	9
329	341	2.9003	1	1	2	4	5
331	29323	7.4644	2	3	6	9	15
332	5847	4.4404	1	2	3	5	9
333	311	7.5949	2	3	5	10	16
334	22366	9.1218	5	6	8	10	14
335	10820	7.2799	5	6	7	8	10
336	105208	5.7983	3	3	4	7	10
337	88453	3.8239	2	3	3	4	6
338	7449	5.2254	1	1	2	6	13
339	3230	4.6889	1	1	2	5	11
340	2	5.0000	3	3	7	7	7
341	12839	4.3806	1	2	3	5	8
342	410	3.8610	1	1	2	4	9
343	2	2.0000	1	1	3	3	3
344	4825	5.3988	1	2	4	6	10
345	2512	4.8949	1	2	3	5	10
346	7797	8.5775	2	3	6	10	17
347	963	4.3894	1	1	3	5	9
348	4269	5.7126	1	2	4	7	11
349	1634	3.1157	1	1	2	4	6
350	7998	5.8718	2	3	5	7	10
351	1	6.0000	6	6	6	6	6
352	770	4.8065	1	2	3	6	10
353	2321	11.4942	5	6	9	14	21
354	9467	8.2451	4	5	6	9	14
355	6005	4.9975	3	4	5	6	7
356	31595	4.3123	2	3	4	5	7
357	6815	12.4031	5	7	10	15	23
358	23005	6.5669	3	4	5	7	11
359	26844	4.4908	3	4	4	5	6
360	9626	5.2339	2	3	4	6	9
361	440	5.7500	1	2	4	6	14
363	5695	4.3392	1	2	3	4	8
364	2642	4.1862	1	1	2	5	8
365	3169	10.7349	3	4	7	13	23
366	5027	10.0072	2	3	7	13	21
367	873	3.9210	1	1	3	4	8
368	1482	7.3657	2	4	6	9	14

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2518	4.594	1	2	3	6	9
370	612	6.363	3	4	5	7	10
371	685	4.419	3	3	4	5	6
372	409	3.807	1	2	3	4	6
373	2513	2.522	1	2	2	3	3
374	67	4.000	2	2	2	3	5
375	7	14.714	1	2	2	7	14
376	146	2.740	1	1	2	3	5
377	27	5.074	1	2	4	7	10
378	138	3.652	2	3	3	4	6
379	310	2.971	1	1	2	3	6
380	66	2.818	1	1	2	3	5
381	222	2.432	1	1	1	3	4
382	58	1.448	1	1	1	2	2
383	842	4.426	1	2	3	5	9
384	98	2.724	1	1	2	3	6
385	5	5.600	1	1	3	6	15
386	1	149.000	149	149	149	149	149
387	1	6.000	6	6	6	6	6
389	9	8.556	1	5	9	9	11
390	28	6.536	1	2	4	11	14
391	1	2.000	2	2	2	2	2
392	2443	14.079	5	7	10	18	27
394	1980	10.330	1	2	6	12	22
395	70959	6.446	2	3	5	8	13
396	13	3.154	1	1	2	2	5
397	12488	7.452	2	3	5	9	15
398	14632	8.302	3	4	6	10	15
399	1681	5.258	1	2	4	7	10
400	8031	13.330	3	5	9	17	28
401	6988	15.257	3	6	11	19	32
402	2355	5.211	1	2	3	7	11
403	27920	11.893	2	5	8	15	25
404	5327	5.685	1	2	4	7	12
405	5	3.000	1	1	3	3	6
406	3783	15.319	4	7	11	19	31
407	977	6.492	2	3	5	8	11
408	5196	8.535	1	2	5	10	20
409	7546	9.030	2	4	5	11	20
410	125087	3.621	1	2	3	5	6
411	165	3.655	1	1	2	5	7
412	142	2.775	1	1	2	3	6
413	9559	10.688	2	4	8	13	22
414	1738	6.013	1	2	4	8	13
415	29908	20.274	5	9	15	25	40
416	135915	10.339	2	5	8	13	19
417	42	5.500	2	3	4	7	8
418	14224	8.258	3	4	7	10	15
419	16976	7.428	2	4	6	9	14
420	3737	5.434	2	3	4	7	10
421	12184	5.583	2	3	4	7	10

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
422	103	6.078	2	3	5	7	11
423	7136	10.896	3	5	8	13	22
424	2826	22.561	3	8	15	27	45
425	17758	6.483	2	3	4	8	13
426	5935	7.293	2	3	5	9	15
427	1979	7.866	1	3	5	9	16
428	1111	10.632	2	3	6	13	25
429	30483	12.055	3	4	7	13	23
430	55787	12.278	3	5	9	16	25
431	243	11.337	1	3	6	9	15
432	534	7.140	1	2	4	8	15
433	5779	4.511	1	1	3	5	11
434	17964	7.667	2	3	5	9	15
435	12086	6.317	2	3	5	7	13
436	2428	17.904	5	10	19	26	28
437	10592	16.628	6	10	15	23	28
439	944	9.394	1	3	6	12	22
440	4601	12.955	2	4	8	16	28
441	845	3.741	1	1	2	4	8
442	11317	9.876	1	3	6	12	21
443	5848	3.719	1	1	2	5	8
444	3891	7.287	2	3	5	8	13
445	2178	4.368	1	2	3	5	8
447	3122	3.495	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29032	5.941	1	2	4	7	12
450	7484	3.318	1	1	2	4	7
451	7	147.571	1	3	5	10	11
452	17447	6.230	1	2	4	7	13
453	5851	3.570	1	2	3	4	7
454	4045	6.901	1	2	4	8	14
455	1100	3.295	1	1	2	4	6
456	173	9.035	1	2	4	10	21
457	122	9.115	1	1	4	11	20
458	1606	22.719	5	10	17	29	45
459	563	14.909	3	6	10	18	31
460	2377	9.176	2	4	7	12	19
461	5830	5.401	1	1	2	5	13
462	6530	17.789	5	8	15	23	33
463	9344	6.762	2	3	5	8	13
464	2953	4.149	1	2	3	5	8
465	533	3.079	1	1	1	3	6
466	3591	4.686	1	1	2	4	9
467	3376	6.102	1	1	2	5	10
468	73065	18.124	4	8	14	22	35
471	7574	14.050	7	9	11	16	23
472	178	29.315	1	9	23	42	62
473	8355	17.029	2	4	10	26	41
475	73010	13.666	2	6	11	18	27
476	10713	16.946	6	10	14	20	29
477	36245	10.355	1	3	7	13	21

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 12/91 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
478	102877	10.2409	2	4	7	13	21
479	17854	5.4843	1	2	5	7	10
480	75	40.4933	11	16	26	45	86
481	67	44.9552	23	31	39	50	72
482	6838	18.0759	6	9	13	21	34
483	32814	54.0528	17	27	43	67	99
484	289	22.9516	2	9	18	33	49
485	2511	16.4552	6	9	12	19	30
486	1730	16.9983	1	7	13	22	35
487	2846	11.1774	2	4	8	14	22
488	844	20.3140	5	9	15	25	39
489	4279	13.8995	3	5	9	16	26
490	1702	8.6710	1	3	5	10	19
491	6713	6.3799	3	4	5	8	11
492	1048	14.4637	3	4	6	24	34
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	10203666						

BILLING CODE 4120-01-C

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1992

State	Urban	Rural
Alabama	0.503647	0.530099
Alaska	0.769846	0.882596
Arizona	0.579847	0.620998
Arkansas	0.583693	0.570674
California	0.511337	0.565421
Colorado	0.586320	0.624826
Connecticut	0.646590	0.688155
Delaware	0.616202	0.640679
District of Columbia	0.572248	
Florida	0.497297	0.505095
Georgia	0.592786	0.578752
Hawaii	0.629273	0.753597
Idaho	0.667878	0.671385
Illinois	0.567290	0.614793
Indiana	0.668811	0.679592
Iowa	0.680816	0.741266
Kansas	0.634933	0.709132
Kentucky	0.586710	0.583233
Louisiana	0.558362	0.598960
Maine	0.670862	0.626500
Maryland	0.768898	0.806322
Massachusetts	0.711945	0.858405
Michigan	0.580700	0.659005
Minnesota	0.662974	0.722065
Mississippi	0.596325	0.583217
Missouri	0.541151	0.565243
Montana	0.675568	0.700140
Nebraska	0.654524	0.722772
Nevada	0.509109	0.677714
New Hampshire	0.679143	0.686632
New Jersey	0.796232	
New Mexico	0.547462	0.582679
New York	0.672745	0.738413
North Carolina	0.627158	0.581949
North Dakota	0.684004	0.712080
Ohio	0.634724	0.662139
Oklahoma	0.574143	0.606318
Oregon	0.634317	0.681224
Pennsylvania	0.531257	0.601704

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1992—Continued

State	Urban	Rural
Puerto Rico	0.532837	0.633205
Rhode Island	0.765000	
South Carolina	0.562383	0.544672
South Dakota	0.664001	0.686325
Tennessee	0.575922	0.579831
Texas	0.574424	0.660252
Utah	0.625688	0.648080
Vermont	0.668931	0.666817
Virginia	0.585301	0.598326
Washington	0.710180	0.739728
West Virginia	0.580977	0.567044
Wisconsin	0.724494	0.736675
Wyoming	0.746141	0.774423

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1992

State	Ratio
Alabama	0.062910
Alaska	0.105552
Arizona	0.076547
Arkansas	0.067798
California	0.051154
Colorado	0.056766
Connecticut	0.040184
Delaware	0.064672
District of Columbia	0.045503
Florida	0.068092
Georgia	0.060021
Hawaii	0.060616
Idaho	0.068879
Illinois	0.052549
Indiana	0.067411
Iowa	0.063290

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1992—Continued

State	Ratio
Kansas	0.062413
Kentucky	0.066616
Louisiana	0.081314
Maine	0.049786
Maryland	0.057705
Massachusetts	0.056731
Michigan	0.058711
Minnesota	0.060940
Mississippi	0.060694
Missouri	0.060135
Montana	0.071759
Nebraska	0.061103
Nevada	0.055191
New Hampshire	0.063597
New Jersey	0.079028
New Mexico	0.060087
New York	0.066052
North Carolina	0.055494
North Dakota	0.073101
Ohio	0.064051
Oklahoma	0.068489
Oregon	0.052530
Pennsylvania	0.053267
Puerto Rico	0.082128
Rhode Island	0.042000
South Carolina	0.067906
South Dakota	0.071816
Tennessee	0.068952
Texas	0.070990
Utah	0.064946
Vermont	0.060000
Virginia	0.069063
Washington	0.083107
West Virginia	0.064799
Wisconsin	0.072273
Wyoming	0.082848

BILLING CODE 4120-01-M

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
010006	07/01/90	06/30/91	1.3318	0.9949
010011	07/01/90	06/30/91	1.3454	0.9988
010012	07/01/90	06/30/91	1.2362	0.9661
010015	04/01/90	03/31/91	1.0662	0.9175
010018	07/01/90	06/30/91	0.8805	0.9916
010020	07/01/90	06/30/91	1.0207	0.9759
010022	07/01/90	06/30/91	0.9361	0.9705
010023	07/01/90	06/30/91	1.2745	0.9881
010024	07/01/90	06/30/91	1.2319	0.9898
010025	07/01/90	06/30/91	1.2077	0.9725
010031	07/01/90	06/30/91	1.3116	0.9928
010034	07/01/90	06/30/91	1.0534	0.9659
010036	04/01/90	03/31/91	1.1152	0.9710
010038	07/01/90	06/30/91	1.1979	0.9851
010039	07/01/90	06/30/91	1.5773	0.9972
010050	07/01/90	06/30/91	0.9590	0.9530
010053	07/01/90	06/30/91	1.0024	0.9443
010054	07/01/90	06/30/91	1.1958	0.9795
010055	07/01/90	06/30/91	1.3327	0.9984
010056	07/01/90	06/30/91	1.2769	0.9925
010058	07/01/90	06/30/91	0.9387	0.9500
010064	07/01/90	06/30/91	1.6140	0.9983
010066	07/01/90	06/30/91	0.9333	0.9334
010068	07/01/90	06/30/91	1.2011	0.9868
010072	07/01/90	06/30/91	1.1296	0.9560
010078	07/01/90	06/30/91	1.1567	0.9896
010080	04/01/90	03/31/91	0.9553	0.9704
010085	07/01/90	06/30/91	1.2940	0.9755
010086	07/01/90	06/30/91	0.9715	0.9642
010089	07/01/90	06/30/91	1.0720	0.9890
010090	07/01/90	06/30/91	1.4694	0.9985
010091	07/01/90	06/30/91	1.0299	0.9703
010098	07/01/90	06/30/91	1.0314	0.9743
010101	07/01/90	06/30/91	1.0561	0.9752
010103	07/01/90	06/30/91	1.5225	0.9988
010104	07/01/90	06/30/91	1.5706	0.9978
010113	04/01/90	03/31/91	1.5668	0.9988
010114	07/01/90	06/30/91	1.1897	0.9854
010118	07/01/90	06/30/91	1.1508	0.9820
010121	07/01/90	06/30/91	1.0974	0.9834
010128	07/01/90	06/30/91	0.8733	0.9528
010131	07/01/90	06/30/91	1.2598	0.9885
010134	04/01/90	03/31/91	0.8210	0.9296
010136	05/01/90	04/30/91	0.9766	0.9505
010138	07/01/90	06/30/91	0.9094	0.9103
010145	02/01/90	01/31/91	1.2126	0.9963
010148	07/01/90	06/30/91	0.9575	0.9381
010150	04/01/90	03/31/91	1.0014	0.9969
020002	07/01/90	06/30/91	1.1907	0.9743
020004	07/01/90	06/30/91	1.1270	0.9683
020007	07/01/90	06/30/91	1.1966	0.9370
020008	07/01/90	06/30/91	0.9888	0.9822
020009	07/01/90	06/30/91	0.8102	1.0000
020010	07/01/90	06/30/91	0.9867	0.9817
020011	07/01/90	06/30/91	0.8982	0.9725
020014	07/01/90	06/30/91	0.9086	1.0000
020024	07/01/90	06/30/91	1.0355	0.9484
030003	07/01/90	06/30/91	1.3396	0.9908
030006	07/01/90	06/30/91	1.5371	0.9983
030007	07/01/90	06/30/91	1.2967	0.9736
030009	07/01/90	06/30/91	1.2077	0.9881
030010	07/01/90	06/30/91	1.4283	0.9981
030011	07/01/90	06/30/91	1.3591	0.9948
030016	07/01/90	06/30/91	1.2920	0.9829
030017	07/01/90	06/30/91	1.3601	0.9968
030019	07/01/90	06/30/91	1.2897	0.9928
030022	07/01/90	06/30/91	1.3555	0.9927
030024	07/01/90	06/30/91	1.6087	0.9985
030027	07/01/90	06/30/91	1.0636	0.9941
030033	07/01/90	06/30/91	1.3781	0.9736
030034	04/01/90	03/31/91	1.0818	0.9743
030037	07/01/90	06/30/91	1.8599	0.9982
030040	07/01/90	06/30/91	0.9830	0.9474
030043	07/01/90	06/30/91	1.1538	0.9556
030049	07/01/90	06/30/91	0.9213	0.9499
030051	07/01/90	06/30/91	1.0406	0.9833
030054	07/01/90	06/30/91	0.8915	0.9644
030055	07/01/90	06/30/91	1.2142	0.9754
030059	07/01/90	06/30/91	1.3584	0.9819
030064	07/01/90	06/30/91	1.5351	0.9934
030080	04/01/90	03/31/91	1.4964	0.9984
030091	07/01/90	06/30/91	0.7698	0.9730
040001	04/01/90	03/31/91	1.0270	0.9645
040002	07/01/90	06/30/91	1.1748	0.9751
040003	07/01/90	06/30/91	1.0253	0.9708
040008	07/01/90	06/30/91	1.0125	0.9738
040011	07/01/90	06/30/91	0.9218	0.9666
040015	07/01/90	06/30/91	1.0427	0.9094
040016	07/01/90	06/30/91	1.4587	0.9968
040017	04/01/90	03/31/91	1.2153	0.9777
040019	07/01/90	06/30/91	1.1983	0.9460
040022	07/01/90	06/30/91	1.6607	0.9974
040025	07/01/90	06/30/91	1.0037	0.9661
040026	07/01/90	06/30/91	1.4063	0.9961
040030	07/01/90	06/30/91	0.9387	0.9412
040032	07/01/90	06/30/91	0.9155	0.9781
040035	07/01/90	06/30/91	0.9287	0.9822
040039	07/01/90	06/30/91	1.0442	0.9772
040040	07/01/90	06/30/91	0.9753	0.9722
040048	07/01/90	06/30/91	1.2030	0.9822
040051	04/01/90	03/31/91	0.9766	0.9387
040053	07/01/90	06/30/91	1.0508	0.9096
040054	07/01/90	06/30/91	0.9589	0.9775
040055	07/01/90	06/30/91	1.3329	0.9984
040058	06/05/90	06/30/91	0.8994	0.9783
040060	02/01/90	01/31/91	0.9341	0.9297

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
040062	07/01/90	06/30/91	1.3005	0.9944
040063	07/01/90	06/30/91	1.4273	0.9972
040064	07/01/90	06/30/91	0.9041	0.9210
040071	07/01/90	06/30/91	1.3970	0.9963
040074	07/01/90	06/30/91	1.1602	0.9876
040076	07/01/90	06/30/91	0.9848	0.9598
040077	07/01/90	06/30/91	0.9402	0.9586
040080	07/01/90	06/30/91	1.0560	0.9402
040082	07/01/90	06/30/91	1.2148	0.9701
040084	07/01/90	06/30/91	1.1084	0.9771
040088	07/01/90	06/30/91	1.1955	0.9869
040090	07/01/90	06/30/91	0.9599	0.9130
040091	07/01/90	06/30/91	1.1241	0.9675
040093	07/01/90	06/30/91	0.9799	0.9613
040095	07/01/90	06/30/91	0.8631	0.9079
040109	07/01/90	06/30/91	1.1434	0.9832
040116	03/01/90	02/28/91	1.2866	0.9990
040124	07/01/90	06/30/91	1.1476	0.9645
040126	07/01/90	06/30/91	0.9731	0.9588
050006	07/01/90	06/30/91	1.3166	0.9912
050009	07/01/90	06/30/91	1.6158	0.9944
050014	07/01/90	06/30/91	1.0829	0.9668
050015	07/01/90	06/30/91	1.4391	0.9748
050016	01/01/90	01/23/91	1.1070	0.9845
050017	04/01/90	03/31/91	1.9631	0.9978
050019	07/01/90	06/30/91	0.8275	0.9656
050025	07/01/90	06/30/91	1.6859	0.9938
050026	07/01/90	06/30/91	1.4891	0.9936
050028	07/01/90	06/30/91	1.2805	0.9877
050029	07/01/90	06/30/91	1.3317	0.9852
050033	07/01/90	06/30/91	1.3733	0.9974
050034	06/01/90	05/31/91	1.2763	0.9883
050036	07/01/90	06/30/91	1.6831	0.9986
050038	07/01/90	06/30/91	1.3836	0.9917
050039	07/01/90	06/30/91	1.6237	0.9968
050040	07/01/90	06/30/91	1.0743	0.9700
050041	06/01/90	05/31/91	1.2943	0.9812
050042	07/01/90	06/30/91	1.2173	0.9718
050045	07/01/90	06/30/91	1.2646	0.9780
050046	06/01/90	05/31/91	1.1725	0.9727
050047	06/17/90	06/16/91	1.6773	0.9982
050051	07/01/90	06/30/91	1.1504	0 9759
050054	07/01/90	06/30/91	1.2745	0.9970
050055	07/01/90	06/30/91	1.2814	0.9935
050056	07/01/90	06/30/91	1.3467	0.9954
050057	07/01/90	06/30/91	1.4468	0.9928
050063	07/01/90	06/30/91	1.3235	0.9936
050065	04/01/90	03/31/91	1.5002	0.9957
050066	04/01/90	03/31/91	1.2849	0.9942
050067	07/01/90	06/30/91	1.2757	0.9800
050068	07/01/90	06/30/91	1.1063	0.9913
050069	07/01/90	06/30/91	1.5585	0.9930
050077	07/01/90	06/30/91	1.6363	0.9990
050079	07/01/90	06/30/91	1.4862	0.9984
050082	07/01/90	06/30/91	1.4779	0.9969
050088	07/01/90	06/30/91	1.1429	0.9920
050089	07/01/90	06/30/91	1.3373	0.9859
050090	07/01/90	06/30/91	1.2284	0.9873
050092	07/01/90	06/30/91	0.9762	0.9720
050093	06/01/90	05/31/91	1.5178	0.9989
050095	07/01/90	06/30/91	1.8435	0.8663
050104	07/01/90	06/30/91	1.3575	0.9968
050110	07/01/90	06/30/91	1.1105	0.9714
050113	07/01/90	06/30/91	1.2424	0.9848
050114	05/01/90	04/30/91	1.5048	0.9818
050115	07/01/90	06/30/91	1.4688	0.9950
050116	07/01/90	06/30/91	1.4136	0.9944
050118	06/01/90	05/31/91	1.1620	0.9835
050124	07/01/90	06/30/91	1.2072	0.9888
050128	07/01/90	06/30/91	1.4877	0.9980
050129	07/01/90	06/30/91	1.5105	0.9956
050133	07/01/90	06/30/91	1.1788	0.9732
050136	07/01/90	06/30/91	1.3058	0.9803
050143	04/01/90	03/31/91	1.4183	0.9963
050147	06/01/90	05/31/91	0.7395	0.9830
050148	07/01/90	06/30/91	1.1109	0.9612
050152	07/01/90	06/30/91	1.4031	0.9938
050153	07/01/90	06/30/91	1.6231	0.9978
050158	04/01/90	03/31/91	1.6706	0.9962
050159	07/01/90	06/30/91	1.3933	0.9913
050161	05/01/90	04/30/91	1.6192	0.9912
050166	07/01/90	06/30/91	1.0269	0.9715
050167	07/01/90	06/30/91	1.3824	0.9940
050168	07/01/90	06/30/91	1.6796	0.9982
050170	07/01/90	06/30/91	1.4186	0.9912
050172	07/01/90	06/30/91	1.3424	0.9916
050174	07/01/90	06/30/91	1.6054	0.9982
050175	07/01/90	06/30/91	1.3782	0.9908
050177	04/01/90	03/31/91	1.2361	0.9949
050179	02/01/90	01/31/91	1.2439	0.9875
050181	07/01/90	06/30/91	1.3230	0.9723
050183	07/01/90	06/30/91	1.1358	0.9837
050188	06/01/90	05/31/91	1.3770	0.9897
050191	07/01/90	06/30/91	1.3900	0.9725
050192	07/01/90	06/30/91	1.1528	0.9812
050193	07/01/90	06/30/91	1.3447	0.9893
050194	07/01/90	06/30/91	1.3465	0.9917
050195	07/01/90	06/30/91	1.4964	0.9964
050197	07/01/90	06/30/91	1.8953	0.9979
050199	07/01/90	06/30/91	1.3072	0.9870
050207	07/01/90	06/30/91	1.2034	0.9920
050213	07/01/90	06/30/91	1.3656	0.9908
050215	07/01/90	06/30/91	1.4195	0.9980
050219	05/01/90	04/30/91	1.3491	0.9873
050220	04/01/90	03/31/91	1.2865	0.9918
050228	07/01/90	06/30/91	1.2481	0.9730

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN - END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
050230	03/01/90 - 02/28/91	1.3559	0.9864
050232	07/01/90 - 06/30/91	1.8510	0.9972
050240	07/01/90 - 06/30/91	1.4347	0.9967
050242	07/01/90 - 06/30/91	1.3816	0.9981
050243	07/01/90 - 06/30/91	1.4278	0.9964
050245	07/01/90 - 06/30/91	1.4570	0.9934
050248	07/01/90 - 06/30/91	1.1256	0.9816
050258	03/01/90 - 02/28/91	1.2539	0.9960
050260	07/01/90 - 06/30/91	0.9582	0.9142
050261	07/01/90 - 06/30/91	1.1889	0.9876
050262	07/01/90 - 06/30/91	1.6956	0.9943
050263	05/01/90 - 04/30/91	1.2801	0.9883
050267	07/01/90 - 06/30/91	1.4913	0.9978
050274	07/01/90 - 06/30/91	0.9849	0.9969
050276	07/01/90 - 06/30/91	1.1464	0.9899
050277	07/01/90 - 06/30/91	1.3527	0.9958
050278	06/01/90 - 05/31/91	1.3892	0.9881
050279	07/01/90 - 06/30/91	1.2355	0.9898
050280	07/01/90 - 06/30/91	1.4806	0.9884
050283	07/01/90 - 06/30/91	1.3910	0.9892
050289	07/01/90 - 06/30/91	1.6600	0.9966
050290	06/01/90 - 05/31/91	1.4497	0.9981
050291	07/01/90 - 06/30/91	1.1755	0.9933
050292	07/01/90 - 06/30/91	1.1551	0.9882
050293	07/01/90 - 06/30/91	1.2646	1.0000
050295	07/01/90 - 06/30/91	1.3291	0.9928
050296	07/01/90 - 06/30/91	1.1227	0.9790
050299	04/01/90 - 03/31/91	1.2349	0.9909
050307	06/01/90 - 05/31/91	1.3821	0.9934
050308	07/01/90 - 06/30/91	1.5545	0.9978
050312	06/01/90 - 05/31/91	1.7470	0.9960
050315	07/01/90 - 06/30/91	1.2767	0.9900
050320	07/01/90 - 06/30/91	1.2591	0.9828
050325	07/01/90 - 06/30/91	1.2670	0.9892
050331	03/01/90 - 02/28/91	1.2859	0.9832
050333	07/01/90 - 06/30/91	1.0043	0.9200
050334	07/01/90 - 06/30/91	1.4558	0.9975
050337	06/01/90 - 05/31/91	1.2079	0.9712
050342	07/01/90 - 06/30/91	1.3145	0.9904
050343	07/01/90 - 06/30/91	1.0605	0.9944
050348	07/01/90 - 06/30/91	1.6552	0.9896
050349	07/01/90 - 06/30/91	1.0430	0.9760
050350	07/01/90 - 06/30/91	1.3930	0.9959
050353	07/01/90 - 06/30/91	1.6318	0.9943
050355	07/01/90 - 06/30/91	0.9531	0.9757
050359	07/01/90 - 06/30/91	1.1069	0.9965
050360	07/01/90 - 06/30/91	1.4111	0.9874
050373	07/01/90 - 06/30/91	1.3496	0.9718
050376	07/01/90 - 06/30/91	1.2950	0.9952
050377	07/01/90 - 06/30/91	0.9950	0.9658
050378	06/01/90 - 05/31/91	1.1799	0.9881
050379	07/01/90 - 06/30/91	1.1738	0.9821
050380	07/01/90 - 06/30/91	1.5920	0.9986
050382	07/01/90 - 06/30/91	1.3964	0.9998
050387	07/01/90 - 06/30/91	0.9757	0.9887
050388	07/01/90 - 06/30/91	0.9395	0.9345
050390	07/01/90 - 06/30/91	1.2347	0.9944
050392	07/01/90 - 06/30/91	0.9208	0.9739
050393	07/01/90 - 06/30/91	1.4767	0.9976
050397	07/01/90 - 06/30/91	0.8635	0.9607
050401	05/01/90 - 04/30/91	1.1843	0.9947
050406	07/01/90 - 06/30/91	1.1036	0.9694
050410	07/01/90 - 06/30/91	0.8326	1.0000
050414	04/01/90 - 03/31/91	1.2749	0.9771
050418	06/01/90 - 05/31/91	1.2857	0.9822
050419	07/01/90 - 06/30/91	1.2536	0.9653
050423	04/01/90 - 03/31/91	1.0784	0.9466
050430	07/01/90 - 06/30/91	0.9386	0.9386
050432	06/01/90 - 05/31/91	1.5941	0.9949
050433	07/01/90 - 06/30/91	1.1255	0.9861
050434	04/01/90 - 03/31/91	1.0708	0.9635
050435	07/01/90 - 06/30/91	1.2687	0.9813
050436	07/01/90 - 06/30/91	1.0005	0.9786
050442	06/02/90 - 06/01/91	1.0000	1.0000
050443	07/01/90 - 06/30/91	0.9192	0.9473
050444	07/01/90 - 06/30/91	1.2239	0.9929
050446	07/01/90 - 06/30/91	0.8703	0.9264
050448	02/01/90 - 01/31/91	1.0455	0.9838
050449	07/01/90 - 06/30/91	1.2840	0.9910
050450	07/01/90 - 06/30/91	0.7792	1.0000
050451	07/01/90 - 06/30/91	0.9672	0.9656
050454	07/01/90 - 06/30/91	1.6324	0.9954
050456	07/01/90 - 06/30/91	1.3553	0.9900
050457	07/01/90 - 06/30/91	1.7728	0.9970
050459	07/01/90 - 06/30/91	1.2936	0.9781
050464	06/01/90 - 05/31/91	1.7723	0.9980
050470	07/01/90 - 06/30/91	1.1205	0.9687
050476	07/01/90 - 06/30/91	1.2633	0.9965
050477	07/01/90 - 06/30/91	1.4046	0.9856
050482	07/01/90 - 06/30/91	0.9911	0.9813
050485	07/01/90 - 06/30/91	1.6939	0.9964
050488	07/01/90 - 06/30/91	1.1848	0.9874
050491	07/01/90 - 06/30/91	1.4548	0.9943
050494	07/01/90 - 06/30/91	1.0993	0.9687
050496	07/01/90 - 06/30/91	1.7649	0.9954
050497	07/01/90 - 06/30/91	0.6934	1.0000
050502	07/01/90 - 06/30/91	1.6736	0.9998
050516	04/01/90 - 03/31/91	1.3195	0.9853
050522	06/01/90 - 05/31/91	1.3278	0.9905
050527	07/01/90 - 06/30/91	1.3130	0.9938
050528	07/01/90 - 06/30/91	1.2087	0.9864
050534	06/01/90 - 05/31/91	1.3954	0.9829
050539	07/01/90 - 06/30/91	1.2107	0.9738
050542	07/01/90 - 06/30/91	1.1138	0.9352
050545	07/01/90 - 06/30/91	0.8839	1.0000
050546	07/01/90 - 06/30/91	1.0031	1.0000

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
050547	07/01/90	06/30/91	0.9880	1.0000
050551	06/01/90	05/31/91	1.2910	0.9855
050559	07/01/90	06/30/91	1.2847	0.9730
050564	06/01/90	05/31/91	1.3180	0.9817
050565	07/01/90	06/30/91	1.1075	0.9827
050566	07/01/90	06/30/91	1.0079	0.9481
050568	07/01/90	06/30/91	1.3406	0.9907
050569	07/01/90	06/30/91	1.1516	0.9809
050573	07/01/90	06/30/91	1.6228	0.9985
050577	07/01/90	06/30/91	1.3112	0.9908
050578	07/01/90	06/30/91	1.4584	0.9608
050579	06/01/90	05/31/91	1.4135	0.9912
050581	06/01/90	05/31/91	1.3394	0.9886
050583	06/01/90	05/31/91	1.6787	0.9974
050584	06/01/90	05/31/91	1.3001	0.9785
050589	06/01/90	05/31/91	1.3231	0.9858
050594	07/01/90	06/30/91	1.9550	0.9930
050599	07/01/90	06/30/91	1.6169	0.9960
050601	04/01/90	03/31/91	1.2700	0.9819
050603	07/01/90	06/30/91	1.4390	0.9971
050608	02/01/90	01/31/91	1.1688	0.9916
050613	07/01/90	06/30/91	1.1084	0.9983
050615	05/01/90	04/30/91	1.4687	0.9968
050616	07/01/90	06/30/91	1.3375	0.9894
050618	07/01/90	06/30/91	1.1252	0.9634
050623	07/01/90	06/30/91	1.0854	1.0000
050625	04/01/90	03/31/91	1.4670	0.9984
050633	06/01/90	05/31/91	1.2098	0.9790
050636	07/01/90	06/30/91	1.2840	0.9754
050637	05/01/90	04/30/91	1.1806	0.9982
050638	07/01/90	06/30/91	0.9760	0.9592
050641	07/01/90	06/30/91	1.1261	0.9963
050651	02/01/90	01/31/91	1.2891	0.9897
050660	07/01/90	06/30/91	1.0823	0.9985
050661	02/01/90	01/31/91	0.8959	0.9909
050666	07/01/90	06/30/91	0.9562	1.0000
050667	07/01/90	06/30/91	1.0577	0.9532
050668	07/01/90	06/30/91	1.1585	0.9556
050671	07/01/90	06/30/91	1.1314	0.9635
050672	07/01/90	06/30/91	0.7000	0.9986
050675	02/01/90	01/31/91	1.5255	0.9945
050676	07/01/90	06/30/91	0.9866	0.8925
050678	07/01/90	06/30/91	1.1846	0.9977
050684	07/01/90	06/30/91	1.2156	0.9820
050685	07/01/90	06/30/91	1.1570	0.9822
050688	07/01/90	06/30/91	1.1460	0.9749
050689	06/01/90	05/31/91	1.3953	0.9714
060008	07/01/90	06/30/91	1.0467	0.9808
060012	07/01/90	06/30/91	1.4161	0.9988
060013	07/01/90	06/30/91	1.1979	0.9858
060015	07/01/90	06/30/91	1.4123	0.9788
060016	07/01/90	06/30/91	1.1173	0.9730
060020	07/01/90	06/30/91	1.4487	0.9919
060023	06/01/90	05/31/91	1.4293	0.9975
060024	07/01/90	06/30/91	1.5697	0.9928
060026	07/01/90	06/30/91	1.3890	0.9948
060028	06/01/90	05/31/91	1.3139	0.9986
060031	07/01/90	06/30/91	1.3764	0.9923
060032	07/01/90	06/30/91	1.3823	0.9998
060036	04/01/90	03/31/91	1.1774	0.9832
060054	05/01/90	04/30/91	1.2768	0.9949
080001	07/01/90	06/30/91	1.5816	0.9992
080002	07/01/90	06/30/91	1.1584	0.9880
080003	07/01/90	06/30/91	1.2413	0.9977
080004	06/25/90	06/24/91	1.2508	0.9965
080006	07/01/90	06/30/91	1.1346	0.9960
080007	07/01/90	06/30/91	1.2098	0.9840
090001	07/01/90	06/30/91	1.4317	0.9981
090003	07/01/90	06/30/91	1.4300	0.9997
090004	07/01/90	06/30/91	1.5547	0.9999
090009	07/01/90	06/30/91	1.2250	0.9994
090010	07/01/90	06/30/91	0.9677	0.9898
090011	07/01/90	06/30/91	1.8233	0.9998
100010	07/01/90	06/30/91	1.3816	0.9951
100027	06/01/90	05/31/91	0.9253	0.9782
100032	07/01/90	06/30/91	1.7467	0.9981
100038	05/01/90	04/30/91	1.5856	0.9968
100039	07/01/90	06/30/91	1.5889	0.9941
100059	07/01/90	06/30/91	1.4927	0.9971
100067	07/01/90	06/30/91	1.4006	0.9949
100068	04/01/90	03/31/91	1.4001	0.9999
100070	07/01/90	06/30/91	1.3171	0.9849
100073	07/01/90	06/30/91	1.8170	0.9984
100075	07/01/90	06/30/91	1.7290	0.9991
100076	04/01/90	03/31/91	1.3035	0.9968
100079	06/01/90	05/31/91	1.1629	0.9795
100084	07/01/90	06/30/91	1.3182	0.9730
100086	07/01/90	06/30/91	1.3079	0.9930
100113	07/01/90	06/30/91	1.8598	0.9993
100114	04/01/90	03/31/91	1.4365	0.9944
100122	07/01/90	06/30/91	1.3201	0.9836
100126	06/01/90	05/31/91	1.4682	0.9926
100145	07/01/90	06/30/91	1.3802	0.9928
100160	07/01/90	06/30/91	1.1880	0.9546
100161	06/01/90	05/31/91	1.5387	0.9849
100168	07/01/90	06/30/91	1.2893	0.9895
100172	06/01/90	05/31/91	1.3761	0.9990
100179	05/01/90	04/30/91	1.6946	0.9978
100191	07/01/90	06/30/91	1.3657	0.9876
100200	07/01/90	06/30/91	1.3440	0.9939
100204	03/01/90	02/28/91	1.5362	0.9984
100207	04/01/90	03/31/91	1.3789	0.9900
100213	05/01/90	04/30/91	1.6078	0.9973
100218	07/01/90	06/30/91	0.8880	0.9946
100225	06/01/90	05/31/91	1.3749	0.9952
100231	06/01/90	05/31/91	1.6939	0.9984

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
100239	06/01/90	05/31/91	1.4130	0.9960
100240	06/01/90	05/31/91	0.8715	0.9990
100242	02/01/90	01/31/91	1.2996	0.9939
100244	07/01/90	06/30/91	1.3472	0.9854
100249	06/01/90	05/31/91	1.3032	0.9772
100252	02/01/90	01/31/91	1.3099	0.9842
100254	05/01/90	04/30/91	1.5618	1.0000
100256	03/01/90	02/28/91	1.6566	0.9943
100258	06/01/90	05/31/91	1.7111	0.9877
100264	03/01/90	02/28/91	1.3496	0.9781
100268	06/01/90	05/31/91	1.2892	0.9765
100270	06/01/90	05/31/91	0.8943	0.9538
100271	07/01/90	06/30/91	1.5335	1.0000
100276	07/01/90	06/30/91	1.3435	0.9851
100277	07/01/90	06/30/91	1.0014	0.9996
110003	03/01/90	02/28/91	1.2541	0.9837
110008	04/01/90	03/31/91	1.1292	0.9844
110011	07/01/90	06/30/91	1.1499	0.9914
110015	07/01/90	06/30/91	1.0642	0.9449
110017	07/01/90	06/30/91	0.9171	0.9807
110026	07/01/90	06/30/91	1.1143	0.9732
110027	07/01/90	06/30/91	1.0537	0.9797
110031	04/01/90	03/31/91	1.2851	0.9877
110034	07/01/90	06/30/91	1.3837	0.9960
110035	07/01/90	06/30/91	1.3294	0.9864
110039	07/01/90	06/30/91	1.3043	0.9918
110040	07/01/90	06/30/91	0.9304	0.9816
110041	07/01/90	06/30/91	1.0706	0.9638
110042	07/01/90	06/30/91	1.0522	0.9785
110043	07/01/90	06/30/91	1.5517	0.9979
110051	05/01/90	04/30/91	1.0464	0.9756
110052	07/01/90	06/30/91	0.9413	0.9786
110054	07/01/90	06/30/91	1.2266	0.9943
110055	03/01/90	02/28/91	0.8844	0.9617
110056	07/01/90	06/30/91	1.0169	0.9630
110062	04/01/90	03/31/91	0.9073	0.9828
110064	07/01/90	06/30/91	1.2220	0.9943
110066	07/01/90	06/30/91	1.2402	0.9909
110069	03/01/90	02/28/91	1.1888	0.9902
110071	07/01/90	06/30/91	1.0509	0.9702
110093	07/01/90	06/30/91	0.9273	0.9546
110094	07/01/90	06/30/91	1.0365	0.9734
110101	07/01/90	06/30/91	1.0162	0.9784
110103	07/01/90	06/30/91	0.9375	0.9982
110104	07/01/90	06/30/91	1.1572	0.9808
110108	07/01/90	06/30/91	0.8679	0.9398
110109	07/01/90	06/30/91	1.0859	0.9791
110113	06/01/90	05/31/91	0.9838	0.9615
110118	05/01/90	04/30/91	1.0455	0.9934
110124	07/01/90	06/30/91	1.0531	0.9860
110125	05/01/90	04/30/91	1.1444	0.9833
110127	07/01/90	06/30/91	0.9496	0.9580
110128	07/01/90	06/30/91	1.1458	0.9913
110132	04/01/90	03/31/91	1.1336	0.9770
110133	07/01/90	06/30/91	0.8958	0.9424
110134	07/01/90	06/30/91	0.8687	0.9716
110135	05/01/90	04/30/91	1.1775	0.9845
110136	07/01/90	06/30/91	1.0711	0.9872
110141	07/01/90	06/30/91	0.8945	0.9502
110143	06/01/90	05/31/91	1.2569	0.9915
110149	07/01/90	06/30/91	1.0577	0.9818
110152	07/01/90	06/30/91	1.0316	0.9631
110153	03/01/90	02/28/91	1.0129	0.9875
110154	07/01/90	06/30/91	0.9935	0.9692
110155	04/01/90	03/31/91	1.1040	0.9843
110156	07/01/90	06/30/91	0.9377	0.9434
110157	04/01/90	03/31/91	1.1274	0.9893
110163	05/01/90	04/30/91	1.3225	0.9959
110164	04/01/90	03/31/91	1.3061	0.9925
110168	07/01/90	06/30/91	1.6267	0.9994
110169	07/01/90	06/30/91	0.7899	1.0000
110174	07/01/90	06/30/91	0.8584	0.9685
110176	07/01/90	06/30/91	1.1772	0.9971
110178	07/01/90	06/30/91	1.2734	1.0000
110181	04/01/90	03/31/91	0.8988	0.9672
110183	02/01/90	01/31/91	1.2711	0.9848
110184	04/01/90	03/31/91	1.2015	0.9862
110185	07/01/90	06/30/91	0.9922	0.9606
110186	05/01/90	04/30/91	1.3079	0.9960
110188	04/01/90	03/31/91	1.3662	0.9916
110191	07/01/90	06/30/91	1.1392	0.9911
110194	07/01/90	06/30/91	0.9021	0.9252
110202	04/01/90	03/31/91	1.0218	0.9863
110204	07/01/90	06/30/91	0.8977	1.0000
120001	07/01/90	06/29/91	1.6161	0.9973
120002	07/01/90	06/30/91	1.1676	0.9833
120003	07/01/90	06/30/91	1.0629	0.9615
120004	07/01/90	06/30/91	1.2318	0.9881
120005	07/01/90	06/30/91	1.1798	0.9934
120007	07/01/90	06/30/91	1.5746	0.9986
120009	07/01/90	06/29/91	0.8718	0.9413
120010	07/01/90	06/30/91	1.5315	0.9996
120012	07/01/90	06/30/91	0.9189	0.9686
120014	07/01/90	06/30/91	1.1690	0.9811
120015	07/01/90	06/30/91	0.9507	0.9653
120016	07/01/90	06/30/91	0.9569	0.9334
120018	07/01/90	06/30/91	1.0198	0.8846
120019	07/01/90	06/30/91	1.2130	0.9771
120021	07/01/90	06/30/91	0.9481	0.9307
120025	07/01/90	06/30/91	0.9026	1.0000
120026	07/01/90	06/30/91	1.2954	0.9944
120027	07/01/90	06/30/91	1.2766	0.9961
130003	07/01/90	06/30/91	1.2441	0.9801
130007	06/01/90	05/31/91	1.4950	0.9878
130008	07/01/90	06/30/91	0.8650	0.9787
130013	07/01/90	06/30/91	1.2388	0.9840

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	-	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
130017	07/01/90	-	06/30/91	0.9497	0.9682
130022	07/01/90	-	06/30/91	1.1469	0.9718
130029	07/01/90	-	06/30/91	0.9822	0.9523
130035	07/01/90	-	06/30/91	0.9812	0.9513
130048	07/01/90	-	06/30/91	0.9891	0.9794
140001	07/01/90	-	06/30/91	1.2625	0.9790
140003	03/01/90	-	02/28/91	0.9531	0.9565
140005	04/01/90	-	03/31/91	0.9086	0.9634
140011	04/01/90	-	03/31/91	1.1000	0.9872
140014	07/01/90	-	06/30/91	1.0680	0.9615
140016	03/01/90	-	02/28/91	1.0015	0.9464
140018	07/01/90	-	06/30/91	1.3825	0.9971
140024	07/01/90	-	06/30/91	0.9846	0.9739
140025	04/01/90	-	03/31/91	1.0949	0.9655
140026	07/01/90	-	06/30/91	1.1280	0.9924
140027	05/01/90	-	04/30/91	1.0857	0.9857
140030	05/01/90	-	04/30/91	1.4864	0.9968
140032	07/01/90	-	06/30/91	1.2879	0.9810
140035	07/01/90	-	06/30/91	1.0059	0.9809
140037	07/01/90	-	06/30/91	0.9764	0.9588
140038	05/01/90	-	04/30/91	0.9986	0.9782
140040	05/01/90	-	04/30/91	1.2435	0.9887
140041	06/01/90	-	05/31/91	1.0349	0.9816
140042	04/01/90	-	03/31/91	1.0403	0.9761
140043	05/01/90	-	04/30/91	1.1614	0.9885
140045	07/01/90	-	06/30/91	0.9380	0.9574
140047	05/01/90	-	04/30/91	1.0454	0.9764
140053	07/01/90	-	06/30/91	1.7141	0.9981
140055	05/01/90	-	04/30/91	0.9679	0.9522
140059	07/01/90	-	06/30/91	1.0708	0.9751
140061	07/01/90	-	06/30/91	1.0903	0.9629
140063	07/01/90	-	06/30/91	1.2859	0.9934
140068	04/01/90	-	03/31/91	1.2469	0.9910
140069	05/01/90	-	04/30/91	1.0658	0.9660
140070	05/01/90	-	04/30/91	1.2542	0.9821
140072	07/01/90	-	06/30/91	1.1325	0.9930
140075	07/01/90	-	06/30/91	1.3837	0.9972
140077	05/01/90	-	04/30/91	1.1258	0.9982
140081	07/01/90	-	06/30/91	1.1398	0.9726
140082	06/25/90	-	06/30/91	1.2353	0.9952
140083	07/01/90	-	06/30/91	1.2504	0.9949
140086	07/01/90	-	06/30/91	1.1064	0.9733
140088	07/01/90	-	06/30/91	1.4748	0.9967
140089	07/01/90	-	06/30/91	1.2439	0.9805
140091	07/01/90	-	06/30/91	1.6428	0.9980
140100	07/01/90	-	06/30/91	1.2348	0.9829
140102	07/01/90	-	06/30/91	0.9977	0.9579
140109	07/01/90	-	06/30/91	1.1105	0.9630
140110	05/01/90	-	04/30/91	1.1867	0.9766
140114	02/01/90	-	01/31/91	1.2307	0.9900
140115	07/01/90	-	06/30/91	1.2003	0.9979
140116	07/01/90	-	06/30/91	1.2356	0.9863
140117	07/01/90	-	06/30/91	1.2706	0.9892
140119	07/01/90	-	06/30/91	1.6225	0.9935
140120	05/01/90	-	04/30/91	1.1540	0.9801
140121	07/01/90	-	06/30/91	0.9590	0.9890
140127	07/01/90	-	06/30/91	1.2620	0.9853
140133	07/01/90	-	06/30/91	1.3341	0.9888
140138	07/01/90	-	06/30/91	1.1226	0.9597
140140	07/01/90	-	06/30/91	1.0470	0.9745
140144	04/01/90	-	03/31/91	0.9880	0.9784
140145	07/01/90	-	06/30/91	1.0405	0.9739
140146	05/01/90	-	04/30/91	0.9139	0.9579
140150	07/01/90	-	06/30/91	1.3414	0.9727
140151	07/01/90	-	06/30/91	1.0772	1.0000
140158	07/01/90	-	06/30/91	1.4364	0.9984
140159	07/01/90	-	06/30/91	1.1803	0.9932
140164	04/01/90	-	03/31/91	1.2499	0.9866
140165	04/01/90	-	03/31/91	1.0697	0.9573
140166	07/01/90	-	06/30/91	1.2561	0.9858
140168	07/01/90	-	06/30/91	1.1759	0.9733
140170	07/01/90	-	06/30/91	0.9486	0.9660
140171	07/01/90	-	06/30/91	0.8433	0.9826
140172	07/01/90	-	06/30/91	1.4939	0.9876
140173	07/01/90	-	06/30/91	0.9694	0.9641
140174	07/01/90	-	06/30/91	1.3286	0.9936
140177	04/01/90	-	03/31/91	1.2660	0.9842
140179	07/01/90	-	06/30/91	1.2512	0.9927
140184	05/01/90	-	04/30/91	1.1516	0.9750
140187	07/01/90	-	06/30/91	1.4172	0.9915
140189	07/01/90	-	06/30/91	1.1711	0.9827
140190	05/01/90	-	04/30/91	1.1778	0.9627
140193	07/01/90	-	06/30/91	0.9716	0.9600
140199	07/01/90	-	06/30/91	1.0005	0.9643
140200	07/01/90	-	06/30/91	1.4470	0.9967
140205	06/01/90	-	05/31/91	0.9464	0.9728
140210	05/01/90	-	04/30/91	1.0545	0.9744
140213	04/01/90	-	03/31/91	1.2028	0.9907
140215	07/01/90	-	06/30/91	1.0217	0.9811
140218	07/01/90	-	06/30/91	0.9701	0.9695
140223	07/01/90	-	06/30/91	1.4899	0.9970
140224	07/01/90	-	06/30/91	1.3180	0.9987
140228	06/01/90	-	05/31/91	1.5122	0.9986
140229	05/01/90	-	04/30/91	0.9841	0.9671
140230	07/01/90	-	06/30/91	0.9419	0.9618
140231	07/01/90	-	06/30/91	1.4738	0.9871
140234	07/01/90	-	06/30/91	1.1549	0.9865
140239	03/01/90	-	02/28/91	1.5307	0.9954
140242	07/01/90	-	06/30/91	1.3990	0.9963
140245	07/01/90	-	06/30/91	1.0259	0.9721
140246	07/01/90	-	06/30/91	1.0184	0.9750
140250	05/01/90	-	04/30/91	1.2229	0.9853
140251	07/01/90	-	06/30/91	1.2785	0.9916
140275	04/01/90	-	03/31/91	1.1947	0.9947
140276	07/01/90	-	06/30/91	2.0017	0.9982
140280	06/01/90	-	05/31/91	1.1627	0.9847

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	-	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
140286	05/01/90	-	04/30/91	1.0958	0.9836
140297	06/01/90	-	05/31/91	1.4644	0.9922
140299	07/01/90	-	06/30/91	0.9061	0.9600
150011	07/01/90	-	06/30/91	1.2054	0.9904
150012	06/01/90	-	05/31/91	1.5356	0.9972
150014	07/01/90	-	06/30/91	1.3162	0.9906
150019	07/01/90	-	06/30/91	1.1806	0.9942
150025	07/01/90	-	06/30/91	1.5000	0.9959
150032	07/01/90	-	06/30/91	1.6723	0.9923
150043	07/01/90	-	06/30/91	1.0463	0.9689
150046	05/01/90	-	04/30/91	1.4368	0.9976
150056	03/01/90	-	02/28/91	1.6483	0.9986
150076	06/01/90	-	05/31/91	1.0106	0.9825
150077	07/01/90	-	06/30/91	1.1483	0.9884
150082	05/01/90	-	04/30/91	1.3756	0.9992
150084	07/01/90	-	06/30/91	1.6502	0.9998
150085	06/01/90	-	05/31/91	0.9815	0.9600
150088	06/01/90	-	05/31/91	1.1415	0.9869
150089	07/01/90	-	06/30/91	1.2727	0.9997
150090	07/01/90	-	06/30/91	1.2749	0.9851
150099	07/01/90	-	06/30/91	1.3224	0.9979
150100	07/01/90	-	06/30/91	1.5650	0.9934
150103	07/01/90	-	06/30/91	1.1350	0.9475
150110	05/01/90	-	04/30/91	0.8663	0.9669
150115	07/01/90	-	06/30/91	1.2561	0.9801
150125	07/01/90	-	06/30/91	1.4009	0.9982
150126	07/01/90	-	06/30/91	1.5552	0.9942
150130	07/01/90	-	06/30/91	1.0930	0.9845
150135	07/01/90	-	06/30/91	0.8726	0.7790
160005	07/01/90	-	06/30/91	1.1284	0.9771
160007	07/01/90	-	06/30/91	0.9942	0.9252
160009	07/01/90	-	06/30/91	1.1264	0.9597
160012	07/01/90	-	06/30/91	1.2010	0.9729
160013	07/01/90	-	06/30/91	1.2253	0.9875
160014	07/01/90	-	06/30/91	0.9644	0.9450
160016	07/01/90	-	06/30/91	1.2801	0.9727
160018	07/01/90	-	06/30/91	0.9963	0.9455
160020	07/01/90	-	06/30/91	1.0889	0.9799
160021	07/01/90	-	06/30/91	1.1383	0.9704
160023	07/01/90	-	06/30/91	1.0926	0.9576
160025	07/01/90	-	06/30/91	1.7993	0.9964
160026	07/01/90	-	06/30/91	1.0176	0.9654
160027	07/01/90	-	06/30/91	1.1020	0.9658
160028	07/01/90	-	06/30/91	1.2532	0.9929
160029	07/01/90	-	06/30/91	1.4286	0.9984
160030	07/01/90	-	06/30/91	1.3156	0.9862
160031	07/01/90	-	06/30/91	1.0430	0.9428
160032	07/01/90	-	06/30/91	1.0381	0.9719
160033	07/01/90	-	06/30/91	1.3362	0.9914
160034	07/01/90	-	06/30/91	1.0004	0.9513
160035	07/01/90	-	06/30/91	0.9167	0.8895
160036	07/01/90	-	06/30/91	1.0264	0.9643
160037	07/01/90	-	06/30/91	1.0090	0.9454
160039	07/01/90	-	06/30/91	1.0594	0.9639
160040	07/01/90	-	06/30/91	1.3683	0.9906
160041	07/01/90	-	06/30/91	1.1307	0.9552
160043	07/01/90	-	06/30/91	0.9522	0.9537
160046	07/01/90	-	06/30/91	1.0361	0.9846
160048	07/01/90	-	06/30/91	1.0502	0.9558
160049	07/01/90	-	06/30/91	0.8964	0.9403
160050	07/01/90	-	06/30/91	1.0265	0.9540
160052	07/01/90	-	06/30/91	1.0132	0.9368
160054	07/01/90	-	06/30/91	1.0667	0.9753
160055	07/01/90	-	06/30/91	1.0381	0.9671
160056	07/01/90	-	06/30/91	1.0472	0.9611
160057	07/01/90	-	06/30/91	1.3664	0.9768
160058	07/01/90	-	06/30/91	1.5856	0.9989
160059	07/01/90	-	06/30/91	1.2447	0.9822
160060	07/01/90	-	06/30/91	1.0670	0.9642
160061	07/01/90	-	06/30/91	0.9750	0.9713
160062	07/01/90	-	06/30/91	0.9540	0.9466
160063	07/01/90	-	06/30/91	1.0822	0.9682
160064	07/01/90	-	06/30/91	1.5155	0.9922
160065	06/01/90	-	05/31/91	1.1304	0.9587
160066	07/01/90	-	06/30/91	1.0695	0.9644
160067	07/01/90	-	06/30/91	1.2389	0.9870
160068	07/01/90	-	06/30/91	1.0828	0.9609
160069	07/01/90	-	06/30/91	1.3270	0.9960
160070	07/01/90	-	06/30/91	1.0843	0.9953
160073	07/01/90	-	06/30/91	0.9085	0.9799
160074	07/01/90	-	06/30/91	1.0137	0.9658
160075	07/01/90	-	06/30/91	1.0738	0.9621
160076	07/01/90	-	06/30/91	0.9634	0.9658
160077	07/01/90	-	06/30/91	1.0967	0.9650
160079	07/01/90	-	06/30/91	1.2936	0.9944
160080	07/01/90	-	06/30/91	1.1280	0.9771
160081	07/01/90	-	06/30/91	1.0805	0.9557
160083	07/01/90	-	06/30/91	1.5385	0.9984
160085	07/01/90	-	06/30/91	1.1202	0.9507
160086	07/01/90	-	06/30/91	1.0076	0.9599
160088	07/01/90	-	06/30/91	0.9972	0.9558
160089	04/01/90	-	03/31/91	1.1967	0.9868
160090	07/01/90	-	06/30/91	1.0765	0.9782
160091	07/01/90	-	06/30/91	1.1241	0.9684
160093	07/01/90	-	06/30/91	1.0461	0.9509
160094	07/01/90	-	06/30/91	1.1848	0.9607
160095	07/01/90	-	06/30/91	1.0452	0.9522
160097	07/01/90	-	06/30/91	1.1179	0.9726
160098	07/01/90	-	06/30/91	0.9759	0.9767
160101	07/01/90	-	06/30/91	1.2025	0.9656
160102	07/01/90	-	06/30/91	1.4498	0.9972
160103	07/01/90	-	06/30/91	0.8779	0.9531
160106	07/01/90	-	06/30/91	1.0484	0.9539
160107	07/01/90	-	06/30/91	1.1084	0.9397
160108	07/01/90	-	06/30/91	1.1588	0.9690
160109	07/01/90	-	06/30/91	0.9842	0.9575

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
160112	07/01/90	06/30/91	1.3473	0.9729
160113	07/01/90	06/30/91	1.0284	0.9757
160114	07/01/90	06/30/91	1.0111	0.9677
160115	07/01/90	06/30/91	1.0240	0.9746
160116	07/01/90	06/30/91	1.1182	0.9779
160117	07/01/90	06/30/91	1.3380	0.9970
160118	07/01/90	06/30/91	0.9921	0.9804
160119	07/01/90	06/30/91	0.8414	0.9528
160120	07/01/90	06/30/91	1.0122	0.9074
160123	07/01/90	06/30/91	1.1013	0.9674
160124	07/01/90	06/30/91	1.1725	0.9555
160126	03/01/90	02/28/91	1.0646	0.9726
168134	07/01/90	06/30/91	0.8913	0.9033
160135	07/01/90	06/30/91	0.9984	0.9685
160140	07/01/90	06/30/91	1.0695	0.9707
160141	07/01/90	06/30/91	0.9299	0.9637
160142	07/01/90	06/30/91	1.1277	0.9349
160143	07/01/90	06/30/91	1.0959	0.9400
160145	07/01/90	06/30/91	1.0324	0.9917
160146	07/01/90	06/30/91	1.3035	0.9932
160151	07/01/90	06/30/91	1.1043	0.9837
160152	07/01/90	06/30/91	1.0531	0.9558
160153	07/01/90	06/30/91	1.5418	0.9979
170003	07/01/90	06/30/91	1.2184	0.9869
170007	07/01/90	06/30/91	1.1130	0.9945
170009	06/01/90	05/31/91	1.1753	0.9952
170010	07/01/90	06/30/91	1.1517	0.9711
170011	07/01/90	06/30/91	1.3391	0.9891
170013	07/01/90	06/30/91	1.2178	0.9937
170015	04/01/90	03/31/91	1.0691	0.9763
170016	06/01/90	05/31/91	1.5642	0.9981
170020	07/01/90	06/30/91	1.2261	0.9805
170025	07/01/90	06/30/91	1.3852	0.9868
170037	07/01/90	06/30/91	1.1576	0.9800
170040	07/01/90	06/30/91	1.3762	0.9942
170044	07/01/90	06/30/91	1.2031	0.9832
170045	07/01/90	06/30/91	1.0186	0.9745
170051	05/01/90	04/30/91	0.9891	0.9608
170052	05/01/90	04/30/91	1.1198	0.9714
170053	04/01/90	03/31/91	0.8675	0.9755
170056	04/01/90	03/31/91	0.9714	0.9742
170057	07/01/90	06/30/91	1.0163	0.9994
170058	07/01/90	06/30/91	1.0155	0.9840
170060	07/01/90	06/30/91	1.0476	0.9737
170061	04/01/90	03/31/91	1.0099	0.9570
170067	07/01/90	06/30/91	1.0297	0.9478
170069	07/01/90	06/30/91	0.8604	0.9586
170072	04/01/90	03/31/91	0.9652	0.9660
170074	05/01/90	04/30/91	1.1516	0.9919
170084	07/01/90	06/30/91	0.9469	0.9366
170085	07/01/90	06/30/91	0.9418	0.9079
170089	07/01/90	06/30/91	0.9941	0.9319
170093	04/01/90	03/31/91	1.0160	0.9449
170095	07/01/90	06/30/91	1.1595	0.9755
170100	05/01/90	04/30/91	0.8024	0.9605
170103	07/01/90	06/30/91	1.1985	0.9741
170105	07/01/90	06/30/91	0.9727	0.9646
170115	07/01/90	06/30/91	1.0944	0.9777
170133	07/01/90	06/30/91	1.1972	0.9787
170140	07/01/90	06/30/91	1.0051	0.9631
170142	07/01/90	06/30/91	1.2524	0.9808
170159	07/01/90	06/30/91	0.9249	0.9530
170171	06/01/90	05/31/91	1.1739	0.9905
180002	07/01/90	06/30/91	1.1371	0.9787
180005	07/01/90	06/30/91	1.0570	0.9808
180006	05/01/90	04/30/91	0.9283	0.9958
180007	07/01/90	06/30/91	1.3870	0.9957
180012	07/01/90	06/30/91	1.2625	0.9912
180013	04/01/90	03/31/91	1.3472	0.9942
180018	07/01/90	06/30/91	1.1808	0.9760
180020	07/01/90	06/30/91	1.0054	0.9710
180021	07/01/90	06/30/91	0.9139	0.9757
180024	07/01/90	06/30/91	1.1659	0.9688
180027	04/01/90	03/31/91	1.1265	0.9784
180028	07/01/90	06/30/91	0.9975	0.9634
180029	07/01/90	06/30/91	1.2749	0.9842
180032	07/01/90	06/30/91	0.9409	0.9710
180033	05/01/90	04/30/91	1.0612	0.9390
180034	07/01/90	06/30/91	1.0579	0.9643
180038	06/01/90	05/31/91	1.3029	0.9934
180042	07/01/90	06/30/91	1.0424	0.9517
180046	07/01/90	06/30/91	1.0433	0.9629
180047	07/01/90	06/30/91	1.0074	0.9273
180049	07/01/90	06/30/91	1.3477	0.9735
180050	07/01/90	06/30/91	1.2956	0.9617
180053	07/01/90	06/30/91	1.1763	0.9753
180054	07/01/90	06/30/91	1.0916	0.9622
180055	07/01/90	06/30/91	1.0289	0.9766
180056	07/01/90	06/30/91	1.0490	0.9817
180062	07/01/90	06/30/91	0.8157	0.9427
180065	07/01/90	06/30/91	0.9780	0.9831
180067	07/01/90	06/30/91	1.8398	0.9970
180069	07/01/90	06/30/91	1.0985	0.9838
180070	07/01/90	06/30/91	1.0591	0.9746
180075	05/01/90	04/30/91	0.9552	0.9793
180087	07/01/90	06/30/91	0.9767	0.9830
180092	07/01/90	06/30/91	1.1226	0.9802
180101	03/01/90	02/28/91	1.2362	0.9840
180105	03/01/90	02/28/91	0.9490	0.9665
180108	07/01/90	06/30/91	0.9097	0.9624
180117	06/01/90	05/31/91	1.2658	0.9623
180118	07/01/90	06/30/91	0.9816	0.9610
180122	07/01/90	06/30/91	0.9400	0.9328
180125	07/01/90	06/30/91	0.9963	0.9721
180129	05/01/90	04/30/91	1.1048	0.9717
180134	07/01/90	06/30/91	1.1039	0.9564

