international partnerships, student exchanges, etc.

4. *A comprehensive line item budget* outlining specific expenditures and sources from which funds are anticipated. Detailed information concerning eligible and ineligible items and required budget format is available in the application packet.

5. *Documentation of institutional support* for the proposed linkage, including signed letters of endorsement from the U.S. and foreign institutions' presidents, chancellors, or directors making specific reference to the 1993 University Affiliations Program and committing their participating institution(s) to maintaining their exchange participants on full salary and benefits during the exchange. *A general letter of support or an agreement between the two institutions without reference to the maintenance of salaries and benefits will not fulfill this requirement.* A sample letter of endorsement and commitment is included in the application packet.

6. *Brief academic resumes,* not to exceed two single-spaced pages, of participating faculty/staff from both institutions, clearly indicating level of language skills, overseas experience, knowledge of prospective partner country, relevant scholarly and non-scholarly travel, publications, and research activities.

Note: All pages in excess of the two-page limit will be discarded.

Review Process

The University Affiliations Program review process is conducted in three stages: Technical, academic, and Agency. Proposals will be deemed ineligible if they do not adhere to the guidelines established herein and in the application packet. Eligible proposals will be forwarded to outside academic panels for advisory review. All proposals recommended for funding will be reviewed in the Agency by the Office of Academic Programs, the appropriate geographic area office, and the budget and contracts offices. Funding decisions are at the discretion of the Associate Director for Educational and Cultural Affairs. Grant awards will be submitted for approval to the J. William Fulbright Foreign Scholarship Board. Final technical authority for grant awards resides with USIA's contracting officer.

Upon completion of the technical review, applicants will be notified in writing of the status of their proposals. A grace period will be granted to applicants whose proposals lack the following:

A signed letter of endorsement from the president, chancellor, or director of the foreign institution, making specific reference to the 1993 University Affiliations Program and committing the institution to maintaining their exchange participants on full salary and benefits during the exchange. The deadline for submission of this document is 5 p.m. Washington, DC time on January 29, 1993.

Review Criteria

Academic Review Criteria

Proposals are reviewed by independent academic peer panels with geographic and discipline expertise which make recommendations to the Agency based on the following criteria:

1. Soundness of proposal indicating academic quality, as reflected by a clear statement of program goals and means to accomplish the goals, and detailed description of project with statement on how the proposed project will be implemented and evaluated.

2. If the proposal requests support for an established active linkage, evidence that the University Affiliations funding would result in innovation in the exchange relationship.

3. Promise of the production of new skills/knowledge and advancement of scholarship in fields covered by the program.

4. Evidence that theme(s) of proposed project fits field(s) stated in the announcement.

5. Evidence of strong mutual benefits to the institutions involved in the exchanges.

6. Feasibility of the program plan as it relates to the stated goals and selected topics and activities.

7. Academic quality of credentials/experience of participants in relation to the goals of the proposed exchange plan (including linguistic proficiency, where required).

8. Appropriateness of length of exchange visits given project goals.

9. Evidence of strong institutional commitment by participating institutions.

10. Evidence of a strong commitment to internationalization of their academic programs by participating institutions.

11. Evidence of mutual advancement of cultural and political understanding of the countries or geographic areas represented in the partnership through development of individual and institutional ties.

12. For proposals focused on research as its primary activity: Inclusion of collaboration by researchers from both institutions, linked to substantial participation in graduate-level seminars.

13. Evidence that the partnership is likely to continue after the expiration of the USIA grant.

Agency Review Criteria

USIA will consider for further review only those proposals recommended by academic review panels. Agency considerations will be based on:

1. Academic quality, reflected in academic review panel's comments and recommendations

2. Feasibility of program plan

3. Advancement of mutual cultural and political understanding between the countries or geographic areas represented in the partnership

4. USIA overseas post assessments of need and feasibility

5. Promise of long-term impact

6. Cost-effectiveness

7. Submission by institutions with significant minority enrollment, applying alone or in consortia with other U.S. institutions.

Notice

The terms and conditions published in this RFP are binding and may not be modified by any USIA representative. Explanatory information provided by the Agency that contradicts published language will not be binding. Issuance of the RFP does not constitute an award commitment on the part of the Government. Final award cannot be made until funds have been fully appropriated by Congress, allocated and committed through internal USIA procedures.

Notification

All applicants will be notified of the results of the review process on or about July 1, 1993. Awarded grants will be subject to periodic reporting and evaluation requirements.

Dated: August 26, 1992.

Barry Fulton,

Acting Associate Director, Bureau of Educational and Cultural Affairs.

[FR Doc. 92-21031 Filed 8-31-92; 8:45 am]

BILLING CODE 8230-01-M

Sunshine Act Meetings

Federal Register
Vol. 57, No. 170
Tuesday, September 1, 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).

AGENCY: AGENCY HOLDING THE MEETING:

Nuclear Regulatory Commission.

DATE:

Weeks of August 31, September 7, 14, and 21, 1992.

PLACE:

Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS:

Open and Closed.

MATTERS TO BE CONSIDERED:

Week of August 31

Tuesday, September 1

3:00 p.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

Thursday, September 3

1:00 p.m. Briefing by EPRI on Status of EPRI Design Requirements Document for Advanced Light Water Reactors (PUBLIC MEETING)

Week of September 7—Tenative

Tuesday, September 8

10:00 a.m. Briefing on Advanced and Evolutionary Reactor Topics: Form and Content for a Design Certification Rule and Follow-up to SECY-90-016 (PUBLIC MEETING) (Contact: Dennis Crutchfield, 301/504-1199)

Wednesday, September 9

3:30 p.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

Friday, September 11

8:00 a.m. Discussion of Management-Organization and Internal Personnel Matters (CLOSED—Ex. 2 and 6)

8:30 a.m. Briefing by Charles Meinhold on 1990 Recommendations of the International Commission on Radiological Protection (ICRP Publication 60) (PUBLIC MEETING)

10:00 a.m. Periodic Meeting with the Advisory Committee on Reactor Safeguards (ACRS) (PUBLIC MEETING) (Contact: Raymond Fraley, 301/492-8049)

Week of September 14—Tentative

Monday, September 14

2:00 p.m. Briefing on Electricity Forecast from Energy Information Administration (EIA) Annual Energy Outlook (PUBLIC MEETING)

Thursday, September 17

2:00 p.m. Status Briefing on Shutdown and Low Power Risk Issues (PUBLIC MEETING) (Contact: Mark Caruso 301/504-3235)

3:30 p.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

Week of September 21—Tentative

Thursday, September 24

11:30 a.m. Affirmation/Discussion and Vote (PUBLIC MEETING) (if needed)

note: Affirmation sessions are initially scheduled and announced to the public on a time-reserved basis. Supplementary notice is provided in accordance with the Sunshine Act as specific items are identified and added to the meeting agenda. If there is no specific subject listed for affirmation, this means that no item has as yet been identified as rquiring any Commission vote on this date.

To verify the status of meeting call (recording)—(301) 504-1292.

CONTACT PERSON FOR MORE INFORMATION: William Hill (301) 504-1661.

Dated: August 27, 1992.

William M. Hill, Jr.,

Office of the Secretary.

[FR Doc. 92-21123 Filed 8-28-92; 3:23 pm]

BILLING CODE 7590-01-M

Corrections

Federal Register
Vol. 57, No. 170
Tuesday, September 1, 1992

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

FEDERAL ELECTION COMMISSION

11 CFR Part 200

[Notice 1992-12]

Administrative Regulations

Correction

In rule document 92-18473 beginning on page 34508 in the issue of Wednesday, August 5, 1992, make the following correction:

§ 200.1 [Corrected]

On page 34510, in the first column, in § 200.1, in the first line, "prescribed" should read "prescribes".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 410

[BPD-423-F]

RIN 0938-AD25

Medicare Program; Fee Schedules for the Services of Certified Registered Nurse Anesthetists

Correction

In rule document 92-16943 beginning on page 33878 in the issue of Friday, July 31, 1992, make the following correction on page 33896, in the second column, under Part 410, in the **Authority** citation, in the third line, remove "7,".

BILLING CODE 1505-01-D

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1002

[Ex Parte No. 246 (Sub--No. 10)]

Regulations Governing Fees for Services Performed in Connection With Licensing and Related Services--1992 Update

Correction

In proposed rule document 92-18949 beginning on page 35557 in the issue of Monday, August 10, 1992, make the following corrections:

§ 1002.2 [Corrected]

1. On page 35558, in the first column, in § 1002.2(f), in entry (1), in the third line, "certification" should read "certificate".

2. On the same page, in the second column, in the same section, in entry (14), "Reserved" should read "[Reserved]".

3. On the same page, in the third column, in the same section, in entry (40), insert a period after "railroads".

4. On page 35559, in the first column, in the same section, in entry (50), in the second line, insert a period after "competition".

5. On the same page, in the same column, in the same section, in entry (54)(i), in the sixth line, insert "; or an application" after "authorization".

6. On the same page, in the second column, in the same section, in footnote 2, "band." should read "bond."

BILLING CODE 1505-01-D

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1109

[Ex Parte No. 55 (Sub No. 83)]

Use of Alternative Dispute Resolution Procedures in Commission Proceedings and Those in Which the Commission is a Party

Correction

In the correction to rule document 92-17290 appearing on page 35628 in the issue of Monday, August 10, 1992, the docket number should read as set forth above.

BILLING CODE 1505-01-D

DEPARTMENT OF JUSTICE

Antitrust Division

Pursuant to the National Cooperative Research Act of 1984; Southwest Research Institute

Correction

In notice document 92-16019 beginning on page 30510 in the issue of Thursday, July 9, 1992, make the following corrections:

On page 30511, in the first column, in the first complete paragraph, in the sixth line, "Mobile" should read "Mobil" and in the same paragraph, in the ninth line, "Texas" should read "Texaco".

BILLING CODE 1505-01-D

RESOLUTION TRUST CORPORATION

12 CFR Part 1625

Procedures Applicable to RTC Investigations

Correction

In proposed rule document 92-16545 beginning on page 33133 in the issue of Monday, July 27, 1992, on page 33134, in the first column, in the fourth full paragraph, in the seventh line, after "provisions" insert "specified therein. The confidentiality provisions".

BILLING CODE 1505-01-D

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[EE-23-92]

RIN 1545-AQ66

Voluntary Employees' Beneficiary Association Qualification--Geographic Locale Restriction

Correction

In proposed rule document 92-18532 beginning on page 34886 in the issue of Friday, August 7, 1992, make the following corrections:

1. On page 34886, in the second column, under **BACKGROUND**, in the first paragraph, in the 3d line from the end of the paragraph, after "same" insert "line of business in the same".

2. On page 34887, in the 1st column, in the last paragraph, in the 11th line, "or" should read "of".

3. On the same page, in the second column, in the last paragraph, in the 8th line, "section 502" should read "section 501".

BILLING CODE 1505-01-D

federal register

Tuesday
September 1, 1992

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412 and 413

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[BPD-756-F]

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: Final rule.

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

Finally, we are changing and clarifying the criteria and procedures concerning the reclassification of hospitals by the Medicare Geographic Classification Review Board (MGCRB). These changes result from public comment and our analysis of hospital reclassifications for Federal fiscal year (FY) 1992.

EFFECTIVE DATE: The provisions of this final rule are effective on October 1, 1992. The changes in Section IV concerning the reclassification of hospitals by the MGCRB will apply for applications received by October 1, 1992 for geographic reclassifications to be implemented on October 1, 1993 (FY 1994).

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

ADDRESSES: To order copies of the **Federal Register** containing this document, send your request to: Government Printing Office, ATTN: New Order, P.O. Box 371954, Pittsburgh, PA 15250-7954.

Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-2465 or by faxing your request to (202) 512-2250. The cost for each copy (in paper or microfiche form) is $1.50. When requesting copies of the **Federal Register** document please refer to stock number 069-001-00044-1. To purchase copies of Tables 3C, 5, 7A and B, and 9 in electronic form, contact the U.S. Government Printing Office by telephone at (202) 512-1530 or by fax at (202) 512-1262. In addition, you may view and photocopy the **Federal Register** document at most libraries designated as U.S. Government Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**. Ask the order desk operator for the locations of the U.S. Government Depository Libraries.

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, a hospital with a FY 1992 hospital-specific rate below the Federal rate is paid based on a fully prospective payment methodology. A hospital with a FY 1992 hospital-specific rate at or above the Federal rate is 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. Summary of the Provisions of the June 4, 1992 Proposed Rule

On June 4, 1992, we published a proposed rule in the **Federal Register** (57 FR 23618) to amend the prospective payment systems for operating costs and capital-related costs as follows:

- We proposed changes for FY 1993 DRG classifications and weighting factors as required by section 1886(d)(4)(C) of the Act. This section requires that we adjust the DRG classifications and relative weights at least annually.

• We proposed a revised wage index for discharges occurring on or after October 1, 1992 that incorporated all reclassifications of hospitals based on decisions made by the Medicare Geographic Classification Review Board (MGCRB) as of March 30, 1992. The proposed wage index also incorporated all corrections of errors that have been identified in the survey wage data since the construction of the wage index implemented for FY 1992 in the August 30, 1991 final rule (56 FR 43196).

• We discussed 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 centers 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.

• We discussed the prospective payment system for inpatient operating costs in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning:

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

• We discussed several provisions of the regulations at 42 CFR part 412, subpart M, concerning capital prospective payment system rules, and proposed changes concerning the following:

—Payments to new hospitals.
—Portions 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.

• We discussed changes to the regulations at 42 CFR parts 412 and 413 for hospitals and units excluded under the prospective payment system. The proposed changes concerned 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.

• In the addendum to the proposed rule, we set forth changes to the amounts and factors for determining the FY 1993 prospective payment rates for operating costs and capital-related costs. We also proposed 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.

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

• In Appendix B of the proposed rule, we set forth the technical appendix on the proposed FY 1993 capital acquisition model and budget neutrality adjustment.

• In appendix C of the proposed rule, we set forth our initial estimate of an update factor for FY 1993 for both prospective payment hospitals and hospitals excluded from the prospective payment system, as required by section 1886(e)(3)(B) of the Act.

• In Appendix D of the proposed rule, we provided our recommendation of the appropriate percentage changes for FY 1993, as required by sections 1886(e)(4) and (e)(5) of the Act, for the following:

—Large urban, other urban, and rural average standardized amounts (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.

In the June 4, 1992 proposed rule, we also discussed in detail the March 1, 1992 recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(e)(2)(A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986 and thereafter. In addition, section 1886(e)(2)(B) of the Act 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 printed ProPAC's March 1, 1992 report, which includes its recommendations, as appendix E of the proposed rule. The recommendations, and the actions we proposed to take with regard to them (when an action is recommended), were discussed in detail in the appropriate sections of the preamble, the addendum, or the appendixes of the proposed rule.

Set forth below in sections II, III, IV, V, VI, and VII of this preamble, the addendum to this final rule, and the appendices, are detailed discussions of the June 4, 1992 proposed rule, the public comments received in response to that proposal, and the responses to those comments as well as any changes we are making. Appendix C sets forth a modified framework for developing the update for the prospective payment system for inpatient hospital operating costs that we are considering for FY 1994. Also, we are adding a new appendix D, which sets forth a preliminary framework for developing the update for the prospective payment system for inpatient hospital capital-related costs. As discussed in the appendices, we are inviting suggestions for improvements that could be made in these frameworks before we propose to implement them in future rulemaking documents.

C. Number and Types of Public Comments Received in Response to the June 4, 1992 Proposed Rule

A total of 527 items of correspondence containing comments on the June 4, 1992 proposed rule were received timely. The main areas of concern addressed by commenters were the following:

- The proposed changes in the criteria for the geographic reclassification of hospitals for purposes of the wage index.
- Proposed changes to the payment methodology for day outliers and the amounts of the FY 1992 outlier payments.
- Proposed changes to the capital prospective payment system rules.
- The rate of increase in the market basket and the update to the standardized amounts.
- The proposed revisions to rate-of-increase limits for hospitals and units excluded from the prospective payment system.
- Requests for changes in DRG classification and relative weights.

II. Changes to DRG Classifications and Weighting Factors

A. Background

Under the prospective payment system, we pay for hospital inpatient 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 changes to the DRG classification system and the 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.

We proposed to make several changes to the DRG classification system. These proposed changes and the comments we received concerning them as well as our responses are set forth below.

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 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

[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.

DRG 412 (History of Malignancy with Endoscopy).