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
180139	07/01/90	06/30/91	1.0016	0.9699
190001	07/01/90	06/30/91	0.8920	0.9937
190005	07/01/90	06/30/91	1.2688	0.9972
190006	07/01/90	06/30/91	1.0634	0.9967
190007	07/01/90	06/30/91	1.0531	0.9663
190008	04/01/90	03/31/91	1.4522	0.9997
190009	07/01/90	06/30/91	1.1074	0.9976
190010	07/01/90	06/30/91	0.9037	0.9825
190011	07/01/90	06/30/91	1.0769	0.9972
190015	07/01/90	06/30/91	1.1941	0.9907
190017	07/01/90	06/30/91	1.1949	0.9873
190019	07/01/90	06/30/91	1.4884	0.9980
190020	07/01/90	06/30/91	1.1401	0.9805
190023	07/01/90	06/30/91	0.8858	0.9699
190027	07/01/90	06/30/91	1.4165	0.9970
190029	07/01/90	06/30/91	1.2454	0.9527
190033	06/01/90	05/31/91	0.9779	0.9904
190035	07/01/90	06/30/91	1.4151	1.0000
190036	05/01/90	04/30/91	1.6235	0.9994
190037	07/01/90	06/30/91	0.9822	0.9600
190041	07/01/90	06/30/91	1.5565	0.9979
190045	07/01/90	06/30/91	1.2905	0.9884
190047	07/01/90	06/30/91	1.1614	0.9775
190048	07/01/90	06/30/91	0.9738	0.9779
190054	07/01/90	06/30/91	1.4017	0.9824
190071	07/01/90	06/30/91	0.9224	0.9754
190075	07/01/90	06/30/91	1.4096	0.9970
190081	07/01/90	06/30/91	0.8500	0.9468
190086	05/01/90	04/30/91	1.2121	0.9885
190098	07/01/90	06/30/91	1.3357	1.0000
190103	05/01/90	04/30/91	0.9457	0.9828
190112	06/01/90	05/31/91	1.2993	0.9930
190114	07/01/90	06/30/91	0.9262	0.9908
190122	07/01/90	06/30/91	1.1690	0.9943
190124	07/01/90	06/30/91	1.4200	1.0000
190131	07/01/90	06/30/91	1.2679	0.9836
190132	07/01/90	06/30/91	1.0926	0.9656
190133	06/01/90	05/31/91	1.0310	0.9721
190138	05/01/90	04/30/91	0.7693	0.9971
190140	05/01/90	04/30/91	0.9928	0.9748
190148	06/01/90	05/31/91	0.9603	0.9739
190152	06/01/90	05/31/91	1.4353	0.9909
190155	07/01/90	06/30/91	0.9519	0.9823
190156	07/01/90	06/30/91	0.8431	0.9688
190158	06/01/90	05/31/91	1.3173	0.9986
190161	07/01/90	06/30/91	0.8502	1.0000
190165	05/01/90	04/30/91	1.0267	0.9499
190166	07/01/90	06/30/91	0.9889	0.9868
190170	04/01/90	03/31/91	1.0066	0.9692
190173	06/01/90	05/31/91	1.4328	0.9957
190176	07/01/90	06/30/91	1.3967	0.9984
190182	03/01/90	02/28/91	1.0245	0.9959
190183	07/01/90	06/30/91	1.0589	0.9984
190187	05/01/90	04/30/91	0.6504	0.9217
190190	04/01/90	03/31/91	1.0107	0.9722
190196	05/01/90	04/30/91	0.8320	1.0000
190199	07/01/90	06/30/91	1.2505	0.9787
190204	06/01/90	05/31/91	1.4451	0.9964
200002	05/01/90	04/30/91	1.0542	0.9698
200003	07/01/90	06/30/91	1.0322	0.9767
200008	07/01/90	06/30/91	1.1920	0.9959
200012	07/01/90	06/30/91	1.1141	0.9802
200013	07/01/90	06/30/91	1.1370	0.9857
200015	07/01/90	06/30/91	1.2617	0.9899
200016	07/01/90	06/30/91	1.0241	0.9669
200019	05/01/90	04/30/91	1.2045	0.9919
200020	07/01/90	06/30/91	1.0464	0.9903
200023	04/01/90	03/31/91	0.8545	0.9776
200024	07/01/90	06/30/91	1.1784	0.9890
200037	07/01/90	06/30/91	1.1593	0.9735
200038	05/01/90	04/30/91	1.0173	0.9803
200039	04/01/90	03/31/91	1.2975	0.9941
200040	06/01/90	05/31/91	1.0690	0.9706
200050	07/01/90	06/30/91	1.1297	0.9837
200051	07/01/90	06/30/91	0.9872	0.9559
200063	04/01/90	03/31/91	1.2307	0.9854
210001	07/01/90	06/30/91	1.3065	0.9998
210002	07/01/90	06/30/91	1.7811	0.9998
210003	07/01/90	06/30/91	1.3074	0.9941
210004	07/01/90	06/30/91	1.2490	0.9915
210005	07/01/90	06/30/91	1.2099	0.9914
210007	07/01/90	06/30/91	1.4036	0.9993
210008	07/01/90	06/30/91	1.2721	0.9983
210009	07/01/90	06/30/91	1.5349	0.9996
210010	07/01/90	06/30/91	1.1546	0.9749
210012	07/01/90	06/30/91	1.4363	0.9958
210013	07/01/90	06/30/91	1.2859	0.9966
210015	07/01/90	06/30/91	1.2214	0.9943
210016	07/01/90	06/30/91	1.7256	0.9981
210017	07/01/90	06/30/91	1.1532	0.9803
210018	07/01/90	06/30/91	1.2356	0.9918
210019	07/01/90	06/30/91	1.3193	0.9995
210021	07/01/90	06/30/91	1.2474	0.9949
210022	07/01/90	06/30/91	1.2865	0.9893
210023	07/01/90	06/30/91	1.2659	0.9894
210024	07/01/90	06/30/91	1.2563	0.9983
210025	07/01/90	06/30/91	1.2417	0.9942
210026	07/01/90	06/30/91	1.3293	0.9954
210027	07/01/90	06/30/91	1.2174	0.9924
210028	07/01/90	06/30/91	1.0342	0.9766
210029	07/01/90	06/30/91	1.3281	0.9823
210030	07/01/90	06/30/91	1.0597	0.9859
210031	07/01/90	06/30/91	1.4101	1.0000
210032	07/01/90	06/30/91	1.1851	0.9960
210033	07/01/90	06/30/91	1.1332	0.9957
210034	07/01/90	06/30/91	1.1874	0.9961

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
210035	07/01/90	06/30/91	1.1340	0.9942
210036	07/01/90	06/30/91	1.1601	0.9897
210037	07/01/90	06/30/91	1.1898	0.9928
210038	07/01/90	06/30/91	1.3667	0.9956
210039	07/01/90	06/30/91	1.1915	0.9893
210040	07/01/90	06/30/91	1.3274	0.9897
210043	07/01/90	06/30/91	1.1730	1.0000
210044	07/01/90	06/30/91	1.1968	0.9966
210045	07/01/90	06/30/91	0.9828	0.9707
210046	07/01/90	06/30/91	1.1161	0.9929
210048	07/01/90	06/30/91	1.1597	0.9915
210051	07/01/90	06/30/91	1.2746	0.9963
210054	07/01/90	06/30/91	1.2398	0.9927
210055	07/01/90	06/30/91	1.1891	0.9949
210056	07/01/90	06/30/91	1.3635	0.9927
210057	07/01/90	06/30/91	1.2376	0.9921
210058	07/01/90	06/30/91	1.7267	0.9749
210059	07/01/90	06/30/91	1.3274	0.9943
220011	07/01/90	06/30/91	1.1694	0.9946
220041	07/01/90	06/30/91	1.1662	0.9897
220083	07/01/90	06/30/91	1.1349	0.9951
220114	07/01/90	06/30/91	1.0456	0.9962
220115	07/01/90	06/30/91	1.3012	0.9942
220131	07/01/90	06/30/91	1.1599	0.9804
220133	07/01/90	06/30/91	0.7435	0.9594
220153	07/01/90	06/30/91	1.0720	0.9518
220154	07/01/90	06/30/91	0.9595	0.9472
220163	07/01/90	06/30/91	1.9736	0.9976
230001	07/01/90	06/30/91	1.1589	0.9747
230002	07/01/90	06/30/91	1.2389	0.9909
230004	07/01/90	06/30/91	1.6683	0.9975
230005	07/01/90	06/30/91	1.1937	0.9881
230006	04/01/90	03/31/91	0.9901	0.9782
230014	04/01/90	03/31/91	0.9487	0.9851
230019	07/01/90	06/30/91	1.5564	0.9990
230024	07/01/90	06/30/91	1.4711	0.9989
230027	07/01/90	06/30/91	1.0871	0.9780
230029	07/01/90	06/30/91	1.4890	0.9988
230030	07/01/90	06/30/91	1.1671	0.9860
230031	07/01/90	06/30/91	1.3634	0.9927
230032	07/01/90	06/30/91	1.6846	0.9995
230034	04/01/90	03/31/91	1.1818	0.9803
230035	07/01/90	06/30/91	1.1484	0.9708
230036	07/01/90	06/30/91	1.2662	0.9775
230037	07/01/90	06/30/91	1.2883	0.9780
230038	07/01/90	06/30/91	1.5364	0.9998
230039	07/01/90	06/30/91	1.2783	0.9994
230041	07/01/90	06/30/91	1.1225	0.9953
230046	07/01/90	06/30/91	1.6964	0.9996
230047	07/01/90	06/30/91	1.2270	0.9886
230054	07/01/90	06/30/91	1.5833	0.9980
230058	07/01/90	06/30/91	1.1375	0.9646
230059	07/01/90	06/30/91	1.4107	0.9972
230060	07/01/90	06/30/91	1.1735	0.9882
230062	07/01/90	06/30/91	1.0550	0.9605
230066	04/01/90	03/31/91	1.3065	0.9931
230068	07/01/90	06/30/91	1.2994	0.9986
230069	07/01/90	06/30/91	1.1071	0.9820
230070	07/01/90	06/30/91	1.2974	0.9904
230072	04/01/90	03/31/91	1.1920	0.9998
230075	07/01/90	06/30/91	1.3133	0.9895
230077	07/01/90	06/30/91	2.1198	0.9982
230081	07/01/90	06/30/91	1.1623	0.9890
230082	07/01/90	06/30/91	1.1530	0.9759
230085	07/01/90	06/30/91	1.1395	0.9726
230086	07/01/90	06/30/91	0.9444	0.9582
230092	07/01/90	06/30/91	1.2447	0.9860
230093	07/01/90	06/30/91	1.1758	0.9815
230095	04/01/90	03/31/91	1.0916	0.9743
230097	07/01/90	06/30/91	1.4659	0.9982
230099	07/01/90	06/30/91	1.2030	0.9921
230100	07/01/90	06/30/91	1.1529	0.9754
230106	07/01/90	06/30/91	1.0858	0.9780
230108	07/01/90	06/30/91	1.1589	0.9826
230111	07/01/90	06/30/91	0.9995	0.9753
230113	07/01/90	06/30/91	1.0017	0.9772
230116	04/01/90	03/31/91	0.9398	0.9727
230117	07/01/90	06/30/91	1.7870	0.9989
230120	07/01/90	06/30/91	1.0076	0.9954
230124	04/01/90	03/31/91	1.1021	0.9810
230132	07/01/90	06/30/91	1.3156	0.9954
230133	07/01/90	06/30/91	1.0997	0.9839
230140	07/01/90	06/30/91	1.2608	0.9982
230144	07/01/90	06/30/91	1.1596	0.9949
230147	07/01/90	06/30/91	1.4790	0.9988
230153	07/01/90	06/30/91	1.0730	0.9761
230154	07/01/90	06/30/91	1.0836	0.9954
230156	07/01/90	06/30/91	1.6313	0.9993
230157	07/01/90	06/30/91	1.4088	0.9892
230159	04/01/90	03/31/91	1.3886	0.9928
230162	04/01/90	03/31/91	0.9233	0.9588
230165	06/24/90	06/23/91	1.6842	0.9993
230172	04/01/90	03/31/91	1.1553	0.9761
230173	07/01/90	06/30/91	1.4160	0.9900
230174	07/01/90	06/30/91	1.2352	1.0000
230178	04/01/90	03/31/91	1.1268	0.9806
230180	07/01/90	06/30/91	1.1255	0.9992
230188	04/01/90	03/31/91	1.1440	0.9912
230189	07/01/90	06/30/91	0.9047	0.9741
230199	07/01/90	06/30/91	1.1575	0.9874
230201	07/01/90	06/30/91	0.9530	0.9576
230207	07/01/90	06/30/91	1.2793	0.9989
230219	04/01/90	03/31/91	0.9288	0.9426
230221	04/01/90	03/31/91	1.2339	0.9964
230222	07/01/90	06/30/91	1.3200	0.9922
230232	07/01/90	06/30/91	1.0267	0.9643

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
230241	04/01/90	03/31/91	1.1339	0.9860
230264	07/01/90	06/30/91	1.3831	0.9895
240002	07/01/90	06/30/91	1.6660	0.9943
240005	07/01/90	06/30/91	0.9399	0.9040
240009	07/01/90	06/30/91	1.0401	0.9659
240017	05/01/90	04/30/91	1.2162	0.9733
240036	07/01/90	06/30/91	1.4798	0.9974
240037	07/01/90	06/30/91	1.0509	0.9973
240040	07/01/90	06/30/91	1.2473	0.9582
240044	05/01/90	04/30/91	1.1733	0.9730
240049	07/01/90	06/30/91	1.6220	0.9971
240075	07/01/90	06/30/91	1.2347	0.9826
240077	07/01/90	06/30/91	0.9707	0.9583
240089	04/01/90	03/31/91	1.0613	0.9887
240090	05/01/90	04/30/91	1.0214	0.9738
240099	06/01/90	05/31/91	0.9927	0.9873
240101	07/01/90	06/30/91	1.1759	0.9692
240104	07/01/90	06/30/91	1.2391	0.9819
240110	07/01/90	06/30/91	1.0044	0.9621
240125	06/01/90	05/31/91	0.9366	0.9807
240129	06/01/90	05/31/91	0.9738	0.9657
240137	04/01/90	03/31/91	1.2096	0.9726
240145	03/01/90	02/28/91	0.9405	0.9625
240158	05/01/90	04/30/91	0.9840	0.9255
240160	07/01/90	06/30/91	0.9661	0.9779
240167	01/01/90	01/12/91	0.8628	0.9311
240171	05/01/90	04/30/91	1.1386	0.9557
240175	06/01/90	05/31/91	0.8325	1.0000
240176	07/01/90	06/30/91	0.9167	0.9851
250001	07/01/90	06/30/91	1.4630	0.9956
250006	07/01/90	06/30/91	0.9807	0.9855
250016	05/01/90	04/30/91	0.8531	0.9958
250017	04/01/90	03/31/91	0.9886	0.9700
250031	05/01/90	04/30/91	1.2181	0.9909
250032	07/01/90	06/30/91	1.1559	0.9908
250033	04/01/90	03/31/91	1.0643	0.9546
250034	07/01/90	06/30/91	1.4511	0.9938
250044	07/01/90	06/30/91	1.0662	0.9809
250046	04/01/90	03/31/91	1.0081	0.9614
250094	04/01/90	03/31/91	1.2087	0.9968
250102	07/01/90	06/30/91	1.3986	0.9990
250123	03/01/90	02/28/91	1.1269	0.9902
250126	04/01/90	03/31/91	0.9989	0.9572
250128	05/01/90	04/30/91	0.9753	0.9570
250134	07/01/90	06/30/91	0.9549	1.0000
250138	05/01/90	04/30/91	1.2602	0.9912
250141	07/01/90	06/30/91	1.1664	0.9854
250143	12/14/89	01/02/91	0.9096	0.9822
260001	07/01/90	06/30/91	1.5647	0.9991
260002	06/01/90	05/31/91	1.3093	0.9876
260006	07/01/90	06/30/91	1.3137	0.9910
260007	04/01/90	03/31/91	1.1853	0.9941
260008	07/01/90	06/30/91	1.2363	0.9933
260009	06/01/90	05/31/91	1.2422	0.9836
260013	05/01/90	04/30/91	1.1233	0.9994
260016	07/01/90	06/30/91	1.2100	0.9934
260020	07/01/90	06/30/91	1.5593	0.9981
260022	06/01/90	05/31/91	1.3887	0.9875
260033	05/01/90	04/30/91	1.2920	0.9919
260037	02/01/90	01/31/91	1.2101	0.9881
260042	07/01/90	06/30/91	1.0944	0.9860
260047	07/01/90	06/30/91	1.3049	0.9894
260048	05/01/90	04/30/91	1.3596	0.9983
260049	07/01/90	06/30/91	0.8563	0.9559
260051	06/01/90	05/31/91	1.2717	0.9978
260052	07/01/90	06/30/91	1.1541	0.9886
260055	07/01/90	06/30/91	1.1939	0.9694
260059	07/01/90	06/30/91	1.0585	0.9570
260061	07/01/90	06/30/91	1.1293	0.9793
260065	07/01/90	06/30/91	1.5749	0.9987
260066	07/01/90	06/30/91	1.0481	0.9664
260067	07/01/90	06/30/91	0.9562	0.9523
260077	07/01/90	06/30/91	1.3796	0.9940
260079	07/01/90	06/30/91	1.0012	0.9700
260081	07/01/90	06/30/91	1.3967	0.9978
260082	04/01/90	03/31/91	1.1584	0.9873
260085	07/01/90	06/30/91	1.4306	0.9979
260086	04/01/90	03/31/91	0.9677	0.9819
260089	05/01/90	04/30/91	1.0935	0.9914
260090	07/01/90	06/30/91	1.4546	0.9924
260094	05/01/90	04/30/91	1.0405	0.9968
260095	07/01/90	06/30/91	1.3605	0.9972
260096	07/01/90	06/30/91	1.4352	0.9985
260104	07/01/90	06/30/91	1.5896	0.9973
260105	07/01/90	06/30/91	1.8521	0.9966
260108	07/01/90	06/30/91	1.6264	0.9988
260109	04/01/90	03/31/91	1.0410	0.9553
260112	05/01/90	04/30/91	1.3629	0.9989
260115	07/01/90	06/30/91	1.0573	0.9394
260127	07/01/90	06/30/91	1.0865	0.9734
260128	07/01/90	06/30/91	1.0149	0.9583
260129	06/01/90	05/31/91	1.0830	0.9910
260131	04/01/90	03/31/91	1.3070	0.9575
260137	06/01/90	05/31/91	1.2395	1.0000
260141	07/01/90	06/30/91	1.9490	0.9899
260142	05/01/90	04/30/91	1.2315	0.9738
260143	07/01/90	06/30/91	1.1842	0.9692
260146	07/01/90	06/30/91	1.2012	0.9903
260147	07/01/90	06/30/91	1.0283	0.9722
260148	07/01/90	06/30/91	1.0108	0.9556
260163	04/01/90	03/31/91	1.1921	0.9570
260164	05/01/90	04/30/91	1.0989	0.9696
260172	07/01/90	06/30/91	1.0282	0.9793
260173	07/01/90	06/30/91	1.1111	0.8950
260175	04/01/90	03/31/91	1.1710	0.9822
260176	05/01/90	04/30/91	1.3154	0.9912

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
260177	07/01/90	06/30/91	1.3056	0.9909
260182	07/01/90	06/30/91	1.0392	0.9655
260183	07/01/90	06/30/91	1.4172	0.9932
260186	05/01/90	04/30/91	1.1376	0.9571
260189	07/01/90	06/30/91	0.9479	0.9752
260197	02/01/90	01/31/91	1.2524	0.9949
260198	07/01/90	06/30/91	1.2822	0.9868
270003	06/01/90	05/31/91	1.1879	0.9887
270004	07/01/90	06/30/91	1.6946	0.9984
270009	06/01/90	05/31/91	1.0669	0.9770
270011	07/01/90	06/30/91	1.1355	0.9720
270012	07/01/90	06/30/91	1.3808	0.9974
270016	07/01/90	06/30/91	0.9477	0.9175
270017	06/01/90	05/31/91	1.2210	0.9802
270023	07/01/90	06/30/91	1.2716	0.9913
270024	07/01/90	06/30/91	1.0515	0.9849
270026	07/01/90	06/30/91	0.9600	0.9560
270027	07/01/90	06/30/91	1.0052	0.9865
270028	07/01/90	06/30/91	1.0193	0.9737
270029	07/01/90	06/30/91	1.0603	0.9841
270031	06/01/90	06/30/91	0.8856	0.9640
270032	07/01/90	06/30/91	1.1106	0.9663
270036	07/01/90	06/30/91	0.9661	0.9928
270040	07/01/90	06/30/91	1.0172	0.9558
270044	07/01/90	06/30/91	1.1592	0.9672
270046	05/01/90	04/30/91	0.9527	0.9657
270047	07/01/90	06/30/91	0.9262	0.9248
270049	06/01/90	05/31/91	1.5876	0.9972
270050	07/01/90	06/30/91	1.0346	0.9576
270051	04/01/90	03/31/91	1.2089	0.9924
270052	07/01/90	06/30/91	1.0396	0.9558
270053	07/01/90	06/30/91	0.8383	0.8336
270055	07/01/90	06/30/91	0.6368	0.9758
270058	07/01/90	06/30/91	0.9847	0.9795
270060	07/01/90	06/30/91	0.9500	0.9091
270067	05/01/90	04/30/91	0.9493	0.9951
270068	07/01/90	06/30/91	0.8888	0.8945
270072	07/01/90	06/30/91	0.8672	0.9038
270073	07/01/90	06/30/91	1.1772	0.9532
270079	07/01/90	06/30/91	0.9509	0.9460
270080	07/01/90	06/30/91	1.0930	0.9736
270081	07/01/90	06/30/91	0.9303	0.9642
270082	07/01/90	06/30/91	0.8880	0.9723
280003	06/01/90	05/31/91	1.8344	0.9977
280009	07/01/90	06/30/91	1.4787	0.9883
280011	07/01/90	06/30/91	1.0097	0.9688
280013	07/01/90	06/30/91	1.8270	0.9960
280014	07/01/90	06/30/91	0.9956	0.9687
280018	07/01/90	06/30/91	0.9430	0.9635
280020	07/01/90	06/30/91	1.4431	0.9925
280021	07/01/90	06/30/91	1.1404	0.9680
280022	07/01/90	06/30/91	1.0412	0.9839
280023	07/01/90	06/30/91	1.3730	0.9845
280024	07/01/90	06/30/91	0.8356	0.9608
280026	07/01/90	06/30/91	1.0319	0.9812
280028	05/01/90	04/30/91	0.8778	0.9576
280029	07/01/90	06/30/91	0.9899	0.9620
280033	07/01/90	06/30/91	0.9512	0.9930
280035	07/01/90	06/30/91	0.9111	0.9373
280037	07/01/90	06/30/91	0.9412	0.9475
280042	05/01/90	04/30/91	1.0014	0.9778
280043	07/01/90	06/30/91	1.1113	0.9684
280045	07/01/90	06/30/91	1.1097	0.9958
280049	05/01/90	04/30/91	1.0162	0.9837
280050	07/01/90	06/30/91	0.9829	0.9640
280051	07/01/90	06/30/91	1.0257	0.9984
280052	07/01/90	06/30/91	1.0660	0.9757
280055	07/01/90	06/30/91	0.9920	0.9408
280056	07/01/90	06/30/91	1.0023	0.9789
280060	07/01/90	06/30/91	1.4360	0.9988
280062	07/01/90	06/30/91	1.1430	0.9664
280064	05/01/90	04/30/91	1.0898	0.9708
280066	07/01/90	06/30/91	1.1385	0.9911
280068	04/01/90	03/31/91	0.8758	0.9128
280070	05/01/90	04/30/91	0.9996	0.9276
280073	07/01/90	06/30/91	1.0010	0.9461
280075	07/01/90	06/30/91	1.3199	0.9813
280077	07/01/90	06/30/91	1.2948	0.9820
280078	05/01/90	04/30/91	0.9194	0.8852
280080	07/01/90	06/30/91	1.0813	0.9689
280082	03/01/90	02/28/91	1.2983	0.9888
280084	07/01/90	06/30/91	0.9546	0.9518
280090	07/01/90	06/30/91	0.9664	0.9719
280091	07/01/90	06/30/91	1.0221	0.9801
280092	07/01/90	06/30/91	0.9631	0.8984
280094	04/01/90	03/31/91	1.0863	0.9748
280097	07/01/90	06/30/91	0.9064	0.9276
280098	07/01/90	06/30/91	0.9917	0.9911
280104	07/01/90	06/30/91	0.9589	0.8916
280105	07/01/90	06/30/91	1.2099	0.9909
280110	07/01/90	06/30/91	1.0343	0.9660
280111	05/01/90	04/30/91	1.2069	0.9830
280117	07/01/90	06/30/91	1.0399	0.9702
280118	07/01/90	06/30/91	0.9524	0.9702
280123	07/01/90	06/30/91	0.9442	0.9000
290001	07/01/90	06/30/91	1.5795	0.9999
290002	04/01/90	03/31/91	0.9768	0.9271
290007	07/01/90	06/30/91	1.6757	0.9972
290008	07/01/90	06/30/91	1.2653	0.9688
290011	07/01/90	06/30/91	1.0149	0.9647
290012	07/01/90	06/30/91	1.3171	0.9843
290013	07/01/90	06/30/91	1.0380	0.9808
290014	07/01/90	06/30/91	0.9425	0.9344
290015	07/01/90	06/30/91	0.9952	0.9179
290016	07/01/90	06/30/91	1.0926	0.9511
290019	07/01/90	06/30/91	1.1997	0.9825

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	-	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
290020	07/01/90	-	06/30/91	0.8756	0.9549
290027	07/01/90	-	06/30/91	0.9515	0.9970
300003	07/01/90	-	06/30/91	1.8397	0.9956
300010	07/01/90	-	06/30/91	1.2596	0.9733
300015	07/01/90	-	06/30/91	1.0261	0.9383
300019	07/01/90	-	06/30/91	1.2401	0.9886
300029	03/01/90	-	02/28/91	1.2481	0.9898
300034	07/01/90	-	06/30/91	1.7137	0.9967
310119	07/01/90	-	06/30/91	1.5159	0.9969
320001	07/01/90	-	06/30/91	1.4283	0.9880
320002	07/01/90	-	06/30/91	1.2533	0.9912
320003	07/01/90	-	06/30/91	1.1558	0.9829
320004	07/01/90	-	06/30/91	1.1740	0.9929
320005	07/01/90	-	06/30/91	1.2622	0.9885
320006	07/01/90	-	06/30/91	1.1903	0.9857
320009	07/01/90	-	06/30/91	1.3160	0.9946
320011	04/01/90	-	03/31/91	0.9783	0.9750
320012	04/01/90	-	03/31/91	0.9280	0.9343
320013	06/01/90	-	05/31/91	1.0896	0.9778
320014	07/01/90	-	06/30/91	0.9685	0.9476
320016	07/01/90	-	06/30/91	1.2000	0.9785
320017	07/01/90	-	06/30/91	1.1867	0.9979
320018	07/01/90	-	06/30/91	1.2056	0.9949
320021	04/01/90	-	03/31/91	1.6351	0.9964
320022	04/01/90	-	03/31/91	1.2168	0.9824
320023	06/01/90	-	05/31/91	1.1190	0.9771
320030	07/01/90	-	06/30/91	1.0400	0.9650
320031	07/01/90	-	06/30/91	0.9575	0.9809
320032	04/01/90	-	03/31/91	0.9144	0.9481
320033	07/01/90	-	06/30/91	1.0408	0.9956
320037	07/01/90	-	06/30/91	1.2383	0.9184
320046	04/01/90	-	03/31/91	1.0655	0.9492
320048	07/01/90	-	06/30/91	1.3045	0.9916
320065	04/01/90	-	03/31/91	1.1809	0.9623
320068	07/01/90	-	06/30/91	0.8598	0.9619
320069	07/01/90	-	06/30/91	1.0743	0.9582
320074	07/01/90	-	06/30/91	1.0522	0.9861
320076	04/01/90	-	03/31/91	1.1648	0.9832
320079	04/01/90	-	03/31/91	1.0681	0.9879
330080	07/01/90	-	06/30/91	1.2402	0.9940
330127	07/01/90	-	06/30/91	1.2268	0.9616
330128	07/01/90	-	06/30/91	1.3881	0.9946
330196	07/01/90	-	06/30/91	1.3913	0.9991
330199	07/01/90	-	06/30/91	1.2429	0.9962
330202	07/01/90	-	06/30/91	1.2290	0.9839
330204	07/01/90	-	06/30/91	1.2010	0.9970
330231	07/01/90	-	06/30/91	1.1931	0.9939
330240	07/01/90	-	06/30/91	1.3066	0.9974
330354	04/01/90	-	03/31/91	1.1394	1.0000
330385	07/01/90	-	06/30/91	1.1988	0.9835
340014	07/01/90	-	06/30/91	1.6111	0.9993
340019	07/01/90	-	06/30/91	1.0695	0.9907
340020	06/01/90	-	05/31/91	1.2379	0.9709
340030	07/01/90	-	06/30/91	1.7215	0.9974
340032	07/01/90	-	06/30/91	1.2876	0.9882
340047	07/01/90	-	06/30/91	1.7385	0.9983
340061	07/01/90	-	06/30/91	1.5983	0.9987
340073	07/01/90	-	06/30/91	1.3335	0.9946
340076	07/01/90	-	06/30/91	1.0047	0.9731
340116	05/01/90	-	04/30/91	1.6776	0.9940
340135	07/01/90	-	06/30/91	1.1003	0.8391
340136	07/01/90	-	06/30/91	0.9989	1.0000
340137	07/01/90	-	06/30/91	1.3079	1.0000
340138	07/01/90	-	06/30/91	1.0945	0.9856
340143	07/01/90	-	06/30/91	1.3605	0.9882
340144	03/01/90	-	02/28/91	1.2847	0.9961
340148	07/01/90	-	06/30/91	1.3048	0.9947
340153	03/01/90	-	02/28/91	1.9009	0.9993
340154	07/01/90	-	06/30/91	0.9967	1.0000
340155	07/01/90	-	06/30/91	1.5121	0.9972
340158	07/01/90	-	06/30/91	1.0621	0.9917
340160	07/01/90	-	06/30/91	1.0394	0.9591
340164	06/01/90	-	05/31/91	1.3063	0.9922
350001	07/01/90	-	06/30/91	1.1017	0.9931
350002	07/01/90	-	06/30/91	1.6667	0.9985
350003	07/01/90	-	06/30/91	1.1090	0.9772
350005	07/01/90	-	06/30/91	1.1289	0.9522
350006	07/01/90	-	06/30/91	1.3771	0.9932
350008	07/01/90	-	06/30/91	1.0511	0.9663
350009	07/01/90	-	06/30/91	1.1467	0.9794
350010	04/01/90	-	03/31/91	1.0950	0.9885
350011	07/01/90	-	06/30/91	1.7378	1.0000
350012	07/01/90	-	06/30/91	1.0006	0.9902
350013	07/01/90	-	06/30/91	1.0679	0.9722
350014	07/01/90	-	06/30/91	1.0694	0.9852
350016	07/01/90	-	06/30/91	0.9791	0.9712
350017	07/01/90	-	06/30/91	1.2278	0.9898
350021	07/01/90	-	06/30/91	1.0964	0.9752
350025	07/01/90	-	06/30/91	0.9736	0.9659
350029	07/01/90	-	06/30/91	0.9546	0.9402
350030	07/01/90	-	06/30/91	1.0611	0.9853
350031	07/01/90	-	06/30/91	0.9771	0.9703
350032	07/01/90	-	06/30/91	1.1451	1.0000
350034	07/01/90	-	06/30/91	0.9603	0.9841
350035	07/01/90	-	06/30/91	0.8435	0.9283
350036	07/01/90	-	06/30/91	0.8991	0.8986
350038	07/01/90	-	06/30/91	0.9377	0.9762
350039	07/01/90	-	06/30/91	0.8850	0.9466
350043	07/01/90	-	06/30/91	1.4861	0.9964
350044	07/01/90	-	06/30/91	0.8672	0.9920
350047	07/01/90	-	06/30/91	1.1156	0.9397
350049	07/01/90	-	06/30/91	1.0699	0.9722
350053	07/01/90	-	06/30/91	0.8745	0.9809
350056	07/01/90	-	06/30/91	0.8789	0.9802
350058	04/01/90	-	03/31/91	1.0174	0.9705
350060	07/01/90	-	06/30/91	0.9915	1.0000

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
350061	04/01/90	03/31/91	1.0214	0.9897
350065	03/01/90	02/28/91	0.9734	0.9403
350067	07/01/90	06/30/91	0.9935	0.9174
360003	07/01/90	06/30/91	1.5017	0.9953
360006	07/01/90	06/30/91	1.6791	0.9984
360008	07/01/90	06/30/91	1.1948	0.9776
360011	07/01/90	06/30/91	1.2533	0.9931
360014	07/01/90	06/30/91	1.1771	0.9728
360017	07/01/90	06/30/91	1.7318	0.9966
360028	07/01/90	06/30/91	1.3095	0.9890
360029	07/01/90	06/30/91	1.1000	0.9868
360035	06/01/90	05/31/91	1.4449	0.9978
360040	07/01/90	06/30/91	1.2708	0.9656
360048	07/01/90	06/30/91	1.6749	0.9963
360052	07/01/90	06/30/91	1.5723	0.9990
360054	07/01/90	06/30/91	1.3044	0.9831
360058	04/01/90	03/31/91	1.0752	0.9752
360085	07/01/90	06/30/91	1.6396	0.9901
360090	07/01/90	06/30/91	1.1621	0.9946
360134	07/01/90	06/30/91	1.5056	0.9994
360161	07/01/90	06/30/91	1.2345	0.9842
360178	07/01/90	06/30/91	1.1999	0.9882
360185	07/01/90	06/30/91	1.1791	0.9884
360187	07/01/90	06/30/91	1.3453	0.9876
360238	07/01/90	06/30/91	0.8813	0.9824
370004	07/01/90	06/30/91	1.1375	0.9758
370005	07/01/90	06/30/91	0.9539	0.9649
370008	07/01/90	06/30/91	1.1991	0.9933
370011	07/01/90	06/30/91	0.9422	0.9775
370012	07/01/90	06/30/91	0.8948	0.9441
370013	07/01/90	06/30/91	1.3686	0.9990
370015	07/01/90	06/30/91	1.1192	0.9757
370016	07/01/90	06/30/91	1.2813	0.9964
370019	07/01/90	06/30/91	1.1148	0.9691
370022	07/01/90	06/30/91	1.3322	0.9800
370023	07/01/90	06/30/91	1.2936	0.9829
370026	07/01/90	06/30/91	1.3037	0.9965
370028	07/01/90	06/30/91	1.5874	0.9989
370029	07/01/90	06/30/91	1.2024	0.9429
370030	07/01/90	06/30/91	1.2150	0.9719
370034	07/01/90	06/30/91	1.1186	0.9837
370035	07/01/90	06/30/91	1.4775	0.9949
370036	07/01/90	06/30/91	1.0831	0.9331
370038	07/01/90	06/30/91	1.0349	0.9484
370041	07/01/90	06/30/91	1.0025	0.9646
370042	07/01/90	06/30/91	0.8910	0.9737
370043	07/01/90	06/30/91	0.9592	0.9718
370045	07/01/90	06/30/91	1.0777	0.9627
370046	07/01/90	06/30/91	1.0141	0.9481
370047	07/01/90	06/30/91	1.2306	0.9918
370048	07/01/90	06/30/91	1.2252	0.9470
370050	07/01/90	06/30/91	0.8390	0.9106
370056	07/01/90	06/30/91	1.4442	0.9954
370059	07/01/90	06/30/91	1.2710	0.9852
370060	06/01/90	05/31/91	0.9757	0.9510
370063	07/01/90	06/30/91	1.1823	0.9717
370064	05/01/90	04/30/91	0.9092	0.9389
370065	07/01/90	06/30/91	1.1184	0.9501
370069	07/01/90	06/30/91	1.0008	0.9670
370071	07/01/90	06/30/91	0.9890	0.9582
370072	07/01/90	06/30/91	0.9622	0.9644
370076	07/01/90	06/30/91	1.0812	0.9903
370079	07/01/90	06/30/91	0.9241	0.9668
370080	07/01/90	06/30/91	0.9558	0.9580
370082	07/01/90	06/30/91	1.0274	0.9390
370083	04/01/90	03/31/91	1.0243	0.9776
370084	07/01/90	06/30/91	0.8456	0.9411
370085	04/01/90	03/31/91	0.8678	0.9601
370086	07/01/90	06/30/91	1.0629	0.9793
370089	07/01/90	06/30/91	1.2536	0.9793
370091	07/01/90	06/30/91	1.5052	0.9991
370097	04/01/90	03/31/91	1.2682	0.9979
370099	07/01/90	06/30/91	1.1150	0.9727
370100	07/01/90	06/30/91	1.0240	0.9635
370103	07/01/90	06/30/91	0.9162	0.9425
370110	07/01/90	06/30/91	0.9846	0.9616
370112	04/01/90	03/31/91	0.9393	0.9443
370113	07/01/90	06/30/91	1.0989	0.9845
370122	04/01/90	03/31/91	0.8986	0.9506
370123	07/01/90	06/30/91	1.1332	0.9947
370125	07/01/90	06/30/91	0.9880	0.9794
370126	07/01/90	06/30/91	1.1067	0.9697
370131	05/01/90	04/30/91	1.0051	0.9419
370133	07/01/90	06/30/91	1.1834	0.9189
370138	07/01/90	06/30/91	1.1626	0.9662
370139	07/01/90	06/30/91	0.9940	0.9724
370140	07/01/90	06/30/91	1.0402	0.9728
370153	07/01/90	06/30/91	1.0965	0.9805
370154	07/01/90	06/30/91	1.0265	0.9540
370156	07/01/90	06/30/91	0.9972	0.9416
370158	07/01/90	06/30/91	1.0318	0.9546
370159	07/01/90	06/30/91	1.1554	0.9812
370163	07/01/90	06/30/91	0.8709	0.9661
370166	02/01/90	01/31/91	1.1121	0.9667
370178	07/01/90	06/30/91	0.9784	0.9761
370183	07/01/90	06/30/91	1.1021	0.9506
370186	07/01/90	06/30/91	0.9547	0.9510
380001	07/01/90	06/30/91	1.3388	0.9877
380002	07/01/90	06/30/91	1.1999	0.9774
380003	07/01/90	06/30/91	1.1124	0.9869
380005	07/01/90	06/30/91	1.2009	0.9831
380007	04/01/90	03/31/91	1.7272	0.9942
380008	04/01/90	03/31/91	1.0688	0.9759
380009	07/01/90	06/30/91	1.6095	0.9968
380011	07/01/90	06/30/91	1.1564	0.9776
380013	07/01/90	06/30/91	1.2606	0.9547

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
380017	04/01/90	03/31/91	1.7207	0.9975
380023	07/01/90	06/30/91	1.3293	0.9613
380024	04/01/90	03/31/91	1.2888	0.9895
380025	04/01/90	03/31/91	1.2479	0.9803
380027	07/01/90	06/30/91	1.2178	0.9871
380031	07/01/90	06/30/91	1.0158	0.9858
380033	07/01/90	06/30/91	1.6581	0.9984
380035	05/01/90	04/30/91	1.2283	0.9764
380037	07/01/90	06/30/91	1.2306	0.9592
380040	07/01/90	06/30/91	1.3621	0.9767
380048	07/01/90	06/30/91	1.0095	0.9459
380059	07/01/90	06/30/91	0.9255	0.9835
380062	07/01/90	06/30/91	0.9483	0.9722
380063	07/01/90	06/30/91	1.2571	0.9888
380065	07/01/90	06/30/91	1.0684	0.9663
380066	07/01/90	06/30/91	1.0904	0.9717
380069	07/01/90	06/30/91	1.1161	0.9897
380071	05/01/90	04/30/91	1.2359	0.9755
380072	07/01/90	06/30/91	0.9356	0.9270
380078	07/01/90	06/30/91	1.1513	0.9661
380081	07/01/90	06/30/91	1.0650	0.9604
380083	07/01/90	06/30/91	1.1666	0.9679
380084	05/01/90	04/30/91	1.2897	0.9792
380087	07/01/90	06/30/91	0.9536	0.9547
380088	07/01/90	06/30/91	0.9528	0.9860
380089	04/01/90	03/31/91	1.3093	0.9788
380090	07/01/90	06/30/91	1.3438	0.9832
380094	07/01/90	06/30/91	1.1364	0.9947
390001	07/01/90	06/30/91	1.2097	0.9933
390002	07/01/90	06/30/91	1.1911	0.9965
390003	07/01/90	06/30/91	1.1548	0.9924
390004	07/01/90	06/30/91	1.2504	0.9990
390005	07/01/90	06/30/91	1.0984	0.9909
390006	07/01/90	06/30/91	1.6355	0.9990
390007	07/01/90	06/30/91	1.1969	0.9904
390008	07/01/90	06/30/91	1.1199	0.9697
390009	07/01/90	06/30/91	1.4935	0.9991
390010	07/01/90	06/30/91	1.1311	0.9868
390011	07/01/90	06/30/91	1.1900	0.9926
390012	07/01/90	06/30/91	1.2037	0.9876
390013	07/01/90	06/30/91	1.1676	0.9888
390014	07/01/90	06/30/91	0.7687	1.0000
390015	07/01/90	06/30/91	1.1115	0.9722
390016	07/01/90	06/30/91	1.1653	0.9885
390017	07/01/90	06/30/91	1.1621	0.9893
390018	07/01/90	06/30/91	1.2418	0.9931
390019	07/01/90	06/30/91	1.1172	0.9747
390021	07/01/90	06/30/91	1.0388	0.9848
390022	07/01/90	06/30/91	1.2521	0.9903
390023	07/01/90	06/30/91	1.2248	0.9980
390024	07/01/90	06/30/91	0.7829	0.9971
390025	07/01/90	06/30/91	0.7981	0.9953
390026	07/01/90	06/30/91	1.2649	0.9883
390027	07/01/90	06/30/91	1.6723	0.9966
390028	07/01/90	06/30/91	1.6719	0.9986
390029	07/01/90	06/30/91	1.6217	0.9980
390030	07/01/90	06/30/91	1.1465	0.9946
390031	07/01/90	06/30/91	1.1501	0.9865
390032	07/01/90	06/30/91	1.1989	0.9923
390035	07/01/90	06/30/91	1.2909	0.9913
390036	07/01/90	06/30/91	1.2175	0.9935
390037	07/01/90	06/30/91	1.2158	0.9877
390039	07/01/90	06/30/91	1.0524	0.9835
390040	07/01/90	06/30/91	0.9540	0.9901
390041	07/01/90	06/30/91	1.2272	0.9825
390042	07/01/90	06/30/91	1.2386	0.9899
390043	07/01/90	06/30/91	1.0626	0.9860
390044	07/01/90	06/30/91	1.5211	0.9983
390045	07/01/90	06/30/91	1.2884	0.9911
390046	07/01/90	06/30/91	1.4060	0.9984
390047	07/01/90	06/30/91	1.4703	0.9955
390048	07/01/90	06/30/91	1.1171	0.9863
390049	07/01/90	06/30/91	1.5110	0.9978
390050	07/01/90	06/30/91	1.8470	0.9983
390051	07/01/90	06/30/91	2.0545	0.9978
390052	07/01/90	06/30/91	1.1390	0.9769
390055	07/01/90	06/30/91	1.6520	0.9989
390056	07/01/90	06/30/91	1.1049	0.9877
390057	07/01/90	06/30/91	1.2691	0.9956
390058	07/01/90	06/30/91	1.3167	0.9858
390059	07/01/90	06/30/91	1.3048	0.9952
390061	07/01/90	06/30/91	1.2385	0.9888
390062	07/01/90	06/30/91	1.1852	0.9851
390063	07/01/90	06/30/91	1.5982	0.9989
390064	07/01/90	06/30/91	1.3726	0.9982
390065	07/01/90	06/30/91	1.2253	0.9833
390066	07/01/90	06/30/91	1.2884	0.9859
390067	07/01/90	06/30/91	1.4798	0.9985
390068	07/01/90	06/30/91	1.2652	0.9898
390069	07/01/90	06/30/91	1.2673	0.9904
390070	07/01/90	06/30/91	1.1561	0.9898
390071	07/01/90	06/30/91	1.1042	0.9911
390072	07/01/90	06/30/91	0.9840	0.9862
390073	07/01/90	06/30/91	1.4683	0.9984
390074	07/01/90	06/30/91	1.2184	0.9896
390075	07/01/90	06/30/91	1.2866	0.9925
390076	07/01/90	06/30/91	1.2191	0.9870
390078	07/01/90	06/30/91	1.0701	0.9824
390079	07/01/90	06/30/91	1.6409	0.9986
390080	07/01/90	06/30/91	1.1679	0.9941
390081	07/01/90	06/30/91	1.2333	0.9934
390083	07/01/90	06/30/91	1.1362	0.9932
390084	07/01/90	06/30/91	1.1530	0.9954
390086	07/01/90	06/30/91	1.0781	0.9722
390088	07/01/90	06/30/91	1.3481	0.9927
390090	07/01/90	06/30/91	1.7695	0.9979

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
390091	07/01/90	06/30/91	1.1114	0.9935
390092	07/01/90	06/30/91	1.1872	0.9891
390093	07/01/90	06/30/91	1.1890	0.9916
390095	07/01/90	06/30/91	1.2294	0.9896
390096	07/01/90	06/30/91	1.2246	0.9924
390097	07/01/90	06/30/91	1.3262	0.9842
390098	07/01/90	06/30/91	1.5682	0.9979
390100	07/01/90	06/30/91	1.7179	0.9983
390101	07/01/90	06/30/91	1.2134	0.9939
390102	07/01/90	06/30/91	1.2887	0.9967
390103	07/01/90	06/30/91	1.0808	0.9906
390104	07/01/90	06/30/91	1.0627	0.9685
390106	07/01/90	06/30/91	1.0623	0.9785
390107	07/01/90	06/30/91	1.1711	0.9952
390108	07/01/90	06/30/91	1.3343	0.9910
390109	07/01/90	06/30/91	1.1987	0.9886
390110	07/01/90	06/30/91	1.2844	0.9923
390111	07/01/90	06/30/91	1.7078	0.9966
390112	07/01/90	06/30/91	1.1809	0.9778
390113	07/01/90	06/30/91	1.2335	0.9905
390114	07/01/90	06/30/91	1.0237	0.9979
390115	07/01/90	06/30/91	1.2915	0.9874
390116	07/01/90	06/30/91	1.1828	0.9856
390117	07/01/90	06/30/91	1.1615	0.9783
390118	07/01/90	06/30/91	1.1204	0.9865
390119	07/01/90	06/30/91	1.3285	0.9970
390121	07/01/90	06/30/91	1.2100	0.9956
390122	07/01/90	06/30/91	1.0753	0.9825
390123	07/01/90	06/30/91	1.2029	0.9882
390125	07/01/90	06/30/91	1.2071	0.9947
390126	07/01/90	06/30/91	1.2074	0.9897
390127	07/01/90	06/30/91	1.0962	0.9885
390128	07/01/90	06/30/91	1.1927	0.9897
390130	07/01/90	06/30/91	1.0649	0.9547
390131	07/01/90	06/30/91	1.2088	0.9958
390132	07/01/90	06/30/91	1.1752	0.9911
390133	07/01/90	06/30/91	1.3936	0.9944
390135	07/01/90	06/30/91	1.2328	0.9943
390136	07/01/90	06/30/91	1.1903	0.9968
390137	07/01/90	06/30/91	1.1600	0.9970
390138	07/01/90	06/30/91	1.2514	0.9824
390139	07/01/90	06/30/91	1.4305	0.9987
390142	07/01/90	06/30/91	1.6931	0.9997
390143	07/01/90	06/30/91	0.9115	0.9997
390145	07/01/90	06/30/91	1.2080	0.9860
390146	07/01/90	06/30/91	1.1824	0.9828
390147	07/01/90	06/30/91	1.1805	0.9934
390148	07/01/90	06/30/91	1.1517	0.9994
390149	07/01/90	06/30/91	1.2262	0.9889
390150	07/01/90	06/30/91	1.2042	0.9814
390151	07/01/90	06/30/91	1.2526	0.9941
390152	07/01/90	06/30/91	0.9936	0.9897
390153	07/01/90	06/30/91	1.1944	0.9898
390154	07/01/90	06/30/91	1.1099	0.9731
390155	07/01/90	06/30/91	1.2475	0.9924
390156	07/01/90	06/30/91	1.3673	0.9964
390157	07/01/90	06/30/91	1.1958	0.9934
390158	07/01/90	06/30/91	1.2307	0.9894
390159	07/01/90	06/30/91	1.2797	0.9907
390160	07/01/90	06/30/91	1.1852	0.9929
390161	07/01/90	06/30/91	1.0620	0.9802
390162	07/01/90	06/30/91	1.2345	0.9969
390163	07/01/90	06/30/91	1.1909	0.9923
390164	07/01/90	06/30/91	1.7807	0.9980
390165	07/01/90	06/30/91	1.0931	0.9884
390166	07/01/90	06/30/91	1.1164	0.9744
390167	07/01/90	06/30/91	1.2352	0.9939
390168	07/01/90	06/30/91	1.1815	0.9892
390170	07/01/90	06/30/91	1.5875	0.9986
390171	07/01/90	06/30/91	1.0941	0.9870
390172	07/01/90	06/30/91	1.1852	0.9946
390173	07/01/90	06/30/91	1.1193	0.9763
390174	07/01/90	06/30/91	1.5378	0.9986
390176	07/01/90	06/30/91	1.2185	0.9908
390178	07/01/90	06/30/91	1.3225	0.9916
390179	07/01/90	06/30/91	1.2383	0.9932
390180	07/01/90	06/30/91	1.3587	0.9928
390181	07/01/90	06/30/91	1.0826	0.9869
390183	07/01/90	06/30/91	1.1504	0.9784
390184	07/01/90	06/30/91	1.1175	0.9853
390185	07/01/90	06/30/91	1.1687	0.9796
390186	07/01/90	06/30/91	1.0656	0.9770
390187	07/01/90	06/30/91	1.1208	0.9800
390189	07/01/90	06/30/91	1.1301	0.9800
390191	07/01/90	06/30/91	1.0850	0.9768
390192	07/01/90	06/30/91	1.0757	0.9837
390193	07/01/90	06/30/91	1.1960	0.9937
390194	07/01/90	06/30/91	1.0956	0.9825
390195	07/01/90	06/30/91	1.5382	0.9991
390196	07/01/90	06/30/91	1.2794	0.9992
390197	07/01/90	06/30/91	1.2889	0.9963
390198	07/01/90	06/30/91	1.2604	0.9940
390199	07/01/90	06/30/91	1.2407	0.9683
390200	07/01/90	06/30/91	1.0501	0.9673
390201	07/01/90	06/30/91	1.2932	0.9876
390203	07/01/90	06/30/91	1.2768	0.9901
390204	07/01/90	06/30/91	1.2898	0.9939
390205	07/01/90	06/30/91	1.2393	0.9904
390206	07/01/90	06/30/91	1.2576	0.9970
390209	07/01/90	06/30/91	0.9776	0.9677
390211	07/01/90	06/30/91	1.1444	0.9872
390213	07/01/90	06/30/91	0.9783	0.9978
390215	07/01/90	06/30/91	1.1795	0.9878
390217	07/01/90	06/30/91	1.1297	0.9890
390219	07/01/90	06/30/91	1.1992	0.9745
390220	07/01/90	06/30/91	1.1300	0.9874

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	-	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
390222	07/01/90	-	06/30/91	1.2141	0.9921
390223	07/01/90	-	06/30/91	1.5440	0.9963
390225	07/01/90	-	06/30/91	1.2638	0.9813
390226	07/01/90	-	06/30/91	1.5905	0.9988
390228	07/01/90	-	06/30/91	1.1899	0.9946
390229	07/01/90	-	06/30/91	1.4208	0.9966
390231	07/01/90	-	06/30/91	1.3050	0.9949
390232	07/01/90	-	06/30/91	1.0673	0.9762
390233	07/01/90	-	06/30/91	1.2736	0.9946
390235	07/01/90	-	06/30/91	1.7961	0.9966
390236	07/01/90	-	06/30/91	1.2007	0.9908
390238	07/01/90	-	06/30/91	0.9871	0.9912
390242	07/01/90	-	06/30/91	1.2275	0.9925
390244	07/01/90	-	06/30/91	0.8597	0.9516
390245	07/01/90	-	06/30/91	1.3470	0.9912
390246	07/01/90	-	06/30/91	1.2248	0.9843
390247	07/01/90	-	06/30/91	1.0993	1.0000
390249	04/01/90	-	03/31/91	0.9896	0.9791
390252	07/01/90	-	06/30/91	0.6968	0.9911
390256	07/01/90	-	06/30/91	1.5971	1.0000
390258	07/01/90	-	06/30/91	1.2989	0.9895
390260	07/01/90	-	06/30/91	1.2344	0.9884
390261	07/01/90	-	06/30/91	1.7899	0.9967
390262	07/01/90	-	06/30/91	1.6652	0.9951
390263	07/01/90	-	06/30/91	1.4484	0.9897
390265	07/01/90	-	06/30/91	1.2533	0.9937
390266	07/01/90	-	06/30/91	1.1276	0.9816
390267	07/01/90	-	06/30/91	1.2248	0.9921
390268	07/01/90	-	06/30/91	1.2240	0.9910
390270	07/01/90	-	06/30/91	1.2906	0.9898
390275	07/01/90	-	06/30/91	0.5649	1.0000
390277	07/01/90	-	06/30/91	1.7555	0.9714
390278	07/01/90	-	06/30/91	0.9309	0.9552
400001	07/01/90	-	06/30/91	1.1779	1.0000
400003	07/01/90	-	06/30/91	1.1181	0.9978
400004	07/01/90	-	06/30/91	1.1114	0.9997
400006	07/01/90	-	06/30/91	1.1534	1.0000
400009	07/01/90	-	06/30/91	0.9782	0.9995
400012	07/01/90	-	06/30/91	1.0365	1.0000
400013	04/01/90	-	03/31/91	0.9533	0.9868
400015	07/01/90	-	06/30/91	1.0859	0.9984
400018	04/01/90	-	03/31/91	1.2573	0.9963
400021	06/01/90	-	05/31/91	1.2920	0.9995
400026	07/01/90	-	06/30/91	0.9438	0.9843
400028	07/01/90	-	06/30/91	1.0016	1.0000
400029	07/01/90	-	06/30/91	1.0192	0.9974
400037	07/01/90	-	06/30/91	0.7007	1.0000
400038	07/01/90	-	06/30/91	0.8530	0.8693
400044	07/01/90	-	06/30/91	1.2211	0.9945
400048	07/01/90	-	06/30/91	1.1380	0.9933
400061	07/01/90	-	06/30/91	1.7356	0.9981
400079	07/01/90	-	06/30/91	1.1456	0.9906
400087	03/01/90	-	02/28/91	1.2197	0.9958
400088	05/01/90	-	04/30/91	0.7940	0.9937
400102	07/01/90	-	06/30/91	1.0980	0.9987
400103	07/01/90	-	06/30/91	1.4353	0.9968
400104	07/01/90	-	06/30/91	1.2608	0.9976
400105	07/01/90	-	06/30/91	1.2810	0.9977
400110	07/01/90	-	06/30/91	1.1678	0.9889
400114	07/01/90	-	06/30/91	1.0679	0.9983
420002	05/01/90	-	04/30/91	1.2944	0.9897
420004	07/01/90	-	06/30/91	1.9072	0.9978
420006	07/01/90	-	06/30/91	1.4690	0.9754
420035	07/01/90	-	06/30/91	0.8228	0.9734
420053	07/01/90	-	06/30/91	1.0876	0.9708
420062	03/01/90	-	02/28/91	1.1626	0.9478
420079	04/01/90	-	03/31/91	1.5274	0.9994
420080	07/01/90	-	06/30/91	1.1316	0.9833
420082	03/01/90	-	02/28/91	1.3316	0.9932
420083	07/01/90	-	06/30/91	1.1658	0.9893
420084	07/01/90	-	06/30/91	0.7915	0.9858
420085	05/01/90	-	04/30/91	1.2280	0.9690
430004	03/01/90	-	02/28/91	1.1402	0.9662
430005	06/01/90	-	05/31/91	1.3185	0.9783
430007	07/01/90	-	06/30/91	1.1639	0.9496
430010	07/01/90	-	06/30/91	1.0791	0.9669
430011	07/01/90	-	06/30/91	1.3043	0.9736
430012	07/01/90	-	06/30/91	1.3139	0.9819
430018	07/01/90	-	06/30/91	0.9506	0.9477
430022	03/01/90	-	02/28/91	0.9585	0.9653
430025	03/01/90	-	02/28/91	0.9697	0.9850
430027	05/01/90	-	04/30/91	1.6450	0.9983
430033	07/01/90	-	06/30/91	1.0076	0.9804
430037	07/01/90	-	06/30/91	0.9559	0.9623
430039	06/01/90	-	05/31/91	1.0101	0.9579
430042	02/01/90	-	01/31/91	0.9559	0.9856
430054	07/01/90	-	06/30/91	0.9351	0.9704
430062	06/01/90	-	05/31/91	0.8614	0.9715
430066	07/01/90	-	06/30/91	1.0587	0.9828
430077	07/01/90	-	06/30/91	1.4025	0.9982
440001	07/01/90	-	06/30/91	0.9762	0.9743
440002	07/01/90	-	06/30/91	1.5374	0.9983
440003	06/01/90	-	05/31/91	1.1209	0.9798
440006	07/01/90	-	06/30/91	1.3686	0.9984
440007	07/01/90	-	06/30/91	1.0311	0.9814
440009	07/01/90	-	06/30/91	1.0392	0.9769
440010	07/01/90	-	06/30/91	0.9363	0.9594
440011	07/01/90	-	06/30/91	1.2235	0.9867
440012	07/01/90	-	06/30/91	1.3204	0.9977
440014	07/01/90	-	06/30/91	0.8939	0.9949
440015	07/01/90	-	06/30/91	1.4676	0.9986
440016	07/01/90	-	06/30/91	0.9608	0.9830
440017	07/01/90	-	06/30/91	1.4413	0.9978
440019	07/01/90	-	06/30/91	1.4770	0.9987
440022	07/01/90	-	06/30/91	1.0793	0.9710
440023	07/01/90	-	06/30/91	0.9704	0.9772

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
440024	07/01/90	06/30/91	1.1161	0.9874
440025	07/01/90	06/30/91	1.1126	0.9969
440029	07/01/90	06/30/91	1.2159	0.9900
440030	07/01/90	06/30/91	1.0423	0.9686
440031	07/01/90	06/30/91	1.0571	0.9691
440032	07/01/90	06/30/91	0.9441	0.9775
440033	07/01/90	06/30/91	1.0930	0.9630
440035	07/01/90	06/30/91	1.1827	0.9803
440038	07/01/90	06/30/91	0.9278	0.9810
440039	07/01/90	06/30/91	1.5872	0.9957
440040	07/01/90	06/30/91	0.8914	0.9545
440051	07/01/90	06/30/91	0.9225	0.9816
440052	07/01/90	06/30/91	1.1395	0.9635
440053	07/01/90	06/30/91	1.1711	0.9860
440054	07/01/90	06/30/91	0.9843	0.9787
440056	07/01/90	06/30/91	0.9636	0.9752
440057	07/01/90	06/30/91	0.9707	0.9735
440059	07/01/90	06/30/91	1.1127	0.9758
440060	07/01/90	06/30/91	1.1625	0.9757
440063	07/01/90	06/30/91	1.4019	0.9985
440065	07/01/90	06/30/91	1.0822	0.9700
440069	07/01/90	06/30/91	1.1234	0.9916
440070	07/01/90	06/30/91	0.9231	0.9444
440073	07/01/90	06/30/91	1.2915	0.9853
440074	07/01/90	06/30/91	0.8812	0.9676
440082	07/01/90	06/30/91	1.8119	0.9986
440084	07/01/90	06/30/91	1.0679	0.9765
440090	07/01/90	06/30/91	1.0384	0.9652
440102	07/01/90	06/30/91	1.0594	0.9790
440103	07/01/90	06/30/91	1.2879	0.9967
440104	07/01/90	06/30/91	1.4274	0.9976
440109	07/01/90	06/30/91	1.0368	0.9507
440111	07/01/90	06/30/91	1.2812	0.9864
440114	07/01/90	06/30/91	1.0346	0.9600
440115	07/01/90	06/30/91	1.1729	0.9781
440121	07/01/90	06/30/91	1.1372	0.9866
440128	07/01/90	06/30/91	0.9548	0.8204
440130	07/01/90	06/30/91	1.1113	0.9826
440131	07/01/90	06/30/91	1.1357	0.9678
440132	07/01/90	06/30/91	1.0409	0.9631
440133	07/01/90	06/30/91	1.4563	0.9988
440135	07/01/90	06/30/91	1.3395	0.9934
440137	07/01/90	06/30/91	1.0512	0.9722
440141	07/01/90	06/30/91	0.8984	0.9648
440142	07/01/90	06/30/91	0.9993	0.9857
440143	06/01/90	05/31/91	1.0145	0.9492
440144	06/01/90	05/31/91	1.1389	0.9783
440147	07/01/90	06/30/91	0.7857	0.9968
440151	05/01/90	04/30/91	1.1401	0.9568
440152	07/01/90	06/30/91	1.5662	0.9896
440153	07/01/90	06/30/91	0.9495	0.9660
440156	04/01/90	03/31/91	1.3462	0.9992
440159	07/01/90	06/30/91	1.1830	0.9904
440160	07/01/90	06/30/91	1.0415	0.9941
440162	02/01/90	01/31/91	1.0256	0.9825
440166	07/01/90	06/30/91	1.2564	0.9914
440170	06/01/90	05/31/91	1.3581	0.9850
440175	03/01/90	02/28/91	1.1497	0.9588
440176	03/01/90	02/28/91	1.2108	0.9966
440180	07/01/90	06/30/91	1.0816	0.9572
440183	03/01/90	02/28/91	1.4033	0.9981
440187	06/01/90	05/31/91	1.0669	0.9765
440192	05/01/90	04/30/91	0.9524	0.9520
440193	06/01/90	05/31/91	1.1061	0.9838
440197	06/01/90	05/31/91	1.2922	0.9883
450004	07/01/90	06/30/91	1.0749	0.9797
450007	07/01/90	06/30/91	1.3505	0.9810
450008	04/01/90	03/31/91	1.2471	0.9928
450021	07/01/90	06/30/91	1.7150	0.9986
450023	07/01/90	06/30/91	1.4203	0.9977
450027	05/01/90	04/30/91	1.1610	0.9978
450029	07/01/90	06/30/91	1.3613	0.9949
450031	04/01/90	03/31/91	1.1709	0.9843
450034	07/01/90	06/30/91	1.4837	0.9969
450035	07/01/90	06/30/91	1.4810	0.9983
450040	07/01/90	06/30/91	1.6102	0.9995
450042	07/01/90	06/30/91	1.6372	0.9980
450044	07/01/90	06/30/91	1.4597	0.9991
450051	07/01/90	06/30/91	1.6535	0.9986
450052	07/01/90	06/30/91	1.0361	0.9876
450056	07/01/90	06/30/91	1.5902	0.9994
450060	07/01/90	06/30/91	1.2988	0.9880
450064	06/01/90	05/31/91	1.4387	0.9988
450070	07/01/90	06/30/91	1.1118	0.9870
450074	06/01/90	05/31/91	1.1344	0.9920
450078	04/01/90	03/31/91	0.9854	0.9775
450079	07/01/90	06/30/91	1.4451	0.9950
450090	07/01/90	06/30/91	1.2122	0.9670
450092	07/01/90	06/30/91	1.2667	0.9670
450096	07/01/90	06/30/91	1.4947	0.9970
450099	05/01/90	04/30/91	1.1759	0.9886
450102	07/01/90	06/30/91	1.6731	0.9968
450109	07/01/90	06/30/91	1.0051	0.9812
450113	06/01/90	05/31/91	1.2182	0.9890
450115	04/01/90	03/31/91	1.0947	0.9772
450123	05/01/90	04/30/91	1.0807	0.9846
450126	03/01/90	02/28/91	1.2054	0.9910
450128	07/01/90	06/30/91	1.1681	0.9820
450143	07/01/90	06/30/91	1.0052	0.9300
450147	07/01/90	06/30/91	1.3377	0.9973
450157	03/03/90	02/28/91	1.0072	0.9834
450170	07/01/90	06/30/91	1.1541	0.9685
450177	07/01/90	06/30/91	1.0633	0.9769
450179	07/01/90	06/30/91	1.0180	0.9849
450184	07/01/90	06/30/91	1.4702	0.9969
450188	04/01/90	03/31/91	0.9583	0.9503

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
450190	07/01/90	06/30/91	1.2678	0.9900
450217	07/01/90	06/30/91	0.8591	0.9888
450219	06/01/90	05/31/91	1.1609	0.9453
450221	07/01/90	06/30/91	0.9886	0.9830
450222	04/01/90	03/31/91	1.6353	0.9921
450233	07/01/90	06/30/91	1.0790	0.9797
450235	07/01/90	06/30/91	1.0403	0.9836
450241	05/27/90	05/31/91	0.9351	0.9653
450249	07/01/90	06/30/91	0.9319	0.9568
450258	06/01/90	05/31/91	1.1145	0.9364
450269	05/01/90	04/30/91	0.9298	0.9673
450270	04/01/90	03/31/91	1.1443	0.9786
450278	07/01/90	06/30/91	0.9402	0.9309
450288	04/01/90	03/31/91	1.1713	0.9856
450289	04/01/90	03/31/91	1.2962	0.9976
450307	05/01/90	04/30/91	0.8981	0.9677
450309	06/01/90	05/31/91	1.0388	0.9531
450320	04/01/90	03/31/91	1.2557	0.9908
450324	07/01/90	06/30/91	1.5592	0.9962
450325	07/01/90	06/30/91	1.2079	0.9849
450341	04/01/90	03/31/91	0.9449	0.9994
450349	07/01/90	06/30/91	1.1624	0.9699
450351	06/01/90	05/31/91	1.2986	0.9871
450362	07/01/90	06/30/91	0.9569	0.9591
450366	04/01/90	03/31/91	1.6917	0.9957
450370	05/01/90	04/30/91	1.2243	0.9776
450372	07/01/90	06/30/91	1.3288	0.9776
450379	06/01/90	05/31/91	1.6042	0.9966
450381	04/01/90	03/31/91	0.8942	0.9622
450393	03/01/90	02/28/91	1.2716	0.9931
450395	07/01/90	06/30/91	1.0685	0.9692
450400	07/01/90	06/30/91	1.0819	0.9441
450411	07/01/90	06/30/91	1.0580	0.9620
450417	01/17/90	01/16/91	1.0451	0.9661
450418	04/01/90	03/31/91	1.3273	0.9835
450447	05/01/90	04/30/91	1.3195	0.9896
450451	07/01/90	06/30/91	1.0247	0.9566
450457	06/01/90	05/31/91	1.5769	0.9998
450460	07/01/90	06/30/91	0.9740	0.9791
450467	07/01/90	06/30/91	1.0455	0.9670
450469	07/01/90	06/30/91	1.2631	0.9938
450473	06/01/90	05/31/91	1.0915	0.9826
450476	07/01/90	06/30/91	0.9312	0.9234
450486	07/01/90	06/30/91	0.9580	0.9418
450489	04/01/90	03/31/91	1.0207	0.9457
450497	07/01/90	06/30/91	1.1645	0.9709
450498	07/01/90	06/30/91	1.0732	0.9735
450508	07/01/90	06/30/91	1.3958	0.9951
450517	07/01/90	06/30/91	0.9424	0.9739
450537	06/01/90	05/31/91	1.3468	0.9916
450545	07/01/90	06/30/91	1.2543	0.9986
450546	06/01/90	05/31/91	1.3419	0.9859
450551	04/01/90	03/31/91	1.0685	0.9622
450563	07/01/90	06/30/91	1.2228	0.9858
450570	04/01/90	03/31/91	0.9889	0.9774
450573	07/01/90	06/30/91	1.0415	0.9580
450586	07/01/90	06/30/91	1.1139	0.9835
450603	04/01/90	03/31/91	0.9061	0.9474
450610	04/01/90	03/31/91	1.3818	0.9947
450620	07/01/90	06/30/91	1.0911	0.9374
450630	05/01/90	04/30/91	1.5898	0.9970
450638	06/01/90	05/31/91	1.4657	0.9970
450641	07/01/90	06/30/91	0.8780	0.9898
450643	07/01/90	06/30/91	1.1757	0.9914
450649	07/01/90	06/30/91	1.0414	0.9347
450651	04/01/90	03/31/91	1.7284	0.9985
450658	07/01/90	06/30/91	0.9943	0.9484
450660	03/01/90	02/28/91	1.6355	0.9975
450665	07/01/90	06/30/91	0.9835	0.9652
450668	06/01/90	05/31/91	1.4893	0.9969
450670	07/01/90	06/30/91	1.2219	0.9928
450675	04/01/90	03/31/91	1.3255	0.9909
450678	06/01/90	05/31/91	1.4577	0.9946
450681	07/01/90	06/30/91	1.5172	0.9998
450682	07/01/90	06/30/91	1.2568	0.9930
450684	07/01/90	06/30/91	1.3312	0.9887
450685	07/01/90	06/30/91	1.2529	0.9926
450688	06/01/90	05/31/91	1.2984	0.9855
450691	07/01/90	06/30/91	1.2668	0.9826
450694	07/01/90	06/30/91	1.1783	0.9775
450704	07/01/90	06/30/91	1.2890	0.9824
450709	07/01/90	06/30/91	1.2506	0.9990
450723	07/01/90	06/30/91	1.2264	0.9920
450730	06/01/90	05/31/91	1.3905	0.9815
450743	07/01/90	06/30/91	1.4399	0.9919
450749	07/01/90	06/30/91	1.0371	0.9832
450750	07/01/90	06/30/91	0.9907	0.9883
450755	06/01/90	05/31/91	0.9754	0.9754
450758	06/01/90	05/31/91	1.7706	0.9930
450768	01/18/90	01/31/91	1.1565	0.9608
460003	06/01/90	05/31/91	1.3985	0.9978
460005	06/01/90	05/31/91	1.2538	0.9880
460008	03/01/90	02/28/91	1.2910	0.9807
460009	07/01/90	06/30/91	1.7523	0.9998
460030	02/01/90	01/31/91	1.0594	0.9797
460032	07/01/90	06/30/91	0.9438	1.0000
460035	07/01/90	06/30/91	0.8822	0.9507
460037	07/01/90	06/30/91	0.9613	0.9642
490007	05/01/90	04/30/91	1.8798	0.9974
490009	07/01/90	06/30/91	1.6345	0.9961
490010	07/01/90	06/30/91	1.1715	0.9744
490022	07/01/90	06/30/91	1.2138	0.9851
490028	04/01/90	03/31/91	1.2815	0.9933
490032	07/01/90	06/30/91	1.6112	0.9973
490035	07/01/90	06/30/91	1.1647	0.9788
490043	07/01/90	06/30/91	1.1543	0.9879

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
490046	05/01/90	04/30/91	1.3366	0.9887
490053	07/01/90	06/30/91	1.2123	0.9756
490090	07/01/90	06/30/91	1.1490	0.9772
490093	05/01/90	04/30/91	1.2694	0.9971
490094	05/01/90	04/30/91	1.0960	0.9941
490098	07/01/90	06/30/91	1.2722	0.9903
490104	07/01/90	06/30/91	0.9212	0.9792
490105	07/01/90	06/30/91	0.6928	0.9789
490106	07/01/90	06/30/91	0.7939	0.9913
490108	07/01/90	06/30/91	0.8653	0.9756
490109	07/01/90	06/30/91	0.7984	0.9873
490111	07/01/90	06/30/91	1.1696	0.9756
490114	07/01/90	06/30/91	1.0166	0.9871
490118	04/01/90	03/31/91	1.6558	0.9986
490120	07/01/90	06/30/91	1.3022	0.9901
490123	04/01/90	03/31/91	1.0860	0.9726
490124	07/01/90	06/30/91	1.2596	0.9950
490127	07/01/90	06/30/91	1.0633	0.9824
490131	07/01/90	06/30/91	0.9289	0.9745
500008	07/01/90	06/30/91	1.9072	0.9979
500021	07/01/90	06/30/91	1.3337	0.9792
500023	07/01/90	06/30/91	1.1630	0.9741
500030	07/01/90	06/30/91	1.3389	0.9928
500039	05/01/90	04/30/91	1.2937	0.9937
500041	07/01/90	06/30/91	1.1912	0.9815
500064	07/01/90	06/30/91	1.5890	0.9886
500076	04/01/90	03/31/91	1.3026	0.9915
500086	07/01/90	06/30/91	1.3282	0.9768
500104	04/01/90	03/31/91	1.2826	0.9610
500108	07/01/90	06/30/91	1.6463	0.9984
500127	07/01/90	06/30/91	1.0645	0.9883
500135	07/01/90	06/30/91	1.0307	0.9830
500137	06/01/90	05/31/91	0.9085	1.0000
500138	07/01/90	06/30/91	4.8258	1.0000
500139	02/01/90	01/31/91	1.3184	0.9936
500141	07/01/90	06/30/91	1.2357	0.9769
510015	07/01/90	06/30/91	0.9353	0.9597
510020	07/01/90	06/30/91	1.1141	0.9791
510023	07/01/90	06/30/91	1.0212	0.9881
510024	07/01/90	06/30/91	1.3061	0.9995
510025	07/01/90	06/30/91	0.9291	0.9608
510026	07/01/90	06/30/91	0.9857	0.9729
510027	07/01/90	06/30/91	1.0185	0.9217
510035	07/01/90	06/30/91	1.0466	0.9639
510036	07/01/90	06/30/91	1.1452	0.9758
510043	07/01/90	06/30/91	0.9712	0.9573
510046	07/01/90	06/30/91	1.2645	0.9929
510058	07/01/90	06/30/91	1.1910	0.9949
510061	07/01/90	06/30/91	1.0755	0.9693
510062	07/01/90	06/30/91	1.1662	0.9935
510070	06/01/90	05/31/91	1.1767	0.9916
510071	07/01/90	06/30/91	1.2691	0.9881
510072	07/01/90	06/30/91	1.0167	0.9763
510080	07/01/90	06/30/91	0.9859	0.9584
510086	07/01/90	06/30/91	1.1067	0.9862
520004	07/01/90	06/30/91	1.2340	0.9936
520006	03/01/90	02/28/91	1.0387	0.9591
520007	07/01/90	06/30/91	1.0545	0.9723
520009	07/01/90	06/30/91	1.4490	0.9933
520011	04/01/90	03/31/91	1.0968	0.9818
520013	07/01/90	06/30/91	1.2851	0.9941
520015	07/01/90	06/30/91	1.1553	0.9600
520016	07/01/90	06/30/91	0.9986	0.9658
520017	07/01/90	06/30/91	1.1666	0.9832
520025	07/01/90	06/30/91	1.1097	0.9735
520027	07/01/90	06/30/91	1.1476	0.9804
520028	07/01/90	06/30/91	1.3402	0.9918
520030	07/01/90	06/30/91	1.5138	0.9962
520040	07/01/90	06/30/91	1.4294	0.9912
520041	07/01/90	06/30/91	1.1147	0.9678
520044	07/01/90	06/30/91	1.3316	0.9918
520047	04/01/90	03/31/91	0.9706	0.9512
520051	07/01/90	06/30/91	2.0142	0.9993
520063	07/01/90	06/30/91	1.1860	0.9785
520066	07/01/90	06/30/91	1.2377	0.9903
520068	07/01/90	06/30/91	1.0729	0.9730
520074	07/01/90	06/30/91	1.1601	0.9753
520075	07/01/90	06/30/91	1.3792	0.9962
520076	07/01/90	06/30/91	1.1635	0.9850
520087	04/16/90	04/14/91	1.5118	0.9983
520088	07/01/90	06/30/91	1.2200	0.9807
520091	04/01/90	03/31/91	1.2625	0.9846
520092	05/01/90	04/30/91	1.1784	0.9606
520096	07/01/90	06/30/91	1.4205	0.9969
520097	07/01/90	06/30/91	1.2820	0.9913
520098	07/01/90	06/30/91	1.6765	0.9951
520104	06/01/90	05/31/91	0.9966	0.9400
520111	07/01/90	06/30/91	1.1364	0.9737
520112	07/01/90	06/30/91	1.1154	0.9735
520114	07/01/90	06/30/91	1.0966	0.9791
520120	07/01/90	06/30/91	1.0999	0.9781
520121	07/01/90	06/30/91	0.9666	0.9653
520122	07/01/90	06/30/91	1.0134	0.9647
520124	04/01/90	03/31/91	1.1020	0.9744
520132	05/01/90	04/30/91	1.2279	0.9747
520134	07/01/90	06/30/91	1.1202	0.9821
520136	07/01/90	06/30/91	1.4663	0.9975
520141	07/01/90	06/30/91	1.1416	0.9549
520142	07/01/90	06/30/91	0.9788	0.9618
520151	03/01/90	02/28/91	1.0810	0.9600
520159	04/01/90	03/31/91	0.9121	0.9564
520161	04/01/90	03/31/91	1.1091	0.9579
520170	07/01/90	06/30/91	1.2614	0.9877
520176	07/01/90	06/30/91	0.8486	1.0000
520178	07/01/90	06/30/91	1.1520	0.9558
520180	07/01/90	06/30/91	0.7340	0.9907

Table 9 -- 1991 Transfer Adjusted Case Mix Index and Transfer Adjustment to Discharges for Capital Hospital-Specific Rate Redeterminations

PROVIDER NUMBER	COST REPORTING PERIOD BEGIN	-	END	TRANSFER ADJUSTED CASE MIX INDEX	TRANSFER ADJUSTMENT TO DISCHARGES
530001	06/01/90	-	05/31/91	1.2612	0.9975
530002	07/01/90	-	06/30/91	1.1473	0.9727
530003	07/01/90	-	06/30/91	0.9898	0.9248
530004	07/01/90	-	06/30/91	0.9709	0.9593
530005	07/01/90	-	06/30/91	1.0754	1.0000
530006	07/01/90	-	06/30/91	1.1214	0.9885
530007	07/01/90	-	06/30/91	1.0385	0.9438
530009	07/01/90	-	06/30/91	0.9655	0.9781
530011	07/01/90	-	06/30/91	1.1226	0.9782
530012	07/01/90	-	06/30/91	1.6146	0.9954
530014	07/01/90	-	06/30/91	1.1026	0.9953
530015	07/01/90	-	06/30/91	1.1318	0.9785
530016	07/01/90	-	06/30/91	1.1586	0.9954
530017	07/01/90	-	06/30/91	0.9973	0.9781
530018	07/01/90	-	06/30/91	1.0510	0.9667
530019	07/01/90	-	06/30/91	0.9685	0.9951
530022	07/01/90	-	06/30/91	1.1265	0.9460
530025	07/01/90	-	06/30/91	1.2447	0.9780
530026	07/01/90	-	06/30/91	1.0658	0.9790
530027	07/01/90	-	06/30/91	0.8558	0.9615
530029	07/01/90	-	06/30/91	0.9180	0.9431
530031	07/01/90	-	06/30/91	1.0417	0.9186

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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 proposed rule that meets one of the E.O. 12291 criteria for a "major rule;" that is, a rule that would 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 proposed rule would 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 proposed 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 and that is located outside of a Metropolitan Statistical Area or New England County Metropolitan Area.

Section 601(g) of th 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 would 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 proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in accordance with E.O. 12291 and the RFA.

II. Objectives

The prospective payment rates for both capital and operating costs create incentives similar to the incentives a hospital faces in pricing and marketing its services in a price competitive market. Under the prospective payment systems, similar hospitals are paid the same rate for similar services, and hospitals know in advance the amount they will be paid per discharge. Because hospitals receive this payment regardless of their specific cost experience, there are strong incentives to operate more efficiently and to minimize unnecessary costs. Our specific objectives include the following:

- Restructuring hospitals' economic incentives.
- Basing payment on a system that more accurately identifies the product being purchased than cost reimbursement.
- Reinforcing the role of the Federal government as a prudent buyer of services.
- Restraining the rate of hospital cost increases, thus moderating the outflow of expenditures from the Medicare trust fund while maintaining high quality care.

In addition, we share national goals of deficit reduction and restraints on government spending in general. We believe the proposed changes would further all of the above goals while maintaining the financial viability of the hospital industry and ensuring access to high quality care for beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are, in general, reasonable and equitable while avoiding or minimizing unintended adverse consequences. Thus, our overall intent is to refine further the prospective payment system without undercutting our objectives.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis is limited to presenting the projected effects of the proposed policy and rate changes on current and projected payment rates. In the analysis that follows, we examine the effects on hospital payments of changes required by statute and changes HCFA is proposing. We accomplish this by projecting estimated payments under each set of proposed policy changes onto current estimated payments and determining the difference between the two sets of payment amounts. That is, we project the effects of each policy change on payments while holding all other payment variables constant. Thus, we are not attempting to predict behavioral responses to our policy changes, and we are not generally accounting for changes in such exogenous variables as admissions, lengths of stay, or case mix. We believe that this approach to the specific impact discussions below is the most reasonable one given the difficulty we have in quantifying impacts and attributing causality. Wherever possible, we have included quantitative representations of the impact of changes being proposed in this document.

As we have done in previous impact analyses, we are soliciting comments and information about the anticipated effects of these changes on the prospective payment system.

IV. Hospitals Included in and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. Only 59 short-term, acute care hospitals remain excluded from the prospective payment systems under section 1814(b)(3) of the Act (in Maryland) or a demonstration project (in the Finger Lakes region of New York State). Thus, as of April 9, 1992, about 5,390 hospitals were receiving prospectively based payments for performing inpatient services. This represents about 83 percent of all Medicare-participating hospitals.

Among the 5,390 prospective payment hospitals, there are over 860 hospitals that are paid on special bases under the prospective payment system for operating costs, as required by statute, as sole community hospitals or rural referral centers. In addition, there are approximately 1,602 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 and 95 as sole community hospitals. About 1,207 hospitals are receiving additional payments for the indirect cost of medical education. There are about 605 hospitals that qualify for additional payments under both the indirect medical education and disproportionate share payment provisions under the prospective payment system for operating costs.

Section 1886(d)(5)(G)(i) of the Act directs the Secretary to pay Medicare-dependent, small rural hospitals on the

basis of the greater of a hospital-specific rate based on their FY 1982 or FY 1987 operating costs per discharge, whichever is higher, or the applicable standardized payment amount. This provision was effective with cost reporting periods beginning after April 1, 1990 and expires with cost reporting periods ending on or before March 31, 1993. Thus, with cost reporting periods beginning after April 1, 1992, over 500 hospitals that meet the criteria for being Medicare-dependent, small rural hospitals will begin receiving only the standardized amount payments.

Under the capital prospective payment system, there are special payment protections for sole community hospitals and for urban hospitals with more than 100 beds and a disproportionate share patient percentage of 20.2 percent or more or which derive at least 30 percent of their total inpatient revenues from State or local government sources for the care of indigent patients. Approximately 532 sole community hospitals and 761 urban hospitals qualify for this protection. An additional 1,486 urban hospitals with more than 100 beds receive additional payments for serving low income patients. (An additional payment is made to all urban hospitals with more than 100 beds that serve low income patients.) Additional payments are also made to 1,207 hospitals with graduate medical education teaching programs.

As of April 9, 1992, about 1,050 Medicare hospitals are excluded by statute from the prospective payment system and continue to be paid on the basis of their reasonable costs, subject to limits on the rate of increase in their costs. These hospitals include psychiatric, rehabilitation, long-term care, and children's hospitals. Another 1,893 psychiatric and rehabilitation units in hospitals subject to the prospective payment system are excluded from the prospective payment system as of the same date. These units, too, are paid on the basis of reasonable cost subject to limits on the rate of increase in their costs. In addition, there are nine hospitals extensively involved either in the treatment of cancer or cancer research that are excluded from the prospective payment system.

V. Impact on Excluded Hospitals and Units

As noted in the previous section of this impact analysis, approximately 1,050 excluded Medicare hospitals and 1,893 units in hospitals included in the prospective payments systems are paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of § 413.40. For hospital cost reporting periods beginning on or after October 1, 1992, excluded hospitals and units would be paid the full increase in their reasonable costs up to the percentage increase in the hospital market basket. We are projecting an increase in the excluded hospital market basket of 4.5 percent.

The impact on excluded hospitals and units of the proposed update in the rate-of-increase limit depends on the rate of cost increases experienced by each hospital and excluded unit since its base period. For excluded hospitals and units with per-case increases in inpatient operating costs below the cumulative update in their rate-of-increase limit, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limit, the major effect will be the amount of excess costs that the hospitals would have to absorb.

In this context, we note that for cost reporting periods beginning in FY 1992, § 413.40(d)(3)(iii) allows an excluded hospital or unit whose cost exceed the rate-of-increase limit to receive the lower of its target amount plus 50 percent of reasonable costs in excess of the target amount or 110 percent of the target amount. In addition, under the various provisions set forth in § 413.40, excluded hospitals and units can obtain substantial relief from the rate-of-increase limit for significant, yet justifiable, increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases to the growth rate in the hospital market basket, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating costs and for capital-related costs. We have prepared separate analyses of the proposed changes to each system.

The data used in developing the quantitative analyses of changes in operating payments that are presented below are taken from FY 1991 billing data and the most current hospital-specific data. For purposes of determining which method of payment to apply for sole community hospitals (the Federal payment rate or the applicable hospital-specific payment rate as prescribed by section 1886(d)(5)(D)(i) of the Act), we assume that all sole community hospitals have a cost reporting period that coincides with the Federal fiscal year.

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 proposed 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 actual payments for FY 1992 and the projected FY 1993 payments under the policies proposed that serve as the bases of our simulation.

To illustrate the effects of hospital geographic reclassifications for FY 1993, 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 FY 1993 geographic classification for purposes of the standardized amount under the prospective payment system after any reclassifications under sections 1886(d)(8) or (10) of the Act, rather than its actual geographic location. For example, our analysis in Table I of hospital operating payments based on actual geographic location shows that the number of hospitals in large urban, other urban, and rural areas is 1,467, 1,411, and 2,516, respectively. The analysis of hospitals that incorporates reclassifications shows the number of large urban, other urban, and rural hospitals to be 1,619, 1,480, and 2,295, respectively. The effects of geographic reclassification are evident from a comparison of the two analyses within Table I.

To simulate the impact of the expiration of section 1886(d)(5)(G) of the Act on payments to Medicare-dependent, small rural hospitals (MDHs), we computed hospital-specific payments from October 1, 1992 through the end of each hospital's cost reporting period that ends on or before March 31, 1993. That is, we simulated payments for this period based on the higher of the hospital-specific payment or the

proposed FY 1993 standardized amount payments for operating costs. We then computed payments for the remainder of the Federal fiscal year based on the proposed FY 1993 standardized amount payments for operating costs. For example, if the hospital's cost reporting period ends December 31 and the hospital-specific payments are higher than the proposed standardized amount payments, we computed hospital-specific payments for 3 months and prospective payments for 9 months. In the simulation, hospitals with cost reporting periods ending before September 30, were paid on the basis of the Federal payment rates for the entire period. Since some of those hospitals lose this special protection during FY 1992, a similar simulation was performed to reduce FY 1992 payments for comparison purposes. Below we present the annual effect of the expiration of the special provision on payments to Medicare-dependent, small rural hospitals. We simulated a full 12 months of payments under the special payment provision compared with 12 months of payment without benefit of the provision.

Average FY 1993 payment/case 12 months payment as an MDH	Average payment/case 12 months payment without the MDH payment protection	Percent change
$3,502	$3,138	−10.4

The analysis in Table I examines the following major changes set forth in this proposed rule—

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG weights required by section 1886(d)(4)(C) of the Act (column 1).
- The effects of hospital reclassifications by the MGCRB (column 2).
- The effect of the proposed outlier payment changes (using a marginal cost factor of .55 and the arithmetic mean to calculate day outlier payments) and increase in outlier payment levels (column 3).
- The combined effect of all changes being presented in this proposed rule (column 4).

In order to present the effects of the separate policy proposals displayed in columns 1, 2, and 3 of table I, we added incrementally the payment variables associated with the provision under examination, so that the percentages in the columns represent the difference in payments relative to the previous column. For example, column 2 (Geographic Reclassification) examines the impact of the standardized amount and wage index changes resulting from geographic reclassifications given the DRG reclassifications and recalibration results displayed in column 1 of Table I. The last column in Table I displays the combined effects of the previous columns as well as, corrections to the wage index values, the phase-out of the MDH Provision, and the update and budget neutrality factors. Thus, the last column is the only one that reflects the effects of all the quantifiable proposed policy changes on simulated FY 1992 payments.

TABLE I.—IMPACT ANALYSIS OF PROPOSED OPERATING COST PROSPECTIVE PAYMENT SYSTEM CHANGES FOR FY 1993

	Number of hospitals [1]	DRG reclassification and recalibration (1) [2]	Geographic reclassification (2) [3]	Outlier payment changes			All changes (4) [6]
				Payment level adjustment (3A) [4]	Proposed Policy (3B) [5]	Sum of (A) and (B) (3C)	
By Geographic Location							
All hospitals	5,394	0.0	0.0	1.6	0.0	1.6	4.3
Large urban areas (populations over 1 million)	1,467	.0	−.1	1.9	+.2	1.7	4.5
Other urban areas (populations of 1 million or fewer)	1,411	.0	.0	1.7	.1	1.8	4.6
Rural Areas	2,516	−.1	.1	.7	.0	.7	3.3
Urban Hospitals	2,878	.0	.0	1.8	.1	1.7	4.5
0–99 beds	670	−.1	−.1	1.1	.2	1.3	4.0
100–199 beds	859	.1	.0	1.4	.2	1.8	4.4
200–299 beds	614	.1	.0	1.7	.1	1.8	4.6
300–499 beds	536	.0	.2	1.9	.1	1.8	4.5
500 or more beds	199	.0	.0	2.2	.4	1.8	4.6
Rural Hospitals	2,516	.1	.1	.7	.0	.7	3.3
0–49 beds	1,239	.2	.3	.2	.0	.2	2.0
50–99 beds	767	.1	.3	.4	.0	.4	2.8
100–149 beds	264	.0	.1	.7	.1	.8	3.5
150–199 beds	128	.0	.2	.8	.0	.8	4.2
200 or more beds	116	.0	.4	1.2	.0	1.2	3.8
Urban by Region:							
New England	172	.2	.2	1.8	−.3	1.5	4.3
Middle Atlantic	460	.3	−.1	2.6	−1.3	1.3	4.2
South Atlantic	418	−.1	.0	1.9	.3	2.2	4.9
East North Central	475	.0	−.2	1.4	.3	1.7	4.3
East South Central	168	.1	−.1	1.8	.4	2.2	5.0
West North Central	183	.0	−.3	1.4	.4	1.8	4.3
West South Central	352	.1	.4	1.7	.6	2.3	5.6
Mountain	110	−.1	−.3	1.6	.6	2.2	4.6
Pacific	492	−.2	.0	1.4	.4	1.8	4.4
Puerto Rico	48	.2	−.2	.9	.1	1.0	3.7
Rural by region:							
New England	57	−.1	−.1	.9	.0	.9	4.3
Middle Atlantic	93	.0	−.4	1.3	−.7	.6	2.0
South Atlantic	343	.0	−.7	1.1	−.1	1.0	3.4
East North Central	346	.0	.6	.4	.1	.5	3.2
East South Central	298	.0	.0	.6	.1	.7	3.6
West North Central	564	−.1	.5	.3	.1	.4	2.5
West South Central	401	−.1	.7	.5	.2	.7	3.5
Mountain	241	−.1	.2	.3	.1	.4	4.1

TABLE I.—IMPACT ANALYSIS OF PROPOSED OPERATING COST PROSPECTIVE PAYMENT SYSTEM CHANGES FOR FY 1993—Continued

	Number of hospitals[1]	DRG reclassification and recalibration (1)[2]	Geographic reclassification (2)[3]	Outlier payment changes			All changes (4)[6]
				Payment level adjustment (3A)[4]	Proposed Policy (3B)[5]	Sum of (A) and (B) (3C)	
Pacific	166	.0	.5	.5	.2	.7	4.2
Puerto Rico	7	.0	−.4	.3	.0	.3	3.7
By Payment Classification							
All hospitals	5,394	.0	.0	1.6	0.0	1.6	4.3
Large Urban areas (populations over 1 million)	1,619	.0	.0	1.9	−0.1	1.8	4.5
Other urban areas (populations of 1 million or fewer)	1,480	.0	.0	1.6	.1	1.7	4.5
Rural areas	2,295	−.1	−.1	.6	.0	.6	3.1
Teaching status:							
Non-teaching	4,186	.0	.0	1.3	.2	1.5	4.2
Resident/bed ratio less than 0.25	968	.0	−.1	1.7	−.1	1.6	4.4
Resident/bed ratio 0.25 or greater	239	.0	.0	2.3	−.6	1.7	4.5
Disproportionate share hospitals (DSH):							
Non-DSH	3,792	.0	.0	1.5	.1	1.6	4.3
Urban DSH:							
100 Beds or more	1,133	.1	.0	1.9	−.3	1.6	4.5
Fewer than 100 beds	95	−.1	.1	.8	.3	1.1	3.9
Rural DSH:							
Sole Community (SCH)	95	−.1	−.4	0.2	.0	.2	3.4
Referral centers (RRC)	44	.0	.0	1.1	−.2	.9	3.7
Other rural DSH hospitals:							
100 beds or more	62	.0	−2.8	1.0	−.2	.8	1.6
Fewer than 100 beds	173	.2	.0	.3	.0	.3	3.0
Urban teaching and DSH							
Both teaching and DSH	605	.1	.0	2.1	−.4	1.7	4.5
Teaching and no DSH	516	−.1	−.1	1.8	.1	1.9	4.5
No Teaching and DSH	623	.1	.1	1.5	.1	1.6	4.5
No Teaching and no DSH	1,355	.0	.0	1.6	.3	1.9	4.7
Rural hospital types:							
Non special status hospitals	1,010	−.1	−.8	.6	.0	.6	3.5
RRC	179	.0	.4	1.0	.1	1.1	4.3
SCH	532	−.1	.0	.1	.0	.1	4.1
Medicare-Dependent hospitals (MDH)	515	−.2	.3	.2	.0	.2	−4.3
SCH and RRC	45	.1	.3	.6	−.2	.4	4.3
SCH and MDH	1,092	−.1	.2	.3	−.1	.2	1.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board							
Reclassification status during FY 92 and FY 93:							
Reclassified during both FY 92 and FY 93	847	.0	−.7	1.2	.0	1.2	3.4
Reclassified during FY 93 only	349	.1	4.1	1.7	−.3	1.4	8.3
Reclassified during FY 92 only	82	.0	−3.6	1.1	.1	1.2	0.5
FY 93 reclassifications:							
All reclassified hospitals	1,196	.0	.9	1.3	−.1	1.2	5.0
All nonreclassified	4,148	.0	−.3	1.7	.0	1.7	4.2
All urban reclassified hospitals	376	.1	1.2	1.7	−.2	1.5	5.7
Urban nonreclassified hospitals	2,502	.0	−.3	1.8	.0	1.8	4.3
All reclassified rural hospitals	820	.0	.4	.8	.0	.8	4.0
Rural nonreclassified hospitals	1,646	−.1	−.3	.4	.0	.4	2.2
Other reclassified hospitals (section 1886(D)(8)(B))	50	.0	.1	1.1	.1	1.2	4.1
Type of ownership:							
Voluntary	3,188	.0	−.1	1.7	−.1	1.6	4.3
Proprietary	749	.0	.0	1.7	.4	2.1	4.9
Government	1,457	.0	.2	1.3	.0	1.3	4.1
Medicare utilization as a percent of inpatient days:							
0–25	277	.1	.2	1.6	−.1	1.5	4.6
25–50	1,934	.0	.0	1.7	.0	1.7	4.5
50–65	2,213	.0	.0	1.5	.0	1.5	4.3
Over 65	727	.0	−.2	1.2	.0	1.2	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 discharges data are from FY 1991, and hospital cost report data are from reporting periods beginning in FY 1990.

[2] Recalibration of the DRG weights and classification changes are based on FY 1991 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. This column reflects the impact of changes in reclassifications between FY 1992 and FY 1993.

[4] This column displays the effects of increasing outlier payments between FY 1992 and FY 1993. The thresholds implemented for FY 1992 were intended to result in 5.1 percent of payments for outlier cases. FY 1992 outlier payments now are estimated to equal 3.6 percent of total prospective payments. FY 1993 outlier payments are estimated at 5.1 percent.

[5] This column displays the impact of the proposed change for computing day outlier cases: using the arithmetic mean length of stay in place of the geometric mean length of stay for computing the per diem payment amount, and using a marginal cost factor of .55 instead of .60.

[6] This column shows the combined effects of all the previous columns as well as the effects of updating the FY 1992 standardized payment amounts by the rates of increase as mandated by section 1886(b)(3)(B)(i)(VII) of the Act. It also reflects the phase-out of the Medicare dependent, small rural hospital provision. In addition, this column captures interactive effects that we are not able to quantify.

B. The Impact of the Proposed Changes to the DRG Weights (Column 1)

In column 1 of Table I, we present the combined effects of the revised DRG classificaton system, 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 make appropriate classification changes and recalibrate 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 impact of reclassification and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral.

The redistributional impact of the proposed classification and recalibration changes across hospital groupings is small. At most, the impact is either a reduction or an increase of 0.3 percent for a few hospital groupings while most hospitals appear to experience no effect. The reductions are concentrated among small urban and rural hospitals. Rural hospitals with fewer than 50 beds are projected to lose an average of 0.2 percent in payments per case, and rural hospitals with between 50 and 99 beds are projected to lose 0.1 percent of their payments. Also, urban hospitals with fewer than 100 beds can expect an average 0.1 percent reduction in payments per case. However, urban hospitals with between 100 and 299 beds can expect an average increase in payments of 0.1 percent.

C. The Impact of MGCRB Reclassification on Hospitals (Column 2)

1. Impact of Current Policies

Section 1886(d)(10) of the Act provides for the establishment of the Medicare Geographic Classficiation Review Board (MGCRB). The MGCRB considers applications by hospitals for geographic reclassification for purposes of receiving a different wage index value, standardized amount, or both under the prospective payment system. By March 30 of each year, the MGCRB makes reclassificaton determinations that will be efffective for the next fiscal year beginning on October 1. The first hospital reclassifications based on decisions of the MGCRB for FY 1992 were effective October 1, 1991. The MGCRB may reclassify a hospital to an adjacent urban area or to another rural 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.)

The proposed FY 1993 standardized payment amounts and wage index values incorporate all the MGCRB's reclassification decisions that will be effective for FY 1993. The MGCRB approved 1,249 hospital reclassifications for FY 1993. This number includes 50 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.

The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of March 30, 1991. Additional changes that result from the Administrator's review of MGCRB decisions will be incorporated into the wage index values and standardized payment amounts to be published in the final rule implementing changes to the prospective payment system for FY 1993.

The later Administrator decisions may affect the wage index value for specific geographic areas. These decisions may also determine whether a redesignated hospital receives the wage index of the area to which it is redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals.

Over 68 percent of all hospitals reclassified for FY 1993 are located in rural areas (820 hospitals). This represents almost 33 percent of all rural hospitals in our data base. Of the total number of rural hospitals that were reclassified, 79 percent (647 hospitals) were reclassified for purposes of their wage index. Ten percent of rural reclassified hospitals were reclassified for purposes of their standardized amounts and about 11 percent were granted reclassification for purposes of both their wage index and their standardized payment amount.

Among the 245 hospitals located in other urban areas that were reclassified for FY 1993, almost 57 percent (140 hospitals) were reclassified for purposes of increasing their wage index value. Another 36 percent (89 hospitals) were reclassified for purposes of both their wage index value and standardized amount. The following table shows the number (and percentage) of reclassified hospitals by their actual geographic location.

DISTRIBUTION OF RECLASSIFIED HOSPITALS

Georgraphic location	Total No. of hospitals reclassified	Reclassified for both wage index vale and standardized amount		Reclassified for standardized amount		Reclassified for wage index	
		Number	Percent	Number	Percent	Number	Percent
Large Urban	131	6	5	0	0	125	95
Other Urban	245	89	36	16	7	140	56
Rural	820	93	11	80	10	647	79
Total	1196	188	16	96	8	912	76

Overall, 76 percent of the reclassified hospitals (912 hospitals) were reclassified for purposes of their wage index value, 8 percent (96 hospitals) were reclassified for purposes of their standardized amounts, and 16 percent (188 hospitals) were reclassified for purposes of both their wage index value and standardized payment amount.

We conducted an analysis that shows the effects of reclassification on payments to reclassified and non-reclassified hospitals in FY 1993. This analysis is presented in Table II, below. This anlysis compares reclassified hospital payments for FY 1993 with payment levels that assume reclassified hospitals are paid on the basis of their geographic location rather than reclassified location. In this respect, the analysis in Table II is comparable to the analysis we presented in the August 30, 1991 final rule (56 FR 43350).

Table II shows the changes in payments per case for all FY 1993 reclassified and nonreclassified hospitals in urban and rural locations

for each of the three reclassification categories.

As evidenced by the increase in payment for reclassified hospitals and the decrease in payments for non-reclassified hospitals, the effects of the MGCRB reclassification decisions are significant. The overall impact on reclassfied hospitals would be to increase their payments per case by an average of 4.4 percent for FY 1993. Hospitals located in rural areas that were reclassified for purposes of both their wage index value and their standardized amount would receive the largest percentage increase in payments per case. They could expect an average increase of nearly 15.1 percent above what they would receive without reclassification. The 16 hospitals located in urban areas that were reclassified for purposes of their standardized amounts would receive an average decrease in payments per case of 0.5 percent compared to what they would receive if there were no reclassifications. This outcome reflects the effects of the budget neutrality adjustment for urban hospitals and 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, on average the decrease in the wage index value for the area would be greater than the increase in their standardized amount after reclassification to a large urban area.

The reclassification of hospitals primarily affects payment to nonreclassifed hospitals through changes in the wage index and through the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that were not reclassifed, the overall impact of hospital reclassifications would be an average decrease in payments per case of about 1.2 percent. Non-reclassified urban hospitals (comprising about 61 percent of non-reclassified hospitals) would experience a 1.3 percent decrease in payments per case compared to what they would receive if there were no reclassifications. The 0.2 percent increase for nonreclassified rural hospitals is largely atttributable to a redistribution of outlier payments between nonreclassified rural hospitals and hospitals that are reclassified for wage index purposes only. In the aggregate, payments to hospitals that are receiving the rural standardized payment amounts are budget neutral (except with respect to wage index only reclassifications, which are accounted for in the budget neutrality adjustment to the urban standardized amount).

TABLE II.—Effects on Payments Per Case of Geographic Reclassification of Hospitals Under Current Reclassification Policies

	Number of hospitals	(a) Payment per case without reclassification [1]	(b) Payment per case after reclassification	(c) Percent change in payment per case due to reclassification only [2]
FY 93 reclassifications:				
All reclassified hospitals	1,196	5,009	5,231	4.4
Standardized amount only	96	4,879	5,003	2.6
Wage index only	912	5,017	5,219	4.0
Both	188	5,009	5,323	6.3
All urban reclassified hospitals	376	5,981	6,128	2.5
Standardized amount only	16	6,826	6,791	−0.5
Wage index only	265	6,163	6,297	2.2
Both	95	5,427	5,628	3.7
All reclassified rural hospitals	820	4,004	4,302	7.4
Standardized amount only	80	3,683	3,906	6.1
Wage index only	647	4,031	4,293	6.5
Both	93	3,959	4,555	15.1
All nonreclassified hospitals	4,148	6,003	5,932	−1.2
Urban non-reclassified hospitals	2,502	6,361	6,279	−1.3
Rural non-reclassified hospitals	1,646	3,544	3,549	0.2

[1] This column shows payments without regard to any previous MGCRB reclassification decision. This column reflects the fact that reclassifications are in effect for only 1 fiscal year.

[2] This column only shows the percentage change in payments resulting from decisions of the MGCRB for FY 1993. It does not reflect other changes such as outliers, DRG recalibration & reclassification or the update.

Table I shows the impact of changes in reclassification status between FY 1992 and FY 1993. The percentage change shown in Column 2 compares current payments (that include payments to currently reclassified hospitals) with payments based on the FY 1993 MGCRB decisions. For example, for hospitals that were reclassified in FY 1992, only the difference between their FY 1992 and FY 1993 payments that is attributable to FY 1993 MGCRB decisions is shown. For hospitals that were reclassified in both FY 1992 and FY 1993, the effect of the increased number of MGCRB reclassifications would be to reduce their payments by 0.7 percent. Hospitals that were reclassified in FY 1993 only would experience a 4.1 percent increase in payments, while those hospitals that were reclassified in FY 1992 but not in FY 1993 would experience a 3.6 percent reduction in payment as a result of no longer being reclassified. Overall payments to rural hospitals are expected to increase by an average of 0.1 percent. However, payments to rural hospitals with fewer than 100 beds are projected to increase by 0.3 percent, while payments to rural hospitals with 200 or more beds are expected to decrease by 0.4 percent. Among urban hospitals, we expect hospitals with between 300 and 499 beds to receive an average decrease of 0.2 percent in payments compared with FY 1992 payments.

Among the hospitals receiving special payments, rural referral centers are expected to benefit the most, receiving an average increase of 0.4 percent in their payments. However, rural disproportionate share hospitals with 100 or more beds may expect an average decrease in payments of 2.8 percent compared with current levels. This reduction is attributable primarily to a few hospitals in this category that were reclassified to an urban area in FY 1992 and received disproportionate share payments at the urban rate. Since these hospitals were not reclassified to urban areas for FY 1993, their payments fall dramatically.

The geographic analysis by census division shows that generally hospitals in urban areas are more likely than rural hospitals to receive a decrease in payments and hospitals located in rural areas are, on average, expected to receive an increase. However, there are notable exceptions in both groups. While urban hospitals in the West North Central and Mountain census divisions are projected to receive decreased payments of 0.3 percent, hospitals in the West South Central census division are expected to receive an average increase of 0.4 percent. Also, rural hospitals in the West South Central census division can expect an increase of 0.7 percent, which is the largest increase for the census divisions. However, our analysis shows that rural hospitals in the South Atlantic census division can expect average payment reductions of 0.7 percent, the largest decrease of any census division.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by March 30 of this year. As previously noted, there will be changes to some MGCRB decisions through the appeals and review process. The outcome of these cases may affect the final results of our analysis, which we will present in the final rule.

2. Impact of Proposed Guideline Changes

Section 412.230(e) specifies the criteria a hospital must meet in order to be reclassified from one labor market to an adjacent one for purposes of the wage index. These criteria are based on average hourly wage differences between the two areas. As discussed in section IV of the preamble to this proposed rule, we are proposing an additional criterion that would require a hospital to demonstrate that its average hourly wage was at least 108 percent of the average hourly wage for hospitals in its current labor market area. The proposed guideline would be effective for applications filed by October 1, 1992 that are reviewed by the MGCRB in FY 1993. They would not affect payment until FY 1994.

Based on the FY 1993 reclassifications, we estimate that under the proposed change in the wage guideline, 75 percent of the hospitals that qualified for reclassification based on their wage index values would no longer qualify. This includes 79 percent of the urban hospitals and 62 percent of the rural hospitals that qualified in FY 1993. The following table shows the effect of the proposed change on the number of hospitals that would qualify for reclassification under the three reclassification categories and by urban and rural geographic location.

DISTRIBUTION OF HOSPITALS BY RECLASSIFICATION STATUS

Reclassification status	Actual FY 1993 reclassification	Proposed change
All Hospitals	5394	5394
All Reclassified Hospitals	1196	526
Standardized Amount Only	96	247
Wage Index Only	912	242
Both	188	37
All Nonreclassified Hospitals	4148	4818
Hospitals Affected by Revised Guideline		759
Changed from Wage Index Only to No Reclassification		608
Changed from Both to Standardized Amount Only		151
All Reclassified Urban Hospitals	376	143
Standardized Amount Only	16	105
Wage Index Only	265	32
Both	95	6
All Nonreclassified Urban Hospitals	2502	2735
Urban Hospitals Affected by Revised Guideline		322
Changed from Wage Index Only to No Reclassification		233
Changed from Both to Standardized Amount Only		89
All Reclassified Rural Hospitals	820	383
Standardized Amount Only	80	142
Wage Index Only	647	210
Both	93	31
All Nonreclassified Rural Hospitals	1646	2083
Rural Hospitals Affected by Revised Guideline		437
Changed from Wage Index Only to No Reclassification		375
Changed from Both to Standardized Amount Only		62

For several reasons, it is difficult to estimate the impact the proposed changes would have on FY 1994 reclassifications (the year in which reclassifications based on the revised guidelines would take effect). Our estimates are based on the best data available. However, there are several policy changes that we anticipate will occur that will affect our estimates, but whose outcome cannot be predicted at this point. The following is a partial list of expected changes:

- The revised MSA definitions based on the 1990 Census that are expected to be effective for FY 1994 are likely to have a significant impact on hospital classifications. Until the new MSA definitions are released and hospitals are regrouped based on these definitions, the impact on hospital reclassifications cannot be determined.
- As indicated in section IV.C of the preamble to this proposed rule, we are in the process of evaluating alternative methods for defining labor market areas and refinements could be implemented as early as FY 1994, the year in which reclassifications based on the revised guidelines would take effect. Any refinements to the labor market area definitions could significantly affect the impact of geographic reclassifications.
- Beginning in FY 1994, the wage data used to develop the wage index will be updated annually. This change, together with revised labor market areas, will affect the impact of FY 1994 wage index reclassifications and the number of hospitals that will qualify for reclassification beginning in FY 1995.
- Wage index reclassifications granted by the MGCRB also affect the geographic adjustment factor (GAF) applied to the capital prospective payment system rates. In addition, the level of the capital prospective payment rate is adjusted to account for any additional payments resulting from geographic reclassification. Therefore, a reduction in the number of reclassifications granted by the MGCRB as a result of changes in the guidelines would result in a corresponding increase in the capital prospective payment rate.
- Finally, beginning in FY 1995, the rural standardized payment amount will be eliminated. As a result, payments to rural hospitals will also be affected by the geographic reclassifications through the budget neutrality adjustment. That is, the standardized payment amount applicable to both urban and rural hospitals will be adjusted in order to finance the additional payments to hospitals that are reclassified by the MGCRB.

D. Effect of Changes in Outlier Payments (Columns 3A, B, and C)

1. Proposed Outlier Policy Changes

For computational reasons, we present in Table I, column 3A, the impact of increased FY 1993 outlier payments compared with estimated FY 1992 outlier payments before the impact of the proposed outlier policy changes, which are shown in column 3B. However, because of its significance, we discuss first the impact of the proposed outlier policy changes and then the impact of revisions to the outlier payment level.

Under current regulations at § 412.82(c), we compute the per diem DRG payment amount for day outlier

cases by dividing the adjusted DRG payment amount by the geometric mean length of stay for the DRG. We then multiply the per diem amount by a marginal cost factor of 60 percent times the number of days beyond the outlier threshold the patient remains in the hospital. As explained in section V.A.1. of the preamble to this proposed rule, the analysis conducted by the RAND Corporation shows that using the arithmetic mean length of stay in place of the geometric mean length of stay and a marginal cost factor of 55 percent instead of 60 percent results in more appropriate payments for day outlier cases and produces both a more equitable distribution of payments across outlier cases and payments that better protect hospitals from losses resulting from those cases.

Since we have made the aggregate effect of the change in outlier policy budget neutral, there is no overall effect on payments under the prospective payment system. Similarly, because there are separate outlier offsets to the urban and rural standardized amounts, there is no payment redistribution between urban and rural hospitals. Our analysis indicates that large hospitals (over 500 beds) located in urban areas would lose about 0.4 percent in payments per case. Also, hospitals located in large urban areas would be expected to receive a decrease in payments of 0.2 percent. On the other hand, urban hospitals with fewer than 100 beds would gain about 0.2 percent.

Among hospitals receiving special payments, hospitals with large teaching programs show a loss of 0.6 percent in payments per case. Also, hospitals that qualify as both sole community and rural referral centers are projected to lose about 0.2 percent in their payments per case. Payments to disproportionate share hospitals would be reduced by 0.3 percent.

When examined by census division, the effects are quite pronounced. Except for hospitals in the New England and Middle Atlantic divisions, we project increases in payments to urban hospitals of between 0.3 and 0.6 percent. Urban hospitals in the Middle Atlantic and New England census divisions would experience decreases in their payments of 1.3 and 0.3 percent, respectively. For rural hospitals, we find a similar though less dramatic pattern of redistributive effects. With the exception of the Middle Atlantic and South Atlantic divisions, the analysis shows increased payments ranging from 0 percent to 0.2 percent. The Middle Atlantic and South Atlantic census divisions are projected to receive decreases in payments amounting to 0.7 and 0.1 percent, respectively.

In conclusion, the principal impact of the proposed changes in computing day outlier payments appears to be one of redistributing payments from hospitals in two of the census divisions to hospitals in the other census divisions, especially among hospitals located in urban areas.

2. FY 1992 Outlier Payments

Section 1886(d)(5)(A)(iv) of the Act requires that the total amount of additional payments made for outlier cases in a fiscal year may not be less than 5 percent nor more than 6 percent of the total prospective payments estimated to be made for discharges in that fiscal year. As described in the August 30, 1991 final rule (56 FR 43246), we established the thresholds for day and high cost outliers based on an estimate that outlier payments would equal 5.1 percent of total prospective payments. In addition, we reduced the standardized amounts by 5.1 percent for the estimated outliers payments. As the analysis in section V.A.4 of the preamble to this proposed rule describes, we now estimate that FY 1992 outlier payments will equal 3.6 percent of total DRG payments (exclusive of indirect teaching and disproportionate share payments) and 3.7 percent of total payments under the prospective payment system for operating costs. The average FY 1992 payment that we use in analyzing the impact of the proposed FY 1993 changes reflects the 3.6 percent outlier payment level. The outlier payment percentage in FY 1993 is estimated to be 5.1 percent. Ordinarily, we account for the difference between the estimated outlier payment percentage in the current year and the outlier payment percentage for the subsequent year in the All Changes column of Table I and indicate that we have done so in a footnote and a brief discussion in the text. However, given the magnitude of the difference between the estimated FY 1992 outlier payments and the 5.1 percent estimated for FY 1993, we are explicitly displaying the increase that will occur in total outlier payments in column 3A. This column reflects the additional outlier payments that we estimate will be made under current outlier policy compared to our estimate of FY 1992 outlier payments.

The effect of the difference between FY 1992 and FY 1993 estimated outlier payments would be to increase average payments per case, overall, by 1.6 percent. Among the hospital groupings, the effect is the greatest for those hospitals that receive a relatively high percentage of outlier payments. In terms of geographic location, the effect would be larger for hospitals located in large urban areas—raising payments an average of 1.9 percent. The effect is smallest for rural hospitals—raising their payments by 0.7 percent. Among hospitals that receive additional payments or are grouped according to certain characteristics, hospitals with large teaching programs would receive the largest payment increases. The increase averages about 2.3 percent.

The analysis by census division shows urban hospitals in the Middle Atlantic census division receiving the greatest increase in payments. Urban hospitals would receive an average increase of 2.6 percent and rural hospitals would receive an average increase of 1.3 percent. Thus, in column 3C, we see that the net effect of the difference between FY 1992 and FY 1993 estimated payments and the proposed outlier policy changes is an increase in payments to hospitals in the Middle Atlantic census division of 1.3 percent for urban hospitals and 0.6 percent for rural hospitals, compared to FY 1992 payments.

E. Combined Effects of All Changes (Column 4)

In column 4 of Table I, we present the expected effects of all proposed changes for FY 1993 compared to expected payments under policies in effect for FY 1992. In addition to the changes being proposed for DRG weights (presented in column 1), the effects of FY 1993 geographic reclassification decisions (presented in column 2), and the changes to outlier payments (presented in columns 3A, B, and C), we incorporate the update factors being proposed for hospitals located in urban and rural areas (2.75 percent for urban hospitals and 3.75 percent for rural hospitals), the phase-out of the Medicare-dependent, small rural hospital provision, and revisions to the wage index and cost of living adjustments. Although we have not explicitly analyzed these changes in this impact analysis, they are discussed in the addendum to the proposed rule and in the preamble. As explained in our introductory remarks to the quantitative analysis section, some changes cannot be captured because we lack either current or complete data. There may also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 4 may not equal the sum of the previous columns plus the other variables we are able to identify.