As a result of our analysis of the FY 1991 Medicare provider analysis and review file (MEDPAR) data, we proposed that endoscopic procedure codes 32.28 and 33.24 be designated as OR procedures and assigned to DRGs 76 and 77 in MDC 4. In addition, 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 OR Procedure) rather than DRG 412.

Although we received no comments on changing the status of the endoscopic procedure codes from non-OR to OR, we have reevaluated our proposal based on more recent information. In modeling the impact of the proposed DRG classification and recalibration changes, we must estimate which cases would be affected by the changes because we do not have a revised GROUPER program at the time the proposed rule is prepared. Thus, our analysis in the proposed rule of the impact of the DRG changes was based on an approximation of the placement of the cases under the proposed reclassification and the resulting recalibration of the DRG weights.

When we receive the revised GROUPER software, we can more accurately test the DRG classification and recalibration changes. This year, after testing the changes, we discovered that the DRG changes including the reassignment of the two endoscopic procedures would have a much more significant negative impact on small hospitals than we had stated in the proposed rule. For example, rural hospitals with under 50 beds would have an average reduction in payment per case of 0.6 percent and rural hospitals with 50 to 99 beds would have an average reduction of 0.3 percent. In the proposed impact analysis, we estimated these reductions at 0.2 and 0.1, respectively (57 FR 23819). The increase in the negative impact is entirely due to the endoscopic change. As the affected hospitals did not have an opportunity to comment on this significant impact on their payments, we believe it would be unfair to proceed with the change at this time. Therefore, we are not making this change effective for FY 1993.

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/defibrillator 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.

After reviewing the current DRGs in terms of clinical coherence and similar resource use, we proposed 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). As explained in the proposed rule, the relative weight for DRG 116 is higher than that of both DRGs 112 (Percutaneous Cardiovascular Procedures) and 120 and, from a clinical perspective, we believe that the surgical implant of an AICD device is similar to a pacemaker implant. (Cases of an AICD lead or generator procedure are assigned to DRG 112 when electrophysiologic (EP) studies are also performed.) In addition, we proposed a new title for DRG 116 "Other Permanent Cardiac Pacemaker Implant or AICD Lead or Generator Procedure."

Comment: While our proposal to reassign procedure codes 37.95, 37.96, 37.97, and 37.98 to DRG 116 met with general approval, we received many comments urging that these codes be reassigned to DRG 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock) instead. The commenters state that these cases will continue to be underpaid in DRG 116 and that reassignment to DRG 115 is more reasonable in terms of both clinical coherency and resource use. Many commenters believe that the AICD cases are as complicated as the cases that currently group to DRG 115. That is, in many cases, the AICD device is being placed in high-risk ventricular arrhythmia patients with poor left ventricular cardiac function, which is as risky as implanting a pacemaker in a patient with AMI, heart failure, or shock.

As a result of a study commissioned by the AICD manufacturer, the commenters estimate that these procedures should be assigned to a DRG with a weight of at least 3.7966, based on an average charge of $26,396 for correctly coded and billed AICD cases. The proposed weights for DRGs 115 and 116 were 3.6230 and 2.4759, respectively. (Several of the commenters mistakenly reported a proposed weight of 3.8230 for DRG 115.) Therefore, the commenters assert that assignment of AICD cases to DRG 115 would be much more equitable. Several commenters also alleged that hospitals are limiting the availability of the AICD device to Medicare patients as a response to the current level of compensation.

Response: As explained in the proposed rule (57 FR 23621), the current clinical composition and weights of the surgical DRGs in MDC 5 do not offer a perfect match with the AICD cases. After reviewing the current DRGs in terms of clinical coherence and similar resource use, we determined that DRG 116 was the best fit possible.

Since publication of the proposed rule, we have reanalyzed these cases based on the most recent update to the FY 1991 MEDPAR file. Based on those data, the average standardized charge for AICD cases is now $19,550 for the 971 cases assigned to DRG 120 and $32,363 for the 288 cases assigned to DRG 112. Thus, the overall average standardized charge for the 1,259 cases is $22,481. If the cases currently assigned to DRGs 117, 118, 478, and 479 are included in the calculation, the average standardized charge is $22,427 (1,284 cases). The average standardized charge for all cases assigned to DRG 116 is $17,224 and $25,737 for DRG 115.

The difference in average charges between our analysis and the analysis performed for the commenters is that we have included all the cases in our data base and they have excluded those cases they believe to be incorrectly coded or for which the charges reported by the hospital appear to be too low. In the proposed rule, we described the measures we had taken in an attempt to improve the charge and coding information on AICD cases. In May 1991, we instructed fiscal intermediaries to return to hospitals any bill for an AICD case for which the total charges

were less than $17,000 (the minimum charge necessary based on the cost of the device ($13,500) and a 4-day inpatient stay). (See Transmittal No. 1525.) This action was designed to ensure proper coding and charge information for these cases.

We have performed a separate analysis using data from bills submitted after June 1, 1991, the date we believe all intermediaries should have had the charge edit in place. Using these data, the average standardized charges for AICD cases in DRGs 112 and 120 are $32,714 and $20,789, respectively. These charges are slightly higher than the charges for all cases; therefore, we believe that the steps we have taken are improving the AICD data in the MEDPAR. Nonetheless, we continue to believe that we should use all the cases in the MEDPAR file in calculating the average standardized charges and in assessing the correct DRG placement for a set of cases.

In reviewing the average charges and the best placement for AICD cases, we note that it is only those cases assigned to DRG 120 that are likely to be AICD-only cases. That is, cases currently assigned to DRGs 112, 117, 118, 478, and 479 that include the performance of an AICD implant also include the performance of another heart-related procedure. Therefore, the charges for these cases encompass resource use for at least one other procedure. For example, an AICD case in DRG 112 has also had either a percutaneous transluminal coronary angioplasty (PTCA) or electrophysiologic (EP) studies performed. Therefore, it is more than likely that the average charge for these cases will be higher than the charges for the single procedure cases within the DRG. In fact, when reviewing the DRG 120 cases, the average charge for an AICD case is only $19,550. This charge is only about $2,300 more than the average charge for other cases in DRG 116 and is well within the variation in charges for that DRG. We believe that it is important to note these facts even though the remainder of our discussion of the data includes all AICD cases.

With regard to the commenters' statement that the cases receiving AICD devices are as complicated as the cases in DRG 115, we rely on two factors to assess that assertion. First, the average charge for the universe of AICD cases is approximately $3,300 less than the average charge for a case assigned to DRG 115. In addition, the average length of stay for the DRG 115 cases is 13.6 days compared to 7.7 days for the AICD cases in DRG 112 and 4.0 days for the DRG 120 cases. Using the same universe of 1,284 cases as we did in the average charge analysis, we compute an average length of stay of 6.7 days. Not only is this length of stay far lower than the one for DRG 115, it is actually lower than the average for DRG 116 (7.1 days). Thus, it is clear that, regardless of the condition of these patients, they are not remaining in the hospital for the same length of time as the DRG 115 and 116 patients. This leads us to conclude that they are neither as severely ill nor as complex to treat as the DRG 115 cases.

We believe that the cost of the AICD device is largely responsible for the high average charge for these cases. If the cost of the device ($13,500) is subtracted from the average charge for the case, the charge for the hospital resources consumed is only $6,050 for DRG 120 cases, $18,863 for DRG 112 cases, and $8,927 for all cases. Thus, the largest component of the charge is for the device, which is currently marketed by a single manufacturer. Based on conversations we have recently had with other device manufacturers as well as staff at the Food and Drug Administration (FDA), we understand that up to three other implantable defibrillator devices may be approved by the FDA in the near future. With increased competition, there may be a decrease in the price of these devices and a corresponding drop in the average charge for a hospital stay for AICD implantation. Pending these developments and future improvements in code and charge reporting, we believe our best course is to assign the AICD cases to DRG 116 as proposed and review our decision in the future as circumstances change.

Finally, with regard to the commenters' concern that hospitals are limiting the availability of the AICD device to Medicare beneficiaries, we note that the regulations at 42 CFR 489.53(a)(2) provide that HCFA may terminate a hospital's Medicare provider agreement if it finds that the hospital places restrictions on the number of Medicare beneficiaries it will accept for a particular treatment if it does not place the same restriction on the other populations it treats. Therefore, individuals and groups that are aware of specific cases where a hospital has refused to provide this covered service to a beneficiary should provide this information to us for review.