At the national level, our simulation of the proposed FY 1993 prospective

payment rates shows that the average payment to hospitals would increase 4.3 percent. Urban hospitals can expect an increase of 4.5 percent, with hospitals in the large urban areas receiving an increase of 4.5 percent and hospitals in the other urban areas receiving an increase of 4.6 percent. Hospitals in rural areas can expect an average increase in payments of 3.3 percent. The lower increase in rural hospital payments is attributable to the phase-out of the Medicare-dependent, small rural hospital provision and a smaller adjustment for FY 1992 outlier payment levels.

The analysis by census division shows that among urban hospitals, those in the West South Central census division are projected to receive an increase in payments per case of 5.6 percent, the largest increase of any census division. With the exceptions of hospitals in Puerto Rico, other projected increases range from 4.2 percent for hospitals in the Middle Atlantic division to 5.0 for the East South Central census division. Hospitals in Puerto Rico are projected to receive average increases of 3.7 percent.

Among the rural areas, the New England census division would receive the largest increase in payments per case of 4.3 percent. The smallest increase is projected for the Middle Atlantic census division. Rural hospitals in that census division are projected to increase 2.0 percent.

Consistent with our expectations, reclassified hospitals would gain the most under the policies being proposed in this document. Hospitals that are being reclassified for the first time in FY 1993 would receive the largest payment gains of 8.3 percent, largely as a result of an increase of 4.1 percent directly attributable to their reclassification. In contrast, hospitals that were reclassified in FY 1992 and will be reclassified again in FY 1993 are projected to receive average payment increases of 3.4 percent, which is below the national average increase. Hospitals that were reclassified in FY 1992 but will not be reclassified in FY 1993 can expect average increases amounting to only 0.5 percent. Again, the small increase is due largely to the drop in payments of 3.6 percent as a result of these hospitals not being reclassified in FY 1993. Nonreclassified hospitals may expect increased payments amounting to about 4.2 percent.

Rural hospitals with fewer than 50 beds are projected to receive a payment increase of averaging 2.0 percent, and hospitals with from 50 to 99 beds are projected to receive average increases of 2.8 percent. Both of these hospital groups are impacted adversely by the phase-out of the Medicare-dependent, small rural hospital provision. Overall, these two groups are estimated to experience payment reductions of 4.3 percent.

Rural, disproportionate share hospitals with 100 or more beds would receive an average increase of only 1.6 percent. As a group, proprietary hospitals are expected to receive a 4.9 percent increase. This represents the largest gain of any other group.

Table III presents the projected average payments per case under the changes proposed for FY 1993 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments with the average estimated per case payments that were effective October 1, 1991. Thus, 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 changes shown in the last column of Table I equal the percentage change in average payments from October 1, 1991 to October 1, 1992.

TABLE III—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE (FY 1992 PAYMENTS COMPARED TO PROPOSED FY 1993 PAYMENTS)

	Number of hospitals	Average FY 1992 payments/ case	Average FY 1993 payments/ case	All changes[1]
By Geographic Location				
All Hospitals	5,394	5,525	5,765	4.3
Large Urban Areas (populations over 1 million)	1,467	6,498	6,787	4.5
Other Urban Areas (populations of 1 million or fewer)	1,411	5,436	5,688	4.6
Rural Areas	2,516	3,839	3,965	3.3
Urban Hospitals	2,878	5,986	6,257	4.5
0–99 beds	670	4,245	4,415	4.0
100–199 beds	859	5,104	5,331	4.4
200–299 beds	614	5,544	5,801	4.6
300–499 beds	536	6,222	6,501	4.5
500 or more beds	199	7,692	8,049	4.6
Rural Hospitals	2,516	3,839	3,965	3.3
0–49 beds	1,239	3,197	3,262	2.0
50–99 beds	767	3,530	3,629	2.8
100–149 beds	264	3,970	4,110	3.5
150–199 beds	128	4,038	4,209	4.2
200 or more beds	116	4,633	4,811	3.8
Urban by Region				
New England	172	6,327	6,598	4.3
Middle Atlantic	460	6,557	6,833	4.2
South Atlantic	418	5,687	5,964	4.9
East North Central	475	5,840	6,089	4.3
East South Central	168	5,187	5,444	5.0
West North Central	183	5,825	6,073	4.3
West South Central	352	5,433	5,738	5.6
Mountain	110	5,892	6,165	4.6
Pacific	492	6,781	7,076	4.4
Puerto Rico	48	2,286	2,371	3.7
Rural by Region				
New England	57	4,550	4,745	4.3
Middle Atlantic	93	4,224	4,368	2.0
South Atlantic	343	4,026	4,161	3.4
East North Central	346	3,859	3,981	3.2

TABLE III—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE (FY 1992 PAYMENTS COMPARED TO PROPOSED FY 1993 PAYMENTS)—Continued

	Number of hospitals	Average FY 1992 payments/ case	Average FY 1993 payments/ case	All changes[1]
East South Central	298	3,443	3,568	3.6
West North Central	564	3,557	3,647	2.5
West South Central	401	3,498	3,619	3.5
Mountain	241	4,093	4,259	4.1
Pacific	166	4,608	4,799	4.2
Puerto Rico	7	1,559	1,615	3.7
All Hospital	5,394	5,525	5,765	4.3
Large Urban Areas (populations over 1 million)	1,619	6,382	6,672	4.5
Other Urban Areas (populations of 1 million or fewer)	1,480	5,374	5,617	4.6
Rural Areas	2,295	3,793	3,909	3.1
Teaching Status				
Non-teaching	4,186	4,599	4,794	4.2
Resident/bed ratio				
Less than 0.25	968	5,949	6,212	4.4
Resident/bed ratio 0.25 or greater	239	9,297	9,717	4.5
Disproportionate Share Hospitals (DSH)				
Non-DSH	3,792	5,006	5,222	4.3
Urban DSH				
100 beds or more	1,133	6,650	6,947	4.5
Fewer than 100 beds	95	4,073	4,230	3.9
Rural DSH				
Sole community (SCH)	95	3,688	3,814	3.4
Referral centers (RRC)	44	4,489	4,657	3.7
Other rural DSH hospitals				
100 Beds or More	62	3,505	3,562	1.6
Fewer Than 100 beds	173	3,020	3,112	3.0
Urban Teaching and DSH				
Both Teaching and DSH	605	7,427	7,758	4.5
Teaching and No DSH	516	6,049	6,320	4.5
No Teaching and DSH	623	5,263	5,501	4.5
No Teaching and No DSH	1,355	4,879	5,110	4.7
Rural hospital Types				
Non Special Status Hospitals	1,010	3,366	3,482	3.5
RRC	179	4,401	4,591	4.3
SCH	532	3,849	4,006	4.1
Medicare-Dependent Hospitals (MDH)	515	3,323	3,182	−4.3
SCH and RRC	45	4,674	4,874	4.3
SCH or MDH	1,092	3,819	3,880	1.6
Hospitals Reclassified by the Medicare Geographic Classification Review Board				
Reclassification Status During FY 92 and FY 93				
Reclassified during both FY 92 and FY 93	847	4,868	5,032	3.4
Reclassified during FY 93 only	349	5,236	5,673	8.3
Reclassified during FY 92 only	82	4,502	4,526	0.5
FY 93 Reclassifications				
All Reclassified Hospitals	1,196	4,982	5,231	5.0
All Nonreclassified Hospitals	4,148	5,694	5,932	4.2
All Urban Reclassified Hospitals	376	5,800	6,128	5.7
Urban Nonreclassified Hospitals	2,502	6,018	6,279	4.3
All Reclassified Rural Hospitals	820	4,136	4,302	4.0
Rural Nonreclassified Hospitals	1,646	3,472	3,549	2.2
Other Reclassified Hospitals (Section 1886(D)(8)(B))	50	4,288	4,463	4.1
Type of Ownership				
Voluntary	3,188	5,670	5,915	4.3
Proprietary	749	5,134	5,384	4.9
Government	1,457	5,093	5,300	4.1
Medicare utilization as a percent of inpatient days				
0–25	277	7,141	7,471	4.6
25–50	1,934	6,098	6,375	4.6
50–65	2,213	4,986	5,201	4.3
Over 65	727	4,554	4,686	2.9

[1] Percentage changes shown in the column are taken from Table I, column 4. Because the dollar amounts shown in this table are rounded to the nearest whole dollar, percentage changes computed on the basis of these amounts will differ slightly from those presented in the last column of Table I.

VII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

Any impact analysis of payment changes for capital-related costs is limited by our ability to develop meaningful projections of new capital investment. Our principal constraint is the lack of hospital-specific data on future hospital capital investments. The lack of hospital-specific data limits our impact analysis in the following ways:

- Major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not

have the necessary hospital-specific budget data to project the individual hospital capital growth rates. Since our projection of capital-related costs could be very inaccurate for individual hospitals, a cross-sectional impact analysis using the usual prospective payment system hospital groupings (for example, urban or rural, teaching or nonteaching, etc.) that rely on individual hospital projections from prior cost reports may not be representative of the impact of the FY 1993 proposed changes in the capital prospective payment system.

• Moreover, our policy of recognizing certain obligated capital as old capital complicates the problem of projecting future capital-related costs for individual hospitals. With the proposed changes we are making to § 412.302(c), a hospital will have until the later of October 1, 1992 or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system to notify its intermediary that it has obligated capital. The intermediary will have one year from the notification date to make its determination as to whether the obligated capital will qualify as old capital. Therefore, we will not know actual obligated capital commitments in time to be used in the FY 1993 capital cost projections. Without knowing what proportion of an individual hospital's future capital spending will qualify as old capital, we cannot accurately project how the hospital will be affected by the transition payment policies.

• A meaningful cross-sectional analysis of the capital prospective payment system would have to control for the two transitional payment methods implemented in the final rule (the hold-harmless method and the fully prospective payment methods) and accurately forecast FY 1993 asset acquisitions and disposals.

Because we will not have complete data reports from our payment systems and cannot accurately predict an individual hospital's FY 1993 capital-related costs, we cannot determine with any certainty the proportion of hospitals within a hospital grouping that will qualify for payment under the hold-harmless payment method or under the fully prospective payment method. A cross-sectional analysis that includes all hospitals without distinguishing between the payment methodologies and asset changes will not fully or accurately present the redistributive effects that are expected to occur between "hold-harmless" hospitals and "fully prospective" hospitals. To present these effects, we use the results of our proposed FY 1993 actuarial model that distinguishes between high capital cost and low capital cost hospitals only. The cross-sectional analysis described later in this impact analysis is intended to provide only a sense of the distribution of the transition payment methodologies across hospital groupings from the provider-specific file used to make interim capital payments. We also present the effect of changes on the adjusted Federal rate across hospital groupings assuming payments were based on 100 percent of the Federal rate.

B. Projected Impact Based on the Proposed FY 1993 Actuarial Model

1. Assumptions

Based on the above considerations, our approach to the impact analysis in this proposed rule is similar to the approach we took in August 30, 1991 final rule (56 FR 43425). In the final rule, we used an actuarial model to project individual hospital capital growth rates for budget neutrality purposes and to estimate the impact of implementing the capital prospective payment methodology. In this impact analysis, we continue to model dynamically the impact of the capital prospective payment system from FY 1992 through FY 1993 using an actuarial model. The proposed FY 1993 actuarial model, described in Appendix B of this Federal Register document, integrates actual data from individual hospitals with randomly generated amounts developed from the results of the capital acquisition model used in the August 30, 1992 final rule. We have available more recent capital cost data from cost reports beginning in FY 1989 and FY 1990 through the Hospital Cost Reporting Information System (HCRIS), interim payment data for hospitals already receiving capital prospective payments through PRICER, and limited capital audit data from intermediary reports. However, we do not have individual hospital data on old capital changes, new capital formation, and obligated capital. Because we can combine actual data for individual hospitals with the results from the capital acquisition model, we need to generate only the old and new capital changes and obligated capital randomly. All Federal rate payment parameters, which were randomly assigned by the capital acquisition model in the FY 1992 final rule, are assigned in the FY 1993 model to the applicable hospital.

For purposes of this impact analysis, the FY 1993 actuarial model includes the following assumptions:

• Medicare inpatient capital costs per discharge will increase at the following rates during these periods:

Fiscal year	Average percentage increase in capital costs per discharge
1992	9.10
1993	10.07

• The Medicare case mix index will increase by 2 percent annually.

• The Federal capital rate as well as the hospital-specific rate will be updated by the two year moving average increase in Medicare capital costs per case, net of case mix change increase, between FY 1988 and FY 1990. The FY 1993 update is 3.76 percent (see Addendum, Part III).

• Consistent with the budget neutrality constraints provided in section 4001(b) of Public Law 101–508, aggregate Medicare payments for capital costs in FY 1993 will equal 90 percent of total Medicare inpatient capital costs. The budget neutrality adjustment factor will be applied to the Federal and hospital-specific rates only and not to the hold-harmless payment for old capital.

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1992 to FY 1993. To show the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals, we are presenting in Table IV the results of our simulation separately for low capital cost and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high cost hospital is a hospital that, based on its initial hospital-specific rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY

Type of hospital	Percent of hospitals	FY 1993 percent of discharges	FY 1993 percent of capital costs	FY 1993 percent of capital payments
Low cost hospital	64	58	40	45
High cost hospital	36	42	60	55

A low cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use. If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital would become a hold-harmless payment hospital as a result of a redetermination in FY 1992 or FY 1993, we have continued to show these hospitals as low cost hospitals in Table IV. The following table shows our estimate of the percentage of low capital cost hospitals that would be paid under the hold-harmless payment methodology through a hospital-specific rate redetermination and the basis of their payment under hold-harmless payment methodology:

Fiscal year	Percent of low cost fully prospective hospitals that qualify as hold-harmless	Of these, percent that are paid:	
		100% federal rate	Hold-harmless
1992	0.7	19	81
1993	0.7	5	95

Assuming no behavioral changes in capital expenditures, Table IV displays the percentage in payments from FY 1992 to FY 1993 using the above described actuarial model.

TABLE IV.—NPRM CAPITAL BUDGET NEUTRALITY FOR FY 1993–1995

[Impact of Proposed Changes for FY 1993 on Capital Payments per Discharge]

	No. of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hosiptal specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
FY 1992 Payments Per Discharge									
Low Cost Hospitals	3,229	5,532,338	$63.68	10.08	$405.26	$1.61	$2.22	$472.77	
Fully Prospective	2,975	5,253,721	63.60	10.00	410.11		1.99	475.71	
Rebase—Fully Prospective	233	257,167	55.36	10.00	340.08		6.20	401.64	
Rebase—100% Federal Rate	4	6,086	463.21	100.00				463.21	
Rebase—Hold Harmless	17	15,364	69.82	14.79		578.93	13.50	662.25	
High Cost Hospitals	1,828	3,997,419	326.13	50.15		464.79	19.59	810.50	
100% Federal Rate	659	1,618,627	671.59	100.00			37.79	709.38	
Hold Harmless	1,169	2,378,792	91.07	14.32		781.05	7.20	879.31	
Total Hospitals	5,057	9,529,757	173.77	27.18	235.27	195.90	9.50	614.44	
FY 1993 Payments Per Discharge									
Low Cost Hospitals	3,229	5,532,338	131.88	20.04	371.83	1.99	6.68	512.39	8.38
Fully Prospective	2,975	5,253,721	132.55	20.00	376.28		5.36	514.19	8.09
Rebase—Fully Prospective	233	257,167	115.32	20.00	311.92		33.43	460.67	14.70
Rebase—100% Federal Rate	1	820	391.02	100.00				391.02	−15.59
Rebase—Hold Harmless	20	20,630	156.83	30.65		534.81	10.85	702.30	6.05
High Cost Hospitals	1,828	3,997,419	396.64	57.63		434.80	35.12	866.57	6.92
100% Federal Rate	703	1,713,592	700.60	100.00			54.25	754.85	6.41
Hold Harmless	1,125	2,283,827	168.58	24.83		761.04	20.77	950.39	8.08
Total Hospitals	5,057	9,529,757	242.94	36.22	215.86	183.54	18.61	660.95	7.57

Under section 1886(g)(1) of the Act, aggregate payments under the capital prospective payment system for FY 1992 through 1995 are to equal 90 percent of what would have been payable on a reasonable cost basis in each year, respectively. (See Addendum, Part III for a full discussion of the budget neutrality provision.) We project that in FY 1992 aggregate payments under the capital prospective payment system are 2.1 percent higher than 90 percent of reasonable costs. To achieve budget neutrality in FY 1993, we estimate there would be an aggregate 7.6 percent increase in Medicare capital payments over the FY 1992 payments.

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average case-weighted

increase in payments of 8.4 percent, and high capital cost hospitals will experience an average increase of 6.9 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 10 percent to 20 percent and the hospital-specific rate payment percentage will decrease from 90 to 80 percent in FY 1993.

The Federal rate payment percentage for a hospital paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for those hospitals receiving a hold-harmless payment for old capital will increase from 14.3 percent to 24.8 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 36 to 38 percent.

We are proposing no changes in our exceptions policies in FY 1993. As a result, the minimum payment levels would be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or beds and a disproportionate share patient percentage of 20.2 percent or more; or,
- 70 percent for all other hospitals.

We estimate that there will be a 96 percent increase in exceptions payments in FY 1993. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1993 EXCEPTIONS PAYMENTS

Type of hospital	No. of hospitals	Percent of exceptions payments
Low Capital Cost	204	20.8
High Capital Cost	316	79.2
Total	520	100.0

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

1. Introduction

Table V presents a cross-sectional summary of hospital by capital prospective payment methodology. This distribution is not generated by our actuarial model. Rather, it is based on the December 31, 1991 update of the Provider-Specific File used by intermediaries to make interim capital payments using the PRICER program. The payment methodology distribution is based on 2,477 hospitals for which capital data are available on file. It is important to note in reviewing the data presented in Table V that we have interim capital payment data from our Hospital Specific File for only 44 percent of the hospitals. The data are not fully representative of the payment methodologies that will be applicable to the full set of hospitals. For example, the reporting cycle for the higher capital intensity teaching hospital group is generally later in the Federal fiscal year and would be expected to alter the proportions of hospitals in the categories shown. These hospital groups should be more adequately represented in the impact analysis presented in the final rule.

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of hospitals	(2) No. of hospitals reporting	(3) Hold-harmless		(4) Percentage paid fully prospective rate
			Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location					
All hospitals	5,394	2,477	17.2	13.3	69.5
Large urban areas (populations over 1 million)	1,467	677	23.5	17.4	59.1
Other urban areas (populations of 1 million or fewer)	1,411	589	20.9	19.9	59.3
Rural areas	2,516	1,211	12.0	7.8	80.3
Urban hospitals	2,878	1,266	22.3	18.6	59.2
0-99 beds	670	286	17.8	18.2	64.0
100-199 beds	859	391	26.9	20.5	52.7
200-299 beds	614	291	23.0	18.2	58.8
300-499 beds	536	218	20.6	17.0	62.4
500 or more beds	199	80	17.5	16.3	66.3
Rural hospitals	2,516	1,211	12.0	7.8	80.3
0-49 beds	1,239	594	7.4	4.4	88.2
50-99 beds	767	364	14.6	9.6	75.8
100-149 beds	264	132	20.5	12.1	67.4
150-199 beds	128	62	16.1	11.3	72.6
200 or more beds	116	58	19.0	17.2	63.8
By Region					
Urban By Region:					
New England	172	138	10.9	13.8	75.4
Middle Atlantic	460	95	21.1	17.9	61.1
South Atlantic	418	137	29.2	18.2	52.6
East North Central	475	286	11.2	25.2	63.6
East South Central	168	39	43.6	10.3	46.2
West North Central	183	121	18.2	14.9	66.9
West South Central	352	133	49.6	24.8	25.6
Mountain	110	60	26.7	15.0	58.3
Pacific	492	233	20.2	16.3	63.5
Puerto Rico	48	24	29.2	0.0	70.8
Rural By Region:					
New England	57	33	6.1	12.1	81.8

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of hospitals	(2) No. of hospitals reporting	(3) Hold-harmless		(4) Percentage paid fully prospective rate
			Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Middle Atlantic	93	1	0.0	0.0	100.0
South Atlantic	343	182	18.7	9.3	72.0
East North Central	346	182	7.7	12.1	80.2
East South Central	298	134	14.9	9.0	76.1
West North Central	564	273	5.1	2.6	92.3
West South Central	401	159	21.4	13.2	65.4
Mountain	241	178	12.9	3.9	83.1
Pacific	166	68	5.9	5.9	88.2
Puerto Rico	7	1	0.0	0.0	100.0
By Payment Classification					
All Hospitals	5,394	2,477	17.2	13.3	69.5
Large urban areas (populations over 1 million)	1,619	775	22.7	18.5	58.8
Other urban areas (populations of 1 million or fewer)	1,480	609	21.0	17.7	61.2
Rural areas	2,295	1,093	11.3	7.1	81.6
Teaching status:					
Non-teaching	4,186	1,968	18.1	12.5	69.4
Resident/bed ratio less than 0.25	968	427	14.8	15.5	69.8
Resident/bed ratio 0.25 or greater	239	81	9.9	21.0	69.1
Disproportionate share hospitals (DSH)					
Non-DSH rural	2,295	1,093	11.3	7.1	81.6
Non-DSH urban	852	376	18.6	17.3	64.1
Urban DSH, 100 beds or more	2,247	1,008	23.2	18.5	58.3
Rural Hospital Types:					
Non special status hospitals	1,010	468	9.6	8.8	81.6
RRC	179	88	20.5	17.0	62.5
SCH	532	282	13.5	4.3	82.3
Medicare-dependent hospitals (MDH)	515	226	6.6	3.1	90.3
SCH and RRC	45	22	22.7	9.1	68.2
SCH or MDH	1,092	530	10.9	4.0	85.1
Type of Ownership					
Voluntary	3,188	1,528	16.2	15.2	68.6
Proprietary	749	251	42.6	18.3	39.0
Government	1,457	698	10.3	7.3	82.4
Medicare Utilization as a Percent of Inpatient Days:					
0–25	277	119	20.2	14.3	65.5
25–50	1,934	951	18.2	15.6	66.2
50–65	2,213	1,030	16.9	11.6	71.6
Over 65	727	295	13.2	8.5	78.3

In Table V, we are presenting the distribution of the capital payment methodologies for teaching hospitals in terms of the resident-to-bed ratio specifically so that readers may compare these analyses with those for the prospective payment system for operating costs. Also, we have not yet developed a break point for distinguishing heavy teaching involvement from light teaching involvement using the resident-to-average-daily-census ratio that is comparable to the break point developed for the resident-to-bed ratio (resident-to-bed ratios less than .25 or ratios equal to or greater than .25). Although we are classifying teaching hospitals according to their resident-to-bed ratio for display purposes, for our Federal rate payment simulations, we have computed the indirect medical education adjustment factor using the ratio of resident-to-average-daily-census.

2. Distribution of Hospitals by Payment Methodology

The cross-sectional distribution of hospital by payment methodology is provided by: (1) Geographic location, (2) region, and (3) payment classification. This provides an indication of what percentage of hospitals within a particular hospital groupings will be paid under the fully prospective payment methodology and under the hold-harmless methodology. The information is based on the 2,477 hospitals with interim capital payment data on the December 31, 1991 Provider Specific File. Since the data are based on 44 percent of hospitals, the distribution does not match the projections in our actuarial model. We expect that as additional hospitals become subject to the capital prospective payment system later in FY 1992, the percentage of hospitals paid under the hold-harmless methodology will increase from 30 to 36 percent.

The distribution of hospitals by capital payment methodology is generally consistent with the distribution of low and high capital cost hospitals in the August 30, 1992 final rule. As expected, a relatively higher percentage of rural and governmental hospitals are being paid on the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. More than 80 percent of these hospitals would be paid under the fully prospective payment methodology compared to an average of 60 percent of hospitals with reported data. In contrast, only 39 percent of the proprietary hospitals with reported data are being paid under the fully prospective payment methodology. This is the only group of hospitals that is expected to have a majority of hospitals paid under the hold harmless methodology. As we noted in the August

30, 1991 final regulations (56 FR 43430), we found that about 62.7 percent of proprietary hospitals have a capital cost per case above the national average cost per case.

3. Federal Rate Payment Simulations.

To estimate the potential impact of our proposed changes for FY 1993 on payments based solely on the Federal rate, we simulated payments under the FY 1992 Federal rate and our proposed FY 1993 Federal rate using a universe of 5,394 hospitals. The individual hospital payment parameters are taken from the best available data, including: FY 1991 MEDPAR bills, the December 31, 1991 update to the Provider-Specific File, and cost report data for cost reporting periods beginning in FY 1990. Table VI presents a comparison of payments per case for FY 1992 and FY 1993 based on 100 percent of the Federal rate. The comparisons are provided by: (1) Geographic location, (2) payment classification, and (3) payment region.

The simulation results show that, on average, Federal rate payments per case, exclusive of any change in the Federal rate payment percentage, can be expected to increase by 2.0 percent. This increase results from the combined effects of: (1) The proposed 3.76 percent annual update, (2) a 1.7 percent increase due to the change in the outlier offset and the increase in outlier payments, (3) a 1.0 percent decrease due to the budget neutrality reduction for changes in the wage index and DRG weights, (4) a 2.07 percent decrease for exceptions, and (5) a 0.4 percent increase in the budget neutrality reduction.

The distributional effects of the changes in Federal rate payments primarily result from DRG recalibration, changes in the geographic adjustment factor (including both wage index corrections and geographic reclassifications), and changes in the outlier payment policy. The increase in payments per case will be larger for urban hospitals (2.1 percent) than for rural hospitals (1.4 percent). We believe that this difference is due to the fact that the increase in outlier payments relative to FY 1992 outlier payments and the DRG classification changes have a predominantly urban effect.

Sole community hospitals realize a smaller increase (0.5 percent) than any other payment classification. This is probably due to the fact that they will realize a smaller gain from the increase in the outlier payments compared to FY 1992 levels because they tend to have fewer outlier cases.

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review board (MGCRB). Fiscal year 1992 is the first year that hospitals were reclassified as a result of decisions by the MGCRB. Hospitals may apply for reclassification for the purpose of obtaining a higher wage index value, standardized payment amount or both a higher standardized payment amount and wage index value. Although there is no difference with respect to the Federal capital rate, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as result of the large urban adjustment factor. Reclassification for wage index purposes affects the geographic adjustment factor since it is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 1993 compared to FY 1992, we show the average Federal Rate payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1993 reclassifications, we are indicating those hospitals reclassified for standardized amount purposes only, for wage index purposes only and for both factors. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified by the Medicare Geographic Classification Board during FY 1993 only can be expected to realize a much larger increase (5.5 percent) than other hospitals. Similarly, hospitals reclassified during FY 1992 only do much worse in FY 1993 (a 0.9 percent decrease) than other hospitals as they lose the higher payments from their geographic reclassification during FY 1992.

By region, the significantly greater gain of urban hospitals in the West South Central region (3.5 percent increase) is probably due to geographic reclassifications.

TABLE VI–COMPARISON OF FEDERAL RATE PAYMENTS PER CASE

[FY 1992 Payments Compared to Proposed FY 1993 Payments Based on 100% Federal Rate]

	Number of hospitals	Average FY 1992 payments/ case	Average FY 1993 payments/ case	All changes
By Geographic Location:				
All Hospitals	5,394	631	644	2.0
Large Urban Areas (populations over 1 million)	1,467	735	750	2.0
Other Urban Areas (populations of 1 million or fewer)	1,411	625	638	2.2
Rural Areas	2,516	447	454	1.4
Urban Hospitals	2,878	682	696	2.1
0–99 Beds	670	503	512	1.8
100–199 Beds	859	596	609	2.2
200–299 Beds	614	644	658	2.2
300–499 Beds	536	708	722	1.9
500 or more Beds	199	838	856	2.1
Unknown	0	0	0	0.0
Rural Hospitals	2,516	447	454	1.4
0–49 Beds	1,239	375	377	0.6
50–99 Beds	767	416	420	1.1
100–149 Beds	264	465	472	1.5
150–199 Beds	128	472	480	1.7
200 or more Beds	116	528	539	2.0
Unknown	2	564	574	1.7
Urban by Region				
New England	172	711	721	1.4
Middle Atlantic	460	731	734	1.7
South Atlantic	418	656	673	2.7
East North Central	475	665	676	1.7
East South Central	168	593	609	2.7

TABLE VI–COMPARISON OF FEDERAL RATE PAYMENTS PER CASE—Continued

[FY 1992 Payments Compared tO Proposed FY 1993 Payments Based on 100% Federal Rate]

	Number of hospitals	Average FY 1992 payments/ case	Average FY 1993 payments/ case	All changes
West North Central	183	675	687	1.7
West South Central	352	628	650	3.6
Mountain	110	688	704	2.3
Pacific	492	772	786	1.7
Puerto Rico	48	275	280	1.5
Rural by Region				
New England	57	519	523	0.8
Middle Atlantic	93	492	496	0.8
South Atlantic	343	469	478	1.8
East North Central	346	451	457	1.3
East South Central	298	404	409	1.1
West North Central	564	416	422	1.3
West South Central	401	412	419	1.7
Mountain	241	465	470	1.0
Pacific	166	536	544	1.5
Puerto Rico	7	220	221	0.5
By Payment classification:				
All Hospitals	5,394	631	644	2.0
Large Urban Areas (populations over 1 million)	1,619	724	739	2.0
Other Urban Areas (populations of 1 million or fewer)	1,480	617	630	2.1
Rural Areas	2,295	441	447	1.3
Teaching Status:				
Non-Teaching	4,186	543	554	2.0
Resident/Bed Ratio less than 0.25	968	681	693	1.9
Resident/Bed Ratio 0.25 or greater	239	962	982	2.1
Disproportionate share hospitals (DSH):				
Non-DSH Rural	2,295	441	447	1.3
Non-DSH Urban	852	496	504	1.7
Urban DSH 100 Beds or more	2,247	689	704	2.1
Rural Hospital Types:				
Non Special Status Hospitals	1,010	412	417	1.2
RRC	179	508	518	1.8
SCH	532	422	426	0.8
Medical-Department Hospitals (MDH)	515	376	379	0.9
SCH and RRC	45	514	522	1.5
SCH or MDH	1,092	423	427	1.0
Hospitals reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY92 and FY93:				
Reclassification during both FY92 and FY93	847	565	571	1.0
Reclassification during FY93 only	349	605	639	5.6
Reclassification during FY92 only	82	514	509	−0.9
FY93 Reclassifications:				
All reclassified Hospitals	1,196	578	592	2.5
All nonreclassified hospitals	4,148	648	660	1.8
All Urban reclassified Hospitals	376	668	688	3.0
Urban nonreclassified Hospitals	2,502	684	697	1.9
All reclassified Rural Hospitals	820	484	493	1.8
Rural nonreclassified Hospitals	1,646	401	404	0.7
Other reclassified Hospitals (section 1886(D)(8)(B))	50	512	521	1.7
Type of ownership:				
Voluntary	3,188	649	661	1.9
Proprietary	749	603	620	2.9
Government	1,457	565	575	1.8
Medicare utilization as a percent of Inpatient Days:				
0–25	277	747	760	1.8
25–50	1,934	687	701	2.1
50–65	2,213	583	594	1.9
Over 65	727	539	548	1.7

Appendix B: Description of the Capital Acquisition Model and Budget Neutrality Adjustment

Section 1886(g)(1) of the Act (as amended by section 4001 of Pub. L. 101–508) requires that for FY 1992 through FY 1995 aggregate prospective payments for operating costs under section 1886(d) and prospective payments for capital costs under section 1886(g)(1) of the Act be reduced each year in a manner that results in savings equal to 10 percent of the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. Under § 412.352, the 10 percent savings is generated entirely from the capital prospective payments. A budget neutrality adjustment factor is applied to the Federal rate and hospital-specific rate so that total capital payments for FY 1992 through FY 1995 approximately equal 90 percent of Medicare inpatient capital costs in each year.

To calculate budget neutrality, the hold-harmless provision of the payment methodology requires that we identify old and new capital; that is, we must be able to project the rate at which old capital will be depreciated and written off and at which new capital will be acquired and depreciated. (Old capital costs are depreciation, lease, interest

expenses, and other capital-related costs defined in § 412.302 that are in use or obligated on or before December 31, 1990.)

In developing the FY 1992 prospective payment rates, there was limited capital data available that could be used to project payments under the capital prospective payment system and develop the budget neutrality adjustment factor. Consequently, we developed a capital acquisition model that relied on Monte Carlo random simulation techniques to project capital costs for 6000 hypothetical hospitals. This model is described in detail in the August 30, 1991 final rule (56 FR 43517–43522). The model will be referred to as the capital acquisition model in the following discussion.

Since publication of the August 31, 1991 final rule, capital data have become available that can be incorporated directly into the determination of budget neutrality. The available data include: the December 31, 1991 update of the Hospital-Specific File that provides the data items needed by the PRICER program used by the intermediaries to determine interim payments to hospitals; cost reports for cost reporting periods beginning in FY 1989 (PPS–6) that overlap the base year for determining the hospital-specific rate; and, data reported by the intermediaries that includes the hospital-specific rate determinations that have been made through February 1992. The December 31, 1991 update to the Provider-Specific File contains data on interim payments under the capital prospective payment system for approximately 44 percent of all hospitals. Generally, the data are for hospitals that became subject to the capital prospective payment system effective with their cost reporting period beginning on or before January 1, 1992.

The available data sources directly supply, or can be used to calculate, the hospital-specific rate. For those hospitals with capital data on the Provider-Specific File, the payment methodology as well as the estimated FY 1992 hold-harmless amount and new capital ratio for hospitals paid under the hold-harmless payment methodology is also available.

The available data still lack certain items which are required for the determination of budget neutrality. These items are the hospital's new capital costs for each year, its old capital costs for each year, and the obligated capital amounts for assets that will be put in use for patient care services and recognized as old capital each year.

For FY 1993, we are proposing to use an integrated model that starts with the available data for existing hospitals and back-fills the missing items with results from the capital acquisition model that was used to develop the FY 1992 payment rates. Since hospitals under alternative payment system waivers are currently excluded from the capital prospective payment system, we excluded these hospitals (hospitals in Maryland and hospitals in the Finger Lakes Area Hospital Corporation in New York) from our proposed model.

We have not modified the parameters of the FY 1992 capital acquisition model; however, we analyzed several capital growth patterns generated by that model to backfill the elements for which actual data are not available. These patterns include the distribution of growth rates in old capital (exclusive of obligated capital), the new capital ratio (which includes obligated capital), and the ratio of obligated capital costs for assets being put in use for patient care to total capital costs. In all cases, the distributions from the model were fitted to the beta distribution. The beta distribution is a two parameter distribution with the range restricted from zero to one. The growth rate for old capital (which is exclusive of obligated capital) must be between zero and one since depreciation and interest on old capital cannot increase. The ratio of new capital to total capital and the ratio of obligated capital to total capital are necessarily between zero and one. Hence, the beta distribution is ideal for this purpose, especially since the two parameters provide a range of shapes.

With regard to the new capital ratio for years after FY 1992, the model fits the change in the ratio from one year to the next to the beta distribution. This is to prevent large swings in the new capital ratio over time. It is possible to have a decrease in the new capital ratio since some new capital may have a short useful life compared to old capital. Therefore, we rescaled the range of the changes in the ratios since the beta distribution must have numbers between zero and one.

The proposed model first develops the hospital-specific rate. Where available, this rate is taken from the December 1991 update of the Provider-Specific File. This file contains the actual amounts used by the intermediaries with the PRICER program to compute interim capital prospective payments. If the hospital-specific rate is not available from the Provider-Specific File, the second source is the audit information reported by the intermediaries. If this is not available, the model computes the hospital-specific rate from the hospital's cost reporting period beginning in FY 1990 as reported on the HCRIS as of December 1991 update.

The proposed model also develops the old capital amount for each hospital. If available, the model uses the hold-harmless payment per discharge from the Provider-Specific File. If the actual hold-harmless amount is not available, the model develops an estimate from the hospital's hospital-specific rate. It computes an FY 1990 capital cost per discharge by dividing the 1992 hospital-specific rate by factors used to inflate base year capital cost per discharge to FY 1992 as set forth in the August 30, 1991 final rule (56 FR 43390). The model updates the base year capital per discharge to FY 1992 using a two-year rate of increase (FY 1990 to FY 1992) in old capital that is randomly generated from the beta distribution described above. This old capital amount for FY 1992 excludes any obligated capital that has been put in use since the base year. Excluding obligated capital from the old capital growth factors produces a more stable growth sequence with lower variance. The development of the hospital's obligated capital costs is described below. Before we update the hospital's old capital costs in a given year, the model adds the obligated capital that is first depreciated in the current year to the old capital cost for that year. As a result, any obligated capital depreciation and interest expense projected by the model is incorporated into the hospital's old capital costs in subsequent years.

The proposed model also develops the new capital ratio for each hospital. If available, the model uses the hospital's new capital ratio from the Provider-Specific File. If the actual new capital ratio is not available, the model generates the ratio from a beta distribution as described above. For purposes of fitting the new capital ratio to the beta distribution, the model treats obligated capital as new capital. The model restricts the new capital ratio to 90 percent in all cases. After fitting the FY 1992 new capital ratio, the year-to-year change in the new capital ratio is fit to the beta distribution. The new capital ratio combined with the old capital amount generates the total capital costs.

Finally, the model develops the obligated capital ratio for obligations first being depreciated in the year under analysis. It generates an obligated capital ratio using a beta distribution fitted to the results of the capital acquisition model (and obligation capital assumptions) as described above. This ratio is an offset to the new capital ratio. Consequently, the

obligated capital ratio is restricted to the magnitude of the new capital ratio. The new capital ratio is reduced by the obligated capital ratio.

If a hospital has a hold-harmless payment amount available on the Hospital-Specific File, this amount includes the effect of obligated capital on its FY 1992 old capital costs per discharge. Therefore, the model does not generate any additional FY 1992 obligated capital for these hospitals. We necessarily generated obligated capital amounts for all hospitals for FY 1993 and later.

The model does not recompute the hospital's total capital costs for obligated capital. Instead, obligated capital costs are the product of the obligated capital ratio rate and total capital costs. The hospital's costs for new capital are the product of the revised new capital ratio times the hospital's total capital costs.

We computed the average total capitals cost per discharge from the capital costs that were generated by the model and compared the results to total capital costs per discharge that we had projected independently of the proposed model. The capital amount in any year is composed of capital previously acquired (old capital) and capital acquired in the current year (new capital and new obligated capital). We cannot adjust the old capital component since it is a function of acquisitions in earlier years. Consequently we can only adjust new and obligated capital amounts. We proportionately adjusted the new and obligated capital amounts so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

To summarize, the proposed model integrates actual data with randomly generated amounts developed from the results of the capital acquisition model. We generated at most three numbers for each hospital each year. Only the old capital increase, new capital ratio, and obligated capital ratio are randomly generated.

Once each hospital's capital-related costs are generated, the model projects capital payments. In FY 1992, we randomly generated all payment parameters (for example, the case-mix index and the geographic adjustment factor). In the proposed model, we use the actual payment parameters that are applicable to the specific hospital.

To project capital payments, the proposed model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital. If available, the model uses the payment methodology method indicated in the Provider-Specific File. Otherwise, the model determines the methodology by comparing the hospital's hospital-specific rate to the adjusted Federal rate applicable to the hospital. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the 1991 MEDPAR file using the proposed FY 1993 DRGs and relative weights. The case-mix index is increased 2 percent per year after FY 1991 consistent with the continuing trend (which we expect to continue) in case-mix increase.

Changes in geographic reclassification and corrections in the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor, and changes in the DRG classification system and the relative weights affect the case mix index. Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year based on the Federal rate after any changes resulting from changes in the DRG classification system and relative weights and in the geographic adjustment factor equal the estimated aggregate payments, payments based on the Federal rate that would have been made without such changes. To determine the budget neutrality adjustment factor needed to make the effect of the DRG and geographic adjustment changes budget neutral on estimated Federal rate payments, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1993 based on its applicable payment methodology. We then compared what aggregate Federal rate payments would be based on the FY 1992 DRG relative weights and geographic adjustment factor to aggregate Federal rate payments based on the FY 1993 relative weights and geographic adjustment factor. In making the comparison, we held the FY 1993 Federal rate portion constant and set the other budget neutrality adjustment factor and exceptions reduction factor to 1.00. We determined that to achieve budget neutrality for the changes in the geographic adjustment factor and the DRG weights, a budget neutrality adjustment factor of 0.9906 should be applied to the FY 1993 Federal rate.

The methodology used to determine the geographic and recalibration budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG weights. Under the capital prospective payment system, there is a single budget neutrality adjustment factor for changes in the geographic adjustment factor (including geographic reclassification change since FY 1992) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on.

In addition to computing the geographic and recalibration budget neutrality adjustment factor, we used the proposed model to project total aggregate payments under the prospective payment system and to compute the budget neutrality adjustment factor that would result in estimated payments under the capital prospective payment system equal 90 percent of what would have been payable on a reasonable cost basis. This budget neutrality factor is applied to the Federal and hospital-specific rates, but not to the hold-harmless payments.

Additional payments under the exceptions process are financed through a reduction in the Federal and hospital-specific rates. Therefore, we used the proposed model to calculate estimated exceptions payments and the exceptions reduction factor. This exceptions reduction factor ensures that estimated aggregate payments under the capital prospective payment system, including exceptions payments, equal what aggregate payments would be under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the budget neutrality and exceptions adjustments factors must be determined through iteration. Further, these two factors interact with each other so that they must be determined simultaneously. We successfully determined values for these factors so that the exceptions adjustment factor is correct and estimated payments under the capital prospective payment system equal 90 percent of estimate Medicare inpatient capital costs.

In the August 30, 1991 final rule, we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next five years. The table below provides the actual FY 1992 factors, the proposed FY 1993 factors, and the estimated factors that would be

applicable through FY 1997. We caution that, except with respect to FY 1992 and FY 1993, these are estimates only and are subject to revisions resulting from continued methodological refinements, more recent data, and any payment policy changes that may occur. The projections are as follows:

Fiscal year	Increase in cost per discharge	Update factor	Exceptions reduction factor	Budget neutrality factor	Federal rate (after outlier reduction)
1992	[1] 6.96	N/A	.9813	.9602	415.59
1993	7.91	3.76	.9610	.9564	416.36
1994	8.91	6.19	.9249	.9786	435.40
1995	8.77	5.99	.9000	.9993	458.56
1996	8.73	7.44	.9000	N/A	493.02
1997	8.71	8.41	.9000	N/A	534.48

[1] Note: Adjusted for estimated 2.0 percent increase in case-mix index.

Appendix C—Letters to Congress

March 30, 1992.

The Honorable Dan Quayle,
President of the Senate, Washington, D.C. 20510

Dear Mr. President: Section 1886(e)(3)(B) of the Social Security Act requires that the Secretary of Health and Human Services, not later than March 1, 1992, report to the Congress his initial estimate of the applicable percentage increase in payments for inpatient operating costs for FY 1993 that he will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for excluded hospitals and units. This submission constitutes the required report.

President Bush's budget incorporates updates consistent with those mandated by current law. The budget recommends an update for hospitals subject to the PPS equal to the rate of increase in the hospital market basket minus 1.55 percentage points for urban hospitals and the rate of increase in the hospital market basket minus 0.55 percentage points for rural hospitals. For hospitals excluded from the PPS, the budget includes an average increase in the Tax Equity and Fiscal Responsibility Act limit equal to the rate of increase in the hospital market basket. In addition, the budget contains a legislative proposal to move the annual update for hospitals from October 1 to January 1 to conform with the update cycle generally used in Medicare. We believe that this move will reduce the hospital industry's frustration with the many payment changes caused by Congressional delays and budget negotiations.

We have not had the opportunity to evaluate fully the recommendations of the Prospective Payment Assessment Commission (ProPAC). Our recommendation for the updates is contingent on the current situation and projections of relevant data. In addition, we note that the President's proposal to move the hospital update will, if enacted, change the market basket and, therefore, the updates for the hospitals. The President's budget assumed the market basket would increase by 4.5 percent for hospitals subject to the prospective payment system and by 4.6 percent for excluded hospitals. These estimates are consistent with our most current projections. A final recommendation on the appropriate percentage increases for FY 1993 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projections available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including ProPAC's recommendations.

Section 1886(d)(4)(C)(iv) of the Social Security Act, as enacted by section 6003(b)(2) of the Omnibus Budget Reconciliation Act of 1989, requires that the Secretary include in his report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time, we do not anticipate recommending any adjustment to the DRG weighting factors for FY 1993.

My staff and I look forward to discussing this recommendation with you.

Sincerely,

Louis W. Sullivan, M.D.

March 30, 1992.

The Honorable Thomas S. Foley,
Speaker of the House of Representatives, Washington, D.C. 20515.

Dear Mr. Speaker: Section 1886(e)(3)(B) of the Social Security Act requires that the Secretary of Health and Human Services, not later than March 1, 1992, report to the Congress his initial estimate of the applicable percentage increase in payments for inpatient operating costs for FY 1993 that he will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for excluded hospitals and units. This submission constitutes the required report.

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My staff and I look forward to discussing this recommendation with you.

Sincerely,

Louis W. Sullivan, M.D.

Appendix D: Recommendation of Update Factors for Operating Cost 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 1993 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 sets the FY 1993 applicable percentage increases in the operating cost standardized amounts for prospective payment hospitals equal to the hospital market basket percentage increase minus 1.55 percentage points for hospitals located in urban areas and

the market basket percentage increase minus 0.55 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 hospitals. In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update 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. Based on the currently forecasted market basket increase of 4.3 percent for hospitals subject to the prospective payment system, the proposed updates in the standardized amounts are 2.75 percent for hospitals in urban areas and 3.75 percent for hospitals in rural areas. The proposed update in the hospital-specific rate applicable to sole community hospitals is 4.3 percent. The proposed update for hospitals excluded from the prospective payment system is based on the percentage increase in the market basket for these hospitals and equals 5.4 percent.

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, 1992 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.

In its March 1, 1992 report, ProPAC recommended update factors to the standardized amounts equal to the percentage increases in HCFA's market basket minus 1.45 percentage points for urban hospitals and the market basket rate of increase minus 0.45 percentage points for hospitals located in rural areas. Further, ProPAC recommended an update to the standardized amounts equal to 3.05 percent for hospitals located in urban areas and 4.05 percent for hospitals located in rural areas (based on a market basket estimate of 4.5 percent). The components of ProPAC's update factor recommendations are described in detail in the ProPAC report, which is published in appendix E to this document. ProPAC recommended the update for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals be equal to the rural hospital update; that is, the percentage increases in HCFA's market basket minus 0.45 percentage points, or 4.05 percent based on a market basket estimate of 4.5 percent. We discuss ProPAC's recommendations concerning the update factors and our responses to those recommendations below.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for FY 1993 that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the recommended FY 1993 update factors that are provided for under section 1886(e)(4) of the Act. Accordingly, this appendix provided our recommendations of appropriate update factors, our analysis of the derivation of the amount of the update factors, and our responses to the ProPAC recommendations concerning the update factors.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that the standardized amounts be increased by an amount equal to the market basket percentage increase minus 1.55 percentage points for hospitals located in urban areas and the market basket percentage increase minus 0.55 percentage points for hospitals in rural areas. We are recommending an increase of the market basket rate of increase minus 1.55 percentage points for the hospital-specific rate for sole community hospitals. With the exception of the higher update for the rural standardized amount, we believe that the hospital-specific rate should be updated by the same percentage increases as the standardized amounts. 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.

We recommend that hospitals excluded from the prospective payment system receive, on average, an update equal to the percentage increase in the market basket that measures input price increases for services furnished by excluded hospitals. That market basket is currently forecast at 4.5 percent. However, we are also recommending that the amount of the update vary according to the base year used to establish the excluded hospital or unit's rate of increase. Those hospitals and units whose base year for purposes of the rate of increase limit began during the period FY 1983 through FY 1987 would receive a higher update than hospitals whose base year was established in FY 1982 or after 1987. The amount of the recommended HCFA update is dependent on the actual base year, as follows:

Base year began in FY	FY 1993 general update	FY 1993 additional update	Recommended FY 1993 update
1982	2.9		2.9
1983	2.9	1.8	4.7
1984	2.9	3.8	6.7
1985	2.9	6.0	8.9
1986	2.9	3.9	6.8
1987	29	1.8	4.7
1988 and later	2.9		2.9

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. Our responses to the ProPAC recommendations concerning the update factor are discussed below.

III. ProPAC Recommendation for Updating the Prospective Payment System Standardized Amounts

For FY 1993, ProPAC recommends that the standardized amount be updated by the following factors:

- The projected increase in the hospital market basket (which was estimated to be 4.5 percent in ProPAC's March 1, 1992 report) plus 0.2 percentage points to account for the different wage and salary price proxies used for the ProPAC market basket.
- A correction of −0.8 percent to reflect the forecast error in the FY 1991 market basket rate of increase.
- A discretionary adjustment factor of 0.0 percent composed of an allowance of 1.0 percent for scientific and technological advancement and an allowance of −1.0 percent for productivity improvement.
- An adjustment for case-mix change of −0.7 percent.
- A differential update of 0.85 percent for hospitals located in rural areas and −0.15 percent for hospitals located in urban areas, to reflect the phasing out of the differential in the standardized amounts between rural and other urban hospitals.

Overall, the net increase employing the above factors is the percentage increase in the hospital market basket minus 1.45 percentage points for urban hospitals and the market basket minus 0.45 percentage points for rural hospitals. Based on the market basket estimate of 4.5 percent used in its March 1, 1992 report, ProPAC recommends a differential update for urban and rural hospitals, with urban hospitals receiving a 3.05 percent update, and rural hospitals receiving a 4.05 percent update.

Reponse: 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 1993 based on the current market basket forecast with the adjustments set forth in section 1886(b)(3)(B)(i)(VIII), as added by section 4002(a)(1)(C) of Public Law 101–508. The latest forecast shows that the FY 1993 market basket has decreased from 4.5 percent, the figure used by ProPAC in determining its update recommendations, to 4.3 percent between the fourth quarter of 1991 and the first quarter of 1992.

Our recommendation is supported by the following analyses which measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix:

• *Productivity:* At the beginning of the prospective payment system update process, HCFA established a conservative normative standard for hospital productivity increases of 1.0 percent per year, based on a review of the literature on historical and potential hospital productivity and average long-run productivity growth in the U.S. economy. In the short run, any increases in productivity in excess of 1.0 percent would be kept by hospitals as increases in operating margins. Productivity increases of more than 1.0 percent would be encouraged by this standard. We believe that substantial gains can be made in hospital productivity, and that we should continue to provide an incentive to increase productivity.

ProPAC also believes hospitals should be given an incentive for additional productivity improvement. ProPAC measures productivity as the ratio of hospital admissions (adjusted for case mix and outpatient services) per FTE employee (adjusted for changes in skill mix). ProPAC includes in its productivity measurement the effect of changes in practice patterns. We have traditionally treated historic practice pattern changes as a separate factor because they represent changes that have occurred in the nature of the hospital product. This year, ProPAC assumes a productivity gain of at least 2.0 percent and recommends a −1.0 percentage point adjustment on the basis that any productivity gains should be shared equally by Medicare and hospitals.

• *Quality Enhancing New Science and Technology*: The new science and technology factor is intended to recognize technological changes that increase costs but also enhance health status. We have no empirical evidence that accurately sets the level for this factor. Typically, a specific new technology increases costs in some uses and decreases costs in other uses. Concurrently, in some situations, health status is improved while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies and new technologies. In the early years of the prospective payment system, ProPAC conducted several studies of new technology costs and concluded that they were fairly low. Those studies focused primarily on the acquisition costs of the new technologies but also looked at diffusion of use and operating costs. Project Hope, under contract with ProPAC, annually estimates the incremental operating costs of specific cost-increasing technologies. However, we know of no definitive studies that establish an appropriate level or range for this factor. ProPAC's adjustment is for the cost-increasing effect of new technologies only, and this year assumes the estimated costs for these technologies at +1.0 percent.

We believe that the ProPAC estimate may be overstated for several reasons. First, the estimate does not account for offsetting changes in revenue due to changes in DRG assignment. Second, it is not clear that all of the new technologies listed in ProPAC's study significantly enhance health status. To the extent the new technologies are not quality enhancing, an adjustment is inappropriate. Finally, some of the technologies have considerable potential for cost savings relative to the technologies they are replacing.

Until a usable measure for the incremental operating costs associated with the implementation of these new sciences and technologies is developed, we believe that this adjustment should be set at a conservative, stable level. We recommend an adjustment of +0.3 to +0.5 percent.

• *Improvements in Practice Pattern*: We measure practice pattern changes based on changes in average length of stay since the beginning of the prospective payment system. Although we have no complete measure of changes in practice patterns, we believe this factor can be modeled appropriately based on this measure. The practice pattern adjustment is based on the belief that the costs on which the initial payment rates were based included a component of unnecessarily high costs reflecting ineffective practice patterns and that it is reasonable for HCFA to share in the savings in the long run.

Average length of stay declined dramatically during the first years of the prospective payment system and gradually increased in subsequent years. However, our latest data indicate that average length of stay declined again and has remained stable over the last few years. Based on updated data on changes in average length of stay and the cumulative practice pattern adjustment implicit in prior update recommendations, we estimate that a residual adjustment of up to −1.8 percent could be supported.

• *Impact of OSHA Rule*: In the December 6, 1991 **Federal Register** (56 FR 64004), the Occupational Safety and Health Administration (OSHA) published a final rule implementing regulations (29 CFR 1910.1030) requiring organizations to use a variety of means to reduce the risk of employees contracting blood-borne pathogens, including hepatitis B virus and human immunodeficiency virus. In that rule, OSHA estimates the impact on hospitals at 0.14 percent of revenues. We are therefore recommending an adjustment of +0.14 percent to account for these additional costs. ProPAC did not recommend any explicit adjustment for the effects of these regulations.

Overall, the combined adjustment for productivity, technology, practice pattern changes, and the new OSHA requirements could range from −2.36 to −0.36 percentage points.

• *Change in Case Mix:* Our analysis takes into account changes in case mix adjusted for changes attributable to improved coding practices and DRG reclassification and recalibration. We found that the observed increase in case mix was 2.5 percent during FY 1991. We estimate real case mix increased 1.0 to 1.25 percent. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. This estimate is supported by past studies of case-mix change by RAND Corporation. In addition, we

estimate that DRG reclassification and recalibration in FY 1992 resulted in a 1.0 percent increase in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. The resulting adjustment to account for changes in case mix during FY 1991, the most recent year for which data are available, is −2.5 to −2.25 percent (the sum of −2.5 percent, +1.0 to 1.25 percent, and −1.0 percent). The −2.5 and +1.8 percent figures used in the ProPAC framework represent, respectively, ProPAC's projection for observed case-mix change, and its projection for real case-mix change, including within-DRG case complexity change, during FY 1992. ProPAC's observed case-mix change is estimated, whereas our observed case-mix change is based on FY 1991 bills received through February 29, 1992. ProPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation (we note that Congress asks the Secretary for an estimate of these effects in our update recommendation).

• *Correction for Market Basket Forecast Error:* The FY 1991 estimated market basket percentage increase used to update the payment rates was 5.2 percent. Our most recent data indicate the actual FY 1991 increase was 4.4 percent, reflecting that the increase in wages was lower than projected. The resulting forecast error in the projected FY 1991 market basket rate of increase forecast was −0.8 percentage points. Our policy has been to make a forecast error correction if our estimate is off by 0.25 percent points or more. Therefore, we are recommending an adjustment of −0.8 percentage points to reflect this overestimation of the FY 1991 market basket. This matches ProPAC's recommended forecast error adjustment.

The following is a summary of the update ranges supported by our analyses compared to ProPAC's framework.

TABLE 1.—COMPARISON OF FY 1993 UPDATE RECOMMENDATION FRAMEWORKS

	HHS	ProPAC
Market Basket (MB)	MB	MB
Difference Between HCFA & ProPAC MB Forecasts [1]		+0.2
Subtotal	MB	MB +0.2
Policy adjustment factors		
productivity	−1.0	−1.0
Science and technology	+0.3 to +0.5	+1.0
Practice patterns	−1.8 to 0	
OSHA requiremens	+0.14	
Subtotal	−2.36 to −0.36	+0.0
Case mix adjustment factors:		
Observed case mix change	−2.5	−2.5
Real across DRG change	+1.0 to 1.25	+1.5
Real within DRG change effect of 1990:	+0.3	
Reclassification and recalibration	−1.0	
Subtotal	−2.5 to −2.5	−0.7
Forecast error correction:	−0.8	−0.8
Total recommended update	MB −5.66 to MB −3.41	MB −1.3

[1] The difference between the HHS and ProPAC market baskets is due to a different treatment of the wage and employee benefit proxies used by ProPAC in its market basket.

While the above analysis would support a recommendation that there be no update in the standardized amounts applicable to urban hospitals and the hospital-specific rates applicable to sole community hospitals in FY 1993, we believe that it would be inappropriate, in view of commitments made as part of the 1990 budget agreement, to recommend an update other than market basket minus 1.55 percentage points for urban hospitals and the hospital-specific rates applicable to sole community hospitals.

In addition, 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, as required by Pub. L. 101–508. Therefore, we are recommending that the rural standardized amount be updated by an additional 1.0 percentage point, for a total update of 3.75 percent (that is, market basket minus 0.55 percentage points). We note that we disagree with ProPAC's recommendation that the hospital-specific rates applicable to sole community hospitals be increased by the update factor applicable to the rural standardized amounts. We believe that the considerations used to develop the update recommendations for the urban standardized amounts are also applicable to the hospital-specific rates, and that the differential update applied to the rural standardized amounts to eliminate the difference between the rural and other urban standardized amounts is not a relevant consideration for the hospital-specific rates.

IV. ProPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

ProPAC recommends an average update factor equal to the market basket rate of increase minus 0.4 percentage points for excluded hospitals and units. The 0.4 percentage point reduction represents a reduction of 0.7 percentage points to account for the forecast error in the FY 1991 market basket rate of increase for excluded units, a 0.2 percentage point increase to reflect the different compensation price proxies used by ProPAC, and an allowance for new technology of 0.1 percent. Further, ProPAC recommends an additional allowance based on the year the hospital or unit was excluded from the prospective payment system. Before FY 1989, excluded hospitals and units received the prospective payment system update, which was reduced to account for rapid growth in payments due to case mix increases. Since excluded facilities do not benefit from the payment-increasing effect of case-mix index change, ProPAC believes that these hospitals should have received the applicable full market basket increase for years prior to FY 1989. ProPAC recommends that the additional allowance to these hospitals be funded through the savings achieved from the 0.4 percentage reduction included in its average update recommendation for excluded hospitals.

Response: We recommend an average update for excluded hospitals that

would 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 4.5 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 1.6 percent. The 1.6 percentage point adjustment is to account for the forecast error in the FY 1991 market basket rate of increase of 0.7 percentage points plus the forecast error in the FY 1990 market basket rate of increase of 0.9 percentage points. 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 agree with ProPAC that a higher update for hospitals and units that were excluded in the early years of the prospective payment system is appropriate. This is because the updates applied to excluded hospitals in FYs 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 agree with ProPAC as to the basis for the cumulative positive allowance adjustment, which is consistent with our calculation of the compounded difference between the updates received and the market basket rate of increase, as described in the June 3, 1991 proposed rule (56 FR 25322).

Base year began in fiscal year	FYs subject to ceiling	Compounded adjustment
1982	1983–1988	−0.5
1983	1984–1988	2.1
1984	1985–1988	4.2
1985	1986–1988	6.9
1986	1987–1988	4.4
1987	1988	2.1

We also agree with ProPAC's recommendation that any additional update allowance be made in a budget neutral fashion. It is not clear that an additional 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 managed to receive substantial incentive payments. 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. Additionally, the lower updates are only part of the explanation for 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. For these reasons, we are recommending a 2.9 percent update for hospitals with an FY 1982 base year, even though a lower update would appear warranted based on the cumulative difference between the market basket increase and the update factors.