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. 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 did not propose any changes to the DRG assignment of major limb reattachment cases.

Comment: One commenter expressed concern that the evaluation of the appropriateness of DRG classification changes, in particular the decision not to make a change in the DRGs for limb reattachment cases, is based on only a sample of MEDPAR cases, rather than the entire MEDPAR file. The commenter stated that it appears to be appropriate to search all records before concluding that no change should be made.

Response: The data we analyzed in deciding whether or not to reassign the major limb reattachment procedures was a 10 percent random sample of the September 1991 update of the FY 1991 MEDPAR, which contained approximately 9.5 million cases. We have found that a 10 percent sample (approximately 1 million claims) is fully representative of the 100 percent file and is completely reliable as a basis for making decisions about DRG revisions.

In response to this comment, using the June 1992 update of the FY 1991

MEDPAR file, which contains approximately 10.4 million Medicare discharges, we searched the entire file for major limb reattachment cases. The limb reattachment procedure codes 84.23 (Forearm, wrist, or hand reattachment), 84.24 (Upper arm reattachment), 84.26 (Foot reattachment), 84.27 (Lower leg or ankle reattachment), and 84.28 (Thigh reattachment). In FY 1991, these procedures were assigned to DRGs 209, 441 (Hand Procedures), 442 and 443 (Other OR Procedures for Injuries), 459 (Nonextensive Burns with Wound Debridement or Other OR procedure), 472 (Extensive Burns with OR Procedure), 485, and 486 (Other OR Procedures for Multiple Significant Trauma). In these DRGs, we found only four cases: Two in DRG 209 and one each in DRGs 441 and 443. All of these cases were reattachments of the upper extremity.

(Note: The upper extremity case in DRG 209 in FY 1991 would be classified in DRG 491 effective October 1, 1991.)

An additional 15 cases of major limb reattachment were found in the review of the full FY 1991 MEDPAR. Of these cases, 11 cases were assigned to DRG 424 (O.R. Procedure with Principal Diagnosis of Mental Illness), which consisted of 9 cases of lower leg or ankle reattachments and 2 cases of forearm, wrist, or hand reattachments. The following DRGs each had one case: DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe), DRG 357 (Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy), DRG 440 (Wound Debridements for Injuries), and DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). All these cases were forearm, wrist, or hand reattachments, except for the DRG 468 case, which is an upper arm reattachment.

The total standardized charges for the 19 cases range from $1,113 to $74,718, with an average charge of $23,731. The lengths of stay range from 1 to 123 days, with an average length of stay of 36 days. These cases were distributed across 19 hospitals, that is, each hospital had only one case.

Based on this analysis, we believe that our proposed decision to make no changes for major limb reattachments was correct. There were only two cases in DRG 209, the DRG from which the commenter wished to move these cases. The charges for these cases were well within the expected variation of charges for cases in this DRG. With a universe of only 19 cases, of which only 4 occurred in DRGs to which the procedures are assigned, and the wide distribution of these cases among hospitals, we continue to believe that there is no support for the creation of a separate DRG for limb reattachments.

Comment: We received three comments regarding the DRG classification of major joint replacements of the lower extremity involving infections or mechanical complications, which are currently assigned to DRG 209. The commenters wrote to support the creation of a separate DRG for these cases, citing the August 30, 1991 final rule (56 FR 43205) where we stated that we intend to address this issue through our refinements to the DRG system to reflect variation in the severity of illness among patients. The commenters pointed out that since a handful of specialty hospitals treat a disproportionate number of these very complicated cases, they are being systematically underpaid under the present DRG classification.

One commenter submitted a report that analyzes the DRG 209 cases treated at one of these specialty hospitals and makes recommendations on how to reclassify certain DRG 209 cases to improve payment equity to these types of hospitals. The commenter believes that the type of severity adjustment HCFA is considering (that is, one in which consideration is given to a set of major complicating conditions applied across all DRGs) is not the type of system that will remedy the problem in DRG 209. The issue in DRG 209 is a type of severity problem in which a specific diagnosis or procedure represents a clinically meaningful subset of patients within a certain DRG that are more severely ill. Therefore, the commenter recommends creating new DRGs for replacement of infected prosthesis of the lower extremity and for mechanical and other complications of limb replacement of the lower extremity. In response to our request in the proposed rule for comments on methods for predicting the effect of DRG changes on coding and payment (see detailed discussion below in section II.D of this preamble), this commenter proposes a methodology and believes that the change he is seeking in DRG 209 could serve as the "field" test for the proposal.

Response: In general, we do not make DRG changes for a small subset of cases in a DRG that tend to have charges higher than average. Our response to requests for such changes is to point out the averaging effect of cases in a DRG. That is, in each DRG there are cases for which the costs are higher than average; however, there are also cases with costs lower than average, and the cases will, over the long run, balance out. We consider making exceptions to this policy when the subset of higher cost cases is not spread over many hospitals but, rather, is concentrated in a few specialty hospitals. Based on the evidence we have seen so far, it appears that the distribution of these complicated joint replacements may be systematically underpaying a small number of hospitals that, because of their specialization, are unable to balance the expensive cases with a comparable number of less expensive cases.

Since we are unable to thoroughly evaluate this suggestion for a possible change in FY 1993, we will add this issue to our FY 1993 DRG analysis agenda.

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.

Effective with discharges occurring on or after October 1, 1987, the alcohol/drug 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

Effective with the same date, 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. (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 inquiries concerning the possibility of

adding a surgical partitioning to MDC 20. Based on our analysis of the FY 1991 MEDPAR data, we estimated in the proposed rule that the total number of cases in MDC 20 that would result in a surgical DRG assignment is under 1 percent. We did not believe that this was a sufficient number of cases to propose the creation of a surgical DRG.

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 MDC 20. 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 proposed 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.

We received no comment on this change; thus, we are incorporating our proposal into this final rule.

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 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 will 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 will 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 lowerweighted 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 that, notwithstanding the foregoing discussion, 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 proposed to modify the surgical hierarchy for the pre-MDC DRGs and MDCs 3, 5, 8, and 12 as set forth below.

- In the pre-MDC DRGs, we proposed to reorder Tracheostomy Except for Mouth, Larynx, or Pharynx Disorder (DRG 483) above Bone Marrow Transplant (DRG 481).
- In MDC 3, we proposed 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 proposed 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 proposed to reorder Foot Procedures (DRG 225) above Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with CC (DRG 223).
- In MDC 12, we proposed to reorder Testes Procedures (DRGs 338, 339, and 340) above Transurethral Prostatectomy (DRGs 336 and 337).

Comment: The only comment we received on the surgical hierarchy changes was from a national association representing children's hospitals regarding two of our proposed changes. The first comment concerned our proposal to reorder pre-MDC DRG 483, Tracheostomy, Except for Mouth, Larynx, or Pharynx Disorder, above DRG 481, Bone Marrow Transplant. The commenter states that, based on his review of data, the arithmetic mean costs for bone marrow transplant patients are the same or more than those for tracheostomy patients. He also suggests that, from a clinical coherence standpoint, it is advantageous to group bone marrow patients above the more heterogeneous tracheostomy grouping. The commenter, therefore, urges that we leave the pre-MDC hierarchy as it is currently.

In addition, the commenter is concerned about our proposal to reorder Myringotomy with Tube Insertion (DRGs 61 and 62) above Cleft Palate and Palate Repair (DRG 52). The commenter

reports that, for a pediatric population, patients are not often admitted for an inpatient stay just for a myringotomy, although there are a number who are admitted for other surgical procedures and also receive a myringotomy. In contrast, many pediatric patients are admitted for the more complex procedure of cleft lip and palate repair. If our hierarchy change is implemented, the commenter foresees a number of cases in which the child will be admitted to the hospital in order to have a cleft palate repair and a myringotomy, and the child will group to one of the myringotomy DRGs rather than the cleft lip and palate DRG.

Response: In our analysis of FY 1991 MEDPAR data, we determined that the average standardized charge for patients in DRG 483 is higher than that for the cases in DRG 481. Based on cases in the FY 1991 MEDPAR file, the average standardized charges for DRG 483 and 481 are $115,093 and $103,213, respectively. The commenter did not report which data were used for his analysis, but we have used consistently the same data (that is, the MEDPAR file) and methodology to make all changes to the surgical hierarchy. It is possible that the commenter has many more pediatric patients in his data than does MEDPAR and that that had an effect on his average costs. However, since the purpose of the surgical hierarchy is to ensure that Medicare cases with multiple surgical procedures are assigned to the Medicare DRG associated with the most resource-intensive surgical class, we are proceeding with this change.

Regarding the second comment about the reordering of DRGs 61 and 62 above DRG 52, we understand the commenter's concern. However, for the Medicare population, this ordering is more accurate than the current hierarchy. As we have stated in previous years, the changes we make to the prospective payment system, and the DRG classification in particular, are based on Medicare data and are designed for the Medicare population, that is, the elderly and disabled. Therefore, changes and modification we make to that system may not always be appropriate for a younger population, such as the one treated most often in children's hospitals. With regard to the commenter's specific concern that this change in hierarchy would result in cases previously classified to DRG 52 now being classified in DRGs 61 and 62 because they have both procedures performed, based on our data, no cases moved from DRG 52 to 61 and 62 as a result of the hierarchy change. We also note that we had previously proposed this change as a part of our FY 1991 changes and, in response to a similar comment, decided not to proceed with the change because of the small difference in average charges. (See the September 1, 1990 final rule; 54 FR 36025.) However, this year, the difference in average charges between these two surgical classes has increased so much we believe we must implement the change to ensure correct payment for the Medicare cases in these DRGs.

Based on a test of the proposed surgical hierarchy using the most recent MEDPAR file and the revised GROUPER software, we find that the changes we proposed are still supported by the data and no additional changes are indicated. Therefore, the proposed surgical hierarchy is incorporated in this final rule.

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 did not propose to make any changes to the current CC list.

We proposed 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.) We proposed the changes in accordance with the principles established when we created the CC Exclusions List in 1987. In this final rule, we are implementing the changes as proposed.

Tables 6g and 6h in section IV of the addendum to this final rule contain the revisions to the CC Exclusions List that are effective for discharges occurring on or after October 1, 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 DRG Definitions Manual, Version 10.0, is available for $195.00, which includes $15.00 for shipping and handling. This manual may be obtained by writing 3M/HIS at: 100 Barnes Road, Wallingford, Connecticut 06492; or by calling (203) 949–0303.

Comment: Although we proposed no changes in our CC list, we received a comment from an association of children's hospitals concerning the CC list. The commenter notes that the CC list would be different if the Medicare DRGs were intended to serve a pediatric population and requested that we restate our explanation, published in the August 31, 1991 final rule (55 FR 43211),

of the intended patient population for the Medicare DRGs.

Response: In response to the commenter's request, we will restate the specified explanation. While we are aware of the fact that changes we make or do not make in the Medicare DRG system may have an impact on children's hospitals with regard to other payment systems that use our DRGs, the prospective payment system, and the DRG classifications in particular, are based on Medicare data and are designed for the Medicare population, that is, the elderly and disabled. Therefore, changes and modifications we make to that system may not always be appropriate for a different population.

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 moving 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 proposed 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 will group to DRG 477 instead of DRG 468 beginning with discharges on or after October 1, 1992.

We received no comments on our proposals for DRG 468 and 477. Therefore, we are incorporating these changes into the final DRG classifications.

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 that 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, health information management professionals, 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 oral comments received at the meetings and written comments received in the 30 days following the December 1991 meeting. The initial meeting for consideration of coding issues for resolution in FY 1993 was held on May 7, 1992 and a second meeting concerning diagnosis codes only was held on August 4, 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 final 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.

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.

No comments were received on our proposed DRG assignments for new and revised ICD-9-CM codes.

10. Other Issues

a. Cochlear Implants

Comment: We received two comments strongly urging us to reassign multi-channel cochlear implants from DRG 49 (Major Head and Neck Procedures) to a new DRG. The commenters noted that this issue has been brought to HCFA's attention every year since 1986 with no change in DRG classification. In the commenters' opinion, classification to DRG 49 vastly underpays these cases, resulting in large losses to hospitals and possible disincentives for hospitals to provide this service to Medicare beneficiaries. This year's proposed reduction in relative weight for DRG 49 (from 2.2790 in FY 1992 to 1.6364 in the proposed rule) will further reduce hospital payment.

One of the commenters commissioned an independent study on payment for cochlear implants and included the report from that study in the comment. This study identified 100 cochlear implant cases in the FY 1991 MEDPAR file assigned to DRG 49. Of that number, 14 cases were from hospitals that had not purchased the cochlear implant device from the only company in the United States that manufactures the devices. An additional 34 claims had billed charges less than $17,000, which the commenter believes is a minimum charge for one of these cases. This minimum charge is based on the cost of the device (approximately $14,695) and the resources consumed by a 2-day hospital stay. These cases were identified as "misbilled" in the study.

The study calculated that the remaining 52 correctly coded and billed cochlear implant cases had average standardized charges of $23,489. The report concluded with four alternative recommendations:

- Reassign cochlear implant procedure codes to DRG 1 (Craniotomy Age > 17 Except for Trauma), which has a proposed weight of 3.2349.
- Reassign cochlear implant procedures to a new DRG within MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) and assign a payment weight of 3.3785.
- Reassign the less costly cases (that is, virtually all cases other than cochlear implants) from DRG 49 to DRG 63 (Other Ear, Nose, Mouth and Throat OR Procedures).
- Allow separate Part B Medicare payment for the external components of the cochlear implant system.

Response: We have previously addressed the issue of cochlear implants, most recently in the prospective payment final rule for FY 1991 published on September 4, 1990 (55 FR 36029). Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49, which is the highest weighted surgical DRG in MDC 3. Since that time, the cochlear industry has contended that the weight of DRG 49 is too low and does not adequately reflect the resources necessary for cochlear implant.

In response to these most recent comments, we analyzed the FY 1991 MEDPAR data for DRG 49 to determine the current charges and length of stay for cochlear implants. The ICD-9-CM procedure codes we used to identify these cases are 20.96 (Implantation or replacement of cochlear prosthetic device, NOS), 20.97 (Implantation or replacement of cochlear prosthetic device, single channel), and 20.98 (Implantation or replacement of cochlear prosthetic device, multiple channel). We found no cases coded with 20.97 (Single channel devices) and, in fact, these devices have been replaced by the multi-channel devices and are no longer available.

In reviewing the FY 1991 data, we identified 100 cochlear implant cases (the same number identified by the independent study). These cases had an average charge of $17,135, compared to an average charge of $11,696 for all other cases in the DRG. This is a change from the last analysis we did using FY 1989 MEDPAR data. At that time, the average charge for cochlear implants cases was $13,338. The average charge for all other cases in DRG 49 was $15,680. However, cochlear implant cases currently comprise only 3.4 percent of the total DRG 49 cases (100 out of 2,963). We also note that, although the number of cases increased from 69 in FY 1987 to 113 in FY 1988, they have been decreasing since then with 107 cases in FY 1989 and 100 in FY 1991.

Although the average charge for cochlear implants has increased, the charge we have calculated based on FY 1991 MEDPAR data is still much lower than the charge calculated by the study. This is because we have included in our calculation all the cases in the FY 1991 MEDPAR file with a cochlear implant procedure code. The study excluded almost one-half of the cases (48 out of 100) because they believe they were miscoded or misbilled. We have previously addressed this problem and, in fact, we issued instructions to the Medicare Part A fiscal intermediaries (Transmittal No. 1525, May 1991) and the Part B carriers (Transmittal No. 1393, May 1991) concerning this issue. The intermediaries were instructed to return to the hospital any claim for cochlear implants where total charges are less than $17,000. The hospitals are instructed to review and verify the procedure codes and total charges. The carriers are instructed to deny charges under Part B for speech processors furnished in support of surgery during an inpatient hospital stay. We believe that these steps should assist in improving the MEDPAR data on cochlear implants.

In the meantime, while there is a higher charge for the 100 cochlear cases than for the noncochlear cases in DRG 49, we note that the cases are distributed across 53 hospitals and the highest volume of cases at any one

hospital is only 8. There are only 10 hospitals with 3 or more cases; 4 with 6 or more. Charges per case range from $1,235 to $32,951. Length of stay is quite low, with many patients staying in the hospital for only one day.