We believe any increase in aggregate payments to excluded hospitals and units, plus an additional update for 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 Congress on recommendations for potential modifications to the rate-of-increase limits sytem 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 approximate the outlays that would result from a 4.5 percent update. Our recommended update factor is 2.9 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 fiscal year	General update	HCFA recommended additional adjustment	HCFA recommended fiscal year 1992 update
1982	2.9		2.9
1983	2.9	1.8	4.7
1984	2.9	3.8	6.7
1985	2.9	6.0	8.9
1986	2.9	3.9	6.8
1987	2.9	1.8	4.7
1988 and later	2.9		2.9

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PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE CONGRESS

MARCH 1, 1992

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March 1, 1992

The Honorable Dan Quayle
President of the Senate
United States Senate
Washington, DC 20510

Dear Mr. President:

I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101-508. This report provides an overview of trends in Medicare spending and sites of care from 1980 to 1990. The report also contains 23 recommendations and addresses several additional concerns that reflect the Commission's collective judgment about issues of substantial importance to beneficiaries, hospitals, other providers, and the Medicare program.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

Prospective Payment Assessment Commission

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March 1, 1992

The Honorable Thomas Foley
Speaker
United States House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101-508. This report provides an overview of trends in Medicare spending and sites of care from 1980 to 1990. The report also contains 23 recommendations and addresses several additional concerns that reflect the Commission's collective judgment about issues of substantial importance to beneficiaries, hospitals, other providers, and the Medicare program.

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Executive Summary

Executive Summary

In this report for fiscal year 1993, the Prospective Payment Assessment Commission (ProPAC) discusses trends in Medicare spending for facility services and their implications. The Commission also presents 23 recommendations and addresses several additional concerns regarding Medicare facility payment methods. This report reflects ProPAC's analysis and the collective judgment of its Commissioners about issues of substantial importance to enrollees, hospitals, other providers, and the Medicare program. The report is made directly to Congress, although the Secretary of Health and Human Services (HHS) is required to respond to the Commission's recommendations.

ProPAC's original mandate was to advise the Congress and the Secretary on the Medicare prospective payment system (PPS) for hospitals. The Commission continues to devote substantial effort to updating and improving policies for paying hospitals under PPS as well as those that are excluded. However, ProPAC's responsibilities have expanded over time to include analyzing and developing prospective payment policies for all facility services furnished to Medicare beneficiaries. The Congress also has asked ProPAC to examine and report on broader issues regarding the effectiveness and quality of health care delivery in the United States. The expansion of ProPAC's responsibilities provides an opportunity for the Commission to examine the interrelationships among alternative facility payment policies and to improve policies so that an appropriate continuum of care at a reasonable level of spending is encouraged.

MEDICARE SPENDING AND SITES OF SERVICE

When Medicare began, most covered services were provided in acute care hospitals and physicians' offices. But as the Medicare program added new benefits, and as medical practice patterns changed and new technological capabilities were developed, the number and types of services provided in outpatient and other settings have increased. Inpatient hospital services continue to account for the largest share of health care spending, although that share is diminishing. An increase in the delivery of services in other sites has been encouraged by Medicare policies and payment incentives. As a result, new providers, facilities, and sites of care have grown rapidly, as has Medicare spending for services furnished outside the hospital.

Medicare payment policies are specific to the type of facility in which a service is provided. As sites of care have emerged, Medicare has developed payment policies for some new categories of providers. The Commission is responsible for analyzing current and proposed prospective payment policies for inpatient hospitals paid under PPS, PPS-excluded hospitals and distinct-part units, hospital outpatient services, skilled nursing facilities (SNFs), home health agencies, and renal dialysis facilities.

Among the other sites of care that Medicare does not specifically recognize for facility payment are ambulatory care centers, diagnostic imaging centers, lithotripsy centers, and outpatient psychiatric clinics. For payment purposes, these sites are often treated as physicians' offices or as physician-directed clinics. Thus, the covered services provided in these facilities are paid for according to Part B rules for physician and other ambulatory services.

Many services can be furnished in alternative settings, so payment policy for one type of facility may affect utilization and spending in others. A comparison of the rate of increase in spending across facility types suggests that the current fragmentation and inconsistency of Medicare payment policies across facilities and settings may be contributing to accelerating program expenditures. Between 1980 and 1990, spending per enrollee for hospital services rose 28 percentage points more than general inflation. Real spending per enrollee at other facilities recognized by Medicare increased 170 percent. Real Medicare expenditures per enrollee for physician services climbed 84 percent. This includes payments for many services provided in facilities not paid separately by

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Medicare. A 20 percent growth in Medicare enrollees during the 1980s contributed to an 89 percent real increase in total program expenditures.

Medicare spending for inpatient hospital services is still the program's largest single expenditure category, totaling almost $59 billion in 1990. Because the growth in spending for inpatient hospital services was slower than that for other types of facility and physician services, the proportion of Medicare spending on inpatient services fell from 67 percent in 1980 to 54 percent in 1990. At the same time, the share of Medicare spending on other recognized facilities increased from 10 percent to 19 percent.

The relatively slow increase in Medicare inpatient spending was due in part to the implementation of PPS. Before PPS, hospitals were reimbursed for the costs they incurred. Since the third year of PPS, payments per discharge have increased substantially less than operating costs per discharge.

Utilization changes have a major influence on Medicare spending patterns. The proportion of Medicare enrollees receiving services increased from 63 percent to 78 percent between 1980 and 1989. The proportion of Medicare enrollees using inpatient hospital services fell from 23.7 percent to 19.2 percent in the same period. The fall-off in admissions occurred in PPS hospitals; admissions to PPS-excluded hospitals and distinct-part units rose rapidly. Utilization of post-acute services in SNFs, rehabilitation hospitals, and home health care agencies also increased. Thus, the relatively slow growth in Medicare spending for inpatient acute care services and the large increases in spending for outpatient and other facility services resulted in part from a shift in the site of care. Increases in the number of services provided per beneficiary also contributed to higher expenditures.

Changes in the use of health care services, including the shift to outpatient settings, contributed to a nearly 20 percent increase in the average complexity of Medicare cases treated in PPS hospitals. These changes also led to a substantial increase in hospital outpatient utilization, with 46 percent of Medicare enrollees receiving these services in 1989, compared with 28 percent in 1980. Utilization of SNF services grew as well, peaking during 1988 and 1989 due to clarification of coverage rules and improved benefits under the Medicare Catastrophic Coverage Act of 1988 (MCCA). SNF utilization declined following the repeal of the Act in 1990, although it remained above pre-MCCA levels. The use of home health care agency services rose sharply during the early 1980s, but leveled off in the mid-1980s. Home health visits have been climbing since coverage criteria were clarified in 1989. The number of beneficiaries receiving dialysis for end-stage renal disease (ESRD) doubled during the 1980s, and annual admissions to hospices rose steadily after the introduction of the hospice benefit in 1984, reaching 100,000 in 1990.

Changes in facility capacity mirrored those in utilization patterns. The number of PPS-eligible hospitals and beds both declined every year from the introduction of PPS in 1983 to 1990. Because total inpatient days fell even more rapidly, however, excess inpatient capacity increased. By contrast, the number of PPS-excluded hospitals rose, with psychiatric and rehabilitation hospitals and distinct-part units showing the largest growth. The number of outpatient facilities participating in Medicare also jumped dramatically after PPS was introduced. Ambulatory surgical centers (ASCs) rose 670 percent, while the number of home health agencies grew by 22 percent.

Payment methods and payment rates can vary when the same service is provided at different sites, thus influencing utilization. Hospitals paid under PPS receive a prospectively determined payment, based on patient diagnosis. Payment to PPS-excluded hospitals, on the other hand, is based on the hospital's own historical costs, trended forward. Skilled nursing facilities and home health care agencies are paid reasonable costs, subject to certain limits. Ambulatory services generally are covered under Part B of Medicare. For services provided in Medicare-recognized facilities, payments are made separately to the facility and to physicians. Ambulatory surgical centers and dialysis facilities are paid a prospective rate. Independent clinical laboratories are paid according to a fee schedule. Payment to most other Medicare-recognized outpatient facilities is based on either reasonable costs or reasonable charges.

The variation in payment methods and rates for the same service at different sites may introduce

inappropriate financial considerations into the clinical decisionmaking process. It may also contribute to the growth in service capacity and encourage inappropriate use of services. The Commission believes that Medicare payment policies should be designed to provide consistent financial incentives and appropriate payment amounts across the different types of providers and practitioners. Related to this, ProPAC believes that the payment systems should promote quality of care throughout an episode of illness. Thus, incentives created by Medicare payment policies should be consistent with the goals of ensuring both access to appropriate high-quality care throughout an episode of illness and cost-efficiency of the care delivered.

The interaction of payment policies for inpatient and outpatient services directly affects both where those services are provided and their quality. Because of this, incremental policy changes cannot be evaluated in isolation. Rather, efforts to alter and improve PPS need to be considered in the broad context of the entire system. The recommendations in this report are consistent with these beliefs.

SUMMARY OF THE RECOMMENDATIONS

In Chapter 2, ProPAC presents 23 recommendations for updating and improving Medicare payment policies. The Commission also comments on other issues of importance to the Medicare program that may require action in the near future. ProPAC believes these proposed changes are necessary for maintaining access to high-quality health care, encouraging hospital productivity and cost-effectiveness, and permitting the adoption of innovative and appropriate technological advances. The Commission developed its recommendations by setting priorities, analyzing information, and deliberating on the implications of alternative policies. ProPAC also pays close attention to the concerns of the Congress, the Administration, health care providers, third-party payers, enrollees, and the public. The recommendations are offered to comply with the Commission's statutory mandate and to contribute to an informed, open debate about hospital payment policy and the Medicare program. For fiscal year 1993, ProPAC focused on six broad areas:

- Updating PPS payments,
- Adjusting the payment system,
- Updating and adjusting payments to PPS-excluded hospitals and distinct-part units,
- Updating payments to dialysis facilities,
- Improving hospital outpatient payment policy, and
- Improving skilled nursing facility payment policy.

Updating PPS Payments–The Commission recommends fiscal year 1993 updates equal to the increase in the Health Care Financing Administration's (HCFA) PPS market basket minus 1.45 percentage points for hospitals in urban areas and market basket minus 0.45 percentage points for hospitals in rural areas. Based on current HCFA projections, these updates are 3.05 percent and 4.05 percent, respectively. The average update is market basket minus 1.3 percentage points, or 3.2 percent.

The update recommendation combines five components. First, the fiscal year 1993 HCFA market basket is forecasted to increase 4.5 percentage points. Second, 0.2 percentage points are added to better reflect the increases in hospital labor costs that are not adequately measured in HCFA's market basket. Third, an adjustment of –0.8 percentage points for errors in the fiscal year 1991 market basket forecast is made. Fourth, a net discretionary adjustment factor (DAF) of zero reflects the Commission's judgment that scientific and technological advancement should be funded out of productivity gains. Fifth, a –0.7 percentage point adjustment for case-mix change offsets the estimated extra revenues hospitals received in fiscal year 1992 from case-mix index (CMI) increases that were not due to treating sicker patients.

The Commission supports the phased elimination of the differential between the standardized amounts paid to hospitals in rural areas and to those in urban areas with fewer than one million people. Therefore, an additional 0.85 percentage points should be added to the update for rural hospitals, and 0.15 percentage points should be subtracted from the update for urban hospitals.

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For hospitals paid on the basis of a hospital-specific rate, the Commission recommends an update equal to the rural update of 4.05 percent.

The update is only one source of the increase in total PPS payments to hospitals. Change in the case-mix index, which is estimated to rise 2.3 percent during fiscal year 1993, will also drive up payments. As a result, the average increase in per case payments, including CMI change and all of ProPAC's recommendations, is expected to be 5.6 percent in fiscal year 1993.

ProPAC believes there should ultimately be one payment for hospital inpatient operating and capital expenses. It therefore recommends the development of a single update factor for adjusting PPS operating and capital payments, consistent with the existing PPS operating update framework. This single update factor should be implemented for fiscal year 1994.

Adjusting the Payment System–The current indirect medical education (IME) adjustment more than adequately compensates hospitals for the increased costs associated with teaching activity. However, the financial performance of major teaching hospitals, especially those that serve a large share of low-income patients, is worse than that of other hospital groups. The Commission is concerned that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care might be impaired by a substantial immediate reduction of Federal support. The Commission therefore believes that gradual reduction of the IME adjustment to the appropriate level would be a prudent course of action. Thus, for fiscal year 1993, ProPAC recommends reducing the level of the IME adjustment from 7.7 percent to 7.0 percent for every 10 percent increase in teaching intensity, with the savings from this reduction returned to disproportionate share (DSH) teaching hospitals through an increase in the DSH adjustment for these hospitals.

Development of a single payment for operating and capital expenses would require a unified set of payment adjustments. ProPAC therefore recommends that, effective in fiscal year 1994, the indirect medical education and disproportionate share adjustments for capital payments should be made consistent with the IME and DSH adjustments for PPS operating payments. A single IME adjustment factor should be based on an evaluation of the relationship between teaching intensity and combined Medicare operating and capital costs per case. To develop a consistent IME adjustment, the measure of teaching intensity used for operating payments—the ratio of residents per bed—should also be used for capital payments. In addition, to develop a consistent DSH adjustment, the criteria used to designate disproportionate share providers for the DSH operating adjustment should be applied to capital.

ProPAC has long believed that the current definition of labor market areas used to make wage index adjustments to PPS payment does not accurately reflect actual labor market conditions. The need to improve these definitions, which are used to construct the area wage index under PPS, was underscored by the recent geographic reclassification of more than 800 hospitals into different labor market areas. The Commission is working with HCFA and the American Hospital Association to develop by fiscal year 1994 an alternative approach to alleviate many of the problems inherent in the current definitions. ProPAC recommends that Congress await the outcome of this effort before taking further action on labor market definitions.

The Commission has been evaluating the impact of two alternative proposals for a major refinement of the diagnosis-related groups (DRG) patient classification system. Both proposals appear to permit more accurate classification of patients under PPS. Thus, payments to hospitals could more accurately reflect cost differences due to variations in severity of illness and other factors. However, further study would be needed to reach a final judgment regarding whether any of the proposed modifications is desirable. The Commission welcomes the views of hospitals and other entities as it continues to evaluate these proposals.

Medicare cases transferred out of one hospital and into another are paid a uniform per diem based on a DRG, up to the full DRG amount. In the Commission's view, these cases should be paid on a graduated per diem, up to the full DRG payment, in recognition of the higher costs associated with stabilization, evaluation, and surgery that generally take place early in a patient's hospital stay. ProPAC also recommends further examination of whether

hospitals have the appropriate incentives to receive and transfer patients, particularly with respect to outlier payments and for recuperative care.

The Commission has determined that current PPS payment policies provide adequate compensation to hospitals that treat Medicare beneficiaries with hemophilia. Therefore, it does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients.

ProPAC recommends that the Secretary evaluate and refine the current DRG assignment for patients with intractable epilepsy, particularly those receiving neurodiagnostic monitoring.

Medicare's Essential Access Community Hospital (EACH) Program is intended to encourage the development of rural regionalization plans with two levels of care. Rural primary care hospitals (RPCHs) will provide emergency and temporary inpatient care. Essential access community hospitals will act as full-service referral hospitals to the RPCHs. The program offers an option to hospitals that have recently closed or are considering discontinuing routine inpatient care. The Commission supports this attempt to increase overall system efficiency without sacrificing access to care, but believes that the current program's focus is too narrow. Therefore, ProPAC urges the Secretary to waive some of the program requirements on an individual case basis to increase hospital participation and to gain additional experience with alternative policies.

The Peer Review Organization (PRO) program should continue to track, at the case and facility levels, the care furnished Medicare beneficiaries, while developing the ability to monitor care at the regional and national levels. ProPAC therefore supports the development of the nationally representative Uniform Clinical Data Set (UCDS). However, it is concerned that monitoring quality of care at the case and facility levels will be deemphasized. The PROs should be funded at an appropriate level to allow them to perform all of these functions.

Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units–The Commission recommends fiscal year 1993 updates of market basket minus 0.4 percentage points for PPS-excluded hospitals and distinct-part units. In addition, hospitals excluded from PPS before 1989 should receive a positive allowance. Based on HCFA's current projections, the update should be 4.2 percent before adding the positive allowance.

The update factor recommendation combines five components. First, the fiscal year 1993 HCFA PPS-excluded market basket is forecasted to increase 4.6 percentage points. Second, 0.2 percentage points are added to better reflect the increases in hospital labor costs that are not adequately measured in HCFA's market basket. Third, an adjustment of –0.7 percentage points for errors in the fiscal year 1991 market basket forecast is made. Fourth, a 0.1 percentage point allowance is recommended for scientific and technological advancement. Fifth, a positive allowance ranging from 2.1 to 6.9 percentage points should be given to hospitals excluded from PPS before 1989. This allowance reflects the difference between the market basket and the actual updates given in earlier years.

Updating Payments to Dialysis Facilities–The Commission does not now have adequate data on which to base a recommendation concerning an appropriate update for ESRD composite rate payments. It therefore urges the Secretary to expedite the development of the data necessary to evaluate the cost of providing dialysis services.

Improving Hospital Outpatient Payment Policy–ProPAC believes that a prospective payment system for outpatient services should be implemented. This system should ultimately include all providers of outpatient services. Reform of outpatient payment policies should take into account the relationship between costs and services across inpatient and outpatient settings. This would imply that the eventual unit of payment should be for a bundle of related services. At this time, however, the unit of payment should be based on individual services.

The outpatient payment system should avoid introducing inappropriate financial considerations into the clinical decisionmaking process. However, it should reward providers for delivering cost-effective quality care in the appropriate setting. ProPAC thus offers the following outpatient payment policy principles. First, the payment method for the technical or facility component should be consistent across sites, but the payment rate should be adjusted to reflect cost differences that have societal benefit, such as standby capacity or emergency capabilities.

Second, if services are included in the Medicare Volume Performance Standard (VPS) when delivered in free-standing settings, they also should be included in the VPS when provided in hospital outpatient departments. Finally, Part B coinsurance for prospectively paid outpatient services should be 20 percent of the payment amount Medicare allows, regardless of delivery site.

To support development of prospective payment for outpatient services, a mechanism for periodic collection of procedure-specific cost data in free-standing settings should be implemented. The Commission supports the research being conducted by the Physician Payment Review Commission (PPRC), and intends to work with both the Secretary and PPRC in assessing available data sources.

ProPAC is concerned about lack of quality oversight in the ambulatory care setting. The Secretary should enhance and further develop methods to assess the quality of care provided to Medicare beneficiaries in all outpatient settings.

In light of the principles outlined above, ProPAC examined current payment policies for outpatient ambulatory surgery and radiology services. It recommends that payment for ambulatory surgeries performed in the hospital outpatient setting should be fully prospective and based on national rates. The national rates, in turn, should be based on a revised classification system that applies to both free-standing and hospital-based ambulatory surgery facilities. The level of the national rates should be computed in a budget neutral fashion, using both average hospital costs and payments to free-standing ambulatory surgery facilities. The national rates should be updated annually, using an appropriate update factor.

The Commission also recommends that payment for outpatient radiology services performed in the hospital outpatient setting should be fully prospective and based on national rates. The payment rates should be computed in a budget neutral fashion, using both average hospital costs and the technical component of the Medicare Fee Schedule for physicians. The rates should be adjusted to reflect differences in labor costs and updated annually.

Improving Skilled Nursing Facility Payment Policy–ProPAC believes it is inappropriate to use the current hospital wage index in calculating SNF cost limits. It recommends that the Secretary collect data on employee compensation and paid hours of employment for workers in nursing homes that receive Medicare patients. Using these data, the Secretary should develop a nursing home wage index to create cost limits for SNF payment.

The current SNF payment methodology does not recognize differences in the costs of care provided to different types of patients. Medicare's per diem payment for patients who require intensive nursing and rehabilitative care is the same as that for patients who require fewer resources. Since Medicare beneficiaries often need more intensive nursing care than other patients, the payment system creates financial disincentives for SNFs to treat Medicare beneficiaries. The Commission therefore supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration.

RECOMMENDATIONS FOR FISCAL YEAR 1993

Updating PPS Payments

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1993, the PPS standardized payment amounts should be updated to account for the following factors:

- The projected increase in the Health Care Financing Administration (HCFA) PPS market basket index, currently estimated at 4.5 percent;
- An upward adjustment of 0.2 percentage points, to reflect the difference between the ProPAC and HCFA market baskets;
- A correction for substantial error in the fiscal year 1991 market basket forecast of –0.8 percentage points;
- A net discretionary adjustment factor of zero; and
- A net adjustment of –0.7 percentage points for case-mix change.

In addition, a positive adjustment of 0.85 percentage points for hospitals in rural areas and a negative adjustment of 0.15 percentage points for hospitals in large urban and other urban areas should be made to reflect a continuation of the phase out of the differential in the standardized amounts between rural and other urban hospitals.

Recommendation 2: Amount of the Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates

The Commission believes that payments based on hospital-specific base-year costs for sole community hospitals and for small rural Medicare-dependent hospitals should be updated by the same factor that applies to the PPS rate for rural hospitals.

Recommendation 3: Updating Capital Payment Rates

The Commission recommends that a single update factor be developed for adjusting PPS operating and capital payment rates. The update framework should be consistent with that currently used by ProPAC to develop the PPS operating rate update recommendation, and should be put into use for fiscal year 1994.

Adjusting the Payment System

Recommendation 4: Level of Indirect Medical Education and Disproportionate Share Adjustments to PPS Operating Payments

The Commission recommends that the indirect medical education adjustment to PPS operating payments be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

Recommendation 5: Consistency of Indirect Medical Education and Disproportionate Share Adjustments to PPS Capital and Operating Payments

The Commission recommends that the same level of indirect medical education and disproportionate share payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in fiscal year 1994. Further, ProPAC believes that the methods of determining these adjustments to PPS operating payments should also be applied to capital payments. Therefore:

- The measure of teaching intensity used for the indirect medical education adjustments should be defined in terms of the ratio of residents per bed, and
- The criteria for designation as a disproportionate share provider should be based on urban or rural location and number of beds.

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the PPS rate.

Recommendation 6: Improvements in Labor Market Definitions

The Commission believes that the current PPS labor market definitions need to be improved or replaced as soon as possible. Suitable alternative definitions, however, are not immediately available. In cooperation with the American Hospital Association and the Health Care Financing Administration, ProPAC is developing alternative labor market definitions that may alleviate many of the current problems. On the basis of this effort, the Commission hopes to be able to recommend substantially revised labor market definitions for fiscal year 1994.

Potential Major Refinements to the DRGs

The Commission has recently completed a partial evaluation of the impact of alternative proposals for major refinement of the DRGs. The results indicate that these refinements would allow more accurate classification and payment for Medicare cases. Further study would be needed, however, to reach a final judgment regarding the desirability of any of the proposed modifications. Therefore, ProPAC is not recommending adoption of major changes at this time. The Commission is interested in the views of hospitals and other entities as it continues to assess the desirability and impact of these refinements.

Recommendation 7: Medicare Transfer Payment Policy

Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. The Commission believes that hospitals are penalized by the current payment for transfers and that further examination of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.

Recommendation 8: Payment for Hemophilia Blood Clotting Factor

The Commission believes that current PPS payment policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, the Commission may reevaluate this issue.

Recommendation 9: Payment for Epilepsy Cases

The current DRG assignment should be revised to account for the resource requirements of patients with epilepsy receiving intensive neurodiagnostic monitoring.

Recommendation 10: Essential Access Community Hospital Program

The Commission recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, the Commission believes that overall system efficiency may be improved without sacrificing access to care.

PRO Review and Quality of Care

The Commission believes the Peer Review Organization program should continue to monitor, at the case and facility levels, the care furnished to Medicare beneficiaries. Although the Commission commends the planned expansion of epidemiologic patterns of care studies using the Uniform Clinical Data Set, these more general analyses should not replace all case-level and facility-level quality review. Further, funding should be sufficient to allow PROs to perform case-level and facility-level review, as well as more general analyses of broad patterns of care.

Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units

Recommendation 11: Fiscal Year 1993 Update Factor for PPS-Excluded Hospitals and Distinct-Part Units

For fiscal year 1993, the target rate of increase for PPS-excluded hospitals and distinct-part units should be updated to account for the following factors:

- The projected increase in the HCFA PPS-excluded hospital market basket, currently estimated at 4.6 percentage points;
- An upward adjustment of 0.2 percentage points, to reflect the difference between HCFA's market basket and that recommended by ProPAC;
- A correction for fiscal year 1991 market basket forecast error of –0.7 percentage points; and
- An allowance for scientific and technological advancement of 0.1 percentage points.

In addition, a positive allowance should be given to TEFRA providers that entered the program before fiscal year 1989, depending on the year on which their target rates were based. This allowance should reflect the difference between the actual updates given to their target rates in earlier years and the market basket for those years. It should result in aggregate payments that are budget neutral with respect to the legislated update.

Updating Payments to Dialysis Facilities

Recommendation 12: Update Factor for Payments to Dialysis Facilities

The Commission is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. The Commission recommends that HCFA expedite work necessary to complete its database of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis facilities and maintain a database with this information.

Improving Hospital Outpatient Payment Policy

Recommendation 13: Outpatient Payment Reform

The Commission believes that a prospective payment system for outpatient services should be implemented. Outpatient facility payment reform should ultimately include all providers of outpatient services, such as hospitals, physicians' offices, and free-standing ambulatory surgical centers.

The same payment method should apply to the facility or technical component of all services. The payment rate, however, should be adjusted to reflect justifiable cost differences such as wages and case mix. Further, cost differences that have some societal benefit like, for example, standby capacity and emergency capabilities, should also be reflected in the payment rate. Where feasible, the unit of payment should be based on bundled related services.

Recommendation 14: Medicare Volume Performance Standard

Services provided in the hospital outpatient setting should be included in the Medicare Volume Performance Standard (VPS) to the extent that these services are included when provided in other settings. Certain services, such as laboratory tests and therapy, currently are included in the VPS when they are furnished in free-standing settings. The Commission believes that hospital-provided services should also be incorporated in the VPS. Their inclusion will make incentives to control volume consistent across sites of care.

Recommendation 15: Cost Data Collection for Outpatient Providers

A mechanism for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers, should be implemented.

Recommendation 16: Beneficiary Liability

Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively should be limited to 20 percent of the payment amount allowed by Medicare.

Recommendation 17: Quality of Care in Outpatient Settings

The Commission is concerned about the lack of Federal quality oversight in many ambulatory care settings. As more services are furnished in outpatient settings, ProPAC believes the Secretary should enhance existing methods and develop new ones to assess and monitor the quality of care provided to beneficiaries in these settings.

Recommendation 18: Payment for Hospital-Provided Outpatient ASC-Approved Surgery

The Commission believes that payments for ambulatory surgery performed in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and free-standing ASC payments. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. National rates should be based on the classification system used to determine payments to free-standing ASCs. However, the Commission believes this classification system should be revised. The rates should be updated annually using an appropriate update factor.

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Recommendation 19: Revision of the Classification System Used to Group Ambulatory Surgery Cases

The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and free-standing ambulatory surgical centers should be used to establish the payment groups.

Recommendation 20: Payment for Hospital-Provided Outpatient Radiology Services

The Commission believes that payments for radiology services provided in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and the technical component of the Medicare Fee Schedule for physicians. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. The national rates should be updated annually using an appropriate update factor.

Recommendation 21: Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services

The Commission believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.

Improving Skilled Nursing Facility Payment Policy

Recommendation 22: Nursing Facility Wage Index

The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

Recommendation 23: Nursing Facility Case-Mix Adjustment

The Commission believes that the payment system should recognize differences in the costs of care for different types of patients. Therefore, it supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

Chapter 1

Medicare Spending and Sites of Service

The Medicare program today covers acute and post-acute care services provided in many different settings. When Medicare was enacted in 1965, the primary settings were acute care hospitals and physicians' offices. This has been changing, however, as the Medicare program has expanded and added benefits such as home health, hospice, and dialysis services. Changes in practice patterns and the development of new technological capabilities have also fostered the treatment of patients outside the hospital. All these factors have led to significant changes in how and where Medicare beneficiaries are treated.

New providers, facilities, and sites of care have grown rapidly; in many instances, the same service can be provided in a variety of settings. Home health agencies, skilled nursing facilities (SNFs), and rehabilitation facilities often provide similar post-acute care services. In many cases, these services can be used to shorten and reduce the cost of a beneficiary's inpatient hospital stay.

Spending for services delivered outside the hospital has increased markedly. Medicare payment is specific to the type of facility in which the service is offered. The payment method for a cataract extraction, for example, differs depending on whether the procedure is performed in an inpatient or outpatient hospital setting, a free-standing ambulatory surgical center (ASC), or a physician's office.

The current Medicare benefit and payment system, therefore, is made up of fragmented and sometimes inconsistent payment policies across the various facilities and settings. These policies may not encourage the most efficient use of resources or the most appropriate care. The coverage of and payment for services furnished by many new providers and facilities may make services for Medicare beneficiaries more accessible. On the other hand, the proliferation of facilities also contributes to the rapid growth in Medicare spending and may make it more difficult for beneficiaries to receive quality care at a reasonable price.

The Prospective Payment Assessment Commission's (ProPAC) original mandate was to advise the Congress and the Secretary of Health and Human Services (HHS) on the Medicare prospective payment system (PPS) for hospitals. This role has since expanded to include payment for hospital outpatient services, excluded hospitals and units, skilled nursing facilities, dialysis treatments for end-stage renal disease (ESRD) patients, and home health services. The broadening of ProPAC's responsibilities gives the Commission an opportunity to examine the interrelationship among alternative facility payment policies and to devise policies that encourage an appropriate continuum of care at a reasonable level of spending. Only through a careful analysis of the complex array of providers, benefits, and payment methods can such policies be developed.

This chapter gives an overview of the facilities that provide services to Medicare beneficiaries. It focuses on Medicare expenditures across the various facilities and explains the reasons for their growth. The first section reviews the types of facilities participating in the Medicare program. Medicare spending, utilization, and capacity. This discussion provides background on how the program has evolved over the past decade. The chapter then examines the reasons for Medicare spending growth by facility type, focusing on payment policy and utilization effects. This is followed by a description of the relationship between utilization and spending trends by taking a broader look at how those forces interact and affect total Medicare

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Table 1-1. Provider and Facility-Specific Payment Policies

Provider/Facility	Method of Payment
Medicare-recognized Part A providers[a]	
Hospitals (inpatient)	PPS and costs subject to TEFRA limits
Skilled nursing facilities	Costs subject to limits
Home health agencies	Costs subject to limits
Hospice programs	Cost-related prospective payment
Medicare-recognized Part B providers[b]	
Hospitals (outpatient)	Varies by service
Comprehensive outpatient rehabilitation facilities	Reasonable costs
Rehabilitation agencies and clinics	Reasonable costs
Other Part B facilities recognized by Medicare	
Ambulatory surgical centers	Prospective rate
Dialysis facilities	Prospective rate
Cardiac rehabilitation facilities	Reasonable charge
Independent clinical laboratories	Fee schedule
Physical and occupational therapy practices	Reasonable charges subject to salary equivalency guidelines
Rural health clinics	Reasonable costs

[a] For beneficianes with Part B but no Part A coverage, some of the services furnished by these providers are covered as a Part B benefit.

[b] Includes ambulance and portable X-ray suppliers.

SOURCE: Information compiled by ProPAC.

expenditures and patterns of care. The chapter ends by highlighting Commission activities related to developing and refining prospective payment for these various facility-based providers.

FACILITIES INVOLVED IN MEDICARE

Medicare beneficiaries receive services in a variety of facilities (see Table 1-1). This section focuses on the major types of facilities included in the Commission's mandate: inpatient hospitals paid under PPS, hospitals and units excluded from PPS, outpatient hospital care, skilled nursing facilities, home health agencies, and renal dialysis facilities. In addition, the section examines changes in spending for independent laboratory, hospice, and physician services. Although Medicare recognizes a number of other facilities and providers for payment, they are not discussed here since they account for relatively low expenditures, and data on them are limited.

There are many additional sites of care that Medicare does not recognize for facility payment, but where specific services furnished are covered under Part B rules (see Table 1-2). In these cases, the facility does not have to meet conditions of program participation. Many of these sites of care are treated as physicians' offices or physician-directed clinics.

Medicare Spending

Medicare spending continues to rise at near double-digit rates, despite a decade of intensified attempts at cost control. Medicare Part B expenditures for physician and other ambulatory services have grown much faster than spending under Part A, which covers hospitals and some other facility services. Between 1980 and 1990, Part B spending increased by more than 280 percent, while spending under Part A rose by about 160 percent. By contrast, general inflation in the U.S. economy during that period was 57 percent.

Between 1980 and 1990, total Medicare spending per enrollee increased by 147 percent. The 28 percent growth in spending per enrollee, adjusted for inflation, was much less in inpatient hospitals than in other settings (see Figure 1-1). Real growth in spending per enrollee increased fastest in other facilities recognized by Medicare (SNF, home health agencies, hospices, outpatient facilities, and clinical laboratories), a cumulative 170 percent between 1980 and 1990. The real growth in physician spending per enrollee was about 84 percent.

Table 1-2. Sites of Care Without Specific Medicare Policies

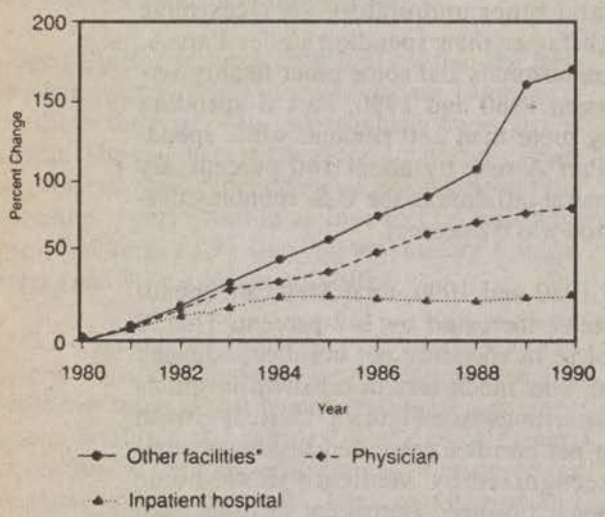
Type of Provider	Major Services Offered
Ambulatory care centers	Primary urgent care, occupational medicine, diagnostic imaging, rehabilitation/sports medicine, psychiatric treatment, substance abuse treatment
Diagnostic imaging centers	X-ray, mammography, ultrasound, magnetic resonance imaging, computerized axial tomography scans
Cancer centers: comprehensive radiation oncology	Radiation therapy, chemotherapy, cancer screening and prevention, patient education, rehabilitation
Women's centers	Mammography, breast services, premenstrual syndrome care, diabetes care/education, pap smear
Lithotripsy centers	Extracorporeal shock wave lithotripsy for kidney stone removal
Outpatient psychiatric clinics	Psychiatric treatment, medication monitoring, substance abuse treatment, suicide counseling
Pain clinics	X-ray, psychological testing, laboratory tests, physical examinations, drug therapy, physical therapy

SOURCE: Project HOPE under contract to ProPAC.

The change in the growth of Medicare spending has shifted the proportion of expenditures accounted for by hospitals and other services. In 1980, about 67 percent of Medicare spending was for inpatient hospital services, 23 percent was for physician services, and 10 percent was for other program benefits (see Figure 1-2). By 1990, only 54 percent of Medicare spending was for inpatient hospital services, and 27 percent was for physician services. Other services accounted for 19 percent of total Medicare spending.

Spending for inpatient hospital services is still by far the largest single expenditure category in Medicare, totaling almost $59 billion in 1990 (see Table 1-3). The growth in spending for inpatient

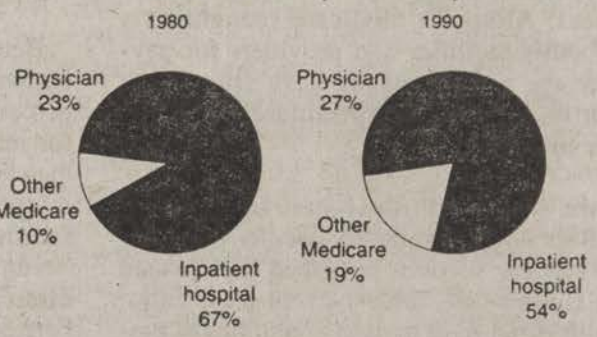
Figure 1-1. Cumulative Growth in Real Medicare Spending Per Enrollee, 1980–1990 (In Percent)



*Other facilities include outpatient hospitals and other included providers, skilled nursing facilities, home health agencies, hospices, and independent laboratories.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Figure 1-2. Total Medicare Spending, by Type of Facility or Service, 1980 and 1990 (In Percent)



SOURCE: Health Care Financing Administration, Office of the Actuary.

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Table 1-3. Estimated Medicare Benefit Payments, by Type of Service, 1980-1990

	Part A								Part B			
	Total Medicare		Inpatient		Skilled Nursing		Home Health Agency*		Physician *		Outpatient	
Year	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change	Payments (In Billions)	Percent Change
1980	$ 36.5	--	$24.4	--	$0.4	--	$0.8	--	$ 8.5	--	$2.0	--
1981	43.7	19.8%	29.2	19.7%	0.5	9.5%	1.1	29.1%	10.1	19.5%	2.4	19.2%
1982	51.2	17.3	33.8	15.7	0.5	9.3	1.4	30.9	12.2	20.2	2.8	19.1
1983	58.1	13.5	37.6	11.2	0.5	6.7	1.8	28.3	14.3	17.2	3.3	16.4
1984	64.8	11.5	41.9	11.4	0.6	6.9	2.1	19.0	15.6	9.7	3.8	14.2
1985	69.9	7.9	44.3	5.7	0.6	2.9	2.2	5.3	17.2	9.8	4.4	16.8
1986	75.4	7.8	45.8	3.5	0.6	0.2	2.2	1.0	19.6	14.0	5.3	20.1
1987	81.7	8.4	48.0	4.7	0.6	9.0	2.2	-0.5	22.2	13.3	6.2	17.7
1988	88.9	8.8	50.8	5.9	1.0	51.7	2.4	8.5	24.5	10.5	7.0	13.1
1989	100.0	12.5	55.0	8.3	3.4	258.1	3.0	24.2	27.1	10.5	7.6	8.3
1990	108.4	8.4	58.9	7.1	2.4	-29.3	4.4	46.8	29.4	8.5	8.5	11.3

Note: Payments reported here are incurred expenditures rather than outlays.

* Includes Part B home health agency expenditures.

SOURCE: Health Care Financing Administration, Office of the Actuary.

hospital services, however, has been much slower than that for other facilities. Although data on spending by type of inpatient facility (PPS short stay or excluded provider) are limited, growth in spending was probably faster in excluded hospitals because the number of Medicare discharges from these providers increased substantially between 1985 and 1988, while discharges declined for short stay facilities. Excluded hospitals accounted for about 8 percent of Medicare inpatient spending in 1990.[1]

Spending for outpatient hospital care and other facilities rose by more than 325 percent between 1980 and 1990, from $2.0 billion to $8.5 billion. Much of this increase was due to a shift in site of service delivery. Cataract surgery, which in the early 1980s was performed almost exclusively in the inpatient setting, is illustrative. By 1990, cataract surgery was performed almost exclusively in outpatient settings.

Spending for SNF care climbed from $0.4 billion in 1980 to $2.4 billion in 1990, a 500 percent increase. The rise was most pronounced in 1988 and 1989. Home health agency spending also rose markedly between 1980 and 1990. In 1980, it totaled about $0.8 billion, but by 1990 had increased by almost 450 percent, to $4.4 billion. Home health agency spending was the fastest growing part of the Medicare program in 1990.

Spending for hospice services was just over $350 million in 1990—a marked increase since the benefit was first introduced in 1984. The magnitude of this spending is quite small, however, compared with expenditures in other parts of Medicare.

In 1989, spending for dialysis services totaled $1.2 billion, with increases averaging 8.7 percent annually between 1984 and 1989.[2] The yearly increase in spending for dialysis treatment has been much more constant than that for other facilities due largely to greater numbers of patients served.

Specific data on spending in other Medicare-approved facilities are available only for independent laboratories. Expenditures for these laboratories rose dramatically between 1980 and 1990, spiraling more than 1,000 percent from $139 million to $1.5 billion.

Medicare spending for physician services totaled almost $30 billion in 1990, an increase from $8.5 billion in 1980. Although the growth in this spending category slowed in the latter part of the decade, it was still substantially faster than that for inpatient hospital services and more than twice the increase in general inflation. Real spending per enrollee rose by 84 percent during the 1980s. Spending controls placed on physicians, such as physician fee freezes, may have had some effect on the slower growth seen by the end of the decade.

Table 1-4. Trends in Medicare Enrollment,1980-1991 (In Millions)

Year[a]	Number of People		
	Total	Aged	Disabled
1980	28.5	25.5	3.0
1981	29.0	26.0	3.0
1982	29.5	26.5	3.0
1983	30.0	27.1	2.9
1984	30.5	27.6	2.9
1985	31.1	28.2	2.9
1986	31.7	28.8	3.0
1987	32.4	29.4	3.0
1988	33.0	29.9	3.1
1989	33.6	30.4	3.2
1990	34.2	30.9	3.3
1991[b]	35.0	31.6	3.4

[a] As of July of the specified year.

[b] Estimated.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and the Office of the Actuary.

Medicare Facility Utilization

Utilization trends for Medicare services in the different sites are related to two basic factors: changes in the number of Medicare enrollees, and changes in treatment patterns due to new technologies and physician practice styles. The interaction of these two factors helps explain a major portion of spending growth.

Between 1980 and 1990, Medicare enrollment increased by about 20 percent to 34.2 million (see Table 1-4). The rise in the number of enrollees, however, generally affects spending growth in all parts of the program equally, contributing about 2 percent annually.

Changes in the proportion of beneficiaries using services are more important in explaining some of the variations in spending trends. Changing utilization is due to several factors. Among these are population aging, a greater supply of services and technological capabilities, and practice pattern changes. The percentage of enrollees receiving services under Medicare each year grew from 63 percent to 78 percent between 1980 and 1989 (see Table 1-5).

Spending growth for inpatient hospital services probably would have been much larger were it not for a decline in inpatient admissions and length of stay. The fall in inpatient use, however, was associated with a substantial increase in outpatient utilization. The decrease in length of stay coincided with greater utilization of SNFs, rehabilitation hospitals and units, and home health care agencies for post-acute care services.

Hospital admissions for those 65 and over decreased during the first three years of PPS. Since 1987, admissions have increased, but not as fast as the number of Medicare enrollees. The proportion of Medicare enrollees using hospital services fell from 23.7 percent in 1980 to 19.2 percent in 1989, an average annual decline of 2.3 percent. Overall, Medicare inpatient hospital utilization per enrollee has continued to drop, but much more slowly than between 1984 and 1986. Admissions to excluded hospitals and units, by contrast, increased substantially in the 1980s, rising by 43 percent between 1985 and 1988.

Medicare utilization of hospital outpatient services has increased notably. In 1980, 27.5 percent of Medicare enrollees used hospital outpatient facilities, compared with 45.8 percent in 1989. Higher outpatient utilization was due to the development of new technologies and changes in practice patterns, as has been noted. These caused a shift in services

Table 1-5. Aged and Disabled Persons Served by Medicare, 1980-1989 (Per 1,000 Enrollees)

Type of Coverage/Provider	Persons Served						Average Annual Percent Change
	1980	1982	1984	1986	1988	1989	1980-1989
Total	633.2	638.2	681.3	726.9	761.7	778.9	2.3%
Hospital Insurance (Part A)	240.6	251.4	239.9	211.0	207.6	206.2	-1.7
Inpatient hospital	237.1	243.5	229.0	203.2	197.5	192.3	-2.3
Skilled nursing facility	9.2	8.7	10.0	9.7	11.9	19.3	8.6
Home health agency	25.9	39.7	49.9	50.3	48.8	51.0	7.8
Supplementary Medical Insurance (Part B)	650.5	653.5	697.5	748.9	789.6	810.3	2.5
Physician	629.9	696.1	674.8	725.9	768.7	792.6	2.6
Hospital-provided outpatient services	275.1	297.3	332.2	399.6	447.6	458.1	5.8

Note: Rates based on enrollment in Part A, Part B or both, as appropriate.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy.

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from inpatient to outpatient settings, as well as an absolute growth in the number of services provided. The movement from inpatient to outpatient settings was further encouraged by Medicare policies and payment incentives.

Utilization also increased substantially for SNFs and home health agencies. In 1989, 1.9 percent of Medicare enrollees used skilled nursing facilities, compared with 0.9 percent in 1980. The number of covered days for SNF care increased markedly in 1988 and 1989, due largely to the clarification of coverage guidelines by the Health Care Financing Administration (HCFA) and to the Medicare Catastrophic Coverage Act of 1988 (MCCA). Utilization in 1990 declined from 1989 levels owing to repeal of the Act, but remained much higher than before the legislation was passed. The number of beneficiaries receiving SNF care continued to expand, however.

Use of home health agency services increased from 2.6 percent of enrollees in 1980 to 5.1 percent in 1989. There was a decided rise in home health visits through the early 1980s, although visits decreased in the 1985 through 1987 period. The early growth was due to the Omnibus Budget Reconciliation Act (OBRA) of 1980, which allowed more home health agencies to participate in the program. Recent growth in utilization is due partly to changes in coverage that expanded the number of beneficiaries covered and broadened the scope of home health agency care.

Medicare admissions to hospice programs have continued to increase since the hospice benefit was created in 1984. In fiscal year 1990, slightly more than 100,000 beneficiaries were admitted to these programs. The number of Medicare beneficiaries undergoing dialysis treatment doubled between 1980 and 1990 due to expanded medical indications.

The proportion of beneficiaries using physician services grew at a slower rate than for other facility services, 2.6 percent annually. However, almost 80 percent of enrollees used physician services in 1989, making this the most widespread benefit.

Facility Capacity

Increased total spending for certain types of facilities is partly explained by the greater number providing Medicare-covered services (see Table 1-6). This has a major effect on enrollees' access to and utilization of these services.

The number of short stay hospitals and beds has fallen every year since 1983. In 1990, there were 921,400 hospital beds, compared with slightly more than a million in 1983, a decline of 8.2 percent. Hospital admissions, however, decreased more rapidly; thus, excess capacity was substantially greater in 1990 than in 1983. While the number of short stay PPS-eligible hospitals has declined, the number of excluded hospitals has increased substantially. In 1990, there were 57 percent more excluded psychiatric hospitals and 173 percent more excluded rehabilitation hospitals than in 1984.

Table 1-6. Medicare Participating Facilities and Suppliers, 1980-1990

Facility/Supplier	1980	1982	1984	1986	1988	1990	Average Annual Percent Change
Hospitals	6,777	6,742	6,675	6,720	6,715	6,520	-0.4%
Short stay	6,104	6,070	6,038	5,994	5,856	5,549	-0.9
Long stay	673	672	637	726	859	971	3.7
Skilled nursing facilities	5,052	5,408	5,952	6,897	7,379	8,937	5.9
Home health agencies	2,924	3,415	4,684	5,978	5,769	5,730	7.0
Independent laboratories	3,447	3,581	3,801	4,138	4,487	4,879	3.5
Outpatient physical therapy providers	419	603	791	907	1,030	1,195	11.0
Portable X-ray suppliers	216	251	269	347	395	443	7.4
Rural health clinics	391	419	420	432	459	551	3.5
Comprehensive outpatient rehabilitation facilities	--	--	48	96	141	186	25.3
Ambulatory surgical centers	--	--	155	574	852	1,197	40.6
Hospices	--	--	108	268	449	825	40.3
Facilities providing services to ESRD beneficiaries	999	1,197	1,335	1,463	1,701	1,992	7.1

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy.

The supply of ambulatory services is growing rapidly. Although the specific number of facilities furnishing outpatient services is not readily available, data on increases in physicians and other information illustrate this trend. One important type of free-standing ambulatory provider for Medicare is the ambulatory surgical center. In 1990, there were 1,197 Medicare-participating ASCs—more than two and one-half times the number in 1985. Further, procedures performed at these centers rose almost 200 percent during this period, from fewer than 800,000 to more than 2.3 million.[3]

There have also been increases in nearly all types of other Medicare-eligible facility providers. The number of skilled nursing facilities furnishing services to Medicare beneficiaries climbed from 5,052 in 1980 to 8,937 in 1990, or 77 percent. The number of home health agencies grew by 96 percent during this period: by 1990, 5,730 home health agencies were participating in Medicare. The number of hospices also rose substantially between 1984 and 1990, largely because the benefit became a covered service in 1984.

The number of facilities providing renal dialysis expanded by about 100 percent between 1980 and 1990. The largest increase was among non-hospital renal dialysis facilities.

As noted earlier, numerous new ambulatory sites of care have emerged recently, among them ambulatory care centers, cancer centers, women's health clinics, and outpatient psychiatry clinics. Physicians, hospitals, for-profit entrepreneurs, and other entities have entered this market. The numbers of these other providers are unknown, however.

The supply of physicians also grew markedly over the decade. In 1980, there were about 468,000 physicians, compared with more than 600,000 in 1989, an increase of 28 percent. In contrast, the U.S. population grew by a little more than 9 percent.

REASONS FOR THE GROWTH IN MEDICARE FACILITY AND NONFACILITY SPENDING

Growth in Medicare spending across facilities has been influenced by a combination of factors: an increase in the beneficiary population, changes in utilization and in sites of care, and inflation. Changing practice patterns and treatment protocols also have had an effect. The largest component of Medicare spending, inpatient hospital services, has seen the smallest growth, while spending in other types of facilities has accelerated more rapidly. Lower rates of growth for inpatient services and higher growth rates in other settings are also partially the result of different Medicare policies to control expenditures. This section describes spending trends observed in each of the major types of Medicare facilities.

Inpatient Hospital

Since fiscal year 1984, payments to short stay hospitals have been based on patient diagnosis. There are about 490 diagnosis-related groups (DRGs) for payment purposes. Payment rates are increased annually based on an update factor set by the Congress. The updates have been less than the per unit increase in costs for inpatient hospital services, which has helped constrain the growth rate in Medicare inpatient hospital spending. Under PPS, a hospital generally knows in advance what it will receive in payment for the services it provides, unless the case is exceptionally costly or the stay is much longer than normal. Before the advent of PPS, hospitals were paid on the basis of costs, subject to certain limits. This payment method provided minimal incentives for efficiency.

Prospective payment coincided with significant changes in how hospitals provide care. A number of trends, such as reductions in length of stay and admission declines, were occurring even before PPS was implemented. In addition to the evolution of practice patterns, the growing use of post-acute services such as SNFs, home health care, and rehabilitation hospitals may have occurred even without implementation of PPS.

Payment constraints have had a substantial influence on spending growth for inpatient hospital services. However, payments per discharge increased dramatically during the first year of PPS because of the way that initial PPS rates were set and increases in the case-mix index (CMI), which is used to measure the severity or amount of service provided to patients (see Table 1-7). Growth in spending has been much lower since then, due to payment rate

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updates that were below the rise in costs. The extent to which these payment constraints have significantly affected increases in the total cost of providing services is unclear, however. In fact, hospital cost increases to furnish care have continued to outpace both general inflation and the hospital market basket, which measures the higher costs hospitals face to provide services.

Changes in the hospital CMI directly affected spending growth. Between fiscal years 1984 and 1990, the Medicare case-mix index rose by 19.2 percent due to the increasing complexity of patients or their treatments and coding practice changes. Greater patient or treatment complexity leads to higher resource costs. On the other hand, coding practice changes do not reflect higher costs, but do cause higher Medicare spending.

Falling inpatient hospital utilization and changing patterns of care—particularly the greater use of outpatient and post-acute care services—also have significantly affected Medicare spending. Lower utilization reduced aggregate spending increases for inpatient hospital services, but contributed to the notable increase in expenditures for other facilities. Changing the inpatient payment to a per case system provided incentives to increase utilization outside the hospital and decrease inpatient utilization. In turn, inpatient capacity, as measured by the number of hospitals and beds, fell after 1983. However, excess capacity, as measured by empty beds, remains at historically high levels.

Total Medicare inpatient hospital payments rose by 40 percent between 1984 and 1990. Payment rate changes and case-mix increases contributed most to this growth. Utilization changes initially were responsible for decreasing spending growth and, later, for holding it close to the payment rate change. Admissions growth rates have been below historical levels since the implementation of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and PPS. This trend indicates a continuing shift to treating patients in other settings.

PPS-Excluded Providers

When PPS was implemented, certain facilities were excluded: rehabilitation and psychiatric hospitals and distinct-part units, as well as children's, long-term, and cancer hospitals.[4] PPS-excluded providers are paid on the basis of each facility's historical costs trended forward, with a limit placed on the rate of increase in per case reimbursable costs. These target rate-of-increase limits, established by TEFRA, are updated annually. The target rate per discharge is derived from hospital-specific Medicare costs in a base year, which varies depending on when the facility was constructed or converted to a PPS-excluded category. The

Table 1-7. Medicare Inpatient Hospital Utilization and Spending, 1980-1990

Year	Inpatient Admissions (In Thousands)	Spending Per Admission	Real Spending Per Admission*	Total Inpatient Spending (In Millions)
1980	10,628	$2,281	$2,281	$24,242
1981	11,118	2,610	2,388	29,022
1982	11,309	2,969	2,558	33,580
1983	11,595	3,222	2,665	37,361
1984	11,358	3,666	2,914	41,638
1985	10,681	4,118	3,168	43,988
1986	10,232	4,442	3,330	45,452
1987	10,180	4,669	3,381	47,528
1988	10,229	4,919	3,418	50,316
1989	10,167	5,352	3,558	54,410
1990	10,282	5,669	3,608	58,288
Average annual percent change:				
1980-1985	0.1%	12.5%	6.8%	12.7%
1985-1990	-0.8	6.6	2.6	5.8

Note: Data excludes ESRD enrollees.

* 1980 dollars.

SOURCE: Health Care Financing Administration, Office of the Actuary.

payment mechanism provides hospitals with an incentive to keep cost increases close to the target increase level. There are no incentives to keep increases below the target rate or to control volume.[5]

PPS-excluded facilities have proliferated since 1984, but growth has not been uniform across all types of these providers (see Table 1-8). Those classified for payment as rehabilitation facilities grew most rapidly between 1984 and 1990. During this period, rehabilitation hospitals increased 173 percent, while rehabilitation distinct-part units rose 120 percent. Psychiatric facilities, which represent most PPS-excluded facilities, also have undergone rapid growth. Some existing psychiatric and rehabilitation hospitals were not recognized initially as excluded facilities and later applied for excluded status, which helps explain this trend.

Medicare discharges from most PPS-excluded facilities grew steadily from 1984 to 1988 (see Table 1-9). Most Medicare discharges from PPS-excluded facilities in 1988 were from psychiatric providers (63 percent of total PPS-excluded discharges). Rehabilitation providers treated about 33 percent of discharges from excluded facilities. The rest were treated at children's, long-term, and cancer hospitals. Distinct-part units, especially rehabilitation units, experienced the fastest growth in number of discharges during this period. The majority of beneficiaries receiving services in PPS-excluded facilities are treated in distinct-part units. By 1988, for example, nearly 70 percent of Medicare discharges from rehabilitation providers were from distinct-part units; about 66 percent of Medicare discharges from psychiatric providers were from such units.

A portion of the growth in utilization and expenditures of excluded facilities can undoubtedly be attributed to PPS. Part of the decline in inpatient care in short stay general acute care hospitals, for instance, may be due to increases in the number of patients admitted to specialty facilities. Further, hospitals created distinct-part units to absorb overhead, excess capacity, and other resources, allowing them to lower inpatient costs. They could also reduce costs by discharging patients to the excluded unit to reduce length of stay. Additional providers saw opportunities for growth as PPS and other forces reduced inpatient stays. It is impossible to attribute how much of the expenditure growth in excluded facilities is due to PPS and how much to changing practice patterns or growing need. This is an example, however, of how cost control attempts in one sector of the health care system increased spending in another.

Outpatient Facilities

Ambulatory services generally are covered under Part B of Medicare. These services include medical visits, diagnostic laboratory tests, X-rays, and durable medical equipment. The services may be provided by hospitals, physicians, non-physician practitioners, and suppliers. Various methods are used by Medicare to pay for beneficiary care in outpatient settings; among them, reasonable costs or charges, prospective

Table 1-8. PPS-Excluded Hospitals and Distinct-Part Units, 1984-1990

Type of Facility	Year*							Percent Increase 1984-1990
	1984	1985	1986	1987	1988	1989	1990	
Hospitals								
Psychiatric	439	481	515	578	608	650	691	57%
Rehabilitation	49	68	79	84	100	120	134	173
Long-term	84	86	92	87	87	88	90	7
Children's	47	53	55	60	58	59	65	38
Cancer	--	--	--	8	8	8	8	--
Total	619	688	741	817	861	925	988	60
Distinct-part units								
Psychiatric	722	762	906	950	1,051	1,104	1,129	56
Rehabilitation	308	386	473	535	565	628	678	120
Total	1,030	1,148	1,379	1,485	1,616	1,732	1,807	75

* Numbers were determined as of September of each year except 1990, which was as of December 17, 1990.

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau.

rates, and blended rates. The payment method differs depending on the site and type of service.[6]

Medicare spending for outpatient services has grown substantially, climbing by 325 percent between 1980 and 1990. Spending growth in the outpatient setting has been much faster than that for either physicians or hospitals. From 1989 to 1990, for instance, hospital outpatient expenditures increased 11.3 percent. This compares with an increase of 8.5 percent for physician services and 7.1 percent for hospital inpatient services.

Due to technological advances and practice pattern changes, hospitals can offer more types of ambulatory services to their patients. For example, 81 percent of hospitals reported having an organized outpatient department in 1989, compared with 32 percent in 1979. About two-thirds of this growth occurred after the introduction of PPS. By 1989, nearly 95 percent of hospitals had ambulatory surgery services.[7] Other outpatient services provided by hospitals include substance abuse treatment, psychiatric care, and rehabilitation.

One example of the changing medical services provided in hospital outpatient departments is surgery. The total volume of surgery in hospitals increased 16.8 percent from 1979 to 1989. Inpatient surgery actually declined 30 percent, while outpatient hospital surgery increased 304 percent. In 1979, outpatient surgical procedures accounted for only 14 percent of total surgeries. By 1989, they accounted for almost 49 percent.[8]

Medicare data on hospital outpatient utilization and spending per visit are rather limited. Information on total hospital outpatient spending, however, may help explain the causes of growth in outpatient expenditures (see Figure 1-3). In the 1980 to 1985 period, real spending growth in hospital outpatient services was due almost exclusively to increased spending per visit or to intensity. The causes for this trend cannot be broken down in detail, but probably include increasing complexity of cases, changing service mix, and higher charges. Some of the growth may also be explained by changes in the way visits are reported through unbundling. (Unbundling is the separate billing of services that were previously included in the same bill.) In the 1985 to 1990 period, the growth in visits due to technological advances and practice pattern changes was responsible for an increasing proportion of the total real growth in outpatient spending.

Some of the growth in Medicare outpatient spending can be attributed to PPS and the incentives to unbundle services by providing preadmission testing in hospital outpatient departments. Peer Review Organization precertification requirements for services like cataract surgery further contributed to the shift from inpatient to outpatient settings. Recent regulations expanding the preadmission time period from one to three days may reduce the number of outpatient visits that are separately reimbursable. Thus, while Medicare payment policy constrained per unit growth in outpatient spending by controlling payment rate increases, it provided

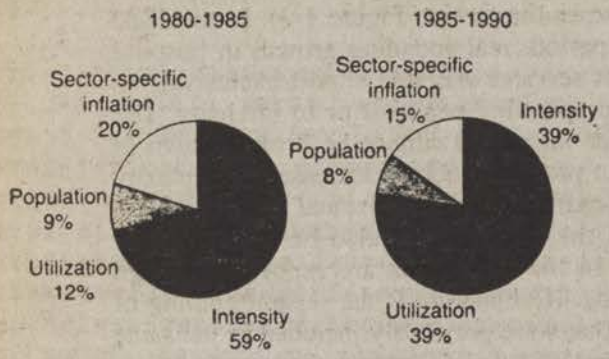
Table 1-9. Medicare Discharges from PPS-Excluded Hospitals and Distinct-Part Units, 1985-1988

Type of Facility	1985	1986	1987	1988	Percent Change 1985-1988
Psychiatric					
Hospitals	71,456	75,059	69,837	76,612	7.2%
Units	93,120	120,739	131,217	148,501	59.5
Total	164,576	195,798	201,054	225,113	36.8
Rehabilitation					
Hospitals	25,429	27,401	31,413	35,567	39.9
Units	45,650	57,566	68,813	82,723	81.2
Total	71,079	84,967	100,226	118,290	66.4
Long-term	14,477	14,666	13,712	14,304	-1.2
Children's	1,690	2,141	2,298	2,281	35.0

Note: These figures understate the actual number of Medicare discharges due to incomplete cost reports.