In response to the recommendation submitted by the commenters to assign cochlear implant cases to a new DRG with a weight of 3.3785, we believe the process for calculating DRG relative weights needs to be clarified. HCFA does not assign weights to DRGs arbitrarily, but, rather, calculates the weight for each DRG based on the resources necessary to treat patients assigned to that DRG relative to all other DRGs. A DRG weight cannot be adjusted or a new DRG created without affecting the weight of other DRGs. It would be inappropriate and inadvisable for us to create a new DRG with a specified weight assigned, as such action would impact the weight and, therefore, the payment, for other DRGs. The process by which DRG weights are recalibrated is described in detail below in section II.C. of this preamble. The weight for DRG 49 in Table 5 reflects both decreases in the charges submitted for the case assigned to DRG 49 and increases in charges for other DRGs, causing a redistribution of the relative weights and resulting in a lower weight for DRG 49.

As discussed above, the reported study recommends several options for resolving the perceived payment inequities for cochlear implants. First, the study suggests moving cochlear implant procedure codes to DRG 1. However, the diagnosis code category assigned to patients admitted for cochlear implants is 389 (Hearing loss). These diagnosis codes are assigned to MDC 3. As noted above in section II.B.1 of this preamble, except for a few special cases, principal diagnosis determines MDC assignment and each code is assigned to a unique MDC. The commenter suggests we handle this problem in the same manner that liver and bone marrow transplant cases are classified, which is by using the procedure codes instead of diagnosis codes for assignment. Liver and bone marrow transplant cases are not assigned to any MDC but are classified by procedure to DRG 480 (Liver Transplant) and DRG 481 (Bone Marrow Transplant) prior to MDC assignment. These DRGs are structured in this way because liver and bone marrow transplants are performed for patients who have principal diagnoses that are assigned to more than one MDC. Therefore, the only way to create one DRG for the procedure and to assign all the appropriate cases to the DRG is to place it before the MDC assignment step.

This method would not be appropriate for cochlear implants. To move these cases to DRG 1, we would have to move the principal diagnosis code category 389 from MDC 3 to MDC 1 (Diseases and Disorders of the Nervous System). However, based on clinical coherence, code category 389 is correctly placed in MDC 3. We note that heart transplant cases are assigned only to MDC 5 (Diseases and Disorders of the Heart) because they are performed only on patients with principal diagnoses assigned to that MDC. Not only would moving cochlear implants to DRG 1 be clinically indefensible, it would also result in significant overpayment to the 100 cochlear cases, which have an average charge of $17,135 compared to the average charge for the cases in DRG 1 of $22,598.

As noted by the commenter, DRG 49 is the highest weighted DRG in MDC 3. Therefore, there is no other DRG conveniently available for assignment of cochlear implants. We believe that the low volume of these cases does not justify the establishment of a new DRG specific to cochlear implants, nor do we generally create DRGs that are specific to a single technology, especially those available only through a single source manufacturer. Assigning less costly cases from DRG 49 to DRG 63, as also suggested by the commenter, would produce the same result, a separate DRG for a small number of technology-specific cases, and would underpay the noncochlear DRG 49 cases (average charge $11,789) relative to other cases in DRG 63 (average charge $7,291). We also note that DRG 63 is the "Other OR procedures" class for MDC 3. This is a group of procedures that are the least likely to be related to the diagnoses assigned to MDC 3, but are occasionally performed on patients with these diagnoses. The procedures assigned to DRG 49 are specifically related to the MDC 3 diagnoses and should not be reassigned to a catchall DRG.

Finally, the commenter states that a substantial portion of the hardware cost of cochlear implant devices is for the externally worn components, the speech processor and headset, which are typically provided to the patient 4 to 6 weeks after the surgery. This commenter suggests these costs be "unbundled" from other inpatient supplies and services and be billed by the surgeon or audiologist to part B Medicare. Since the short length of stay incurred by these patients (70 percent of the admissions in the FY 1991 data had a length of stay of only 1 or 2 days) indicates that the cost of the device is the major component of the charges, allowing this practice would substantially lower the average charge for these cases.

Prior to implementation of the prospective payment system, it was a practice for certain nonphysician services and supplies furnished to hospital inpatients to be billed directly to patients under part B of the program. However, with the enactment of Public Law 98–21 and the implementation of the prospective payment system, several statutory changes concerning the bundling policy were made. More specifically, section 1862(a)(14) of the Act provides that, to qualify for Medicare payment, all services (with limited exceptions) furnished to hospital inpatients must be provided directly or arranged for by the hospital. Thus, these services become inpatient hospital services payable under part A. Section 1833(d) of the Act, in turn, requires that services that are payable under part A may not be paid for under part B. Therefore, all the services provided to a Medicare beneficiary as part of the inpatient hospital stay are covered under part A and may not be billed under part B. This includes the external components of the cochlear device that is implanted during a inpatient stay covered under part A. Therefore, we cannot allow separate part B payment for part of the cochlear device.

We acknowledge that the payment for cochlear implant patients has been an issue for several years. We will continue to evaluate the payment for these cases and its impact on hospitals.

b. HIV-Related Conditions

Comment: We received three comments urging HCFA to adopt the newly identified conditions that are considered by the Centers for Disease Control (CDC) to be HIV-related. The commenters state that these conditions should be included in the list of "major related conditions" as soon as practicable after they are identified to allow these cases to group to DRG 489 (HIV with Major Related Condition).

Response: As we stated in the September 4, 1990 final rule (55 FR 36019) and the August 30, 1991 final rule (56 FR 43208), the HIV-related conditions that qualify for classification to MDC 25 (HIV Infections) are limited to those conditions identified by CDC as being HIV-related. This process includes listing these conditions in Volume 1 of ICD–9–CM in the "Includes Only" notes under diagnosis codes 042.0, 042.1, 042.2, 043.1, 043.3, and 044.0. Since we

established the HIV DRGs effective with discharges in FY 1991, we have worked with the National Center for Health Statistics (NCHS), CDC to ensure that our classification of HIV patients is as current and inclusive as possible. In response to this comment, we again contacted NCHS to ensure that our list of HIV-related conditions is complete. Although CDC has reported that new diagnoses are occurring with increasing frequency within the HIV-infected population, these diagnoses have not yet been added to the list of HIV-related conditions. When they are, we will incorporate them into our next list of conditions for MDC 25.

We note that whether these conditions will be considered "major" will be determined by the nature of the condition. Using our criteria, a major HIV related condition involves a disease or disorder of the central nervous system, a malignancy, an infection, or other major related condition.

c. MCE Age Conflict Edits

Comment: We received two comments concerning certain age conflict edits in the MCE. Currently, the MCE identifies and rejects for further development claims that include codes for congenital conditions for patients who are no longer in the newborn age period. However, as stated in the November-December 1986 issue of Coding Clinic for ICD–9–CM, it is correct to report congenital conditions as principal diagnoses for patients beyond the newborn stage. The commenters recommend that, while it may be appropriate to edit for these conditions in the Medicare population, recoding of the cases should not be required and cases should be grouped and paid by the fiscal intermediary once the accuracy of the coding has been verified.

Response: The purpose of the MCE is to identify cases that may require further review due to questionable information on the Medicare claim, and a case that lists a diagnosis that is unlikely in a patient of a certain given age is considered questionable. However, all edits in the MCE can be overridden by the fiscal intermediary once it has verified the correctness of the claim. Although some edits should never be overridden (for example, a noncovered procedure edit or a sex conflict edit), most of the age edits may be occasionally overridden after verification of the claim. We believe the reason that the commenters are experiencing trouble recently is not due to the actions of the fiscal intermediaries, but rather the fact that the HCFA Common Working File (CWF), through which all Medicare inpatient hospital claims must pass before payment, does not provide a mechanism to override MCE edits. We agree with the commenters that Medicare payment should be made for claims that have been coded properly based on coding principles and instructions. Therefore, we will pursue revising the current data edits in the CWF to allow payment for correctly coded claims.

d. Lung Transplants

Comment: We received three comments requesting that immediate consideration be given to recognizing single and double lung transplants as approved, covered Medicare services and creating one or more new DRGs specifically for these cases. One of the commenters (a consulting firm writing on behalf of the other two commenters) submitted an analysis of the cost of these cases and asserted that the payment currently being made for these cases under the prospective payment system is inadequate. In addition, the commenter submitted a recently completed evaluation of the risks, benefits, and clinical effectiveness of lung transplants prepared by the Office of Health Technology Assessment, Agency for Health Care Policy and Research, HHS. ("Single and Double Lung Transplantation", Health Technology Assessment Reports, 1991, Number 5, May 1992, Pub. No. 920028.)

Response: Currently, lung transplants have not yet been the subject of a national coverage decision. Therefore, under HCFA policy, the Medicare contractors (that is, the Part A fiscal intermediaries and the Part B carriers) determine whether or not to cover and pay for claims associated with a lung transplant. Under the current DRG classifications, ICD–9–CM procedure code 33.5 (Lung transplant) is assigned to DRG 75 (Major Chest Procedures) in MDC 4 (Disease and Disorders of the Respiratory System). We note that combined heart-lung transplants (procedure code 33.6) are not covered under Medicare as provided in the notice of HCFA ruling that extended coverage to heart transplants, which was published in the **Federal Register** on April 6, 1987 (52 FR 10936).

HCFA has begun exploring the possibility of covering lung transplants on a national basis. However, based on our recent experience with other transplant coverage decisions, we believe this process could take a year or more to complete. As part of that process, we will also consider the appropriateness of establishing a new DRG for these cases. We will consider the commenters' suggestions as a part of this determination. We note that any classification of lung transplants, and the resulting DRG relative weight, will be based, to the extent possible, on the cost of providing this service to Medicare beneficiaries.

e. Classification of Vascular Device Infections

Comment: We received a comment requesting that consideration be given to moving ICD–9–CM diagnosis code 996.62 (Infection and inflammatory reaction due to other vascular device, implant and graft) from DRGs 144 and 145 (Other Circulatory System Diagnoses) to DRG 416 and 417 (Septicemia). The commenter states that patients with vascular devices are prone to developing septicemia as a result of the device. However, coding rules require that the complication code (996.62) be coded as the principle diagnosis and the code for septicemia be a secondary diagnosis. (Coding Clinic for ICD–9–CM, Second Quarter 1990, PDX #15.) This results in the patient being classified to DRGs 144 and 145, with proposed weights of 1.0691 and .6304, respectively. A septic patient whose condition is not attributed to the presence of a vascular device will group to DRG 416, with a proposed weight of 1.5203. Therefore, the commenter believes we should consider changing the DRG assignment for code 996.62.

Response: The commenter is correct in stating the applicable coding rules. When the admission is for the treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 966 through 999 series, an additional code for the specific complication may be assigned. Thus, the case as described by the commenter is correctly coded with 996.62 as the principal diagnosis and the applicable diagnosis code for septicemia from the 038 series as secondary.

According to our medical consultants, patients with vascular devices rarely develop septicemia that is attributable to the presence of the device. It is much more likely that the septicemia is not related to the device. The attending physician is responsible for stating in the medical record the relationship between the septicemia and the presence of the medical device. However, if the case described by the commenter does occur, it is correctly placed in DRGs 144 and 145, which are located in MDC 5. We note that all the complication codes associated with devices of the circulatory system are assigned to these DRGs. It would be

inappropriate to place these codes in MDC 18 (Infectious and Parasitic Disease (Systemic or Unspecified States). Code 996.62 is neither a systemic or unspecified infection and is clinically coherent with the other MDC 5 diagnoses. Therefore, we do not intend to move it to any other MDC.

C. Recalibration of DRG Weights

We proposed to use the same basic methodology for the FY 1993 recalibration as we did for FY 1992. That is, we proposed to recalibrate the weights based on charge data for Medicare discharges. However, we proposed to use the most current charge information available, the FY 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 were 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 at that time included data for approximately 10.2 million Medicare discharges. The MEDPAR file updated through June 1992 includes data for approximately 10.4 million discharges and this is the file used to calculate the weights set forth in Table 5 of the addendum to this final rule.

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

- All the claims were regrouped using the revised DRG classifications 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) and liver transplants (DRG 480) in a manner consistent with the methodology for all other DRGs except that the heart and liver transplant cases that were used to establish the respective weight were limited to those Medicare-approved heart and liver transplant centers that have cases in the FY 1991 MEDPAR file.
- 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 proposed to use that same case threshold in recalibrating the DRG weights for FY 1993. Using the FY 1991 MEDPAR data set, there are 37 DRGs that contain fewer than 10 cases. We computed the weight for the 37 low-volume DRGs by adjusting the original weights of these DRGs by the percentage change in the average weight of the cases in the remaining DRGs.

The weights developed according to the methodology described above, using the 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 final rule, we are making a budget neutrality adjustment to assure the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Comment: We received one comment recommending that Medicare exclude the low-volume DRGs from the prospective payment system. The commenter stated that, because the FY 1993 weights for these DRGs were set by applying the average increase in the case-mix index across all cases to the FY 1992 weights for these DRGs, the weights no longer reflect the resources used to treat patients in these DRGs. The commenter notes that all but three of these DRGs are for pediatric (the age 0–17 category) or neonatal cases. These "artificial" weights have a minor impact on payments under Medicare but may result in severe distortions in payments for other populations for whom the Medicare weights are used. Therefore, HCFA should refrain from calculating and publishing weights for these DRGs.

Response: As described above, the weight for every DRG with fewer than 10 cases was computed by adjusting the DRG's original weight by the percentage change in the average weight of the cases in the remaining DRGs. Increasing the weight by the percentage change in the average case weight maintains a constant relationship between the average resources required for these cases and the average Medicare case. We believe that this is a reasonable approach to establishing the relative weight when there are insufficient cases to calculate the weight based on current charge data. The original weights for the low volume DRGs were calculated by supplementing the MEDPAR data with records from Maryland and Michigan. (See the September 1, 1983 final rule with comment period (48 FR 39768).) There were 109 DRGs whose weights were calculated in this manner. We note that there have been fewer than 40 low-volume DRGs for several years and that these DRGs vary somewhat from year to year. In addition, although low volume, cases continue to be classified to these DRGs. It would be inappropriate to

exclude the low volume DRGs from the prospective payment system because we have no other basis for paying the cases that are classified to these DRGs.

In response to the concern that others who use the Medicare weights may experience distortions in payments due to the presence of these low volume DRGs, we reiterate that the DRG weights set forth in this final rule are established for the Medicare population. While other payers may wish to follow the Medicare classification scheme, we have consistently cautioned against the use of Medicare DRG weights for other populations.

Comment: One commenter examined the impact of the proposed DRG weights for the top 58 high volume DRGs at his hospital. Based on this analysis, the commenter notes that payments to his hospital will decrease dramatically. The commenter protests a loss in payment that is attributable only to recalibration, further reducing overall payments to hospitals already suffering from the effects of the recession.

Response: Each year, as directed by section 1886(d)(4)(C) of the Act, we recalibrate the DRG weights to accurately reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The DRG weights are not arbitrarily set by HCFA, but rather are calculated based on the actual case charges submitted by hospitals.

Because the DRG weights are relative to each other, it is impossible for weights to increase for all DRGs. As some increase, others must decrease. In the past few years, average charges in the more resource-intensive DRGs have tended to rise more rapidly than those in the less resource-intensive DRGs. As a result, those hospitals that tend to treat cases that are assigned to the more resource-intensive DRGs will realize an overall increase in payments due only to the recalibrated weights (regardless of any update factor applied to the standardized amounts), whereas hospitals that tend to treat cases in the less resource-intensive DRGs will realize an overall decrease in payments. Reclassification and recalibration are intended to reflect changes in relative resource costs and to distribute the payments made to all hospitals under the prospective payment system in the most equitable way possible based on the types of cases the hospitals treat.

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). 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 1991) 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.

Based on our analysis of the MEDPAR received by HCFA through December, 1991, 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 percent.

The following table illustrates the changes:

DRG	Number of cases in DRG		DRG cases as percent of total cases		Percent increase
	Estimate	Actual	Estimate	Actual	
483	25,191	32,751	0.25	0.32	30
488	261	473	.003	.005	81
489	1,801	4,187	.02	.04	133
490	780	1,679	.01	.02	115
Total MDC 24	2,842	6,334	.03	.06	123
Total cases	28,013	39,085	.28	.38	40

As noted above, we believe that the increases in the tracheostomy and HIV DRGs are due, in large part, 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 a secondary diagnosis 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, in setting the FY 1991 relative weights, 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 increased between FY 1989 and 1991, we believe a 123 percent increase must also be attributable to improved coding for HIV infection.