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Figure 1-3. Factors Accounting for Real Growth in Hospital Outpatient Expenditures, 1980-1990 (In Percent)



SOURCE: Health Care Financing Administration, Office of the Actuary, Office of National Health Statistics.

no incentive to control volume or intensity—the primary contributors to higher spending.

Skilled Nursing Facilities

Medicare's skilled nursing facility benefit is limited to payment for extended care services furnished in SNFs. The Medicare SNF benefit covers skilled nursing services; physical, speech, and occupational therapy; medical social services; drugs and biologicals; whole blood and packed red blood cells; supplies, appliances, and equipment; and other diagnostic and therapeutic items or services provided by the SNF or a hospital with which the SNF has a transfer agreement.[9]

To be eligible for the SNF benefit under Part A, beneficiaries must need skilled nursing or other skilled rehabilitation services on a daily basis. In addition, they must have completed a minimum three-day hospital stay and must have been transferred to a SNF within 30 days after discharge from the hospital. The need for SNF care must have been caused by the medical condition that led to the hospital stay or by one that arose during the hospitalization. The benefit is limited to no more than 100 days of post-hospital care per spell of illness. A daily coinsurance payment, equal to $81.50 in 1992, is required after the twentieth day of service.[10]

In general, Medicare reimburses SNFs under Part A on the basis of reasonable costs subject to certain limits. The limits apply nationwide but are set separately for urban and rural facilities, and hospital-based and free-standing providers. The Medicare SNF payment method creates an incentive for providers to increase costs up to the limit. Because Medicare accounts for a relatively small share of SNF care, however, cost growth is influenced more by the payment policies of the Medicaid program, which is the dominant payer.

Between 1980 and 1990, expenditures for the Medicare SNF benefit climbed sixfold, from $0.4 billion to $2.4 billion (see Table 1-10). Most of this increase occurred after 1988. Between 1988 and 1989, expenditures for this benefit jumped an unprecedented 258 percent. This was caused by two major changes to the SNF program in 1988 and 1989 that dramatically affected utilization, namely clarification of coverage guidelines in 1988 and the Medicare Catastrophic Coverage Act.[11] Both of these increased the number of enrollees using the benefit. In 1990, SNF expenditures decreased 29 percent after the Act was repealed.

Between 1980 and 1990, Medicare SNF payments per covered day of service increased 96 percent, from an average of $47.54 to $93.12. This growth was 39 percentage points more than general inflation over the period.

Medicare SNF payments per person served remained fairly constant between 1980 and 1985, rising roughly 3 percent annually. However, in 1987 they began to accelerate, increasing by 13 percent and, in 1988, by 16 percent.

Between 1988 and 1989, however, enrollees using the benefit increased 66 percent, and covered days escalated almost 175 percent because of the clarification of coverage guidelines and the MCCA cited earlier. In 1990, SNF expenditures fell almost 30 percent due to a decline in covered days per patient. The number of patients served, however, continued to grow. The clarification of coverage guidelines in 1988 kept both utilization and expenditures higher than pre-MCCA levels. Clearly, the dramatic increase in total program expenditures is due primarily to increased utilization rather than to price increases.

Utilization was substantially affected by changes that allowed more enrollees to use the SNF benefit. Higher SNF costs per day accounted for less than

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Table 1-10. Medicare Skilled Nursing Facility Utilization and Spending, 1980-1990

Year	Covered Days (In Thousands)	Patients Served* (In Thousands)	Days Per Patient Served	Cost Per Skilled Nursing Facility Day	Total Spending (In Millions)
1980	8,645	257	33.6	$ 47.54	$ 411
1981	8,518	251	33.9	52.83	450
1982	8,814	252	35.0	55.82	492
1983	9,314	265	35.1	56.37	525
1984	9,640	299	32.2	58.20	561
1985	8,927	314	28.4	64.64	577
1986	8,160	304	26.8	70.83	578
1987	7,451	293	25.4	84.55	630
1988	11,033	384	28.7	86.65	956
1989	30,046	636	47.2	113.93	3,423
1990	26,000	815	31.9	93.12	2,421
Average annual percent change:					
1980-1985	0.6%	4.1%	-3.3%	6.3%	7.0%
1985-1990	23.8	21.0	2.3	7.6	33.2

* These numbers are for fee-for-service only and may not include health maintenance organization enrollees.

SOURCE: Health Care Financing Administration, Office of the Actuary.

one-third of the growth. A small part of the increased utilization may also have been brought on by PPS, which provided hospitals with an incentive to reduce the length of inpatient stays by transferring patients to SNFs for post-acute care services. In 1984, for example, the number of Medicare patients receiving SNF care rose 12.8 percent over 1983.

Hospital Swing Beds

The Medicare swing-bed program was designed to address the shortage of nursing home beds in rural areas and low occupancy rates in rural hospitals. A swing-bed hospital is a small hospital that can use its beds interchangeably to furnish either acute care services or SNF-type services to Medicare beneficiaries. Swing-bed hospitals are generally allowed to use any number of their acute care beds for SNF-level care.

Hospitals began participating in the swing-bed program in 1982; only hospitals with fewer than 50 beds could qualify. In 1987, the program was extended to rural hospitals with fewer than 100 staffed beds, although additional requirements were placed on these hospitals. The number of hospitals participating in the program has increased every year since its implementation. In 1989, approximately 844 of 1,255 eligible hospitals participated in the program.

The Medicare swing-bed per diem rate, calculated for each state, is based on the state's average Medicaid SNF rate in the previous calendar year. Medicaid SNF payment levels and methods vary from one state to another.

The number of Medicare admissions to swing beds has increased. The average number of covered days for beneficiaries staying in swing beds has consistently been less than 20—substantially lower than that for beneficiaries in skilled nursing facilities.

Swing-bed days account for only a small proportion (about 5 percent) of total SNF care days provided to Medicare beneficiaries. However, the creation of swing beds may have increased access to post-acute care for beneficiaries living in rural areas who may not have such care available close to home. In 1988, there were fewer SNF beds per 1,000 population in areas where swing beds were located compared to those without swing beds.[12]

Home Health Care

Medicare beneficiaries can qualify for home health care benefits if they are confined to their homes and need occasional skilled nursing care for an acute or post-acute condition. Covered home health care services include part-time or intermittent nursing care; physical, occupational, or speech therapy; medical social services; part-time or inter-

mittent services of a home health aide; medical supplies; and durable medical equipment. There is no time limit or prior hospitalization requirement. Program guidelines generally limit part-time or intermittent nursing care to 35 hours per week for up to three weeks. There is no deductible or coinsurance charge for this care. Services must be provided by a Medicare-certified home health agency.

Payment to home health agencies is based on reasonable cost reimbursement subject to certain limits. The limits are set at 112 percent of the mean labor-related and non-labor related per unit costs for each type of service provided by freestanding home health agencies. The limits are applied on an aggregate basis to all visits made by the agency. The payment mechanism for home health care services provides an incentive to control costs for agencies that are above or near the payment cap. Agencies with costs below the cap, however, do not have as much incentive to keep costs down.

Spending for home health care climbed by 440 percent between 1980 and 1990. The largest increase occurred from 1989 to 1990, when spending jumped 47 percent to $4.4 billion (see Table 1-11). About 1.7 million beneficiaries received home health care services in 1990, an increase of 129 percent over 1980. Intensity of care, as measured by the number of visits per patient served, has fluctuated throughout the decade. It increased substantially, however, after 1988.

Between 1981 and 1984, beneficiaries served rose at double-digit rates because of a provision in OBRA 1980 that allowed for-profit home health agencies to participate in Medicare in states that do not require their licensing. This change significantly boosted the number of home health agencies participating in the program. There were 5,730 Medicare participating home health agencies in 1990, an increase of 96 percent over 1980.

The latest increase in utilization occurred because of a court case that required HCFA to revise the eligibility and coverage manual, and clarify the rules for part-time or intermittent care criteria. These changes, which became effective in July 1989, reduced provider concerns about retroactive coverage denials of intermittent or part-time care and included a provision for case management services.

The average charge per visit rose 76 percent from 1980 to 1990, only 19 percent more than general inflation. The increase between 1985 and 1990 was actually less than general inflation. Higher spending therefore is due to greater numbers of beneficiaries served and more visits per patient. The average charge per visit accounted for only a small part of the growth in home health expenditures.

Table 1-11. Medicare Home Health Care Utilization and Spending, 1980-1990

Year	Visits (In Thousands)	Patients Served[a] (In Thousands)	Visits Per Patient Served	Spending Per Visit	Spending Per Patient Served	Total Spending (In Millions)[b]
1980	16,322	726	22.5	$37.19	$ 836	$ 817
1981	22,688	948	23.9	41.34	989	1,054
1982	30,628	1,154	26.5	11.50	1,181	1,380
1983	36,898	1,318	28.0	47.35	1,325	1,770
1984	40,422	1,498	27.0	51.46	1,389	2,107
1985	39,449	1,549	25.5	55.49	1,413	2,220
1986	38,000	1,571	24.2	58.21	1,408	2,242
1987	35,588	1,544	23.0	61.71	1,422	2,232
1988	37,100	1,582	23.5	64.10	1,503	2,422
1989	46,173	1,685	27.4	63.78	1,748	3,008
1990	65,985	1,665	39.6	65.62	2,601	4,415
Average annual percent change:						
1980-1985	19.3%	16.4%	2.5%	8.3%	11.1%	22.1%
1985-1990	10.8	1.5	9.2	3.4	13.0	14.7

[a] These numbers are for fee-for-service only and may not include enrollees in health maintenance organizations.

[b] Includes Part B expenditures.

SOURCE: Health Care Financing Administration, Office of the Actuary.

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Changes in coverage and eligibility requirements fueled the growth in home health visits. Greater utilization can also be attributed to expansion in the number of agencies eligible to participate in the program. It is difficult, however, to differentiate the effect of PPS on home health care expenditures due to other changes taking place in the 1980s that may also have influenced spending and use.

Hospice Care

The Medicare hospice benefit was introduced in 1984. Terminally ill Medicare beneficiaries whose life expectancy is six months or less are eligible to receive these services. Hospice care provided to dying persons and their families is supportive rather than cure-oriented. Once a beneficiary chooses to receive the hospice benefit, he or she must waive the right to all other Medicare benefits. Coverage is limited to 210 days, but beneficiaries can receive an additional 90-day period of coverage if they are recertified as terminally ill. Hospice benefits include nursing care, various therapies, medical social services, homemaker-home health services, physicians' services, short-term inpatient care, and patient counseling.

Hospices are paid prospectively for the care they deliver, and the rates vary according to level of care furnished to the beneficiary. They are paid one of four predetermined rates for each day of care they provide: routine home care, continuous home care, inpatient respite care, and general inpatient care.

The number of Medicare-certified hospice providers increased from 108 in 1984 to 825 in 1990. Both spending for hospice care and the number of beneficiaries receiving it have grown markedly (see Table 1-12). Total spending for hospice care was about $320 million in fiscal year 1990, and there were slightly more than 100,000 hospice admissions. Spending for the benefit is expected to increase dramatically, to more than $1 billion, by 1995. The hospice benefit, however, substitutes for spending in other parts of Medicare that might occur if the benefit were not available.

The rise in hospice spending is due to higher hospice admission rates and more days of care per admission. The admissions increase reflects the fact that the benefit is new and that more providers are furnishing this care. The number of days per admission climbed from 29 in fiscal year 1984 to 51 in fiscal year 1990, or 76 percent. The cost per patient day rose by only 37 percent over this period, a relatively small amount after accounting for inflation.

Dialysis Facilities

People with ESRD are eligible for all Medicare benefits if they are fully or currently insured under Social Security, entitled to monthly Social Security benefits, or the spouse or dependent child of someone insured under Social Security. About two-thirds of enrollees are under 65. Entitlement to Medicare benefits generally begins in the third month after the month in which renal dialysis is initiated and ends 12 months after dialysis stops. Patients accepting home dialysis training can become entitled to Medicare benefits earlier.[13]

Table 1-12. Estimates of Hospice Program Data, Fiscal Years 1984-1995

Fiscal Year	Hospice Admissions	Days Per Admission	Cost Per Hospice Day	Cost Per Admission	Total Cost (In Millions)
1984	2,200	29	$62	$1,800	$2
1985	11,000	33	66	2,200	15
1986	28,012	37	66	2,442	35
1987	68,721	41	74	3,034	63
1988	84,770	44	74	3,256	90
1989	89,008	48	74	3,470	211
1990	102,359	51	85	4,245	320
1991	112,595	53	93	4,828	465
1992	120,477	55	98	5,270	605
1993	126,501	57	103	5,749	760
1994	132,826	59	108	6,258	920
1995	139,467	61	114	6,811	1,100

SOURCE: Congressional Budget Office estimates, 1984-1989, and baseline projections for 1990-1995.

Program expenditures for ESRD beneficiaries almost doubled over the 1984 to 1989 period, to $4.4 billion. The program spent an average of $26,600 per beneficiary in 1989, this includes all Medicare-covered services. About one-fifth of program expenditures are for outpatient dialysis treatment.

Medicare spending for dialysis treatment totaled $1.2 billion in 1989, a 50 percent increase over 1984. Similarly, the number of enrollees receiving dialysis grew by 49 percent between 1984 and 1989. A total of 129,800 beneficiaries received dialysis treatment in 1990. Facilities that provide dialysis receive a prospectively set rate per treatment. The payment rate per treatment has essentially been unchanged since 1983, so that price changes have not been responsible for increases in Medicare expenditures. The average number of treatments per patient year has also not changed appreciably. The growth in Medicare spending for dialysis, therefore, was due to greater numbers of beneficiaries receiving this treatment.

Other Facilities, Providers, and Suppliers

Medicare recognizes for payment purposes a host of other facilities, providers, and suppliers (see Tables 1-1 and 1-6). Available information shows their proliferation between 1980 and 1990, which may have enhanced beneficiaries' access to care. Data on expenditures, on the other hand, are quite limited except for independent laboratories.

Spending for independent laboratories rose more than 1,000 percent, from $139 million to $1.5 billion, between 1980 and 1990. Most of this growth occurred after 1984. Despite higher expenditures, the number of facilities increased by only 42 percent between 1980 and 1990. Since 1984, clinical laboratory services have been paid according to a fee schedule that limits increases in per unit costs for a given procedure. However, it does not control growth related to heavier utilization and greater sophistication of services. These latter two factors, along with increased utilization of independent laboratories rather than hospital outpatient and physicians' offices laboratories, contributed significantly to the dramatic rise in spending.

Nonfacility Providers

Medicare payment for physician services has recently undergone a major change, moving to a fee schedule using relative value scales. Throughout most of the 1980s, however, physician services were paid using a fee-for-service system based on reasonable charges, with each service billed separately. Since the mid-1980s, Congress has increasingly put restrictions on increases in physician payment. Targeted particularly at doctors who did not accept Medicare payment as payment in full, these strategies were designed to encourage physician participation in the Medicare program. They were also aimed at restraining spending growth and limiting beneficiary liability.

Between 1980 and 1990, real spending for physician services rose by 121 percent due to increased utilization and intensity, and higher charges. Between 1980 and 1989, the percentage of beneficiaries receiving physician services paid for by Medicare grew 26 percent. Some of this increase may be explained by the fact that the Part B deductible changed very little over this period.[14]

Growth in the number and intensity of services substantially contributed to the higher physician spending over the decade. Between 1980 and 1984, increased volume and intensity contributed about 7 percent annually to this trend. These factors contributed about 6 percent annually to physician expenditures between 1984 and 1988.[15]

By contrast, higher physician prices contributed about 9 percent annually to the growth in spending between 1980 and 1984, compared with only about 3 percent between 1984 and 1988.[16] The slower growth in physician payment rates was due to controls placed on physician fee increases and lower inflation in the latter part of the decade.

RELATIONSHIP OF UTILIZATION AND SPENDING TRENDS TO PATTERNS OF CARE

Medicare spending continues to spiral at twice the rate of general inflation, despite attempts to constrain it through changes in Medicare payment and coverage policies. There are many complex and

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interacting forces that affect total spending, including the price, overall utilization, and intensity of services; an increase in the number of Medicare beneficiaries; inflation; technological advances; and practice pattern changes. Modifications to Medicare payment and coverage policies also influence spending in ways that were not necessarily intended. The importance of these factors differs substantially among the types of facilities and the services beneficiaries receive.

Expenditures for inpatient acute care hospital services continue to be the largest component of spending, but the rate of growth has slowed partly because of declining admissions. Controls on payment rate increases have also played a substantial role in reducing spending growth. Under PPS, hospitals have an opportunity for financial benefit if they control the services provided throughout the hospital stay, including those furnished within three days of admission. Nevertheless, incentives remain to maximize payment by unbundling services that would have been provided during the inpatient stay. Reduced length of stay and increased utilization of post-acute care service are evidence of this phenomenon.

PPS and other factors that constrained inpatient hospital utilization at the same time helped drive up Medicare spending for other services. For example, the rapid expansion of rehabilitation services is likely related to PPS incentives to shorten inpatient length of stay. The growth in SNF and home health agency use may also partially be attributed to these incentives, although changes in coverage rules probably had a more significant impact.

In other cases, higher spending reflects the interaction of new technological capabilities and changes in policy. Ambulatory surgery is illustrative. In the early 1980s, Medicare began to cover and pay for surgery performed in free-standing units. Technological advances allowed procedures that previously had been performed primarily in inpatient settings, such as cataract surgery and arthroscopy, to be performed on an outpatient basis. This change in setting was encouraged by the Medicare program because it substantially lowered the cost of providing individual services. The result, however, was that more beneficiaries received services, thus boosting spending in outpatient settings.

Post-acute care increasingly can be delivered not only in skilled nursing facilities, but also in rehabilitation hospitals and units and through home health care providers. Similarly, certain surgical procedures can be provided in inpatient and outpatient hospital units, in free-standing ambulatory surgical centers, and in physicians' offices. The availability of multiple facilities and sites of service creates opportunities to meet the needs of a diverse population of enrollees in an appropriate fashion. However, multiple settings contribute to the inability to contain total health care spending and to ensure appropriate patterns of care across an entire episode of illness.

Changes in coverage and benefits also exert an influence on the growth in Medicare spending. This is particularly evident in the case of SNF and home health agency services. Recent changes clarifying coverage requirements for these services are major contributors to higher utilization and spending.

Other considerations in the context of cost control are the various payment methods employed across facilities and sites, even for essentially similar services. Because of this, cost control efforts are fragmented and generally are directed only at constraining the unit price of a service rather than at checking overall utilization and total expenditures. The Medicare program implemented PPS to control the costs of services provided during an inpatient hospital stay, but has not developed similar controls for other sites of care. This may help explain the faster growth in spending observed in other parts of the program. Multiple payment methods also contribute to the inability to ensure the most appropriate pattern of care across settings.

Many of the payment strategies for controlling expenditures in other settings have focused on spending per unit of service. But these approaches do not constrain growth in intensity or volume of services provided. Although Medicare SNF payment methods can be used to control the price per SNF day, for instance, they do not control the number of beneficiaries receiving care or the number of days provided. The Medicaid program and state efforts to control the number of facilities, as well as the limited nature of the Medicare SNF benefit, probably have much more of an impact on overall Medicare spending for these services. Other ser-

vices, such as home health and clinical laboratories, are less subject to constraints on volume.

While maintaining or even improving the package of services furnished during an episode of care, Medicare's efforts to control growth in spending thus affect and are affected by the diversity of practitioners and suppliers. Further, patterns of care are shaped not only by clinical decisions and technological capabilities, but also by payment methods and service availability. The Commission's goals in modifying payment methods consider how all these factors affect the broader health care delivery system.

Goals of Medicare Payment Methods

ProPAC believes that Medicare's payment methods should result in consistent financial incentives across all treatment settings. These methods should reward productivity improvements and discourage unnecessary intensity. To achieve this, system modifications should account for the different types of providers and facilities that may be involved in the services delivered during an episode of care.

In addition, the payment systems should promote appropriate quality of care throughout an episode of illness, from ensuring access to necessary services to coordinating the array of services provided. Clearly, factors other than Medicare's payment methods have a major impact on quality and access. These include licensure and certification requirements, health care personnel training, and policies of other payers, to name a few. To the extent that Medicare payment policies encourage coordination of services over an episode, they should promote these policy goals.

Further, the Commission believes that individual providers should be adequately compensated for the services they furnish. Inadequate payment could have serious implications for access to and quality of care. ProPAC is mindful, however, of the current fiscal environment and the Federal budget deficit: Rising health care costs are a grave concern, and payment policy changes need to address this issue. Achieving the balance between appropriate payment levels and cost containment presents a significant challenge in efforts to reform Medicare's payment methods.

Commission Payment Reform Activities

Since its inception, the Commission has been involved in payment reform for inpatient hospitals and excluded facilities. This mandate was recently expanded to include hospital outpatient facilities, skilled nursing facilities, home health agencies, and dialysis facilities. ProPAC will incorporate the goals discussed above into its analyses and recommendations on payment reform for this diverse group.

In its forthcoming March report on hospital outpatient payment policies, ProPAC offers recommendations on an incremental approach to fully prospective payment methods for outpatient services. The Commission believes that for all outpatient facilities and providers, prospective payment is an appropriate means to achieve consistent financial incentives for productivity and the right level of intensity and cost containment. Along with policy changes, adequate quality assurance mechanisms also need to be developed. In March, ProPAC will also issue a preliminary report on SNF payment. Although this report will not recommend a specific payment method, it will provide information and a framework for achieving the same goals with SNF payment reform. The Commission's activities on the other facilities under its expanded mandate will be directed toward these ends.

Notes to Chapter 1

1. Health Care Financing Administration estimate.

2. Health Care Financing Administration, Office of Research, unpublished data from a forthcoming report, September 25, 1991.

3. SMG Marketing Group, *Freestanding Outpatient Surgery Center Directory and Report* (Chicago, IL: SMG Marketing Group, 1991).

4. Cancer hospitals have been excluded from PPS only since 1989.

5. For more information, see the Commission's forthcoming June 1992 report to Congress on excluded providers.

6. For more information, see the Commission's March 1992 report to Congress on hospital outpatient payment.

7. American Hospital Association, *Hospital Statistics*, 1990-1991 edition (Chicago, IL: AHA).

8. Ibid.

9. For more information, see the Commission's March 1992 report to Congress on skilled nursing facility payment.

10. During 1989, when the Medicare Catastrophic Coverage Act was in effect, SNF services were covered for 150 days per calendar year and did not require a prior hospitalization. In addition, coinsurance of $25.50 was required only for the first eight days of coverage

11. In April 1988, HCFA clarified the SNF coverage guidelines. This resulted in an expansion of Medicare SNF utilization; previously, many beneficiaries did not apply or were not encouraged to apply for Medicare coverage because of the possibility of retroactive denial of coverage. The MCCA eliminated the three-day prior hospitalization rule, expanded the allowable days of coverage, and modified the coinsurance policy, resulting in increased utilization of the Medicare SNF benefit.

12. Unpublished ProPAC analysis.

13. For more information, see the Commission's forthcoming June 1992 report to Congress on dialysis facility payment.

14. Beneficiaries do not start receiving Medicare Part B benefits until they have reached the Part B deductible amount, which was $75 from 1983 to 1989 and increased to $100 in 1990. Only enrollees who exceed the Part B deductible are counted as using physician services.

15. Physician Payment Review Commission, *Fee Update and Medicare Volume Performance Standards for 1992*, Report No. 91-3, May 15, 1991.

16. Ibid.

Chapter 2

Recommendations

Chapter 2

Recommendations

The Prospective Payment Assessment Commission (ProPAC) was created by Congress in 1983. Its primary responsibility then was to analyze issues and make recommendations for updating and improving the Medicare prospective payment system (PPS). Over time, Congress has expanded ProPAC's responsibilities to include analyzing current payment policies for all facility services furnished to Medicare beneficiaries and developing policies for the future.

These expanded responsibilities include payment for hospital outpatient services, services furnished by skilled nursing facilities (SNFs) and home health agencies, and dialysis services for end-stage renal disease (ESRD) patients. The Congress has also requested that ProPAC examine and report on broader issues regarding the effectiveness and quality of health care delivery in the United States. The Commission, however, continues to devote a substantial amount of effort to updating and improving payment for PPS hospitals and excluded hospitals and distinct-part units.

From 1985 through 1990, ProPAC's recommendations were delivered to the Secretary of Health and Human Services (HHS). Following the enactment of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Commission's report and recommendations are now made directly to Congress. The Secretary, however, is still required to consider ProPAC's recommendations and respond to them in the annual notice of PPS rulemaking published in the *Federal Register*.

ProPAC's analyses and decisionmaking are guided by a set of principles that were initially based on the goals of PPS, but which also are applicable to other facility services. These principles provide the foundation for the Commission's recommendations. They are:

- Ensuring beneficiary access to high-quality health care;
- Encouraging productivity and long-term cost-effectiveness;
- Facilitating innovation and appropriate technological change;
- Promoting equity in the distribution of payments;
- Maintaining stability for providers, consumers, and third-party payers; and
- Making decisions based on reliable, timely data and information.

Along with these principles, the Commission is mindful of the current fiscal environment. Rising health care costs and their effect on the Medicare trust funds and the Federal budget are concerns the Commission takes into account with each recommendation. Moreover, budgetary pressures intensify the need to address distributional and technical payment issues that may affect access and quality of care furnished to Medicare beneficiaries.

ProPAC's recommendations reflect the collective judgment of the 17 Commissioners. Some of the subjects of these recommendations are repeated every year, such as the annual update. Others are either modifications of previous recommendations or cover new issues. All incorporate recent research findings. This year, in addition to its specific recommendations, the Commission has highlighted several areas of concern. Work on these and other issues continues.

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RECOMMENDATIONS FOR FISCAL YEAR 1993

The Commission's recommendations and concerns fall into six areas:

- Updating PPS payments,
- Adjusting the payment system,
- Updating and adjusting payments to PPS-excluded hospitals and distinct-part units,
- Updating payments to dialysis facilities,
- Improving hospital outpatient payment policy, and
- Improving skilled nursing facility payment policy.

Updating PPS Payments

The Commission is mandated by law to recommend to the Congress each year the appropriate update to the inpatient hospital payment rates under PPS. As required, ProPAC considers several factors in developing its annual update recommendation: the hospital market basket index (which reflects the prices of resources used by hospitals in providing inpatient care), scientific and technological advances, hospital productivity, the quality of health care, and long-term cost-effectiveness. The Secretary of Health and Human Services is required to take the Commission's recommendation into consideration in developing his update recommendation. The actual update is determined by Congress.

In OBRA 1990, the PPS update was established for each fiscal year through 1995. For fiscal year 1993, the update is set equal to the change in the hospital market basket index minus 1.55 percentage points for urban hospitals, and the change in the index minus 0.55 percentage points for rural hospitals. Even though the fiscal year 1993 update has been set by law, ProPAC has continued to follow its approach of examining the individual factors that together determine the appropriate update to the PPS payment rates. The Commission believes that this approach will result in an update that is sufficient to maintain Medicare beneficiaries' access to high-quality care while encouraging hospital efficiency in providing such care.

In addition to the update to the PPS payment rates, the Commission in this report recommends an update for rates derived from hospital base-year costs. These rates may be used in place of the PPS rates for sole community hospitals and small rural Medicare-dependent hospitals. ProPAC also considers the update for the Federal payment rate under the prospective payment system for capital, which became effective in fiscal year 1992. The update for facilities currently excluded from PPS is addressed in a later section of this chapter.

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1993, the PPS standardized payment amounts should be updated to account for the following factors:

- **The projected increase in the Health Care Financing Administration (HCFA) PPS market basket index, currently estimated at 4.5 percent;**
- **An upward adjustment of 0.2 percentage points, to reflect the difference between the ProPAC and HCFA market baskets;**
- **A correction for substantial error in the fiscal year 1991 market basket forecast of –0.8 percentage points;**
- **A net discretionary adjustment factor of zero; and**
- **A net adjustment of –0.7 percentage points for case-mix change.**

In addition, a positive adjustment of 0.85 percentage points for hospitals in rural areas and a negative adjustment of 0.15 percentage points for hospitals in large urban and other urban areas should be made to reflect a continuation of the phase out of the differential in the standardized amounts between rural and other urban hospitals.

ProPAC's recommendation would result in an estimated average update factor of 3.2 percent for fiscal year 1993, with an increase of 3.05 percent for urban hospitals and 4.05 percent for rural hospitals. This recommendation reflects the Commission's judgment about the appropriate increase in the level of PPS payment rates. Since it is based on current projections of the fiscal year 1993 increase in the market basket index, the effective value of ProPAC's update factor recommendation may be modified as more current forecasts become available. The components of ProPAC's update factor recommendation are summarized in Table 2-1, and a discussion of each of those components follows.

It should be noted that the increase in average per case payments to hospitals in each year is greater than the PPS update. This is because increases in the Medicare case-mix index (CMI) result in proportional increases in hospital payments. Future changes in case mix are difficult to project; however, on the basis of currently available data, ProPAC estimates that the CMI will increase by 2.3 percent in fiscal year 1993. Based on the Commission's recommendation of a 3.2 percent average update, the average increase in per case payments would be about 5.6 percent.

PPS Market Basket Increase Forecast and Forecast Error Correction–The forecasted increase in the market basket index is the expected change in the prices paid by hospitals for the resources used during a typical hospital stay. This forecast is the reference point used in updating the PPS payment rates. The current forecast is for a 4.5 percent increase in HCFA's PPS market basket index during fiscal year 1993.

In its March 1990 *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services*, ProPAC proposed modifications to the market basket used by HCFA. Although

Table 2-1. Recommended PPS Update Factor for Fiscal Year 1993

Components of the Update		
Components applied to all hospitals:		
Fiscal year 1993 HCFA PPS market basket forecast*		4.5%
Adjustment for difference between HCFA and ProPAC market baskets*		0.2
Correction for fiscal year 1991 forecast error		- 0.8
Components of discretionary adjustment factor		
Scientific and technological advancement allowance	1.0	
Productivity adjustment	-1.0	
Net discretionary adjustment factor		0.0
Adjustments for case-mix change (fiscal year 1992)		
Total DRG case-mix index change	- 2.5	
Real across-DRG case-mix change	1.5	
Within-DRG case-complexity change	0.3	
Net adjustment for case-mix change		-0.7
Additional adjustments to the standardized amounts:		
Adjustment for large urban areas	-0.15	
Adjustment for other urban areas	-0.15	
Adjustment for rural areas	0.85	
Total Update Factor		
Overall average		3.2
Large urban	3.05	
Other urban	3.05	
Rural	4.05	

* Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1991. The market basket forecast is subject to change as more current forecasts become available.

HCFA adopted most of these modifications, it did not incorporate the key provision that increased the weight of internal hospital wages in the computation of the market basket index. The Commission believes that the market basket as currently constructed does not adequately recognize the unique characteristics of the hospital labor market.

Since the PPS update for fiscal year 1993 is legislated relative to a market basket that HCFA would implement, HCFA's market basket is used as the basis for the update. ProPAC's update recommendation takes this into account by making an adjustment of 0.2 percentage points to account for the estimated effect of the modifications it believes are justified.

A forecasted market basket increase of 5.2 percent was used to set payments in fiscal year 1991. The actual market basket increase, however, was 4.4 percent. The update for fiscal year 1991 was thus set 0.8 percentage points higher than if the actual market basket increase had been known at the time.

The Commission believes that a correction for substantial error in market basket forecasts is an important part of its update framework. This correction protects both hospitals and the Federal government by adjusting the base payment rates so that the effects of past forecast errors (both positive and negative) are removed. Therefore, ProPAC's update recommendation also includes a –0.8 percentage point adjustment for fiscal year 1991 market basket forecast error.

Discretionary Adjustment Factor–The discretionary adjustment factor (DAF) incorporates considerations related to scientific and technological advancement and hospital productivity improvement, as provided in the statute establishing PPS. While the market basket index measures the cost of the resources used during a typical hospital stay, the components of the DAF reflect changes in the mix of those resources over time. In general, scientific and technological advancement accounts for the use of new resources that may increase costs; productivity accounts for changes in resource use that may decrease costs.

The scientific and technological advancement allowance is a future-oriented policy target. It provides additional funds for hospitals to adopt quality-enhancing health care advances, even when they increase costs. To develop an informed judgment as to the appropriate level of this allowance, ProPAC each year sponsors a study that examines a set of the most important new cost-increasing technologies and scientific developments. For fiscal year 1993, these technologies are expected to increase Medicare operating costs by 0.9 percent. However, the cost-increasing effects of "small-ticket" technologies and changes in practice patterns are not included in this estimate. Given these considerations, the Commission believes that 1.0 percent is an appropriate level for the scientific and technological advancement allowance.

The productivity adjustment is also a future-oriented target. The Commission believes it is reasonable to expect hospitals to achieve productivity improvements during fiscal year 1993 comparable to those achieved in other sectors of the economy. The recommended adjustment of –1.0 percent is based on ProPAC's determination that hospital productivity should increase by 2.0 percent, and that the savings from such improvement should be shared equally by hospitals and the Medicare program.

The Commission therefore concludes that the positive scientific and technological advancement allowance and the negative productivity improvement adjustment should offset each other. ProPAC believes that it is appropriate for the costs of scientific and technological advancement to be financed by expected productivity gains, to provide an incentive for hospitals to strive for productivity improvement as they adopt new technologies. (See Appendix A for more information on the DAF.)

Adjustments for Case-Mix Change–For fiscal year 1993, the PPS update should be reduced by 0.7 percentage points to account for the net effect of case-mix change during fiscal year 1992. This adjustment reflects:

- A 2.5 percentage point reduction for the estimated change in the CMI;
- A positive allowance of 1.5 percentage points for real case-mix change across diagnosis-related groups (DRGs); and
- A positive allowance of 0.3 percentage points for within-DRG case-complexity change.

Adjusting for these factors allows payments to increase due to real changes in the resources required to treat an average Medicare patient. At the same time, it removes the effect of changes in medical record documentation and coding practices that are unrelated to patient resource requirements (also referred to as upcoding).

The annual rate of increase in the CMI has generally declined over time. This pattern reflects a dramatic change in the distribution of patients across DRGs (due both to treatment patterns and to upcoding) when PPS was implemented, followed by a gradual settling toward a new equilibrium. This trend, however, has been interrupted when revisions to the payment system created new opportunities for upcoding—particularly in fiscal year 1988, when the criteria for assigning patients to DRGs were changed.

Each year, ProPAC estimates the increase in the CMI for the previous year, based on available data on the trend in prior years and expectations about the effects of any DRG changes that may have been implemented. ProPAC's estimate for fiscal year 1991 indicates that changes in the DRG assignment rules led to another acceleration in the CMI. ProPAC's estimate of the increase in the CMI for fiscal year 1991 is 2.7 percent. In fiscal year 1992, DRG changes and increases in the numbers of fields for entering diagnosis and procedure codes on the Medicare bill may provide additional opportunities for upcoding. Nonetheless, the Commission expects that the increase in the CMI will be 2.5 percent in fiscal year 1992, lower than in the previous year.

Real CMI change is that portion related to actual increases in patient resource requirements across DRGs. ProPAC's estimate of real CMI change takes into account previous studies that apportioned increases in the CMI into real and upcoding components. These studies indicate that real CMI change in past years has been in the range of 1.5 percent to 1.6 percent. In the Commission's judgment, 1.5 percentage points of the 2.5 percent increase in the CMI for fiscal year 1992 will be related to real changes in patient resource requirements.

ProPAC's estimate of within-DRG case-complexity change takes into account information from a series of studies, in which a more detailed patient grouping mechanism is applied to Medicare data for discharges within each DRG. As with the CMI, the rate of increase in case complexity tends to decline over time. The most recent estimates are that case complexity rose by 0.6 percent in fiscal year 1989 and by 0.5 percent in fiscal year 1990. On the basis of this trend, ProPAC estimates that case-complexity change in fiscal year 1992 will be 0.3 percent.

During the first eight years of PPS, CMI change generated payment increases that were almost equal to those resulting from the annual updates and all other payment policies combined. Given the magnitude of this factor and its failure to diminish as much as expected, it remains an important topic on the Commission's analytic agenda.

Differential Adjustments to the Standardized Amounts–ProPAC supports the provisions in OBRA 1990 that eliminate the difference between the standardized payment amounts for hospitals in rural areas and for those in other urban areas (metropolitan areas with fewer than one million people). This is to be accomplished by fiscal year 1995 by providing higher updates to rural hospitals. Consistent with current law, the Commission is recommending that the PPS update for rural hospitals be 1 percentage point higher than that for urban hospitals. The overall average update of 3.2 percent based on ProPAC's PPS update framework would be maintained by increasing the rural update by 0.85 percentage points, and decreasing the large urban and other urban hospital updates by 0.15 percentage points.

Since the beginning of PPS, Medicare payments have been higher relative to costs for urban hospitals than for rural hospitals. This is primarily the result of two factors. Urban hospitals have benefited more from the PPS payment adjustments—particularly the effects of CMI change and the indirect medical education (IME) and disproportionate share (DSH) adjustments. In addition, rural hospitals have had large declines in inpatient volume, raising fixed costs per case.

However, as indicated in ProPAC's October 1991 report to Congress, *Rural Hospitals Under Medicare's Prospective Payment System*, several recent policy changes have improved the relative

performance of rural hospitals under PPS. This trend promises to continue. The Commission will monitor and analyze the further effects of these policies as additional data become available.

Recommendation 2: Amount of the Update Factor for Hospitals Paid on the Basis of Hospital-Specific Rates

> **The Commission believes that payments based on hospital-specific base-year costs for sole community hospitals and for small rural Medicare-dependent hospitals should be updated by the same factor that applies to the PPS rate for rural hospitals.**

This recommendation would result in an update to the hospital-specific rates of 4.05 percent for fiscal year 1993, consistent with the Commission's recommendation on the PPS update. Since the update is based on current projections of the fiscal year 1993 increase in the market basket index, its effective value may be modified as more current forecasts become available.

OBRA 1989 provides that certain hospitals be paid on the basis of the PPS rate, their own 1982 base-year costs updated to the current year, or their updated 1987 base-year costs, whichever would yield the largest payment. Two groups of hospitals qualify for this special treatment: sole community hospitals, which meet certain criteria based on distance from other hospitals or market share; and small rural Medicare-dependent hospitals, which are rural hospitals with fewer than 50 beds and at least a 60 percent Medicare share of total discharges or inpatient days. The provision for small rural Medicare-dependent hospitals applies only to cost reporting periods ending on or before March 31, 1993.

Current law requires that the hospital-specific rates for these hospitals be updated at a rate equal to the increase in the PPS hospital market basket index. PPS rates, however, are to be updated by less than this amount in fiscal year 1993. This discrepancy means that hospitals with relatively high base-year costs (above the PPS rate) would receive a larger update than those with relatively low base-year costs. High-cost hospitals would therefore be twice advantaged. They would receive both their higher base-year cost rate and a higher update to those rates compared with lower-cost hospitals.

The update applied to the hospital-specific rates for sole community hospitals and small rural Medicare-dependent hospitals should be equal to that applied to the PPS rates under which the same hospitals would be paid. This option provides relief for hospitals with high base-year costs due to their special circumstances by raising their payment base. However, once the payment base is raised, it subjects them to the same payment constraints deemed appropriate for all other comparable PPS hospitals.

Recommendation 3: Updating Capital Payment Rates

> **The Commission recommends that a single update factor be developed for adjusting PPS operating and capital payment rates. The update framework should be consistent with that currently used by ProPAC to develop the PPS operating rate update recommendation, and should be put into use for fiscal year 1994.**

Medicare's capital payment method was changed from a cost basis to a prospective per case payment beginning in fiscal year 1992. The new capital payment method will be phased in over a 10-year transition period. During the transition, an increasing portion of capital payments will be based on the national average payment rate.

The Secretary plans to update the base capital payment rate for fiscal year 1993 using the average per case increase in Medicare inpatient hospital capital costs in fiscal years 1989 and 1990, adjusted for case-mix change. The fiscal year 1994 and 1995 capital updates are to be based on a similar methodology. Starting in fiscal year 1996, the Secretary will determine the capital update factor using a framework similar to that used for updating PPS operating payment rates. Because the statute requires that Medicare capital payments be budget neutral with respect to 90 percent of costs through fiscal year 1995, the proposed updates will affect the base payment rate, but not total capital payments. Beginning in fiscal year 1996, however, the resulting base payment rate will determine the capital payments each hospital receives.

The Commission believes that ultimately there should be one payment for hospital inpatient operating and capital expenses. ProPAC understands that it is not possible to combine operating and capital payments until the transition to fully prospective capital payment is complete. Despite the separate payment rates, hospitals do not distinguish between their operating and capital payments. Operating payments may be used to defray capital shortfalls and vice versa. Thus, hospitals should face the same financial incentives for operating and capital decisions. Therefore, the Secretary should move to a single update approach for inpatient operating and capital payment rates as soon as possible.

The Commission believes that a formula-based update, consistent with that applied to the PPS update, should be used before fiscal year 1996. In ProPAC's view, the use of past cost increases to set future payment rates is inappropriate. This would incorporate past cost increases that may reflect inefficient capital spending behavior into the fiscal year 1996 base. Capital payments should be set at a level that reflects efficient capital spending per case. This would be accomplished by incorporating the update for capital payment rates into the current PPS update framework.

ProPAC therefore recommends the development and use of an update framework that combines capital and operating payments for fiscal year 1994. Like the operating update currently used by ProPAC, the new combined update framework should incorporate a market basket to measure changes in prices, as well as adjustments for scientific and technological advances, productivity, and case-mix change. This would ensure that updates to both operating and capital base payment rates reflect increases in the cost of the goods and services that hospitals require to produce inpatient hospital care efficiently.

Adjusting the Payment System

The PPS payment system adjusts hospital payments in several ways to account for factors such as the level of teaching activity, wage rates, and case complexity, which may legitimately affect hospital costs. These adjustments are important for providing a fair level of payment to hospitals depending on the circumstances they face.

As part of its mandate, the Commission examines the distribution of PPS payments across hospitals and makes recommendations concerning the various adjustments to the payment system. ProPAC considers adjustments that are made both at a hospital level and at a case level. In this year's report, the Commission makes recommendations concerning the indirect medical education and disproportionate share adjustments, improvements in the definition of labor markets, transfer payment policy, hemophilia clotting factor, epilepsy centers, and the program establishing essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs). In addition, the Commission makes statements concerning DRG refinement, and Peer Review Organizations (PROs) and the quality of care.

Recommendation 4: Level of Indirect Medical Education and Disproportionate Share Adjustments to PPS Operating Payments

The Commission recommends that the indirect medical education adjustment to PPS operating payments be reduced from its current level of 7.7 percent to 7.0 percent for fiscal year 1993. This reduction should be implemented in a budget neutral fashion, with the anticipated decrease in indirect medical education payments returned to teaching hospitals that are designated as disproportionate share providers through a corresponding increase in their disproportionate share adjustment percentages.

The IME adjustment is intended to recognize the higher costs teaching hospitals incur in treating Medicare patients. These costs have been attributed to caring for patients with more severe or complex illnesses, providing a broader scope of more intense services, and using a costlier mix of staff.

ProPAC annually estimates the relationship between teaching intensity and adjusted Medicare operating costs per discharge. The adjustments control for differences in costs that are accounted for by other PPS payment factors, such as geographic differences in the PPS base payment amounts, the local area wage index, the hospital's Medicare case-mix index, and outlier payments for extremely long or costly cases. The most recent analysis was based on cost data from the sixth year of PPS and pay-

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ment rules for fiscal year 1992. The results indicate that, on average, a 10 percent difference in teaching intensity is associated with a 5.7 percent difference in Medicare operating costs per discharge.

The Commission recognizes that, since PPS began, the Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. The current 7.7 percent IME operating payment adjustment is substantially higher than the empirical estimate of 5.7 percent indicated by the most recent analysis. Moreover, PPS operating margins consistently have been higher for teaching hospitals than for nonteaching hospitals. PPS margins have been especially high for major teaching hospitals (that is, those with the highest levels of teaching intensity).

However, the overall financial performance of major teaching hospitals has been poor relative to other hospitals. Major teaching hospitals have had lower total margins than other hospital groups. The Commission is concerned that the continued operation of these hospitals and the fulfillment of their unique role in the provision of health care might be impaired by a substantial immediate reduction of Federal support.

ProPAC believes that the Medicare program's responsibility to its enrollees is broader than merely paying for Medicare operating costs. This responsibility includes the maintenance of access to high-quality health care, which might be affected adversely if the poor financial condition of major teaching hospitals were to worsen. A sharp reduction of the IME adjustment might have that undesirable effect.

Given these considerations, the Commission believes that a gradual reduction of the IME adjustment is a prudent course of action. ProPAC would reduce the adjustment by approximately one-third of the difference between the current level and the Commission's estimate of 5.7 percent each year for three years. Based on the current estimate of the relationship between teaching intensity and Medicare operating costs, the IME adjustment would be reduced to 6.3 percent in fiscal year 1994 and to 5.7 percent in fiscal year 1995. This approach recognizes as an ultimate objective the use of the IME adjustment to compensate appropriately for differences in Medicare costs that are attributable to differences in teaching intensity. ProPAC will continue to examine the financial status of teaching hospitals to avoid any deleterious effects on access to high-quality care for Medicare enrollees.

The DSH adjustment is designed to ensure that Medicare beneficiaries have access to high-quality health care at hospitals that treat a large share of low-income patients. Both access to care and the quality of the care provided by these hospitals might be affected adversely if their generally poor financial condition were to worsen. The Commission believes that the Federal government and the Medicare program have a broad responsibility to avoid that situation.

In recent analyses, ProPAC has compared several methods of measuring the burden of uncompensated care and distributing disproportionate share payments. These analyses indicate that, except for hospitals with the highest uncompensated care loads, the current DSH adjustment mechanism distributes payments reasonably proportional to the amount of uncompensated care provided. However, the hospitals that provide the largest share of uncompensated care receive a low share of DSH payments relative to that burden.

ProPAC's analyses indicate that DSH hospitals with teaching programs tend to have much lower total margins than other hospital groups (see Table 2-2). The Commission is concerned that the unique role of these hospitals in the provision of high-quality health care to low-income patients, including low-income Medicare patients, might be adversely affected if their financial condition were to worsen.

ProPAC analyzed the effects of several alternatives for distributing the savings that would result from a reduction of the IME adjustment. Redistributing these savings through an increase in the DSH adjustment for hospitals with teaching programs would greatly reduce the disparity in total margins across hospital groups. The Commission therefore recommends that the IME adjustment be exactly offset by corresponding increases in DSH payments for teaching hospitals designated as disproportionate share providers.

As noted earlier, changes in the IME and DSH adjustments should be considered in the context of their interactions with other components of the

Table 2-2. Simulated Aggregate Total Margins, in the Sixth Year of PPS, Using Fiscal Year 1992 Payment Rules with Alternative Adjustments (In Percent)

Adjustment Alternative	Payment Adjustment Category			
	IME Only	DSH Only	IME and DSH	Neither
Fiscal year 1992 payment rules, including a 7.7 percent indirect medical education adjustment	4.2%	4.0%	2.8%	4.5%
Fiscal year 1992 payment rules, with a 5.7 percent indirect medical education adjustment and savings redistributed to:				
Disproportionate share teaching hospitals	3.7	4.0	3.2	4.5
All disproportionate share hospitals	3.7	4.7	2.9	4.5
All hospitals	4.0	4.3	2.5	4.7
Fiscal year 1992 payment rules, with 5.7 percent indirect medical education adjustment and no redistribution of savings	3.7	4.0	2.2	4.5

SOURCE: ProPAC analysis of Medicare Cost Reports and MedPAR file data from the Health Care Financing Administration.

payment system and their effects on PPS payments, as well as hospitals' overall financial status. The impact on the quality of care and access to that care should also be considered. In general, any change in Medicare payment policy must be evaluated in terms of its effect on the health care system as a whole.

In the coming year, ProPAC will continue to examine the level and structure of the IME and DSH adjustments, as well as other factors that affect hospitals' payments, costs, and financial condition. The distribution of PPS and total margins and the other effects of potential changes in the IME and DSH adjustments will also be studied. ProPAC's most recent analysis is described in a technical report, *Indirect Medical Education and Disproportionate Share Hospital Payment Adjustments* (March 1992).

Recommendation 5: Consistency of Indirect Medical Education and Disproportionate Share Adjustments to PPS Capital and Operating Payments

The Commission recommends that the same level of indirect medical education and disproportionate share payment adjustments be applied to both operating payments and the prospective component of capital payments, beginning in fiscal year 1994. Further, ProPAC believes that the methods of determining these adjustments to PPS operating payments should also be applied to capital payments. Therefore:

- **The measure of teaching intensity used for the indirect medical education adjustments should be defined in terms of the ratio of residents per bed, and**
- **The criteria for designation as a disproportionate share provider should be based on urban or rural location and number of beds.**

These changes would better reflect the policy objectives of the Congress in defining and setting the levels of the payment adjustments. They would also be consistent with the principle of incorporating capital into the PPS rate.

Through fiscal year 1991, PPS operating payments were determined prospectively, while capital costs were paid on a pass-through basis. Therefore, the IME and DSH adjustments were applied only to PPS operating payments. In fiscal year 1992, capital payments began a 10-year transition to a fully prospective payment system. The prospective component of PPS capital payments also includes adjustments for teaching and disproportionate share

hospitals. However, both the definitions and the levels of these adjustments differ from the IME and DSH adjustments to operating payments.

A single IME adjustment applied to both operating and capital payments requires a consistent definition of teaching intensity. The measure of teaching intensity used for the IME adjustment for operating payments is based on the number of residents per available bed. By contrast, the number of residents per patient is used to define teaching intensity for capital payments.

The two measures of teaching intensity are similar for hospitals with high occupancy rates, but the per patient measure is much higher for hospitals with low occupancy rates. Therefore, basing the IME adjustment on the per patient measure would tend to reward low occupancy teaching hospitals at the expense of high occupancy teaching hospitals. The Commission believes this result is inconsistent with the PPS objective of encouraging the efficient provision of health care services.

Furthermore, ProPAC's analyses indicate that use of the per patient measure would substantially reduce payments to high occupancy major teaching hospitals in urban areas, which have a large share of low-income patients and low total margins. By contrast, the per patient measure would substantially increase payments to low occupancy (often suburban) hospitals, with smaller teaching programs, a smaller share of low-income patients, and higher total margins. Because the per patient measure would both produce inappropriate incentives and reduce IME payments to the teaching hospitals with the greatest need for Federal support, the Commission believes that the measure of teaching intensity for IME adjustments to both operating and capital payments should be based on the ratio of residents to available beds.

The IME adjustment applied to operating payments is based on an analysis of the relationship between teaching intensity and operating costs per Medicare case. The IME adjustment applied to capital payments is based on the relationship between teaching intensity and combined operating and capital costs per Medicare case. In the longer term, the Commission believes that a single IME adjustment applied to both operating and capital payments should be based on the combined measure. As with the current operating adjustment, the level should be set to reflect not only the empirical relationship, but also the broader policy objectives that have been incorporated by the Congress.

The eligibility criteria for the DSH adjustments to operating and capital payments also differ. The operating adjustment is based on urban or rural location and the number of beds, as well as the hospital's low-income share. However, only urban hospitals with at least 100 beds are eligible for the DSH capital payment adjustment. Thus, many hospitals that receive the DSH operating payment adjustment are not eligible for the capital payment adjustment.

In addition, the two DSH adjustments use different distribution formulas: The DSH operating payment adjustment is graduated, and directs more payments to hospitals with the highest shares of low-income patients than the DSH capital payment adjustment. ProPAC compared several alternative methods for distributing DSH payments and found that, of the alternatives considered, the graduated DSH operating payment formula distributes payments that most closely correspond to the broader objectives of the policy.

The Commission therefore recommends that the eligibility criteria and adjustment formulas developed for DSH operating payment adjustments be applied to capital payments. In anticipation of a fully prospective system for both operating and capital payments, ProPAC has recommended that consistent update factors be implemented in fiscal year 1994. The Commission also recommends that the IME and DSH adjustments applied to the prospective component of capital payments should be the same as the adjustments applied to operating payments, effective in fiscal year 1994.

Recommendation 6: Improvements in Labor Market Definitions

The Commission believes that the current PPS labor market definitions need to be improved or replaced as soon as possible. Suitable alternative definitions, however, are not immediately available. In cooperation with the American Hospital Association and the Health Care Financing

Administration, ProPAC is developing alternative labor market definitions that may alleviate many of the current problems. On the basis of this effort, the Commission hopes to be able to recommend substantially revised labor market definitions for fiscal year 1994.

Under PPS, an area wage index is used to adjust hospitals' DRG payment rates per discharge to reflect variations in the wage rates hospitals must pay for labor in different geographic areas. The index measures the level of average hourly compensation for hospital workers in each labor market area relative to the national average. Under current law, changes in the wage index are required to be budget neutral. Therefore, changes in the wage index do not affect aggregate payments to hospitals under PPS. However, the index is a key determinant of the distribution of payments among hospitals because of its impact on each hospital's base payment rate. A 10 percent difference in the wage index for a hospital's labor market area will lead to about a 7 percent difference in its total PPS payments.

Since the inception of PPS, the wage index has been constructed using labor market areas based on county boundaries. Urban labor market areas have been defined by metropolitan statistical areas (MSAs). Each MSA includes a set of contiguous, economically integrated counties, generally incorporating a central city and its surrounding suburbs. A single statewide rural labor market area has been defined for each state, including all counties in the state that are not in an MSA.

The use of labor market areas based on county boundaries has created two important problems. First, large differences in wage index values often exist between nearby hospitals located on either side of such boundaries. In fiscal year 1991, for example, the wage index for hospitals located in the Joliet, Illinois, MSA was 33 percent higher than that for nearby hospitals located in adjacent rural counties. Differences of somewhat lesser magnitude often exist among adjacent MSAs and among adjacent rural labor market areas in neighboring states.

In addition, many of these labor markets cover extensive geographic areas that include a large and diverse population of hospitals. This occurs because of the vast size of many counties, especially in the West. Hourly compensation for hospital workers often varies markedly among the hospitals within such areas. Consequently, many hospitals are paid according to an index that does not accurately reflect their actual labor market conditions.

These problems have led to numerous complaints about inequities in PPS payments. Hospitals in many rural areas have argued that they are treated unfairly because they compete for labor with hospitals in nearby MSAs. Similarly, hospitals in the highly urbanized central counties of MSAs have argued that their payments are too low because they are grouped with suburban hospitals.

In OBRA 1989, Congress established the Medicare Geographic Classification Review Board to consider hospital applications for geographic reclassification. Under this legislation, hospitals are permitted to apply for reclassification for the purpose of the wage index, the standardized amount, or both. Generally, hospitals may apply for reclassification to an adjacent MSA, or to an adjacent statewide rural area.

In its first year of operation, more than 1,100 hospitals applied to the board for reclassification effective in fiscal year 1992, mostly for the purpose of the wage index. About 90 percent of all applications were approved by the board. As a result, more than one-quarter of all rural hospitals and about 6 percent of urban hospitals have been reclassified from the PPS labor market areas in which they are actually located to nearby (generally urban) labor market areas.

These reclassifications have led to substantial increases in payments for many hospitals. HCFA estimated that payments to hospitals reclassified for the wage index would increase in fiscal year 1992 by 5.2 percent, due to reclassification alone. The estimated increase averaged 6.8 percent for reclassified rural hospitals and 2.9 percent for reclassified urban hospitals.

Statutory provisions governing the calculation of the wage index after reclassification protect most hospitals from declines in their wage index values. Therefore, the increase in aggregate payments due to reclassification was substantially larger than it otherwise would have been. However, the statute

also requires the Secretary to adjust the standardized payment amounts for urban hospitals so that aggregate PPS payments do not change as a result of reclassification. Consequently, payments to urban hospitals were reduced by 1.0 percent (about $450 million) in fiscal year 1992. Thus, payments are expected to increase about 2.9 percent for urban hospitals that were reclassified for the wage index. Payments are expected to decline by 1.0 percent for most of the remaining urban hospitals.

ProPAC analysis of the recent reclassification decisions suggests that this policy has failed to resolve many of the problems it was intended to address. Although reclassification has clearly increased payments for many of the affected hospitals, large differences in wage index values still exist across the boundaries of adjacent labor market areas. The current labor market areas also continue to include diverse sets of hospitals with widely varying hourly compensation rates. Further, the reclassification process has created a sizable ongoing administrative burden and considerable uncertainty for hospitals.

Some of the failure of reclassification may be due to problems with the qualifying criteria. Improvements in the criteria for approving reclassification requests could reduce the number of inappropriate reclassifications. However, this would not solve the fundamental problems associated with the current labor market definitions because reclassification modifies only the edges of each labor market area.

Congress has continued to receive numerous complaints about the fairness of the wage index. Consequently, both the Senate Finance Committee and the House Ways and Means Committee have asked ProPAC to develop a new approach to labor market definitions. The American Hospital Association and HCFA have also expressed strong interest in this effort.

The most serious limitations of the current labor market definitions are related to the large size and fixed boundaries of MSAs and statewide rural areas. It is assumed, implicitly, that hospitals located within each area compete for labor, while those located on opposite sides of area boundaries do not. This produces large differences in wage index values for adjacent labor market areas. At the same time, substantial variations in hourly compensation rates within each area are unrecognized.

To define alternative labor market areas that recognize the local nature of labor competition, the Commission plans to develop hospital-specific labor markets based on the set of hospitals located nearest to each hospital, measured by road miles. These labor market areas will not have fixed geographic boundaries like county borders. Instead, for each hospital, the areas will merely identify other nearby hospitals as the most probable competitors for labor. The implicit assumption is that a hospital's nearest neighbors will provide the best measure of the labor market conditions it faces. Because this approach will produce overlapping labor market areas for nearby hospitals, it is likely to reduce substantially the strong boundary effects among labor market areas in the current wage index.

A number of difficult issues need to be resolved to determine whether this approach would result in appropriate labor market areas. Moreover, the distance data needed for this project are not likely to be available before mid-1992 at the earliest. In addition, the analysis will take several months. Thus, even if the project is highly successful, it is improbable that the resulting wage index could be implemented for fiscal year 1993. The Commission believes, however, that other currently available policy options are not likely to produce significant overall benefits. Therefore, ProPAC recommends that Congress await the outcome of this effort before taking further action.

Potential Major Refinements to the DRGs

The Commission has recently completed a partial evaluation of the impact of alternative proposals for major refinement of the DRGs. The results indicate that these refinements would allow more accurate classification and payment for Medicare cases. Further study would be needed, however, to reach a final judgment regarding the desirability of any of the proposed modifications. Therefore, ProPAC is not recommending adoption of major changes at this time. The Commission is interested in the views of hospitals and other entities as it continues to assess the desirability and impact of these refinements.

The Commission recently conducted a partial evaluation of the impact of alternative proposals for major refinement of the DRG patient classification system. These proposals were developed by the Health Systems Management Group at Yale University and by 3M Health Information Systems for New York State.

The results of ProPAC's analysis indicate that both proposals would permit more accurate classification of Medicare patients under PPS. Consequently, payments to hospitals would more accurately reflect cost differences due to variations in severity of illness and other factors.

Adoption of either proposal also would substantially affect the distribution of PPS payments among hospitals. Under current law, the Secretary is required to adjust payments to hospitals so that any change in the DRGs or the DRG weights would be budget neutral. (That is, the standardized payment amounts would be adjusted so that estimated aggregate payments after the change are equal to those that would have been made without it.) This means that changes in the DRGs leading to higher payments for some hospitals must result in offsetting reductions in payments to other hospitals.

On average, either set of DRG refinements would lead to an increase of about 1 percent in payments per discharge for major teaching hospitals and for disproportionate share hospitals located in large urban areas. Conversely, average payments per discharge would decrease by about 1 percent for small rural hospitals and for sole community hospitals. This would occur because the refined DRGs would better reflect differences in the average severity of illness of the patients treated by various types of hospitals.

However, the distribution of PPS payments would change even more within any hospital category. The percentage change in payments per discharge for individual major teaching hospitals would range from –1.8 percent to 2.6 percent using the Yale DRG refinement. Similarly, the percentage change in payments per discharge for individual rural hospitals would range from –3.0 percent to 3.8 percent. The pattern of change would be quite similar under the New York refinement, although the size of the change would be somewhat smaller in every hospital group.

In addition, uncertainty remains regarding other potential effects of adopting either of these refinements. First, it is not clear how much other payment adjustments, such as the indirect medical education or disproportionate share adjustments, would need to be modified to accommodate changes in patient classification. It is also unclear to what extent large differences in payment rates between patients with different classes of comorbidities and complications would encourage undesirable changes in coding behavior. Moreover, the administrative burden hospitals and intermediaries would face in converting to either system is uncertain.

Resolving these issues will require further evaluation. In addition, the Commission believes that it may be more desirable to consider adopting these refinements as part of a broader package of payment reforms. Other reforms might include major changes in the construction of the PPS wage index, changes in the methods and data used to calculate DRG weights, and changes in the definition and financing of payments for outlier cases. (See Recommendation 6 for a discussion of the wage index.) Consequently, ProPAC is not at this time recommending adoption of either of the proposed DRG refinements. The Commission is interested in the views of hospitals and other entities as it continues to assess the desirability and impact of these proposals.

Recommendation 7: Medicare Transfer Payment Policy

> **Cases transferred out of a hospital should be paid based on a graduated per diem up to the full DRG payment to recognize the higher daily costs associated with the first few days in a patient stay. In addition, outlier payment policy should be reexamined, particularly with respect to transfer cases received by a hospital. The Commission believes that hospitals are penalized by the current payment for transfers and that further examination of whether hospitals have the appropriate incentive to transfer patients, particularly with respect to recuperative care, is warranted.**

Medicare cases transferred out of one hospital and into another are paid a uniform per diem based on the DRG, up to the full DRG amount. The final

hospital in a transfer sequence receives the full DRG payment, although the patient involved may be assigned to a different DRG for each hospitalization.

Over the past few years, ProPAC has conducted an extensive analysis of transfer payment policy. The analysis found that the uniform per diem payment provided to the transferring hospital undercompensated the hospital for the care provided. Payment to cost ratios were substantially below average for cases with short lengths of stay, but were closer to average for cases with typical stays. This is because a uniform per diem payment does not recognize the frequently higher costs associated with stabilization, evaluation, and surgery that generally take place early in a patient's hospital stay.

The analysis found that the receiving hospital was also undercompensated for transfer cases due to a higher incidence of outliers among these patients. A ProPAC technical report outlining the findings from the analysis will be published in April 1992.

The Commission believes that the payment system should not influence the decision to transfer a patient. Rather, the decision should be based solely on appropriate patient care. ProPAC is concerned that the current payment method may inappropriately penalize hospitals that transfer patients to another institution for more complex care or for recuperative care.

A graduated per diem payment could more accurately reflect the higher daily costs associated with the first few days of care by more closely tracking these costs. A graduated per diem payment, to vary by day of stay, would be highest for the first day of care and lowest for the last day. The cumulative per diem payments would not exceed the full DRG payment. The methodology for developing a graduated per diem payment could follow a study conducted by RAND for ProPAC (*How Services and Costs Vary by Day of Stay for Medicare Hospital Stays*). This study examined how cost varied for each day of a patient stay for a number of DRGs. The Commission would be happy to work with the Secretary in developing a graduated per diem payment for transfer cases.

The current payment method also discourages the transfer of cases from one hospital to another for recuperative care, as noted above. A graduated per diem for all but the final admission in a transfer sequence could reduce the penalty faced by these hospitals. However, the full DRG payment amount for cases requiring recuperative care may be too high. Further, it is uncertain whether a graduated per diem payment would affect hospital behavior in these situations. Nor is it known if behavioral change would be desirable. ProPAC therefore encourages the Secretary to explore the benefits of encouraging these kinds of transfers, as well as what payment policy would be appropriate. Finally, the Commission believes PROs should continue to review transfer cases in order to monitor changes in frequency that are related to any new financial incentives.

The Commission is also concerned that Medicare's outlier payment policy penalizes hospitals that receive numerous transfer cases. ProPAC analysis has shown that a larger than average proportion of transfer cases become outliers and that the losses on these cases are substantially greater than those for the average outlier case. ProPAC strongly urges the Secretary to reexamine outlier payment policy, giving particular attention to transfer cases. The Commission also plans to reexamine outlier payment policy in the near future and is willing to work with the Secretary on the issue.

Recommendation 8: Payment for Hemophilia Blood Clotting Factor

The Commission believes that current PPS payment policies are adequate to prevent significant payment inequities for hospitals that treat Medicare beneficiaries with hemophilia. Therefore, ProPAC does not recommend reinstatement of an add-on payment for the costs of blood clotting factor provided to hemophilia patients. However, should the current situation change, the Commission may reevaluate this issue.

In 1989, the Commission recommended implementation of an add-on payment, for a two-year period, for the costs of providing blood clotting factor to Medicare patients with hemophilia. This payment was needed because the prices of clotting factors had risen dramatically in 1987 and 1988. These increases were due mostly to new manufacturing processes designed to reduce the risk of transmitting the human immunodeficiency

virus (HIV). Congress enacted ProPAC's recommendation in OBRA 1989. The add-on payment was effective for discharges occurring after June 18, 1990, and before December 19, 1991. Congress has asked ProPAC to reevaluate this issue.

Reinstatement of the add-on payment for clotting factor could be justified if there were many beneficiaries who required it, if the costs to administer it were substantial, and if these cases were concentrated in a few hospitals. But in fiscal year 1990, there were fewer than 3,000 discharges of Medicare beneficiaries with hemophilia. Not all required blood clotting factor. These cases were treated in more than 1,300 hospitals. Of the hospitals providing this care, 94 percent treated five or fewer Medicare beneficiaries with hemophilia. So there are relatively few of these cases, and they are widely scattered among many hospitals. Further, even though hemophiliacs are, on average, more costly to treat than other cases within a given DRG, there are insufficient data to indicate that these differences are due to the administration of clotting factor.

Current PPS payment policies adequately compensate hospitals that treat Medicare beneficiaries with hemophilia. Hospitals' billed charges, which are used to recalibrate the DRG weights, include the costs of clotting factors. Therefore, these costs are refleeted in higher weights for the DRGs that include these patients. In addition, while payment to cost ratios are lower than average for hemophilia discharges compared with all Medicare discharges, the process of averaging offsets the losses from these cases against the profits from cases with lower average costs. Finally, outlier payment policy is designed to provide additional compensation to hospitals for exceptionally costly cases.

If the current situation changes, and future evidence indicates that the costs of administering clotting factors to patients with hemophilia become significantly burdensome for some hospitals, the Commission will reevaluate this issue.

Recommendation 9: Payment for Epilepsy Cases

The current DRG assignment should be revised to account for the resource requirements of patients with epilepsy receiving intensive neurodiagnostic monitoring.

Epilepsy is a chronic disorder of the brain, characterized by the tendency to have recurrent seizures. Approximately 10 percent of epilepsy patients do not attain an adequate level of seizure control: Their seizure disorders are characterized as intractable. In 1987, concerns over the adequacy of PPS payment for the treatment of intractable epilepsy patients receiving intensive neurodiagnostic monitoring were brought to the Commission's attention.

ProPAC reported preliminary findings on this issue in its March 1988 report to the Secretary. At that time, only three centers were identified as providing specialized care for the treatment of intractable epilepsy. Within the two DRGs to which the majority of these cases were assigned (DRG 24 and DRG 25), payment shortfalls were larger for patients with epilepsy than for other patients. However, the Commission deferred making a recommendation at that time because there were no specific codes to identify patients with intractable epilepsy. Since then, the number of hospitals providing these specialized services has increased to more than 40, and codes that distinguish patients with intractable epilepsy have been implemented.

Commission analyses of data from fiscal year 1990 found that the majority of patients with epilepsy are not concentrated in any hospital type. However, hospitals providing specialized services had a higher percentage of patients with epilepsy who receive monitoring. Further, nearly 64 percent of the patients in these hospitals who were assigned to DRGs 24 and 25 had intractable epilepsy, compared with about 31 percent in other PPS hospitals.

Payment to cost ratios were lower for patients with epilepsy compared with other patients in the same DRG. For example, ratios were about 10 percent lower for epilepsy patients compared with other patients in DRG 25. These differences were larger for patients with intractable epilepsy and for those receiving monitoring. In DRG 25, the payment to cost ratios were 18 percent lower for patients with intractable epilepsy. Those receiving monitoring had ratios nearly 22 percent lower than other patients in the same DRG. The same pattern was seen in DRG 24 as well.

Therefore, the Commission believes that the Secretary should evaluate the current DRG

assignment for patients with intractable epilepsy, particularly those receiving intensive neurodiagnostic monitoring. The payment system should not discourage hospitals from treating these patients. The Commission realizes, however, that more accurate codes may need to be implemented to ensure that the appropriate type of monitoring is reflected in the patient records.

Recommendation 10: Essential Access Community Hospital Program

> **The Commission recommends that the Secretary waive, on an individual case basis, some of the requirements for participation in the Essential Access Community Hospital Program. This would encourage increased hospital participation and allow the Secretary to gain additional experience with alternative policies. Over time, policies should be expanded to target the larger group of hospitals that should continue to operate but offer limited, less specialized inpatient services. By refocusing these hospitals' operations, the Commission believes that overall system efficiency may be improved without sacrificing access to care.**

OBRA 1989 required the Secretary of Health and Human Services to establish an Essential Access Community Hospital Program in up to seven states. By restructuring the delivery of services in rural areas, the program seeks to ensure access to care through the provision of emergency services and an entry point for inpatient care. Restructuring is also designed to reduce the cost of providing appropriate care, primarily through downsizing inpatient capacity.

The program requires every participating state to develop a rural regionalization plan with two levels of care. Rural primary care hospitals are to provide emergency and temporary inpatient care for cases needing stabilization prior to discharge or transfer. Essential access community hospitals are to act as full-service referral hospitals for the RPCHs.

Participating RPCHs must transform from providing routine inpatient care to offering more limited emergency inpatient and outpatient services. Specifically, all hospitalizations in RPCHs must be certified as emergencies by a physician, and patients must be discharged or transferred within three days. In addition, a RPCH is limited to six inpatient beds, unless the hospital has swing beds. In that case, the RPCH may have up to 12 total beds, with no more than 10 beds concurrently used for skilled nursing level services. Further, formal agreements with at least one other hospital must be established for the referral and admission of cases that cannot be treated at the RPCHs. By limiting the services offered at these hospitals, the extra costs of maintaining inpatient capacity while serving a small number of patients may be avoided. Instead, local residents requiring non-emergency inpatient care are to be treated in a hospital offering an appropriate array of services.

The Commission agrees with the intent of this program. Nevertheless, it has concerns regarding several specific RPCH provisions, as outlined in its report to Congress, *Rural Hospitals Under Medicare's Prospective Payment System.* ProPAC questioned the following: (1) the condition of payment requiring certification that the admissions were required on a temporary, inpatient basis; (2) the six-bed limitation; and (3) the maximum three-day length of stay.

The program also contains several provisions for EACHs. These facilities must be located 35 miles from another EACH or rural referral center and have at least 75 beds. The hospitals must agree to provide emergency and medical backup services to RPCHs, offer admitting privileges to RPCH physicians, and accept RPCH patients as transfers. The Commission is troubled by the 75-bed requirement, which may encourage unnecessary bed capacity or disallow participation of small, full-service hospitals.

In the Commission's judgment, the EACH program provisions are so restrictive that many otherwise eligible hospitals may choose not to participate. Without sufficient participation, the program is unlikely to meet its goals. Therefore, ProPAC encourages the Secretary to waive certain provisions on an individual case basis. This flexibility may result in higher hospital participation while experience is gained regarding alternative policies.

The EACH program is not designed to solve the problems facing those rural hospitals that wish to remain open but are not financially viable in their current configuration. Because this program is limited to hospitals that will discontinue their routine inpatient care, it is unlikely to have a large impact on the organization and delivery of rural hospital care. Thus, the Commission recommends that policies eventually should be expanded to target larger hospitals that will remain open as inpatient facilities. These hospitals should be made more efficient through appropriate restructuring of their services. The Rural Transition Grant Program, administered by HCFA, is one effort aimed at helping hospitals adapt to their changing circumstances. Begun in 1987, this program provides funds to help small rural not-for-profit hospitals and their communities adapt to changing demand for services, excess acute care capacity, and the inability to provide appropriate staffing. It is designed to ensure access to emergency and inpatient care in areas where services are eliminated.

Alternatively, the EACH program could be expanded to permit the participation of hospitals offering routine inpatient services for treatment of appropriate cases. This could enable other hospitals that wish to remain open to use EACH funds to downsize and develop linkages with full-service hospitals. The Commission would gladly collaborate with Congress and other interested parties to develop a workable strategy to achieve a more efficient hospital system.

PRO Review and Quality of Care

The Commission believes the Peer Review Organization program should continue to monitor, at the case and facility levels, the care furnished to Medicare beneficiaries. Although the Commission commends the planned expansion of epidemiologic patterns of care studies using the Uniform Clinical Data Set, these more general analyses should not replace all case-level and facility-level quality review. Further, funding should be sufficient to allow PROs to perform case-level and facility-level review, as well as more general analyses of broad patterns of care.

Peer Review Organizations, which are private organizations under contract to HCFA, generally operate at the state level. These organizations review hospital medical records in a given state to determine whether payment should be made for services provided under Medicare. HCFA specifies the major responsibilities of the PROs in their contracts, which are awarded for three years. One-third of these contracts come up for renewal each year.

Historically, the mandate of the PROs has included quality of care and utilization review at the hospital level. Past ProPAC recommendations have addressed the need to improve quality of care review by, for instance, implementing better quality screens (the specific criteria against which care is evaluated). The Commission has also called for more sophisticated methods of quality review that emphasize outcomes measures.

The fourth PRO contracting cycle began in the fall of 1991. The contracts issued during the latest cycle reflect the Secretary's overall strategy of shifting the PRO program's focus from an emphasis on individual record review to a more systematic analysis of patterns of use and patterns of outcome. This strategy is consistent with recommendations made in the recent Institute of Medicine (IOM) report, *Medicare: A Strategy for Quality Assurance*. The IOM's recommendations reflect its belief that hospitals, together with their medical staffs, will continue to improve the quality of care furnished to all patients.

In conjunction with this changed focus, the Uniform Clinical Data Set (UCDS) is being implemented. An automated record review system, the UCDS is designed to standardize the review process and produce a detailed, patient-level database. This database will be important in conducting epidemiologic studies of patterns of health care delivery. The Commission strongly supports this type of activity.

However, with increased emphasis on a more nationally representative database, the hospital-level review of the care furnished to Medicare beneficiaries has been deemphasized. No other external entity will perform this function. The Commission is concerned that this shift in PRO orientation is at the expense of quality monitoring at the individual and facility level. All levels of quality should be examined, from individual cases and facilities to local, regional, and national patterns of

care. Therefore, although the UCDS is a useful and important tool, it does not substitute for facility and case-level review of the quality of care provided to Medicare beneficiaries.

PRO funding should be sufficient to provide for adequate review at the case and facility level. Funding should also permit analyses of broad patterns of care. ProPAC is concerned that budget cuts will have an unfavorable impact on both of these important types of activities.

Updating and Adjusting Payments to PPS-Excluded Hospitals and Distinct-Part Units

Since the implementation of Medicare's prospective payment system in 1983, certain hospitals (psychiatric, rehabilitation, long-term, and children's) and distinct-part units (psychiatric and rehabilitation) have been exempt. Further, cancer hospitals were exempted from PPS as a result of OBRA 1989. The primary reason for their exemption was that DRGs failed to predict accurately the resource costs for patients treated by these providers.

PPS-excluded hospitals and distinct-part units are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). They are paid on the basis of each facility's historical costs trended forward, with a limit placed on the rate of increase in per case reimbursable costs. These TEFRA target rate-of-increase limits are updated annually. The target rate per discharge is based on hospital-specific Medicare costs in a base year, which varies depending on when the facility was constructed or converted to a PPS-excluded category.

Facilities with costs less than the target rate per discharge receive their costs plus an additional payment that is the lesser of 50 percent of the difference between their costs and the TEFRA target rate, or 5 percent of this target rate. Beginning in fiscal year 1992, providers with costs exceeding their target rates will receive 50 percent of these costs subject to a total payment ceiling of 110 percent of the target amount. Further, the Secretary is required to provide for an adjustment to the amount of payment for a hospital when events beyond the hospital's control distort the increase in costs for a cost reporting period.

The TEFRA target rate-of-increase limits are updated annually. PPS-excluded hospitals and distinct-part units received the same update provided to PPS hospitals until fiscal year 1989. Congress then set the TEFRA target rate update equal to the projected increase in the market basket. Beginning in fiscal year 1991, the Secretary has implemented a separate market basket for PPS-excluded providers. Although the update has been legislated, Congress requires the Commission and the Secretary of HHS to recommend an annual update factor to the TEFRA target rates.

OBRA 1990 requires the Secretary to develop a proposal to modify the current payment system for PPS-excluded providers (including operating and capital-related costs) or to replace it with a prospective payment system. The Secretary is required to submit this report by April 1, 1992. ProPAC is to analyze and comment on the Secretary's proposals by June 1, 1992.

Recommendation 11: Fiscal Year 1993 Update Factor for PPS-Excluded Hospitals and Distinct-Part Units

For fiscal year 1993, the target rate of increase for PPS-excluded hospitals and distinct-part units should be updated to account for the following factors:

- **The projected increase in the HCFA PPS-excluded hospital market basket, currently estimated at 4.6 percentage points;**
- **An upward adjustment of 0.2 percentage points, to reflect the difference between HCFA's market basket and that recommended by ProPAC;**
- **A correction for fiscal year 1991 market basket forecast error of –0.7 percentage points; and**
- **An allowance for scientific and technological advancement of 0.1 percentage points.**

In addition, a positive allowance should be given to TEFRA providers that entered the program before fiscal year 1989, depending on the year on which their target rates were

based. This allowance should reflect the difference between the actual updates given to their target rates in earlier years and the market basket for those years. It should result in aggregate payments that are budget neutral with respect to the legislated update.

The legislated update to the TEFRA target rate equals the projected increase in the market basket. The Commission's recommendation results in an average update to the target rate equal to the market basket minus 0.4 percentage points (see Table 2-3). The savings achieved from this reduction should be used to fund the allowance for the pre-1989 TEFRA providers.

Market Basket–The update recommendation is determined primarily by the projected increase in the PPS-excluded market basket index. The current HCFA market basket forecast for fiscal year 1993 is 4.6 percent. The Commission, however, believes that the market basket as currently constructed does not adequately recognize the unique characteristics of the hospital labor market. The major reason is that the proportion of internal hospital wages used in the wage component of the HCFA market basket is understated. (See the discussion of the market basket index in Appendix A.) Therefore, the Commission recommends an additional 0.2 percentage point adjustment.

Forecast Error Correction–ProPAC continues to believe that the update should be corrected for past market basket forecast errors. This requires comparing the actual market basket increase in a given year with the forecast used to update payments in that year. A two-year lag exists between when the forecast is used and when the actual market basket increase is known. In the Commission's judgment, corrections should be made only for errors that equal or exceed 0.25 percentage points. Taking this approach, the Commission compared the actual fiscal year 1991 market basket increase with the forecast used to update the TEFRA target limits in that year. The fiscal year 1991 market basket forecast was 5.3 percent, and the actual market basket increase was 4.6 percent. The forecast error correction for fiscal year 1991 is thus –0.7 percentage points.

Scientific and Technological Advancement–ProPAC has also developed an allowance for scientific and technological advancement for PPS-excluded facilities. This allowance reflects the Commission's judgment about hospitals' financial requirements for the adoption of quality-enhancing but cost-increasing technologies. To arrive at an informed judgment on the allowance, each year ProPAC examines a set of the most important new technologies and scientific advances used in PPS-excluded facilities. Based

Table 2-3. Recommended PPS-Excluded Update Factor for Fiscal Year 1993

Components of the Update	
Components applied to all hospitals and distinct-part units:	
Fiscal year 1993 HCFA PPS-excluded market basket forecast[a]	4.6%
Adjustment for difference between HCFA and ProPAC market baskets[a]	0.2
Correction for fiscal year 1991 forecast error	-0.7
Allowance for scientific and technological advancement	0.1
Average update before positive allowance adjustment	4.2
Basis for cumulative positive allowance adjustment[b]	
1984-1988	2.1
1985-1988	4.2
1986-1988	6.9
1987-1988	4.4
1988	2.1

[a] Market basket forecast provided by the Health Care Financing Administration, Office of the Actuary, December 1991. The market basket forecast is subject to change as more current forecasts become available.

[b] *Federal Register* 56(106), June 3, 1991, 251778-25323.

on this examination, an increase of 0.1 percentage points to the target rate is needed to offset the cost of new technologies.

Unlike the update for PPS hospitals, the update for excluded facilities should not include a productivity adjustment. The productivity adjustment to the PPS update is based on the principle that Medicare should share in the savings generated by productivity improvements. However, Medicare automatically shares in the savings under TEFRA. Facilities with costs less than the target amount receive their costs plus the lesser of 5 percent of the target amount, or 50 percent of the difference between their target amount and costs. Therefore, part of any productivity increase is factored into reduced Medicare payments. ProPAC believes that further reductions in payments for productivity improvement are not appropriate for PPS-excluded providers.

Positive Allowance–Based on the Commission's initial analysis of PPS-excluded facilities, it appears that the earlier a provider was excluded from PPS, the more financially vulnerable it has become. This is partly because hospitals and distinct-part units excluded before fiscal year 1989 received the same update as PPS hospitals. The PPS update was reduced to account for growth in payments resulting from CMI increases. PPS-excluded providers, however, did not benefit from increased payments due to CMI changes.

ProPAC believes that these providers should have received the full increase in the market basket during this period. To ensure budget neutrality, the savings achieved from the Commission's average update recommendation should be distributed to these providers based on the difference between the market basket increase and the actual update received. Further, the Secretary is required to provide for adjustment of a hospital's payments when events beyond its control affect the increase in costs during a reporting period. In general, the provider must request an adjustment each year in which costs exceed payments. In these cases, the Secretary is permitted to use the most appropriate method for adjustment, including the assignment of a new base year.

ProPAC believes that giving a positive allowance to providers excluded in the early years will reduce the amount of the adjustments that will be requested and granted in the future. The savings based on the difference between the market basket increase and the actual update should be considered in determining the positive allowance. Again, providers that had new target rates computed to reflect more recent cost data should not receive the positive allowance.

The Commission will continue to evaluate the appropriateness of the TEFRA system for PPS-excluded providers. As required by Congress, ProPAC will prepare a report by June 1, 1992, analyzing and commenting on proposals developed by the Secretary. If the Secretary's report is delayed, the Commission will submit a preliminary report in June 1992 evaluating TEFRA payment policy. Several factors will be examined, including (1) cost and payment increases in PPS-excluded facilities, (2) payment variation and potential reasons for it, and (3) beneficiaries' access to services at these facilities. Further, the report will review the general criteria for reform and present various payment policy options. The Commission will submit a subsequent report reviewing the Secretary's recommendations, as appropriate.

Finally, ProPAC believes that the Secretary should systematically collect data on successful adjustment applications. Medicare Cost Report data are a valuable source of information used to assess the financial effects of TEFRA. However, cost reports are not amended to reflect these adjustments. Therefore, these data may not accurately reflect the overall impact of TEFRA payments on providers.

Updating Payments to Dialysis Facilities

The Omnibus Budget Reconciliation Act of 1990 directs the Commission to recommend "an appropriate change factor which should be used for updating payments" for the facility component of dialysis services. This recommendation is due by March 1 of each year, starting in March 1992 for services provided in fiscal year 1993.

The legislation also instructs the Commission to submit a report in June 1992 that includes recommendations regarding payment methods and levels for the facility component of dialysis services. In making these recommendations, ProPAC is to study the costs, services, and profits associated with the various types of dialysis.

Since 1983, dialysis facilities have been paid a prospectively set amount per dialysis treatment; hospital-based facilities and independent facilities receive slightly different base rates. The rate was set using a sample of Medicare Cost Reports from 1977 through 1979. This prospectively set rate is referred to as the composite rate, because it was based on a formula that factored in the lower costs of providing dialysis at home and the proportion of patients receiving dialysis in this setting. While this payment rate was meant to encourage the use of home dialysis, the proportion of patients receiving such treatment has increased only minimally. This increase is due to growth in the number of patients receiving peritoneal dialysis at home. The number of home dialysis patients receiving hemodialysis has decreased since 1983.

Although there have been some minor changes to base payment rates, they are essentially the same as the rates set in 1983. There has been no annual process for updating payment to dialysis facilities like the one used in PPS.

Recommendation 12: Update Factor for Payments to Dialysis Facilities

> **The Commission is not recommending an increase in payments for dialysis services at this time. Currently, data are inadequate to assess the relationship between the payments and the costs of furnishing various types of dialysis services in different settings. The Commission recommends that HCFA expedite work necessary to complete its database of unaudited dialysis facility cost reports. In addition, HCFA should annually audit the cost reports of a representative sample of dialysis facilities and maintain a database with this information.**

The Commission believes that developing an appropriate update factor for dialysis services requires information on payments and costs for the different types of dialysis furnished in the alternative settings. Existing data are inadequate to evaluate payments and costs by type of treatment and by setting.

The latest available data are from a sample of 1988 audited cost reports, which was to be the basis for proposing new payment rates. The sampling strategy was intended to produce cost estimates that reflected efficiently produced services. To do this, larger facilities with lower production costs were overrepresented. This sampling strategy was appropriate for its originally intended purpose. But because it was not representative of all dialysis facilities, the sample did not allow the comprehensive evaluation of costs and payments that the Commission believes is necessary.

Patients may receive hemodialysis or peritoneal dialysis. These services may be provided by hospital-based or independent facilities in the facility or in the home. The 1988 audited cost report sample was not representative of either the proportion of patients treated at home or the types of dialysis provided. Nor did it represent other facility characteristics that should be analyzed, such as location, size, chain affiliation, ownership, and whether the facilities were hospital-based or independent. To correct these data deficiencies, the Commission recommends that HCFA expedite the collection of unaudited cost report data from later years and complete the work necessary to make this database operational. In addition, HCFA annually should audit a representative sample of cost reports to use in evaluating payments and costs by type of treatment and setting.

The sampling issues inherent in the available cost report data create problems for many analyses. These data, however, represent the best systematically collected information available on costs per treatment in hospital-based and independent facilities, and therefore on the industry's financial status. In 1988, the costs of hospital-based facilities were, on average, higher than Medicare payments, whereas costs in independent facilities, the largest group, were lower. The majority of facilities were profitable in 1988. Other organizations that did similar analyses using data from 1988 or before reached comparable conclusions.

Additional analyses, notably one conducted by the Institute of Medicine (IOM) entitled *Kidney Failure and the Federal Government*, indicate that facilities have apparently been able to adapt to unchanged payment rates by introducing productivity improvements. These improvements are based at least partly on scientific and technological advances that have reduced the time needed to

dialyze patients and, hence, the labor and other costs associated with each dialysis session. Another productivity improvement occurring during the 1980s was the increased reuse of dialyzers, a key component in the dialysis process. The IOM report states that "the introduction of the composite rate in 1983 had several general effects on providers and, derivatively, on innovation. It increased the severity of the economic discipline on all providers, further encouraging the search for efficiency."

Evidence concerning quality of care is inconclusive. Further, even though payments have not changed since 1983, the number of dialysis facilities continued to grow steadily through 1989, suggesting that access to care has not been reduced.

On the basis of this information, the Commission believes it is appropriate to wait until data are available to evaluate the dialysis industry thoroughly before recommending an update factor. In its June report on dialysis payment rate, ProPAC will describe its approach to a comprehensive analysis of the dialysis facilities and the issues related to developing an update to payment rates.

Improving Hospital Outpatient Payment Policy

During the 1980s, there was unprecedented growth in the delivery of care in the outpatient setting. Medicare payments for outpatient hospital services increased more than three times faster than those for inpatient services between 1984 and 1990. Outpatient revenues are a particularly large proportion of total revenues for small hospitals and for those located in rural areas.

OBRA 1990 requires the Commission to issue a report by March 1, 1992, analyzing and commenting on the Secretary's proposal for developing a hospital outpatient payment based on prospectively determined rates. Although the Secretary has not yet issued a report, ProPAC will present its recommendations to Congress by the mandated date. The Commission will comment on the Secretary's proposal after it is released.

The following nine recommendations are excerpted from ProPAC's report. They provide principles for improving the outpatient payment system, and apply these principles to specific recommendations on ambulatory surgery and outpatient radiology services.

Recommendation 13: Outpatient Payment Reform

The Commission believes that a prospective payment system for outpatient services should be implemented. Outpatient facility payment reform should ultimately include all providers of outpatient services, such as hospitals, physicians' offices, and free-standing ambulatory surgical centers.

The same payment method should apply to the facility or technical component of all services. The payment rate, however, should be adjusted to reflect justifiable cost differences such as wages and case mix. Further, cost differences that have some societal benefit like, for example, standby capacity and emergency capabilities, should also be reflected in the payment rate. Where feasible, the unit of payment should be based on bundled related services.

The Commission believes that one major goal of outpatient payment reform is to provide incentives for controlling total expenditures in an appropriate manner. Reform should reward providers for delivering cost-effective quality care in the appropriate setting. A prospective payment method promotes incentives to deliver cost-effective care by allowing an opportunity for a profit as well as the risk of financial loss. However, ProPAC realizes that various payment methods may be used during the transition to a fully prospective system.

In attempting to control total costs, the Commission recommends that outpatient reform should eventually include all providers of ambulatory care, including physicians' offices and independent laboratories. This broad scope is necessary because most ambulatory care is furnished outside of the hospital setting.

Physicians and beneficiaries should not have financial incentives to favor one site of care over another, but should choose the most medically appropriate site. Applying the same prospective payment method to all outpatient services, regardless of whether care is provided in hospitals, free-standing ambulatory care settings, or physicians' offices, will help achieve this goal. Using the same method of payment, although not necessarily the same level of payments, will help ensure that payment incentives across providers are consistent.

Although the reforms should be applied to all providers of outpatient services, the payment rate may vary for different providers. There are many reasons why costs may differ among similar providers (such as teaching and non-teaching hospitals) and across treatment sites (such as hospitals and physicians' offices). These factors include differences in patient severity, the intensity of teaching activities, and geographic location. The Commission believes it is desirable to adjust for some of these factors in the payment system, particularly those that represent a benefit to society and are beyond the control of the provider. (See Recommendation 21.) However, the lack of cost data for free-standing settings may complicate the determination of appropriate differences in payment rates. (See Recommendation 15.)

ProPAC recommends that outpatient facility payment reform should contain incentives consistent with those of physician payment reform. Beginning in 1992, physicians will be paid using a resource-based Medicare Fee Schedule. The fee schedule is designed to increase payment equity among physicians, constrain Medicare expenditures, protect beneficiaries' access to services, and promote predictability and administrative simplicity. The Commission believes that these features should also characterize the reform of outpatient payment methods, as it noted in its March 1991 *Report and Recommendations to the Congress.*

While a prospective payment method controls the price of the individual unit of service, it has limited impact on the volume of services provided. (See Recommendation 14.) ProPAC believes that over time, payment should move from the current fee for an individual service to a larger payment unit containing more services (known as bundling). A bundling approach is necessary to control the volume and intensity of services provided. These packages, or bundles, could be based on services furnished during a single visit or over multiple visits, such as a week or an entire episode of care. Eventually, payments could be set to cover the costs of bundles of services deemed to be appropriate or necessary for high-quality, cost-effective care.

Initially, there may be less comprehensive approaches to bundling. Analysis of the 1987 hospital outpatient file by the Urban Institute, for example, indicates that bills for certain outpatient services had a significant number of related ancillary charges (such as radiology and laboratory). Nearly 58 percent of surgical claims had ancillary charges. This suggests that limited bundling for selected services in the hospital outpatient setting may be appropriate.

To define the unit of payment, the Commission supports the research funded by the Secretary to develop a classification system for ambulatory services. However, ProPAC is concerned that this research currently focuses only on hospital-provided outpatient services. For example, the Ambulatory Patient Groups (APGs) outpatient case-mix classification system was developed for use in the hospital outpatient setting. While additional research is under way, it is unclear whether APGs can be appropriately applied in the non-hospital setting.

To the extent that free-standing facilities are providing the same package of services, ProPAC believes any classification system should be applicable to these settings as well. The Commission encourages the expansion of the Secretary's research in this direction.

Recommendation 14: Medicare Volume Performance Standard

Services provided in the hospital outpatient setting should be included in the Medicare Volume Performance Standard (VPS) to the extent that these services are included when provided in other settings. Certain services, such as laboratory tests and therapy, currently are included in the VPS when they

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are furnished in free-standing settings. The Commission believes that hospital-provided services should also be incorporated in the VPS. Their inclusion will make incentives to control volume consistent across sites of care.

Several of Medicare's current outpatient payment methods (such as blended rates and fee schedules) control the price of individual services. However, these payment methods fail to control the volume of services provided. The Commission believes that a policy to control inappropriate volume is warranted.

The Volume Performance Standard, enacted in OBRA 1989, offers an approach for controlling some Medicare Part B expenditures. The primary purpose of the VPS is to provide a collective incentive for physicians to control the rate of increase in the volume and intensity of services furnished to beneficiaries. The VPS is designed to give physicians incentives to order fewer tests and other procedures of limited value to patients. The Commission realizes that reductions in volume and intensity growth will be achieved gradually.

Services commonly furnished by physicians or in physicians' offices and billed through Part B carriers are included in the VPS. Services provided in the hospital outpatient setting and billed through Part A fiscal intermediaries are excluded because the intermediaries do not collect service-specific data. To the extent that these services are included in the VPS when provided in free-standing settings, they should also be included when supplied by hospitals. This change would prevent physicians from attempting to circumvent the objectives of the current VPS. Since hospital-provided outpatient laboratory services are not included in the VPS, for example, physicians have incentives to shift these services to the hospital setting. If these services were included in the VPS, physicians would have the same incentive to control their use as they would to control the use of laboratory tests performed in their offices or independent laboratories.

In his response to the Commission's previous recommendation, the Secretary has stated that outpatient hospital services may be included in the VPS as data systems evolve over time. ProPAC believes that the Secretary should advance the development of these systems so that outpatient services provided in the hospital setting can be included in the VPS as soon as possible.

Recommendation 15: Cost Data Collection for Outpatient Providers

A mechanism for periodic collection of procedure-specific cost data in free-standing settings, including physicians' offices and ambulatory surgical centers, should be implemented.

To implement and maintain a prospective payment system across outpatient providers, comparable patient and financial data are needed. Under a prospective payment rate, comparisons must be made between hospitals and other providers of ambulatory care—such as physicians' offices and free-standing ambulatory surgical centers (ASCs)—to determine the appropriate level of payment.

Cost data for free-standing settings therefore are necessary to ensure comparable financial incentives across different types of providers. However, data are not now available to compare the costs of ambulatory care across providers. Because most outpatient services are available in a variety of settings, the Commission believes that collection of non-hospital cost data is necessary to develop appropriate outpatient payment policy.

ProPAC believes that systematic and comprehensive methods of collecting data on services provided in non-hospital settings need to be developed. For ambulatory surgical centers and some other types of providers, an annual cost report would be the appropriate data collection mechanism. The Secretary's survey of ASCs could serve as a model for collecting service-specific cost data from other ambulatory care providers. The Commission supports the research being conducted by the Physician Payment Review Commission (PPRC) on the direct practice costs for certain services provided in physicians' offices. This research will provide guidance on how service-specific cost data can be collected in these settings.

In the short term, alternative methods for using readily available data should be considered. Data used to construct the practice expense component

of the fee schedule, for instance, may be useful in establishing a fair price for services across settings. The Secretary has indicated that alternative methods for data collection will be explored. The Commission intends to work with both the Secretary and PPRC in assessing available data sources.

Recommendation 16: Beneficiary Liability

> **Beneficiary Part B coinsurance for hospital outpatient services that are paid for prospectively should be limited to 20 percent of the payment amount allowed by Medicare.**

Under current law, beneficiary liability for outpatient services differs depending on the site of care. In the hospital outpatient setting, for example, coinsurance equals 20 percent of submitted charges. In free-standing ambulatory surgical centers, however, coinsurance equals 20 percent of the ASC payment rate. The ASC payment rate is likely to be lower than charges submitted by hospitals.

Historically, hospital outpatient services were reimbursed on the basis of reasonable costs. These costs could not be determined until after the services were performed. Consequently, it was administratively infeasible to base beneficiary coinsurance on actual Medicare payments or costs. As a result, beneficiary coinsurance was based on submitted charges, which were known when the services were performed. Some hospital services are still reimbursed on the basis of reasonable costs. However, when services are paid prospectively, as recommended in this report, Medicare reimbursement will be known at the time services are furnished. Therefore, it will be feasible to follow Medicare's general policy—that beneficiary coinsurance equal 20 percent of the payment amount and Medicare payment, 80 percent.

Analysis conducted by the Commission indicates that beneficiary coinsurance tends to be higher in hospital settings than in free-standing settings. For example, for hospital-provided ASC-approved surgery and radiology services, patients may pay as much as 35 percent and 46 percent, respectively, of the amount Medicare ultimately allows.

In the Commission's view, this policy unfairly penalizes beneficiaries who receive care in the hospital outpatient setting. ProPAC believes legislation should be adopted to eliminate this discriminatory policy and reduce the burden on beneficiaries who use hospital outpatient services.

The Commission realizes that this policy will increase Medicare expenditures. However, the Medicare program should assume responsibility for 80 percent of the payment amount. If such an increase in expenditures is unacceptable, less discriminatory ways of sharing the financial burden should be explored.

Recommendation 17: Quality of Care in Outpatient Settings

> **The Commission is concerned about the lack of Federal quality oversight in many ambulatory care settings. As more services are furnished in outpatient settings, ProPAC believes the Secretary should enhance existing methods and develop new ones to assess and monitor the quality of care provided to beneficiaries in these settings.**

The quality of care provided in hospital outpatient departments and free-standing ambulatory surgical centers is subject to some Federal review, primarily through Medicare conditions of participation and PRO activities. Many other ambulatory care settings, however, are not subject to any Federal quality assurance mechanisms. Medicare conditions of participation require a setting to be inspected by the Medicare program, or some agent of the program, to ensure that it meets specific quality standards. Peer Review Organizations have medical practitioners review cases of beneficiaries seen in specific settings to make certain these standards have been met.

By contrast, many ambulatory care settings, including ambulatory care centers, diagnostic imaging centers, cancer centers, and lithotripsy centers, do not have to meet any Medicare conditions of participation, nor are they subject to PRO review. Some of these facilities are voluntarily accredited by private organizations, although many do not even undergo voluntary accreditation. In addition, many surgical procedures previously performed in hospitals now can be performed in

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physicians' offices, for which there is no Federal oversight of quality assurance mechanisms.

PROs review a sample of cases treated in hospital outpatient departments and in ASCs. However, the sample of ambulatory surgery cases reviewed in these facilities has recently been reduced from 5 percent to 3 percent. Cases treated in hospital outpatient departments are reviewed only if the outpatient services were received between hospitalizations that occurred within 31 days of each other. Because these "intervening care" cases are part of a random 10 percent sample of beneficiaries who were discharged from a hospital, the number of a hospital's outpatient cases the PRO reviews can be quite small.

As more care is delivered in ambulatory settings, the Commission is concerned about the limited role of the PROs and the lack of any Federal quality oversight for much of this care. In addition, many of the voluntary accreditation processes do not focus on outcomes of care, but rather on the physical aspects of the settings and the procedures used to provide care. The Commission believes that more emphasis should be placed on ensuring the quality of ambulatory care and, more specifically, evaluating quality in terms of the outcomes.

Recommendation 18: Payment for Hospital-Provided Outpatient ASC-Approved Surgery

> **The Commission believes that payments for ambulatory surgery performed in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and free-standing ASC payments. These rates should be computed in a budget neutral fashion; that is, aggregate spending should neither increase nor decrease. National rates should be based on the classification system used to determine payments to free-standing ASCs. However, the Commission believes this classification system should be revised. The rates should be updated annually using an appropriate update factor.**

The Commission supports congressional intent to establish prospective payment methods for outpatient services. These methods will create incentives for controlling total expenditures by encouraging hospitals to deliver cost-effective care. Thus, providers will have the opportunity for a profit as well as the risk of financial loss. In addition, prospective payments are more predictable.

The current payment method for ambulatory surgery fails to achieve this goal. Hospitals are paid the lesser of costs (or charges, for those hospitals with charges below costs) or a blended amount, which is equal to 42 percent of hospital-specific costs and 58 percent of the ASC payment rate. This method provides no incentive for hospitals to lower their costs. If a hospital reduces its costs, the payments it receives correspondingly decline, thus eliminating some of the incentive to deliver care more efficiently. By contrast, ASCs are reimbursed on the basis of a prospective fee schedule for the same service, thereby providing more incentive to control costs.

The Commission believes that payment rates should recognize justifiable differences in the costs of furnishing services. Costs may differ between hospitals and free-standing providers for several reasons, including patient severity, standby capacity, and the presence of an emergency room. While there are no data to measure the costs in free-standing settings, payment rates between these settings and hospitals vary. Lacking complete information on the reasons for these payment differences, ProPAC believes that hospitals' rates should incorporate a portion of the difference between hospital costs and the ASC payment rates.

The Commission realizes that if national rates were established in this manner, without modification, Medicare expenditures would increase. For example, preliminary analysis indicates that about 26 percent of hospitals currently receive payments for all ambulatory surgery based on costs or charges. This indicates that the costs or charges of these hospitals are below the comparable ASC payments. Paying these hospitals the current blended rate will increase Medicare expenditures. Therefore, the Secretary should adjust the national rates to maintain budget neutrality. ProPAC's preliminary estimates indicate that the national rate will reflect a 28:72 blend of average hospital costs and the free-standing ASC rate. These rates should be

updated annually to reflect increases in the market basket and other appropriate cost increases.

ProPAC believes that better cost data are necessary to understand the implications of using current ASC payment rates. (See Recommendation 15.) Such data will help to determine the reasons for and the magnitude of cost differences between settings. Future payment rates could be adjusted to reflect better cost data. In addition, these national rates should be adjusted to reflect differences in wages. (See Recommendation 21.) Finally, the classification system used to group cases for payment should include both ASC and hospital cases. (See Recommendation 19.)

Recommendation 19: Revision of the Classification System Used to Group Ambulatory Surgery Cases

The Secretary should revise the classification system used to group ambulatory surgery cases for payment. Cases treated in both hospitals and free-standing ambulatory surgical centers should be used to establish the payment groups.

The current classification system used to group cases for ambulatory surgery payment was developed using cases treated in free-standing ASCs. Audited charge data for 90 ASCs were standardized for area wage differences, converted to costs using an average cost to charge ratio, and arrayed in descending order. The procedures were then classified into the payment groups using $75 intervals. Over time, as the number of approved ASC procedures has increased, the number of surgery groups has increased from four to nine.

The Commission is concerned that the current ASC classification system may not accurately reflect the costs or mix of cases treated in hospitals. It is likely that the mix and costs of hospital cases would result in different groupings. Thus, while the number of groups may remain the same, the classification of certain procedures may vary from the current classification system. Therefore, the Commission recommends that hospital data be combined with free-standing ASC data in establishing the classification system used for payments.

Recommendation 20: Payment for Hospital-Provided Outpatient Radiology Services

The Commission believes that payments for radiology services provided in the hospital outpatient setting should be fully prospective based on national rates adjusted for area wage differences. The payment rates should be established using average hospital costs and the technical component of the Medicare Fee Schedule for physicians. These rates should be computed in a budget neutral fashion;that is, aggregate spending should neither increase nor decrease. The national rates should be updated annually using an appropriate update factor.

The Commission supports congressional intent to establish prospective payment methods for outpatient services. These methods will create incentives for controlling total expenditures by presenting the opportunity for a profit as well as the risk of financial loss. Thus hospitals will be encouraged to deliver cost-effective care. In addition, prospective payments are more predictable.

The current payment method for radiology services fails to achieve this goal. Hospitals are paid, by law, the lesser of costs (or charges, for those hospitals with charges below costs) or a blended amount, which equals 42 percent of hospital-specific costs and 58 percent of 62 percent of the global fee schedule amount. This method provides no incentive for hospitals to lower their costs because it simply reduces payments rather than establishing a reward system for hospitals that deliver care more efficiently. By contrast, physicians are reimbursed on the basis of a prospective fee schedule for the same service, thereby encouraging them to control costs.

Physician-provided radiology services have been paid on the basis of a fee schedule for several years. The original fee schedule was based on a professional services component and a technical component. The professional component measured the physician's time, skill, and intensity of service. The technical component measured the physician's practice costs—rent, employee salary, and equipment costs, and so forth. When constructed, it was assumed that 62 percent of the physician's charge

for radiology services represented the technical component. Therefore, payment for hospital-provided radiology services was based on the same percentage.

Beginning January 1, 1992, payments to all physicians are based on the Medicare Fee Schedule. Radiology services are incorporated into this fee schedule. It also includes professional and technical components. However, the technical component has been refined to measure practice costs for individual radiological procedures more accurately. ProPAC believes, therefore, that the technical component of the new physician fee schedule should be used to calculate payments for individual hospital outpatient radiology services.

In ProPAC's view, payment rates should recognize justifiable differences in the costs of furnishing services. Costs may differ between hospitals and free-standing providers for several reasons, including patient severity, standby capacity, and the presence of an emergency room. While data are not available to measure radiology service costs in free-standing settings, payment rates vary between these settings and hospitals. Despite the lack of information explaining these differences, the Commission believes that the hospital payment rate should incorporate a portion of the payment difference. ProPAC acknowledges that radiology services provided in physicians' offices are comparable to those provided in the hospital outpatient setting, to some degree. Therefore, the national payment rate should also reflect physician payments.

The national payment rate for radiology services furnished in the hospital setting should be computed using average hospital costs and the technical component of the Medicare Fee Schedule for physicians. Preliminary analysis indicates that about 10 percent of hospitals currently receive payments based solely on costs. This indicates that these hospitals' costs are lower than the comparable physician payments. Eliminating the "lesser of" provision in current law and reimbursing these hospitals using rates calculated with the current blended rate would increase Medicare expenditures. Therefore, the Secretary should adjust the national rates to maintain budget neutrality. ProPAC's preliminary estimates indicate that the national rate will reflect a 36:64 blend of average hospital costs and the technical component of the Medicare Fee Schedule for physicians. These rates should be updated annually to reflect changes in the market basket and other appropriate cost increases.

Better cost data are necessary to determine the reasons for and the magnitude of cost differences between settings to understand the implication of using the technical component of the current physician fee schedule. (See Recommendation 15.) Future payment rates could be adjusted to reflect better cost data. Finally, the Commission believes that these national rates should be adjusted to reflect differences in wages. (See Recommendation 21.)

Recommendation 21: Payment Adjustments for Hospital-Provided, ASC-Approved Surgery and Radiology Services

> **The Commission believes that national prospective payment rates for ASC-approved ambulatory surgery and radiology services should be adjusted to reflect differences in labor costs. This adjustment should take into account the appropriate labor share and occupational mix of ASC-approved surgery and radiology services in the hospital outpatient setting. The Secretary should conduct additional research to determine whether other adjustments are warranted.**

The Commission supported the concept that the payment system should be neutral with respect to certain providers, settings, and area characteristics. The payment system should not inappropriately influence the site where services are furnished.

ProPAC's recommendation for payment of ASC-approved surgical procedures and radiology services furnished in hospitals incorporates hospital costs to reflect differences between hospitals and other ambulatory care providers. These rates should also be adjusted to reflect differences among geographic areas. Payments to free-standing providers and physicians are now adjusted for differences in area wages. To ensure equity among providers located in various areas of the country, as well as maintain consistency with other payment methods, payments for hospital outpatient services should also account for variations in area wage levels.

The proportion of costs attributed to labor and the mix of occupations employed differs between the outpatient and inpatient settings. Under PPS, for example, 71 percent of the standardized amount is adjusted for the cost of labor. Conversely, in free-standing ASCs, about 35 percent of the rate is labor adjusted. Therefore, the labor share and the wage index used for inpatient services may not be appropriate for outpatient services.

If the labor share were less for outpatient services than for inpatient services, reimbursing outpatient services based on the inpatient labor share would tend to overpay hospitals in higher wage areas (urban); it would underpay those in lower wage areas (rural). In addition, the over-adjustment would tend to obscure other differences in outpatient costs that are associated with an urban location, such as teaching or disproportionate share status.

Further, if the mix of occupations employed in the outpatient setting differed from the overall facility mix, using the hospital wage index for an outpatient payment system would lead to inaccurate payments for outpatient services. The complexity of services and the resulting differences in the occupational mix in inpatient and outpatient settings may vary considerably. The Secretary should undertake research to determine and adjust for the appropriate labor share for outpatient services, as well as the mix of occupations employed in outpatient settings.

Besides variations in costs due to geographic location, costs may differ among hospital groups. Under PPS, payment adjustments account for these differences. The need for additional payment adjustments for hospital groups, such as those to teaching, disproportionate share, and sole community hospitals, should be evaluated. Preliminary analyses indicate that average hospital costs for radiology and ASC-approved surgery did not vary substantially for hospitals with teaching or disproportionate share status. These costs did, however, appear to vary by hospital size and geographic location. Rural hospitals had lower costs than hospitals in urban areas, and larger hospitals had lower costs than smaller ones. While size appears to influence costs, multivariate analysis should be conducted to consider, simultaneously, teaching, location, disproportionate share status, and size. Once these analyses are complete, the need for and the amount of adjustments can be determined.

Improving Skilled Nursing Facility Payment Policy

OBRA 1990 requires the Secretary and ProPAC to report on a prospective payment system for extended care services provided in skilled nursing facilities. The Secretary was charged with developing a proposal to modify the current system or, alternatively, to develop a proposal to pay for skilled nursing care on the basis of prospectively determined rates. The Secretary was to have issued the report by September 1, 1991, but has not yet done so.

ProPAC was to have commented on the Secretary's report by March 1, 1992. Instead, the Commission is issuing a background report on skilled nursing facility payment by the March deadline, and will review the Secretary's SNF payment proposal after it has been released. The following recommendation and discussion are excerpted from ProPAC's forthcoming report.

Recommendation 22: Nursing Facility Wage Index

The Secretary should collect data on employee compensation and paid hours of employment for nursing facilities that care for Medicare SNF patients. Once these data become available, the Secretary should develop a nursing facility wage index and use it to adjust Medicare SNF payments.

The current Medicare SNF payment system uses the hospital wage index to adjust payments. However, there is evidence to suggest that geographic differences in the unit prices of labor for hospital employees are not similar to those for employees of nursing facilities. ProPAC simulated a nursing facility wage index with limited data and found significant differences from the hospital wage index. For example, the HCFA hospital wage index is much lower than the estimated nursing home wage index in urban areas of the New England and Mid-Atlantic states and higher in the West South Central region.

These indexes may differ due to wide variations in state regulations affecting nursing homes. Through their certification and oversight roles, states have a

major impact on the costs and staffing of nursing facilities. It is appropriate for Medicare to recognize these differences in labor costs imposed by the states. Increased Federal involvement through OBRA 1987 may reduce variations in state regulations that affect nursing homes. This legislation provides for far greater Federal oversight of nursing homes. OBRA 1987 also mandates new standards for quality of care in these facilities, requirements related to overall staffing, and minimum training for nurse aides.

Another potential reason for the failure of the hospital wage index to reflect adequately the variation in skilled nursing facility wages is the skill mix differences between hospitals and nursing facilities. Nursing facilities employ proportionately more aides than hospitals. In addition, the relative level of aides' salaries compared with nurses' salaries may not be the same across geographic areas. The hospital wage index does not capture these differences in the mix of employees and in relative wages.

The use of the hospital wage index under the current system contributes to inequitable Medicare SNF payments across regions. The relationship of payments to costs varies significantly by geographic area. For example, almost half of the facilities in New England and almost a third of those in the Mid-Atlantic region receive less than 85 percent of their costs. This compares with an average of only 15 percent of the facilities in other regions. In addition, only 17 percent of the facilities in New England and 30 percent in the Mid-Atlantic region receive 100 percent of their costs, compared with 66 percent of the facilities in the West South Central region and 50 percent in the Pacific region.

Regardless of the payment method for nursing facilities under Medicare, an accurate wage index is necessary to account for geographic differences in wages. As with the hospital wage index, the method used to collect wage and hour data for nursing facilities should be prospective and incorporated with the current Medicare Cost Report to maximize the consistency of the data and minimize the reporting burden. Further, the Commission suggests that the Secretary phase in the use of the nursing facility wage index to allow time for facilities to adjust.

The Commission also recognizes that collecting nursing facility wage data and developing an index may take several years to complete. As an interim measure, separate cost limits could be developed for each geographic region. This would partially address the problems associated with the use of the hospital wage index.

Recommendation 23: Nursing Facility Case-Mix Adjustment

> **The Commission believes that the payment system should recognize differences in the costs of care for different types of patients. Therefore, it supports the Secretary's efforts to develop and implement a case-mix adjustment to Medicare SNF payments under the Multistate Nursing Home Case Mix and Quality Demonstration. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.**

Under the current Medicare SNF payment method, skilled nursing facilities face a financial disincentive to admit Medicare patients, especially those who require the most care. Medicare beneficiaries are often sicker and require more nursing and rehabilitative care than other SNF patients. The current Medicare method of cost finding, however, attributes routine costs (including nursing care costs) to Medicare on the basis of the program's share of patient days. That is, Medicare patients and other nursing facility patients are treated as if they all incurred the same average per diem cost for routine care services. As a result, Medicare's share of allowable costs tends to understate the true costs of caring for Medicare patients. Further, this discrepancy, and the related financial disincentive, may be especially large for Medicare beneficiaries who require more than average care. A payment adjustment that explicitly recognized differences in cost for different types of patients would mitigate the disincentive to admit patients who require more extensive care.

A case-mix index is being developed under the Multistate Nursing Home Case Mix and Quality Demonstration. This demonstration, which is being conducted in six states, will use the index for Medicare and Medicaid payment and evaluate its performance. If the case-mix adjustment developed under the demonstration proves to be appropriate, it should be implemented.

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June 4, 1992

Part III

Department of Agriculture

Agricultural Stabilization and Conservation Service

7 CFR Part 703
Wetlands Reserve Program; Final Rule

DEPARTMENT OF AGRICULTURE

Agricultural Stabilization and Conservation Service

7 CFR Part 703

Wetlands Reserve Program

AGENCY: Agricultural Stabilization and Conservation Service, USDA.

ACTION: Final rule.

SUMMARY: Title XIV of the Food, Agricultural, Conservation, and Trade Act of 1990 (the 1990 Act), enacted on November 28, 1990, amended the Food Security Act of 1985 (the 1985 Act) to provide for the establishment of the Wetlands Reserve Program (WRP). The 1990 Act amendments authorized the Secretary of Agriculture to purchase easements from owners of eligible land who voluntarily agree to restore and protect farmed wetlands or converted wetlands and eligible adjacent acres. For fiscal year 1992 only, the WRP shall be available to producers in only the following states: California, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New York, North Carolina, and Wisconsin. This final rule adopts, with changes, the proposed rule published in the **Federal Register** (57 FR 4378) on February 5, 1992, which set forth the proposed regulations which are necessary for the implementation of the program.

EFFECTIVE DATE: June 1, 1992.

FOR FURTHER INFORMATION CONTACT: James R. McMullen, Director, Conservation and Environmental Protection Division, ASCS, P.O. Box 2415, Washington, DC 20013; phone (202) 720–6221.

SUPPLEMENTARY INFORMATION: This final rule has been reviewed under USDA procedures established in accordance with Executive Order 12291 and provisions of Departmental Regulation 1512–1 and has been classified as "major." It has been determined that these provisions may result in an annual effect on the national economy of $100 million or more. However, (1) no major increases in costs or prices for consumers, individual industries, State or local agencies, or geographic regions, or (2) significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of the United States-based enterprises to compete with foreign-based enterprises in domestic or export markets will result upon implementation of these provisions. However, a regulatory impact analysis has been prepared and is available upon request.

It has been determined that the Regulatory Flexibility Act is not applicable to this rule since Agricultural Stabilization and Conservation Services (ASCS) is not required by 5 U.S.C. 553 or any other provision of law to publish a notice of proposed rulemaking with respect to the subject matter of this rule.

It has been determined by an environmental assessment that this action will not have any significant adverse impact on the quality of the human environment. Therefore, an environmental impact statement is not needed. Copies of a final environmental assessment are available upon request.

This program/activity is not subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. See notice related to 7 CFR part 3015, subpart V, published at 48 FR 29115 (June 24, 1983).

The title and number of the Federal Domestic Assistance Program, as found in the Catalog of Federal Domestic Assistance to which this rule applies are: Wetlands Reserve program 10.072.

The information collection requirements of the final rule at 7 CFR part 703 have been submitted to OMB for approval under provisions of 44 U.S.C. chapter 33. Further, the OMB number 0560–0139 has been assigned.

The public reporting burden for the information collections that would be required for compliance with these regulations is estimated to average 31 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This final rule has been reviewed in accordance with Executive Order 12778. The provisions of this final rule: are not retroactive; and preempt State and local laws to the extent such laws are inconsistent with the provisions of this final rule. Before an action may be brought in a Federal court of competent jurisdiction, the administrative appeal rights afforded program participants at 7 CFR part 780 must be exhausted.

Discussion of Program

The WRP is authorized by title XII of the 1985 Act. Under the WRP, the Agricultural Stabilization and Conservation Service (ASCS) will purchase easements from persons voluntarily agreeing to restore farmed and converted wetlands. The 1990 Act creates an umbrella program called the Agricultural Resource Conservation Program (ARCP) which includes the Environmental Conservation Acreage Reserve Program (ECARP). ECARP includes the Conservation Reserve Program (CRP) and the WRP. On April 19, 1991, the Commodity Credit Corporation published a rule in the **Federal Register** (56 FR 15980) containing final regulations which would add to the Code of Federal Regulations a new part (7 CFR part 1410) for the CRP program. General provisions for the ARCP were included as subpart A of pqrt 1410 and specific regulations for the CRP were set out as subpart B. This rule establishes a new part (7 CFR part 703) for WRP.

Maximum Acreage Enrollment, Land Eligibility, and Easement Priorities

Section 1237 of the 1985 Act sets a 1991–95 enrollment goal of a maximum 1 million acres for the WRP, but provides further that enrollment through 1991 may not exceed 200,000 acres, enrollment through 1992 may not exceed 400,000 acres, enrollment through 1993 may not exceed 600,000 acres, enrollment through 1994 may not exceed 800,000 acres, and enrollment through 1995 may not exceed 1,000,000 acres.

Section 1237 specifies that eligible land will include farmed or converted wetlands, but not wetlands converted after December 23, 1985, together with adjacent lands on which the wetlands are functionally dependent so long as the likelihood of successful restoration of such land and the wetland values merit inclusion in the program taking into account the cost of restoring the wetlands. ASCS is also permitted to include in the program: (1) Farmed wetlands and adjoining lands that are enrolled in the CRP with the highest wetland functions and values and that are likely to return to production at the end of the CRP contract; (2) other wetlands that would not otherwise be eligible if it is determined that inclusion in the program would add to the value of the easement; and (3) riparian areas that link wetlands that are protected by easements or by some other device or circumstance that achieves the same purpose as an easement. In addition, prior converted wetlands enrolled in the CRP may be eligible to be included in the WRP if there is a high probability the wetlands can be restored.

Nationwide, eight pools will be established that correspond with the country boundaries of Soil Conservation Service's (SCS) Major Land Resource Regions (MLRR's). Bids accepted, generally, will be based on a ratio of acres of hydric cropland soils in a particular pool area compared to the acres of hydric cropland soils in the nation. If bids are not accepted which equal the total allocated acreage within

a pool area, ASCS may, at ASCS's discretion, redistribute any remaining acreage in such pool to other pools. Section 1237 prohibits acquiring WRP easements for land that contains timber stands established under the CRP.

With respect to owner eligibility, section 1237E of the 1985 Act provides that no WRP easement shall be created on land that has changed ownership in the preceding 12 months unless: (1) The new ownership was acquired by will or succession as a result of the death of the previous owner; or, (2) the Secretary determines that the land was acquired under circumstances that give adequate assurances that such land was not acquired for the purpose of placing it in the WRP.

Section 1237A provides that the easements purchased under the WRP shall be in a recordable form and shall be for 30 years, permanent, or the maximum duration allowed under applicable State laws. Section 1237C(c) provides that in determining the acceptability of offers, consideration may be given to the extent to which the purposes of the program can be accomplished on the land, the productivity of the land and the on-farm and off-farm environmental threats if the land is used for the production of agricultural commodities. In addition, section 1237C(d) provides that to the extent practicable, taking into consideration costs and future agricultural and food needs, the Secretary shall give priority to obtaining permanent easements before shorter term easements and, in consultation with the Secretary of the Interior, shall place priority on acquiring easements based on the value of the easement for protecting and enhancing habitat for migratory birds and other wildlife. In order to accomplish this goal, § 703.12 provides that permanent easements will be preferred whenever possible. The final rule at § 703.10 provides that the duration of the easement is one of the factors which will be evaluated in rating bids to be accepted into the program. ASCS's intention is that a bid which offers less than a permanent easement shall be substantially lower in priority than a bid offering a permanent easement. For fiscal year 1992 and subsequent enrollment periods, requirements regarding the duration of WRP easements shall be as announced by ASCS.

A formula will be used to determine a ranking for bid acceptance when an excess of eligible bids are received during any given signup period. ASCS's intention in ranking the bids is to enroll the wetlands that provide the greatest environmental benefits for the government money expended on restoration and easement purchase. Initially, the prioritization formula will emphasize factors that ensure the effectiveness of the restored wetland when compared to a site's particular wetland functions and values. The weight of particular factors may change if credible new information is developed that characterizes the environmental benefits of wetlands by their specific functions and values.

Further, if it is determined that special circumstances exist which increase the value of the area to be accepted and the wetland to be restored, the SCS State Conservationist, upon the recommendations of the Fish and Wildlife Service (FWS) and the local SCS office, may request acceptance of no more than five percent of the total acreage enrolled in the State during each signup period irrespective of the ranking. Each request for such acceptance will be considered on a case-by-case basis taking into consideration the information submitted by SCS for each such request.

Successful permanent easement bidders have an option of either receiving lump-sum payments or equal annual payments over 10 years. For bid evaluation purposes, the net present value of a lump-sum bid will be calculated to equitably compare the two options to ensure that the maximum environmental benefit per taxpayer dollars expended is obtained.

The final regulations implement the owner and land eligibility provisions in §§ 703.6–703.9. In order to assure maximum benefits from the expenditure of WRP funds, the regulations set out crop-history requirements and other provisions which include limiting the eligibility of "adjacent lands" to buffer areas that in each case may neither, for the particular easement, average more than 100 feet wide nor be more than twice the area of the restored wetland. Landowners will be allowed to transfer eligible land from the CRP to WRP during the first 2 WRP sign-up periods established in their county without having to refund CRP payments or having to accept a reduction of their WRP payment. Transferring eligible land from CRP to WRP after the first 2 WRP signup periods will result in a reduction in any WRP amount due equal to any CRP payments received after the second available WRP signup period.

Specifications are also set out in the final regulation for the wetland functional values which may be considered relevant by ASCS in determining whether particular parcels should be accepted for enrollment in the program. Sections 703.10–703.11, provide for a bid system to be used to determine enrollment and those sections provide for the use of priorities in assessing bids, as is provided in the statute. Section 703.12 provides specifically that, to the extent practicable, all easements shall be permanent easements unless it is determined by ASCS upon evaluation of offers that accepting an offer for a shorter period, which still meets the minimum length requirements of the 1985 Act, is necessary for accomplishment of the national program goals in individual cases.

With respect to fiscal year 1992 only, WRP shall be available to producers only in the following states: California, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New York, North Carolina, and Wisconsin. These states have been determined to be those which will provide the eligible acres necessary to enroll approximately 50,000 acres and allow an evaluation of WRP implementation procedures.

Producer Requirements

Section 1237A of the 1985 Act provides that an owner of land placed in the program must: (1) Grant an easement on the land; (2) implement a Wetlands Reserve Plan of Operation (WRPO); (3) provide for the creation and recordation of a deed restriction covering the easement area; and (4) ensure consent to the easement from persons holding a security interest in the property.

The 1985 Act requires, in addition, that the easement permit: (1) Repairs, improvements, and inspection on such lands that are necessary to maintain existing public drainage systems and; (2) landowners to control public access on the easement area while identifying access routes to be used for wetland restoration activities, management and monitoring. Section 1237A requires that the easement: (1) Prohibit the alteration of wildlife habitat and other natural features of the land unless specifically permitted by the WRPO; (2) prohibit spraying with chemicals or mowing of the land except as permitted by the WRPO to comply with Federal or State noxious weed laws or Federal or State emergency pest treatment programs. The 1985 Act provides further that the Secretary may impose other conditions as needed and authorizes the Secretary to permit compatible uses of the property which are deemed consistent with the primary purposes of the easement. Section 1237B requires, generally, that participants must comply with all program requirements and specifies that as a condition for

participation, the participant must agree to the permanent retirement of any existing cropland base and allotment history for such land under production adjustment programs administered by the Secretary.

Section 1237A provides that in the case of any violation of the terms and conditions of the easement or related agreement, the easement shall remain in force and the owner may be required to refund all or part of any payment made for such easement, together with interest. With respect to WRPO's, section 1237A provides that such WRPO's will be developed and agreed to at the local level by representatives of the SCS and the FWS, United States Department of Interior, in conjunction with the landowner. However, if agreement between SCS and FWS cannot be reached at the local level, the WRPO shall be developed by the State Conservationist in consultation with FWS.

Sections 703.12 and 703.15 set out the obligations of WRP participants. These provisions require participants to control noxious weeds or pests to the extent specified in the WRPO taking into consideration the needs of wildlife and water quality. Each participant will be required, prior to submitting a bid for participation in the program, to have an approved WRPO which would set out the manner in which the land would be restored to a wetland status and other measures which would be required for the property including adjacent areas.

Under § 703.12 participants are required to be responsible for the long-term management of the easement in accordance with the terms of the easement and related agreements including the WRPO. However, participants will continue to have the option, at their sole discretion, to enter into an agreement with a Federal, State, or private conservation entity to secure management assistance or other commitment of action from such entities that the landowner determines to be in their interest. Arranging for a conservation entity to become the owner of record of the land, including the management responsibilities associated with the easement area, is one potential option available to the present owner as a means of transferring long-term management responsibility.

Section 703.15 sets out provisions which authorize ASCS to permit certain uses to be considered compatible uses of the property in appropriate cases. Those uses can include fee hunting and fishing, and, in addition, timber production under an approved management and harvesting plan. Compatible uses may also include haying or grazing if allowed by the WRPO in a manner consistent with the easement. Provisions for remedies for ASCS in the event of a program or easement violation are set out in § 703.19 of the final regulations.

Payments

WRP payments are subject to advance appropriations. ASCS may make easement payments, cost-share payments and reimbursement for fair and reasonable legal costs associated in acquiring an easement. With respect to easement payments, section 1237A of the 1985 Act provides that the easement payment may not exceed the amount which is equal to the difference between the fair market value of the land less the fair market value of the land encumbered by the easement. Easements will be accepted based on the market value of the agricultural land. A formula to determine the value of the land will be used based on the average market value of agricultural land in a county adjusted for: (1) Soil productivity, (2) landowner cost of wetland restoration; (3) long term easement area operation; maintenance, and replacement costs; (4) long term costs of providing for an easement access route; and (5) any other factors authorized by ASCS. This section provides further that the payments may be made on an annual basis, in equal or unequal amounts, for a period which may not be less than 5 years or more than 20 years. This section also provides: (1) In the case of permanent easements, a lump-sum payment may be made; and (2) that the total amount of easement payments made to a person for any year under the WRP may not exceed $50,000, except that such limitation will not apply with respect to payments for permanent easements. With respect to cost-share payments, section 1237C of the 1985 Act provides that, for non-permanent easements, the Secretary shall authorize cost-shares equal to not less than 50 percent nor more than 75 percent of the cost of carrying out the establishment of restoration measures and practices and the protection of the wetland functions and values, as set forth in the WRPO, to the extent that the Secretary determines that cost-sharing is appropriate and in the public interest. At § 703.13 the final rule provides that cost sharing for easements which are less than permanent may receive cost shares at a rate as low as 50 percent while easements which are permanent may receive cost shares at a rate which is no less than 75 percent of eligible costs. It is ASCS's intention to use a 50 percent cost share rate on less than permanent easements and a 75 percent rate on permanent easements.

Unlike CRP participants, WRP participants are not subject to the wetland conservation and highly erodible conservation provisions of Title XII of the 1985 Act under which participants may lose eligibility for certain USDA benefits as the result of prohibited activities related to wetlands and highly erodible lands. Section 1237D of the 1985 Act provides that WRP payments are not subject to a budget sequester order issued under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

Provisions for payments are made in § 703.13. Those provisions specifically authorize withholding a portion of the easement payments otherwise due pending installation of the practices agreed to in the WRPO. In addition, the final rule provides that cost-share payments may be made under the WRP for the establishment or installation of the eligible restoration practices or reestablishment or reinstallation if failure is due to an unforeseen natural disaster or similar act. With respect to the limitation on payments for non-permanent easements, § 703.14 provides that payment limitation determinations will be made in accordance with 7 CFR part 1497 (including § 1497.109(a)) which provides that payments will be attributed to each member of an entity.

Miscellaneous Provisions

The final regulation contains other miscellaneous provisions to implement the program provided for in the 1985 Act. These provisions cover, among other matters, assignments of payments, the transfer of the enrolled property, and the enrollment limitations of 25 percent of the county cropland. In the case of a land transfer, the easement will "run with the land;" therefore, all parties having or acquiring an interest of any kind in the property are subject to the easement. Section 703.4 of the final rule provides for the acceptance of long term easement offers in counties where cropland enrollment into ECARP already exceeds 25 percent of the county's cropland.

Discussion of Comments

ASCS received sixty-nine letters containing 274 comments concerning the proposed rule published February 5, 1992. Entities responding included individuals, State governments, local governments, State wildlife and conservation organizations, national wildlife and conservation organizations, national farm and commodity

organizations, and Members of Congress. Comments came from twenty-eight states and that District of Columbia.

Changes in this final rule from the proposed rule of February 5, 1992, are based upon public comments to the proposed rule. A few minor editorial and other changes have also been made in the text for clarity and to facilitate the application of the regulations. The discussion of comments that follows is organized by section in the same sequence as the final rule.

Section 703.1 Applicability

Twenty-eight comments were received regarding the proposal to limit the implementation of WRP in the fiscal year 1992 to 8 states. The respondents indicated that other States and types of restored wetlands are desirable to be included as pilot States. Although an argument can reasonably be made for the inclusion of any specific State based on local conditions, only one State, Wisconsin, was added. Implementation of the CRP in Wisconsin provides a unique opportunity to study the effects that an existing State restoration program, that in over 20 years has established over 1,500 wetlands in the State, may have on participation in the new WRP. Wisconsin also ranks high in potential hydric soils suitable for restoration to better ensure sufficient bids are submitted in order to reach the 50,000 acre goal during the pilot program.

Section 703.2 Administration

Nineteen comments suggested changes in the proposed administration of the WRP. These comments addressed the issues of the roles and responsibilities of environmental and conservation groups in implementing the WRP. Several minor editorial and other changes have been adopted. Accordingly, the provisions of § 703.2(f)2 have been expanded to include consultation with State and non-governmental organizations at the State and local level; the provisions of § 703.12(a)15 have been clarified to include private organizations; and § 703.15(d) to include conservation districts as approving officials on the WRPO. Designating a different lead agency or requiring the local drainage district as an approving official are not viable alternatives and were not adopted. Although ASCS is the administering agency, the success of this program lies with the technical agencies, namely SCS and FWS, that will make the technical decisions regarding land eligibility and development of the WRPO with the landowner, and FS where tree planting for timber production is approved.

Section 703.3 Definitions

One comment suggested that the term "non-permanent easements" include 10-year agreements. The 1985 Act provisions specifically state the types of easements which may be accepted and the length of the easements. There is no statutory basis to adopt this suggestion.

One comment recommended expanding program provisions to specify the role and function of environmental and conservation organizations at the local level. These organizations are important and expected to play a major role in the effective implementation of the WRP. Section 703.3 has been amended to specify that ASCS will consult with non-governmental agencies regarding issues when necessary and appropriate.

Another comment requested that trees and vine crops be included in the definition of an agricultural commodity. Generally, for the purposes of this program, an "agricultural commodity" is defined to be an annually tilled crop or sugarcane. Adding trees or vine crops would go beyond that criteria and would not generally produce the same public benefit as the enrollment of other lands into the program. Accordingly, no change has been made by the final rule.

One comment offered another definition for "riparian areas." In response to this comment an addition to the proposed definition has been included in § 703.3 to expand the definition of a "riparian area" to provide that areas along "channels" shall also be included.

Finally, one comment pointed out the proposed definition of an "easement area" included only the land being restored and not necessarily the adjacent lands. The definition of "easement area" has not been revised, since the term is used to delineate that portion of the farm on which the restored wetland is located, or which is described on the easement document as being the location of the required practices necessary to restore the hydrology and protection to the restored area. However, the easement document will specify that no action may be undertaken anywhere on the easement farm which affects the restored wetland or other area designated as the easement area.

Section 703.4 Maximum County Acreage

Three comments were received favoring a waiver of the 25 percent maximum cropland permitted to enter into the Environmental Conservation Acreage Reserve Program (ECARP) and one comment was received opposing any waivers. Since long-term easements are preferred over shorter-term easements and CRP contracts will begin expiring in 1996, it has been determined ASCS may accept and approve offers in counties in excess of the 25 percent cropland rule when such acceptance is deemed not to have an adverse effect on the local economy. The final rule has been modified to reflect that ASCS will accept WRP intentions and a waiver be granted in order to accept acreage into the WRP in an amount which is in excess of 25 percent of the county's cropland.

Section 703.6 Eligible Person

Six comments recommended waiving or eliminating any ownership requirement. One comment opposed allowing a person to purchase farmland solely for the intent of enrolling such land into the WRP. The proposed rule has been adopted without change since experience with the CRP has shown that program abuse is likely to occur if there is no prior ownership requirement.

Section 703.7 Eligible Land

Twenty-eight comments were submitted for review and consideration. Four of these were from California, recommending the cropping history requirement be modified or eliminated so as to permit the eligibility of pasture land for inclusion into the WRP. Since only slight to moderate enhancement of wetland functions and values would be achieved, this provision was not amended regarding cropping history.

Other comments recommended expanding the "adjacent area" which may be included in an easement from the average of 100 feet set forth in the proposed rule to 300 feet or to cover an entire watershed. Based on the advice provided by representatives of the technical agencies, the proposed 100 feet provision provides the nesting habitat and the restored area will be adequately protected from siltation or other water quality contaminants without defeating the intent of the program which is to restore wetland hydrology. ASCS does not believe that the additional acreage is necessary to achieve WRP goals. Therefore, no change was made in this regard.

Three comments suggested placing a higher priority for acceptance on eligible riparian areas. Five comments were supportive of the riparian area criteria, buffer area inclusion, or supported the eligibility criteria "as is." Other comments suggested including as eligible areas, areas with: trees;

bottomland hardwoods; or habitats for threatened or endangered species. These comments generally went beyond the scope of the WRP by including sizable increases in non-hydric cropland areas. Therefore, except as noted in the discussion on changes to § 703.8, none of these suggested changes were adopted.

Section 703.8 Additional Land Eligibility Provisions

One comment recommended inserting for inclusion "land including pasture lands or adjacent lands that have been identified as being habitat of an endangered or threatened species." The suggestion was not adopted; however, § 703.10(d) is being modified to allow for additional consideration under easement priority for wetlands which may aid in the protection of threatened or endangered species.

Section 703.9 Transfer of Lands From the CRP to the WRP

Thirteen comments were received with respect to the issue of allowing current CRP contract holders to enroll eligible land in the WRP prior to the maturity of the CRP contract. Generally, these comments opposed the proposal requiring CRP participants to bid in the first available WRP signup period; those CRP participants who did not bid at that time would have to wait until their CRP contract terminated before a WRP bid could be submitted. These comments also opposed the manner in which ASCS proposed to take into account previously paid CRP payments when making the WPP payments with respect to land subject to both contracts. In response to these comments, ASCS will allow CRP participants the opportunity to submit a WRP bid during all WRP signups; however, any CRP payment which is made after the second WRP signup period available to the CRP participant will be deducted from the WRP payment made to such person. This will allow for greater WRP participation without defeating the purposes of either program while ensuring that limited funding is used to the maximum possible extent.

Section 703.10 Easement Priority

Seventeen comments were received. Three comments support the use of a formula for selection purposes. One comment stated the formula was too complex. One comment recommended deleting the formula. Two other comments recommended either including the formula in the rule or providing copies of the formula to eligible landowners. One comment felt it was unfair to stress permanent easements. Two comments recommended that ASCS provide appraisals for review while one commenter was concerned how land values will be established. Another comment suggested expanding criteria to include North American Waterfowl Management Plans. One comment believed the prioritization should be the function of the technical agencies and not ASCS. In order to ensure that proper weight is given to all bids and to ensure that all factors involving the offered area are given sufficient consideration, a formula or other internal guidance is needed for use by ASCS personnel. Experience with prior ASCS administered programs has shown that disclosure of all criteria used in the bid evaluation process is not feasible and also defeats the whole concept of a bid program. Accordingly, these suggestions were not adopted except that the factor for "wetlands location significance" was clarified to include the contribution that restoration of the wetland may make toward the recovery of threatened or endangered species.

Section 703.11 Statement of Intention; Submission of Bids

Seven comments were received with six expressing concern over the most beneficial use of technical agency time in working with potential WRP participants. Each of the six comments recommended using "draft" Wetland Reserve Plans of Operation (WRPO) or not requiring any actual planning until after a producer had enrolled into the WRP. SCS has agreed to furnish a comprehensive plan to the landowner for assistance in formulating a competitive bid based on out-of-pocket costs to be incurred and any rights afforded under the easement such as haying, grazing, fee hunting, or planned timber harvest. The WRPO is a tool to bid competitively for acceptance into the program. However, detail design plans may not be completed by the technical agency until the bid is accepted. ASCS and SCS believe anything less than full disclosure as to requirements, costs, and rights retained would be unfair to a landowner and could cause increased program costs if any uncertainty existed. In addition, in order to properly prepare the easement document, the producer and ASCS must have a firm agreement as to the action to be undertaken or prohibited on the easement area and easement farm. For these reasons, this suggestion has not been adopted.

The seventh comment recommended providing copies of easement forms and other relevant forms to producers at the time of submission of an intention to participate. Any person may request and receive a copy of the WRP forms at any time. Each landowner signing an intention to participate will be given a packet of information including a basic easement document at that time to ensure a thorough understanding of the WRP and to assist in the formulation of a bid after the WRPO is completed.

Section 703.12 Obligations of the Landowner

Fifty-three comments were submitted for review and consideration on this section. Fourteen of these were regarding the length of easement. Most were strongly supportive toward permanent easements and did not support the use of short-term easements. Due to the limited funding available and due to the highest returns to be gained from these funds, it has been determined that ASCS will only accept permanent easements unless otherwise announced by the Deputy Administrator, State and County Operations, ASCS.

Eleven comments recommended changes for clarity with respect to permissive and restrictive uses in the adjacent areas of a participant's farm not included in the easement area. This suggestion is adopted in the final rule; § 703.12 is revised to provide that the WRPO will specify the prohibition of any activity that will cause excessive sedimentation or contaminants to enter the easement area or that may alter the flow of surface or subsurface water.

Five comments recommended deleting the requirement to control pests and weeds on the easement area. Two comments were concerned on the use of pesticides in weed or insect control. One comment suggested that the WRP regulations should take into account that the creation of wetlands through restoration may create nuisance problems in some instances. ASCS deemed no change is needed since State and local laws are applicable to the easement area.

Section 703.13 Payments to Landowners by ASCS

Thirteen comments were received. Three comments recommended clarifying the provisions of the regulations concerning easement cost and filing cost responsibilities. The final rule has been clarified to specify that ASCS will reimburse participants for fair and reasonable costs concerning title search and filing costs.

Five comments recommended higher cost-share rates. One comment suggested including as an eligible cost any water requirements in arid areas. One comment recommended lump-sum payments be offered to owners offering

less than permanent easements. Another comment disagreed with the proposal to refrain from making total payment until completion of practices necessary for restoration. These comments were not adopted since the 1985 Act specifically limits lump-sum payments to only those landowners granting a permanent easement and extending the benefits beyond that proposed would not be maximizing the possible program extents.

Finally, one comment recommended that the regulations clearly provide that landowner's be made aware that the WRP was funded by advance appropriations for the total value of the easement prior to ASCS accepting any offers. This suggestion was not adopted since it was determined that the issue is not one properly addressed in a regulation; however, participants may be fully apprised of their rights with respect to receiving payments by contacting their county ASCS office.

Section 703.15 Wetland Plan of Operations

Thirty-two comments were offered for consideration regarding the WRPO. Many of the comments recommended that the regulations be expanded to clarify those actions which are covered by the WRPO. Other comments related to the proposed provisions regarding weed control. With some comments recommending stricter provisions concerning the landowner's responsibilities, other comments recommended deleting the requirement of weed control entirely.

Many of the comments addressed the appropriateness of including grazing, haying, and mowing. Several comments recommended that the WRPO also be signed by State agencies and local drainage districts. There was also concern that the WRPO submitted with the bid not be so detailed that it burdens the landowner or the agencies preparing the WRPO.

The regulations have been expanded to address or clarify some of the above concerns. Specifically, the landowner will be assisted by the SCS, FWS, and other appropriate agencies in the preparation of the WRPO, therefore, the development of the WRPO will not demand a great deal of the landowner's resources. Although the WRPO is a comprehensive document, details regarding restoration designs and subsequent operation and maintenance will be developed following bid acceptance. In addition, the WRPO development allows for State agencies and drainage districts to be consulted by SCS while developing the WRPO.

The WRP allows for haying, grazing, timber harvesting, and hunting and fishing, if determined by SCS and FWS that such use is compatible with the goals and objectives of the program. Specific guidelines concerning compatible uses will be site specific and agreed to by the landowner, SCS, FWS, and ASCS before bid acceptance.

Section 703.16 Easement Modifications

Four comments were received. Two comments recommended prohibiting any blanket waivers for haying or grazing of the easement area during an emergency. Because the WRP easements may be perpetual in nature and due to the fact that it is not possible to foresee the possible feed needs of landowners in an emergency situation, the regulations do not prohibit such action. However, any such approval would be made only in those instances in which ASCS has determined that adverse affects to the easement area would not occur. One comment recommended concurrence by FWS and SCS and plan modifications. SCS and FWS will concur on plan modifications because it has been determined that all modifications will be approved in the same manner as initial plan development. The fourth comment believes that ASCS has the authority to arbitrarily lessen or weaken program participation. The final rule has been clarified to eliminate this concern.

Section 703.17 Transfer of Land

Four comments were submitted recommending several changes for clarity. This section has been reorganized to clarify the manner in which the owner submitting a WRP contract will receive payment and how a new owner establishes eligibility for cost-share payments if the required practices were not completed by the previous owner.

Section 703.18 Monitoring and Enforcement of Easement Terms and Conditions

Eight comments were received. Three comments recommend that non-government organizations be delegated this responsibility. One comment volunteered their services in this endeavor. One comment was in opposition to any delegation of the monitoring or enforcement to other Federal or State agencies. Another comment believed ASCS should obtain written permission from the landowner in order to inspect the easement area. One comment recommends that management agreements may be entered into by the landowner and a third party at any time. Several comments indicated it is unreasonable to expect a landowner to foresee all future management capabilities and needs at the time the easement is finalized. Allowing third party agreements at any time will increase the effectiveness of WRP by combining the efforts of Federal, state or private organizations having expertise for management and monitoring. Two comments stated that local groups may provide the most cost effective management and monitoring for this program. In many cases the partnership may be essential to enable landowner participation. The final rule has been amended to allow participants to enter into third party agreements for maintenance with private conservation organizations to ensure continued management of the easement area without the need for additional public funding.

Section 703.19 Violations

Six comments were received with a broad range of positions. One comment supported the position in the proposed rule. One comment recommended that graduated penalties be applied for program violations. One comment stated that the court system is too slow to enforce WRP easements. The fourth comment claimed it is not due process to require a refund from someone not receiving payment. Another comment stated that ASCS should not reimburse legal expenses. Finally, the sixth comment stated that the proposed provision was arbitrary and punitive. Based upon these comments, the provisions of this section have been amended to provide that any refund of WRP payments shall be made only by the person who received payment from ASCS. Since this program is designed to provide easements for the benefits of the United States, ASCS will avail itself of any and all remedies which it has, including the right to seek damages or equitable relief from Federal courts. Accordingly, no change in the provisions relating to use of the court system is made. There is no statutory basis to establish graduated penalties. Accordingly this suggestion has not been adopted.

Other Comments

Several comments suggested that landowners enrolling into the WRP should be exempt from property or real estate taxes after enrollment. Since ASCS is purchasing only a property right and is not obtaining ownership of the property, State tax liabilities remain with the landowner. Since this is a State law issue, ASCS does not have the authority to choose the manner in which

taxes are assessed on the WRP easement area. Accordingly, these suggested changes are not adopted.

Several comments also stated that ASCS should furnish the water necessary to ensure continuance of the restored wetland areas where water is currently being purchased or there is the potential for a lack of water to ensure continuance of the restored wetland area. This suggestion goes beyond the scope of the authorizing legislation. Accordingly, no change has been made in the regulation based on these comments.

Two comments encouraged the inclusion of a provision to allow subsequent cost-share assistance in the event of a natural disaster or similar event over which the producer had no control. The final rule at § 703.13(b) has been amended to authorize ASCS to provide cost-share assistance, at the discretion of ASCS, for the replacement or restoration of practices destroyed or lost due to reasons beyond the owner's control.

List of Subjects in 7 CFR Part 703

Administrative practices and procedures, Compliance procedures, Easements, Natural resources, Technical assistance and Wetlands Reserve Plan of Operations (WRPO).

Final Rule

Accordingly, title 7 of the Code of Federal Regulations, chapter VII is amended by adding a new part 703 to subchapter A to read as follows:

PART 703—WETLANDS RESERVE PROGRAM

Sec.

703.1 Applicability.
703.2 Administration.
703.3 Definitions.
703.4 Maximum county acreage.
703.5 Maximum acreage limitation.
703.6 Eligible person.
703.7 Eligible land.
703.8 Additional land eligibility provisions.
703.9 Transfer of lands from the CRP to the WRP.
703.10 Easement priority.
703.11 Statement of intention to participate; submission of bids.
703.12 Obligations of the landowner.
703.13 Payments to landowners by ASCS.
703.14 Payment limitation.
703.15 Wetlands Reserve Plan of Operations.
703.16 Easement modifications.
703.17 Transfer of land.
703.18 Monitoring and enforcement of easement terms and conditions.
703.19 Violations.
703.20 Performance based upon advice or action of the Department.
703.21 Access to land under agreement.
703.22 Program payments and provisions relating to tenants and sharecroppers.
703.23 Payments not subject to claims.
703.24 Assignments.
703.25 Appeals.
703.26 Scheme and device.
703.27 Filing of false claims.
703.28 Miscellaneous.

Authority: 16 U.S.C. 3801 *et seq.*

§ 703.1 Applicability.

(a) The regulations in this part govern the Wetlands Reserve Program (WRP). With respect to fiscal year 1992 only, WRP shall be available to producers only in the following States: California, Iowa, Louisiana, Minnesota, Mississippi, Missouri, New York, North Carolina, and Wisconsin. These states have been determined to have the highest incidence of:

(1) Significant acreage of hydric cropland;

(2) Potential capacity of restoration;

(3) Diversity in kinds of wetlands; or

(4) Substantial benefits for migratory birds.

(b) Under the Wetlands Reserve Program, ASCS will accept voluntary offers for the purchase of easements from eligible persons who have eligible land with respect to which they agree to restore and protect farmed wetlands or converted wetlands and eligible adjacent lands. Such voluntary easements will be for the purpose of restoring the hydrology and vegetation, and protecting the functions and values of wetlands for wildlife habitat, water quality improvement, flood water retention, ground water recharge, open space, aesthetic values, environmental education, and other values determined appropriate by ASCS.

§ 703.2 Administration.

(a) The regulations in this part will be administered under the general supervision and direction of the Administrator, ASCS. In the field, the regulations in this part will be administered by the Agricultural Stabilization and Conservation State and county committees ("State committees" and "county committees", respectively).

(b) State executive directors, county executive directors and State and county committees do not have authority to modify or waive any of the provisions of this part.

(c) The State committee may take any action authorized or required by this part to be taken by the county committee which has not been taken by such county committee. The State committee may also:

(1) Correct or require a county committee to correct any action taken by such county committee which is not in accordance with this part; or

(2) Require a county committee to withhold taking any action which is not in accordance with this part.

(d) No delegation herein to a State or county committee shall preclude the Administrator of ASCS, or a designee, from determining any question arising under this part or from reversing or modifying any determination made by a State or county committee.

(e) Data furnished by the applicants will be used to determine eligibility for program benefits. Furnishing the data is voluntary; however, without it program benefits will not be provided.

(f)(1) The eligibility of the land for inclusion in the WRP will be based on the likelihood of successful wetland restoration and the merit of including the land in the program, taking into account the cost of the restoration.

(2) The development of the WRPO to achieve the desired objectives shall be made by the Soil Conservation Service (SCS) in agreement with the Fish and Wildlife Service (FWS), except that no determination by the SCS and the FWS shall compel ASCS to execute a contract or an easement which ASCS determines will serve the purposes of the program established by this part.

(3) The detailed designs to implement the practices and management measures in the WRPO shall be completed by the SCS, except that the Forest Service or State agency will assist with tree planting plans.

(4) ASCS shall consult with the SCS and FWS for such other technical assistance in the implementation of the WRP and may consult with State agencies and other groups and organizations for technical assistance in developing and implementing the WRPO.

(g) ASCS shall consult with the Forest Service (FS) or the State Forestry Agency for such assistance as is determined by SCS to be necessary for implementing WRPO's which include tree planting practices.

(h) ASCS may consult with the Extension Service (ES) to coordinate the related information and education program as deemed appropriate to implement the WRP.

§ 703.3 Definitions.

(a) The terms defined in part 719 of this chapter shall be applicable to this part and all documents issued in accordance with this part, except as otherwise provided in this section.

(b) The following definitions shall be applicable to this part:

Agricultural commodity means any crop planted and produced by annual tilling of the soil or on an annual basis by one trip planters or sugarcane planted or produced in a State or alfalfa and other multiyear grasses and legumes in rotation as approved by the Secretary. For purposes of determining crop history, as relevant to eligibility to enroll land in the program, land shall be considered planted to an agricultural commodity during a crop year if, as determined by ASCS, an action of the Secretary prevented land from being planted to the commodity during the crop year.

Annual payment means, unless the context indicates otherwise, the payment specified in the WRP agreement which is made annually to a participant to compensate such participant for placing eligible land in the WRP.

Applicant means a person who submits to ASCS an intention to participate in a WRP easement.

ASCS means the Agricultural Stabilization and Conservation Service.

Bid means, unless the context indicates otherwise, the total payment requested by the owner for granting an easement.

Conservation District (CD) means a subdivision of a State organized pursuant to an applicable State Conservation District Law or in instances where a conservation district does not exist, the State Conservationist of the Soil Conservation Service.

Contract means the document specifying the contracted obligations and rights of any person who is participating in the program.

Cost-share payment means the payment made by ASCS to assist program participants in establishing the practices required in a WRPO.

CRP means the Conservation Reserve Program provided for in 7 CFR parts 704 and 1410.

Deputy Administrator means the ASCS Deputy Administrator for State and County Operations (DASCO).

Easement means the real property interest acquired by ASCS under this part, and which is filed with the appropriate local or State government official.

Easement area means the land on which the approved restoration practices are required.

Easement farm means the area of land, including the easement area which has been conveyed by the most current deed recorded in the land records of the county where the easement area is located.

FWS means the Fish and Wildlife Service of the United States Department of the Interior.

Local ASCS office means the county office of the Agricultural Stabilization and Conservation Service serving the county or combination of counties in the area in which the landowner's farm or ranch is administratively located.

Non-permanent easement means an easement for the maximum duration permitted by State law or for 30 years.

Participant means a landowner who has an approved easement contract.

Permanent easement means an easement in perpetuity.

Practice means the wetland and easement area development restoration measures agreed to in the WRPO to accomplish the desired program objectives.

Riparian areas mean areas of land, which are directly influenced by free water in the soil, that occur along streams, channels, rivers, and other water bodies. They are normally distinctly different from the surrounding lands because of unique soil and vegetation characteristics. They may be identified by distinctive vegetative communities which are reflective of soil conditions normally wetter than adjacent soils.

SCS means the Soil Conservation Service of the United States Department of Agriculture.

Technical assistance means the assistance provided under the WRP to owners by a representative of the Department of Agriculture or the FWS in determining cropland eligibility, suitability for restoration, developing WRPO's, and implementing and certifying practices. State agencies, non-governmental organizations, and individuals, with the concurrence of the landowner, may provide technical assistance in the development of the WRPO.

WRP means the Wetlands Reserve Program provided for in this part.

WRPO means the Wetlands Reserve Plan of Operations provided for in this part.

§ 703.4 Maximum county acreage.

(a) Except for areas devoted to windbreaks or shelterbelts after November 28, 1990, the maximum acreage which may be placed in the ECARP may not exceed 25 percent of the total cropland in the county of which no more than 10 percent of the total cropland in the county may be subject to an easement.

(b) When statements of intention to participate in the WRP are received in counties that have exceeded the 25 percent limit, the county committee may request a waiver for the purpose of enrolling such lands in the WRP. The limitation in paragraph (a) of this section shall not apply if ASCS determines that such action will not adversely affect the local economy of the county.

§ 703.5 Maximum acreage limitation.

ASCS will attempt to enroll no more than 1,000,000 acres in the WRP during the 1991–1995 calendar years and the cumulative total acreage enrolled will not exceed:

(a) 200,000 acres through 1991;
(b) 400,000 acres through 1992;
(c) 600,000 acres through 1993;
(d) 800,000 acres through 1994; and
(e) 1,000,000 acres through 1995.

§ 703.6 Eligible person.

To be eligible to offer land for the WRP a person must be the owner of the eligible property for which enrollment is sought and must have been the owner of such land for at least the preceding 12 months prior to the end of the period in which the intent to participate is declared, as provided in this part, unless:

(a) It is determined by ASCS that the land was acquired by will or succession as a result of the death of the previous owner; or

(b) It is determined by ASCS that adequate assurances have been presented that the new owner of such land did not acquire such land for the purpose of placing it in the WRP.

§ 703.7 Eligible land.

(a)(1) Except as otherwise provided in this section, land may only be considered eligible for enrollment in the WRP if it is determined by SCS that the land:

(i) Is wetland farmed under natural conditions, a farmed wetland, or prior converted cropland which is cropland except that converted wetlands shall not be eligible for enrollment if the conversion was not commenced prior to December 23, 1985; and

(ii) Merits inclusion in the program based on the likelihood of successful restoration of the enrolled land and the resultant wetland values when considering restoration cost.

(2) Except in the case of land which qualifies as non-croplands under paragraph (b) of this section, land enrolled in the WRP must also:

(i) Have been annually planted or considered planted to an agricultural commodity in at least 1 of the 5 crop years 1986 through 1990;

(ii) Be suitable for planting to an agricultural commodity at the time of enrollment unless the land is wetlands

that have been restored on the land under a CRP contract, or under a Federal or State wetland restoration program without an easement of at least 30 years in which case the land need only to have been planted to an agricultural commodity 2 of the 5 crop years, 1981 through 1985; and

(iii) Not be a wetland mitigated under part 12 of this title.

(b) Non-cropland may qualify as eligible adjacent land if ASCS determines that including such land in the program would contribute significantly to the restoration of adjacent wetlands under paragraph (a) of this section;

(c) Determinations under this section will be made in accordance with the provisions of part 12 of this title, in such manner as may be prescribed by the Deputy Administrator.

(d) Eligible land also includes land which SCS determines to be:

(1) A riparian area along a stream or other waterway that links or after restoring the riparian area will link wetlands which are protected by an easement or other agreement that achieves the same objective as an easement;

(2) Land adjacent to the restored wetland, which would contribute significantly to the restoration of adjacent wetlands, but not more than an average of 100 feet wide, and not more than twice the area of the restored wetland as needed to protect the functions and values of wetlands restored under this part unless DASCO determines a larger area is necessary to meet the objectives of the WRP;

(3) Lands that otherwise meet the requirements of paragraph (a) of this section subject to an existing CRP contract, with the highest wetland functions and values, that are likely to return to production after the expiration of the CRP contract and adjacent lands that otherwise meet the requirements of paragraph (b) of this section; or

(4) Other wetlands of an owner that would not otherwise be eligible if the inclusion of such wetlands in the WRP easement would significantly add to the functions and values of the wetlands to be restored under this part.

(e) Notwithstanding any other provision of this section, land which meets the requirements of paragraphs (a) through (d) of this section, shall not be considered eligible land unless it is determined by the SCS in consultation with the FWS that:

(1) The wetland hydrology and vegetation can be restored to a condition approximating conditions which existed before conversion.

(2) Significant restoration and protection is probable, taking into consideration the cost of the restoration, for wetland functions and values of such land. Wetland functions and values shall include but are not limited to:

(i) The improvement of habitat for migratory birds and other wildlife;

(ii) The protection and improvement of water quality;

(iii) The attenuation of water flows due to flood;

(iv) The recharge of ground water;

(v) The protection and enhancement of open space and aesthetic quality; or

(vi) The educational and scientific values of the area.

(f) Eligible land must be configured in a manner which allows the owner to meet the objectives of the WRP.

§ 703.8 Additional land eligibility provisions.

Notwithstanding other provisions of this part, land that is eligible for enrollment in the WRP must not be:

(a) Converted wetlands if the conversion was commenced after December 23, 1985;

(b) Land that contains timber stands or trees established in connection with a CRP contract;

(c) Lands owned or acquired by an agency of the Federal Government; or

(d) Land subject to a deed restriction prohibiting the production of agricultural commodities or the alteration of existing wetland hydrology.

§ 703.9 Transfer of lands from the CRP to the WRP.

Land subject to an existing CRP contract may be offered for acceptance and transfer into the WRP only if:

(a) The land is eligible land for purposes of the WRP as provided in §§ 703.7 and 703.8 and

(b) The application for such transfer into the WRP is agreed to by ASCS. If such transfer is requested by the owner and agreed to by ASCS, the CRP contract for the property shall be terminated or otherwise modified subject to such terms and conditions as are mutually agreed. Transfers from CRP to WRP after the second available WRP signup period will only be permitted if the owner agrees to refund all payments received under the CRP since the close of the second available WRP signup period.

§ 703.10 Easement priority.

(a) In implementing the WRP, ASCS shall, to the extent practicable, in determining which WRP bids to accept, take into account the costs of obtaining an easement, future agricultural and food needs, and the benefits for protecting and enhancing habitat for migratory birds and other wildlife that would be acquired through purchase of the easement.

(b) A formula will be used to ensure that offers will not be accepted in excess of the value of agricultural land, adjusted for: Soil productivity; nonland assets idled; landowner cost of wetland restoration; long term easement area operation and maintenance; long term costs for providing easement access route; and any other factors as may be allowed.

(c) In evaluating easement offers, different priorities for selection may be established by ASCS from time to time as determined by ASCS in order to accomplish the goals of the WRP.

(d) ASCS will rank the bids based on the environmental benefits per dollar of government expenditures on restoration and easement purchase. The factors for determining the priority for selection may include the following:

(1) Wetland hydrology restoration potential;

(2) Wetlands location significance including the contribution the restoration may make to the recovery of threatened and endangered species;

(3) Wetlands functions and values;

(4) Management risks;

(5) Duration of easements;

(6) Cost of restoration and easement purchase; and

(7) Any other factors as determined appropriate by ASCS.

§ 703.11 Statement of intention to participate; submission of bids.

(a) A person seeking to enroll land in the WRP must apply for enrollment by stating on an approved ASCS form their intention to participate in the WRP. The statement of intention must be filed with the local county ASC committee during an announced period for such submissions. Such periods may be announced periodically by ASCS.

(b) Following the statement of intention, the application will be considered complete only if such applicant:

(1) Obtains an approved WRPO; and

(2) Submits to ASCS a WRP bid setting out the total amount of easement payments that the person is willing to accept in return for participation in the program and for agreeing to other conditions for participation that may be required by ASCS, including the creation of an easement on the property. Such bids may be made no later than 90 days after the close of the period announced by ASCS for submitting a statement of intention to participate, unless a later date is agreed to by ASCS.

No bid may be accepted unless submitted on the approved ASCS form and unless it is determined that the land is eligible and that the submitter of the bid is an eligible person. The determination of which bids to accept shall be at the exclusive discretion of ASCS.

(c) A person submitting a statement of intention to participate shall not be obligated to submit a bid.

(d) A bid may be submitted only if signed by all owners of the property or their duly authorized representative.

§ 703.12 Obligations of the landowner.

(a) All owners of land for which a WRP bid is accepted by ASCS shall:

(1) Grant to ASCS an approved easement for the land which shall run with the land and shall be in favor of ASCS and its assigns or delegates which provides that the property shall be maintained in the manner specified by ASCS to ensure that the land is maintained in accordance with the goals and purposes of this part, including the maintenance of the restored wetland and eligible lands as specified in the WRPO for the full life of the easement. Such easement shall:

(i) Be a reserve interest easement that the Deputy Administrator determines is for a sufficient term of time necessary to achieve the purposes of the program. Permanent easements will be accepted and preferred whenever possible. However, the term of the easement shall be at least 30 years or the maximum extent allowed under State law;

(ii) Require that the maintenance of the land in accordance with the easement and with the terms of the WRPO shall be the responsibility of the owners of the property and their successors of any kind, including, but not limited to, the owner's heirs and assigns;

(iii) Grant to ASCS a right of access in favor of ASCS and its delegates, assigns and successors of any kind, to the portion of the property which is subject to the provisions of the WRPO. Maintenance of such access shall be the responsibility of the owner and their successors of any kind;

(iv) Reserve to ASCS the right to permit such compatible uses of the easement area as may be identified in the WRPO; and

(v) Reserve to the landowner those compatible uses identified in the WRPO that are permitted to be pursued by the landowner.

(2) Comply with all terms and conditions of the WRPO;

(3) Provide for creating and recording an appropriate deed restriction, as determined by ASCS, for such land as necessary to meet the requirements of this subpart;

(4) Provide that the easement granted to ASCS is superior to the rights of all others, except as authorized by ASCS. Such action shall include, but not be limited to, providing a written statement of consent to such easement and disclaimer by those holding a security interest or any other encumbrance with respect to such and;

(5) Agree to the permanent retirement of the aggregate a total of crop acreage bases, and allotment and mandatory quota history on the farm or ranch to the extent that such crop acreage bases are not supported by the cropping pattern on the farm not including cropland enrolled in WRP;

(6) Not allow the grazing of the land or any other commercial use on the land, except as provided for in the WRPO, or harvesting of any agricultural commodity produced on the land subject to the WRP easement;

(7) Comply with Federal or State noxious weed laws in the manner specified in the WRPO;

(8) Control other identified weed and pest species, in the manner specified in the WRPO;

(9) Establish, maintain, and replace, as specified in the easement contract, the practices required in the WRPO as needed to meet the requirements of the WRPO, the easement contract, and the terms of the easement;

(10) Be responsible for repairs, improvements, and inspections of the WRPO practices as necessary to maintain existing public drainage systems when the land is restored to the condition required by the terms of the WRPO, the easement contract and the easement;

(11) Be permitted to control public access, in accordance with the WRPO, on the land enrolled in the program;

(12) Implement any additional provisions that are required by ASCS in consultation with SCS and FWS in the easement contract, WRPO, or easement, in order to, as determined by ASCS, facilitate the administration of the WRP;

(13) Not plant for harvest an agricultural commodity on the enrolled land for crop years subsequent to the acceptance of a WRP bid by ASCS;

(14) Not alter the vegetation, except to harvest already planted crops or forage, or hydrology on such offered acres subsequent to acceptance of a bid by ASCS except as provided for in the easement or WRPO;

(15) Be responsible for the long-term management of the easement in accordance with the terms of the easement and related agreements including the WRPO provided that owners will have the option to enter into an agreement with governmental or private organizations to assist in the management of the easement area. No ASCS funds will be provided to the designated agencies or organizations for management expenses and the responsibility to ASCS for the management of the easement shall in all cases remain with the owner and the owner's successors of any kind regardless of whether such arrangements for third-party management are made with governmental or private organizations, including federal agencies;

(16) Agree that each person on the easement contract with ASCS, or who is subject to the easement, shall be jointly and severally responsible for compliance with the WRPO, the easement contract and the provisions of this subpart and for any refunds or payment adjustment which may be required for violation of any terms or conditions of the WRPO, the easement contract, or provisions of this subpart;

(17) Refrain from taking any action on the easement area unless specifically authorized in the reserve interest easement or the WRPO; and

(18) Secure any necessary local, State and Federal permits prior to commencing restoration of the designated area.

(b) In addition, program participants and their successors of any kind may:

(1) Not alter wildlife habitat and other natural land features of the enrolled land unless authorized by the WRPO;

(2) Apply pesticides or fertilizers on the enrolled land or mow such land, only as provided for in the WRPO; or

(3) Not engage in activities on other land on the person's farm area that will:

(i) Cause excessive sediment or other pollutants to enter the easement area;

(ii) Alter the flow of surface or subsurface water into or out of the easement area except as specified in the WRPO; or

(iii) Otherwise be inconsistent with the terms of the easement.

(c) The activities of any person on the property shall be considered for purposes of this section to be the actions of the program participant, except to the extent that ASCS determines that the activities of such other person were beyond the control of the owner, in which case ASCS may adjust the remedies that are otherwise provided for in this part to the extent determined consistent with program goals. Obligations created by the easement shall run with the land and shall bind all persons having an interest in the property at any time whether such

interest is created by death of the owner, sale, assignment, or otherwise.

§ 703.13 Payments to landowners by ASCS.

(a) ASCS will share the cost with landowners of rehabilitating the enrolled land in the WRP as provided in the WRPO, or the easement contract. The amount of the cost-share assistance shall be specified in the easement contract. Eligible costs for such cost-share assistance by ASCS shall only include those costs which ASCS determines are appropriate, and shall be subject to the following restrictions:

(1) ASCS shall pay:

(i) As determined by ASCS, not less than 75 percent of: the actual cost of establishing or installing the practices specified in the WRPO; or the average cost of establishing the practices specified in the WRPO for a permanent easement; and

(ii) Not less than 50 percent nor more than 75 percent, as determined by ASCS, of: the actual cost of establishing or installing the practices required by the WRPO; or the average cost of establishing the practices specified in the WRPO for other than a permanent easement.

(2) For purposes of determining average establishment or installation costs ASCS may take into account recommendations of the State and County Conservation Review Groups provided for in § 701.2(a) of this chapter and the determination of average costs shall be the average for the part of the county in which the land is located, except that if such an estimate is not possible, then an estimate for the whole county may be used, or if an estimate for part of the county or the whole county is not readily determinable, an estimate may be used for the State or part of the State in which the land is located;

(3) Cost-share payments may be made only upon a determination by ASCS that an eligible practice or an identifiable unit of the practice has been established in compliance with appropriate standards and specifications;

(4) Cost-share payments may be made only for the establishment or installation of an eligible practice and not for the maintenance of the practice except as specifically permitted in writing by the Deputy Administrator; and

(5) Cost-share payment determinations shall be made by the county committee but no easement contract may be approved which would allow for total WRP cost-shares in excess of 50 percent of the pre-easement fair market value of the property subject to the WRPO without written approval by the State committee or for more than 100 percent of such fair market value without the written approval of the Deputy Administrator.

(b) Notwithstanding paragraph (a)(4) of this section, cost share payments may be authorized for the replacement or restoration of practices for which cost share assistance has been previously allowed under the WRP, but only if:

(1) Replacement or restoration of the practice is needed to meet the objectives for which the easement was established; and

(2) The failure of the original practice was due to reasons beyond the control of the participant.

(c)(1) ASCS shall pay, at the times determined by ASCS, the agreed upon amount for the easement as determined through the acceptance of bids for eligible land through annual payments made in equal or unequal amount over a period not less than 5 years nor more than 20 years; except that in the case of permanent easements the easement payment may be made in a lump-sum amount.

(2) ASCS payments shall be made in cash;

(3) In the case of any non-permanent easement, the amount of payments that may be received per person, as determined under part 1497 (specifically § 1497.109(a)) of this title, shall be limited as provided for in this part;

(4) For all easements, ASCS shall withhold a portion of the payments that might otherwise be made pending completion of the restoration plan for the property and ASCS may condition any payment on satisfactory progress toward completion of the plan. At a minimum, ASCS shall pay no more than 10 percent per year of the total purchase price for the easement pending completion of the restoration of the wetlands;

(5) No payment may be made which would exceed the total amount bid and accepted for the property and payments may only be made if the person on whose account the payment is to be made:

(i) Has agreed to all terms and conditions of the program set out in this part;

(ii) Submitted an accepted bid on the standard ASCS-approved form for the WRP; and;

(iii) Is in full compliance with the terms and conditions of the WRP easement except to the extent that relief is authorized by this part and is approved under guidelines issued by the Deputy Administrator.

(d) ASCS will reimburse landowners offering an acceptable easement for fair and reasonable expense incurred for title searches, filing expenses, and related costs, as determined by ASCS.

§ 703.14 Payment limitation.

With respect to non-permanent easements, the annual amount of payments paid to a person, as determined under part 1497 (specifically § 1497.109(a)) of this title, shall not exceed $50,000.

§ 703.15 Wetlands reserve plan of operations.

(a) At the time of submitting a bid to enroll land in the WRP, the landowner must have obtained a WRPO for the land which has been approved by ASCS.

(b) The WRPO shall:

(1) Include an aerial photo displaying the land offered for enrollment;

(2) Specify the manner in which the farmed or converted wetlands included in the enrolled land shall be restored, operated, and maintained to accomplish the goal of the program together with other practices which may be necessary or appropriate to accomplish the goals of the program, including, where appropriate:

(i) Measures necessary to control noxious weeds and insect pests in order to comply with applicable Federal, or State noxious weed and pest control laws; and

(ii) Measures to the extent determined necessary in the WRPO to control other specified species of weeds, insects or pests.

(3) Specify compatible land uses for personal enjoyment or for which compensation may be received, if any, reserved to the landowner in the easement and the manner in which these uses are to be carried out, such uses may include among others:

(i) Recreational use, hunting and fishing;

(ii) Managed timber production including harvesting; and

(iii) Periodic haying or grazing consistent with the goals of the program.

(4) Set out cost estimates of the practices required by the WRPO;

(5) Identify access routes to be maintained for wetland restoration activities and future management and easement monitoring in connection with the land to be enrolled;

(6) Make provisions deemed necessary for maintaining public drainage system if present on lands subject to the WRPO;

(7) Contain scheduled implementation dates for restoration practices;

(8) In areas where natural runoff is no longer sufficient to support natural wetland vegetation, include appropriate

provisions, to ensure adequate hydrology; and

(9) Contain other provisions or limitations as ASCS, in consultation with the SCS and FWS, determines to be necessary.

(c) SCS and FWS will cooperate and may consult with any other agency or person as deemed necessary on the development of the WRPO with the landowner.

(d) The WRPO must be signed by SCS, FWS, CD, and the landowner before submission of a bid by an applicant. However, if agreement between SCS and FWS at the local level is not reached within 20 calendar days, the WRPO shall be developed by the State Conservationist of SCS in consultation with FWS.

(e) The WRPO may require that a temporary vegetative or water cover be established on the property if immediate establishment of a permanent cover is not practicable or otherwise desirable.

(f) The terms of an ASCS-approved WRPO shall not relieve the program participant of any obligation or term imposed or provided for in the easement contract, the easement, or this part.

(g) The WRPO, where appropriate, will provide for the development of a tree planting plan with the assistance of the Forest Service or State forestry agency.

(h) The WRPO, where appropriate will provide for the development by SCS of detailed plans for weed control, structural measures and their operation, vegetation establishment and management, and other measures as needed.

(i) Revisions of the WRPO to enhance or protect the value for which the easement was established may be made at any time at the request of and with the concurrence of the owner, SCS, FWS, and ASCS.

§ 703.16 Easement modifications.

After the easement has been recorded, no change will be made in the easement without a written request by the landowner and the written agreement of the Deputy Administrator, or a designee, who may grant such approval only where such approval is determined necessary or appropriate by the Deputy Administrator, or a designee, to achieve the goals of WRP or facilitate the practical administration and management of the easement area or the program, and will not adversely affect the functions and values for which the easement was established.

§ 703.17 Transfer of land.

(a) If a new owner purchases or obtains the right and interest in, or right to occupancy of, the land subject to a WRP easement, such new owner shall be subject to the terms and conditions of the easement. The seller who is the signatory to the contract shall be entitled to receive all remaining WRP easement payments, if any. Eligible cost-share assistance shall be paid to the seller with respect to costs incurred by such seller.

(b) Upon the transfer of the property, any remaining cost-share payments shall be withheld and shall be paid only if the new owner or purchaser becomes a party to the easement contract within 60 days of the recordation of the deed transferring title to the new owner. Such payments shall be paid in the manner agreed to by the seller and the buyer. The new owner or purchaser shall be held responsible for assuring completion of all measures and practices required by the contract and the WRPO.

(c) Any transfer of the property prior to the filing of the easement shall void any intention to participate, bid, or WRP easement contract unless the new owner agrees to be a party to the intention to participate, bid, or contract within 60 days of the recordation of the deed transferring the land to the new owner.

§ 703.18 Monitoring and enforcement of easement terms and conditions.

(a) ASCS or its representative shall be permitted to inspect each easement area at any and all times determined necessary or appropriate by ASCS to ensure that:

(1) Structural and vegetative restoration work are properly maintained;

(2) The wetlands and adjacent upland habitat of the easement area is being managed as required in the WRPO, and the terms of the easement; and

(3) Uses of the area are consistent with the terms and conditions of the easement contract, the WRPO and any related agreement.

(b) If an owner or other interested party is unwilling to voluntarily correct, in a timely manner, deficiencies in compliance with the terms of the WRPO, the WRP easement, or any related agreements, ASCS may at the expense of any person who is subject to the WRP easement correct such deficiency. Such ASCS action shall be in addition to other remedies available to ASCS.

(c) Management, monitoring and enforcement responsibilities may be delegated by ASCS at any time to other Federal or State agencies or, for management responsibilities only, private conservation organizations that have the appropriate authority, expertise, and resources necessary to carry out such delegated responsibilities, as determined by ASCS.

§ 703.19 Violations.

(a) If a violation of the terms and conditions of the easement contract, the WRPO or the recorded WRP easement occurs, the easement shall remain in force and ASCS may, in addition to taking action as provided in § 703.26:

(1) Require the owner to fully restore the easement area, to fulfill the terms and conditions of the easement and WRPO; and

(2) Require the owner, who received payments from ASCS to refund all or part of such payments received together with interest as determined appropriate by ASCS.

(b) If an owner fails to carry out the terms and conditions of an easement, appropriate legal action may be initiated under civil law, or such other authority available to the entity assigned management responsibilities to compel such compliance may be used. The owner of the property shall reimburse ASCS for all costs incurred including but not limited to legal fees.

§ 703.20 Performance based upon advice or action of the Department.

The provisions of part 790 of this chapter relating to performance based upon the action or advice of a representative of the Department shall be applicable to this part.

§ 703.21 Access to land under agreement.

In order to determine eligibility and compliance with respect to this part, representatives of the Department, or designee thereof, shall have the right of access to:

(a) Land which is the subject of an application made in accordance with this part,

(b) Land which is subject to an easement made in accordance with this part, and

(c) Records of the producer which release such land.

§ 703.22 Program payments and provisions relating to tenants and sharecroppers.

(a) Payments received under this part shall be divided in the manner specified in the applicable easement contract.

(b) ASCS shall ensure that producers who would have shared in the risk of producing crops on land subject to such easement receive treatment deemed to be equitable in accordance with § 1413.150 of this title.

§ 703.23 Payments not subject to claims.

Subject to parts 3 and 1403 of this title, any cost-share or easement

payment or portion thereof due any person under this part shall be allowed without regard to any claim or lien in favor of any creditor, except agencies of the U.S. Government.

§ 703.24 Assignments.

Any participant who may be entitled to any cash payment under this program may assign the right to receive such cash payments, in whole or in part, as provided in part 1404 of this title.

§ 703.25 Appeals.

(a) Except as provided in paragraph (b) of this section, a participant in the WRP may obtain a review of any administrative determination rendered under the program in accordance with the administrative appeal regulations provided in part 780 of this chapter.

(b) Determinations concerning land eligibility, development of WRPO's or determining the potential for restoration of an offered area may be reviewed in accordance with procedures established under part 614 of this title or as otherwise established by SCS.

§ 703.26 Scheme and device.

(a) If it is determined by ASCS that a landowner has employed a scheme or device to defeat the purposes of this part, any part of any program payment otherwise due or paid such landowner during the applicable period may be withheld or be required to be refunded with interest thereon, as determined appropriate by ASCS, and the contract with the landowner may be terminated. In such a case, ASCS may also continue to hold the easement interest acquired under this part.

(b) A scheme or device includes, but is not limited to, coercion, fraud, misrepresentation, depriving any other person of cost-share assistance or land payments for easements, and obtaining a payment that otherwise would not be payable.

(c) An owner of land subject to this part who succeeds to the responsibilities under this part shall report in writing to ASCS any interest of any kind in the land subject to this part that is retained by a previous participant. Such interest shall include a present, future or conditional interest, reversionary interest or any option, future or present, with respect to such land and any interest of any lender in such land where the lender has, will, or can obtain, a right of occupancy to such land or an interest in the equity in such land other than an interest in the appreciation in the value of such land occurring after the loan was made. A failure of full disclosure will be considered a scheme or device under this section.

§ 703.27 Filing of false claims.

If it is determined by ASCS that any participant has knowingly supplied false information or has knowingly filed a false claim, such participant shall be ineligible for payments under this part. False information or false claims include claims for payment for practices which do not meet the specifications of the applicable WRPO. Any amounts paid under these circumstances shall be refunded, together with interest as determined by ASCS, and any amounts otherwise due such participant shall be withheld.

§ 703.28 Miscellaneous.

(a) Except as otherwise provided in this part in the case of death, incompetency, or disappearance of any landowner, any payment due under this part shall be paid to the landowner's successor in accordance with the provisions of part 707 of this chapter.

(b) The provisions of 7 CFR part 791 are applicable to this part.

(c) Any remedies permitted ASCS under this part shall be in addition to any other remedy, including, but not limited to criminal remedies, or actions for damages in favor of ASCS as may be permitted by law.

Signed this May 21, 1992 in Washington, DC.

Keith D. Bjerke,

Administrator, Agricultural Stabilization and Conservation Service.

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