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 will 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 was 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		Actual	
		Number of cases	DRG cases as percent of total cases	Number of cases	DRG cases as percent of total cases
DRG 320	1.0055	145,039	1.47	162,874	1.60
DRG 321	.6507	34,523	.38	28,718	.28

Thus, the actual number of cases assigned to the higher-weighted DRG was higher than the number we had estimated, and the actual number of cases assigned to the lower-weighted DRG was lower. 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 affect 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 as of December 1991 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.

Even though 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 this 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.

As we stated in the proposed rule, we are strongly committed to making changes in the DRG system to improve payment equity; however, in light of the mandate of budget neutrality, our current inability to predict the changes in coding behavior that may result from our revisions limits the extent to which we can revise the system. Thus, we announced in the proposed rule that, 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 will increase by less than 0.1 percent if we have underestimated by 10 percent the number of cases that will receive more favorable payment under the DRG classification changes that provide incentives for coding improvement.

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. We emphasize that we will continue to make certain DRG reclassification changes that are appropriate. In fact, as discussed above in section II.B of this preamble, we are implementing changes in this final rule to reflect changes in relative resource use. The limitation on making DRG classification changes applies only to significant modifications to the system.

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 final estimated average FY 1991 DRG relative weight is 1.3647, this type of comparison is not readily accomplished using normalized DRG relative weights.

We solicited public comments on this and other possible approaches that could be implemented to account for coding changes that result from

revisions in the DRGs. These comments and our responses are presented below.

Comment: One commenter protested our decision to do only minor recalibration of the DRG weights. The commenter believes that the result of this action is to keep payments artificially low for many of the higher-cost DRGs.

Response: We believe that this commenter misunderstood what we stated in the proposed rule. We intend to fully recalibrate the DRG weights every year based on the most recent MEDPAR data. We intend to limit only the extent to which we will make changes to the classification of cases into DRGs.

Comment: Many commenters objected to our decision not to make significant revisions in the DRGs until we improve our ability to predict the results of those changes or until we have made methodologic changes in the recalibration or in the determination of the annual update factor applied to the standardized amounts. The commenters urged us to adhere to the requirements of section 1886(d)(4)(C)(i) of the Act, which mandates annual revisions to the DRG classifications to reflect changes in resource use. The commenters believe that HCFA's current inability to account for the impact of DRG classification changes does not relieve the agency, legally or logically, of its statutory obligation to make all appropriate changes on an annual basis.

Response: We acknowledge our obligation to make appropriate DRG classification changes and to recalibrate DRG relative weights as mandated by section 1886(d)(4)(C) of the Act. In accordance with this provision, as the DRG reclassification changes set forth in this final rule demonstrate, we will continue to make changes to the DRGs to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Our decision to limit our changes is not an attempt to circumvent our statutory obligation. On the contrary, we are making every effort to improve our ability to account for valid changes in case mix, technology, and treatment patterns that legitimately affect hospital resource consumption. At the same time, we are also mindful of our obligation under section 1886(d)(4)(C)(iii) to make the DRG changes in a budget neutral manner. In light of this provision, we do not intend to recommend DRG modifications with inflationary outcomes that we are unable to predict and that may, therefore, result in a violation of the mandate of budget neutrality. Our goal is to refine our methodology so that we can fulfill both statutory requirements in the most appropriate manner.

Comment: We received one recommendation that we seek a legislative change that would allow the DRG reclassification and recalibration budget neutrality adjustment to be based on estimated rather than actual experience. Thus, budget neutrality would require that, for the distribution of cases used for reclassification and recalibration of the DRGs, estimated total payments under section 1886(d) of the Act after reclassification and recalibration are equal to estimated total payments before reclassification and recalibration.

Response: The use of "estimated" versus "actual" payments is an issue only to the extent that we are unable to predict accurately the impact of modifications on program payments. Changing the law to require only that the estimated impact of DRG reclassification and recalibration be budget neutral does not address the inflationary effects of coding improvements and other areas prone to misestimation. Regardless of whether the statute requires that "estimated" or "actual" payments be budget neutral, we need to improve our methodology for projecting changes that will occur between the estimation year and the payment year in the distribution of cases, enabling us to fulfill both the letter and the spirit of the law. To the extent we are unable to improve the estimation methodology, we need to establish a methodology that will avoid building the inflationary impact of the changes into future program payments. Unlike other estimates that are redone on an annual basis (for example, estimated outlier payments), misestimating the effect of DRG changes results in a permanent increase in the average case weight. Thus, since implementation of the prospective payment system, the average case weight has increased 35 percent. Although some portion of this increase reflects real changes in the mix of cases treated by hospitals, we believe much of it is a result of improved coding practice. Thus, we will continue to seek suggestions and explore and evaluate a variety of methodologies to improve our ability to make our DRG modifications budget neutral.

Comment: Commenters argued that in analyzing the unanticipated change in case movement following the FY 1991 DRG changes, we overstated the impact of the changes on coding. These commenters believe that there is an actual increase in case complexity every year and that attributing all the change to improved coding practice overstates the problem. The example used most frequently by the commenters is the HIV Infection DRGs. They believe that the incidence of these cases is increasing at such a rate that it could easily have accounted for the 123 percent increase we saw between FYs 1989 and 1991 data.

Response: We agree with the commenters that HIV infection is a condition for which there is real change in case numbers. And, in fact, we acknowledged this trend in the proposed rule (57 FR 23628). However, the increase in case numbers between those 2 years for HIV patients far exceeded the increase we would have expected based on the trends in previous years. We note that our methodology for determining the effect of the DRG changes compares the average DRG weight for the actual FY 1991 cases using the FY 1991 GROUPER and relative weights to the average DRG weight for the same cases using the FY 1990 GROUPER and relative weights. By using the actual FY 1991 cases on both sides of the comparison, all coding changes, whether real or not, are recognized. The analysis is designed to determine how much of the increase in the case-mix index is attributable to the DRG changes and recalibration. The analysis is not designed to determine how much of the observed case-mix change is real and how much is attributable to coding improvements.

Comment: Some commenters objected to our proposal to maintain the average case weight at 1.0 after recalibration. Many commenters urged us never to adopt this procedure. Other commenters agreed that normalizing the recalibrated DRG weights to an average of 1.0 each year and making an accompanying adjustment for real case-mix change in the annual update factor is appropriate, but they do not believe we currently have a method to distinguish real case-mix change from changes in coding practice.

Many of the comments expressed concern that, in an effort to control for changes in coding behavior, we would risk eliminating the effects of real case-mix increase. The commenters state that real case-mix changes are occurring due to shifts from inpatient to outpatient settings for less resource-intensive patients, increasing patient age, and improvements in technology. They believe that recalibrating to 1.0 would introduce a bias against recognizing new medical technologies and practices in DRG classification, particularly those that increase hospital costs.

Among the other recommendations received were suggestions that there

should be a built-in mechanism to reduce standardized amounts in future years to account for any overpayment in past years made as a result of DRG changes. It was suggested that HCFA develop and propose a method for measuring and reflecting real case-mix change in the update factor. This method should measure increases in case complexity within DRGs as well as across DRGs. However, one commenter was concerned that any positive real case-mix allowance HCFA recommended for the update factor would be vulnerable because section 1886(b)(3)(B)(i) of the Act specifies all future update factors applied to the standardized amounts. Legislation would be needed to ensure that the update factor in the law allows an explicit adjustment for real case-mix change.

ProPAC states that the proposal to rebase the case-mix index annually is consistent with the approach ProPAC recommended in its annual discussion of the prospective payment update factor through 1988, but indicated that it could not support such a methodological change unless the update were adjusted to reflect real case-mix change.

Response: As noted above, we will continue to work toward a methodology that will allow us to make the appropriate changes to the DRG classifications without risking an inflationary effect on payments. As a part of this process, we will carefully consider the concerns expressed by the commenters. We recognize that if we were to recalibrate to 1.0 each year, there would need to be an on-going adjustment to the standardized amounts to account for real case-mix change. In our update framework, we reduce the standardized amount for observed case-mix change and increase it for real case-mix chanqe. Our estimate of real case-mix change is based on a study by the Rand Corporation using reabstracted medical records. We would need a mechanism to update the results from that study or an alternative way to determine real-case mix change.

Comment: The suggestion we received most frequently from commenters concerning better methods for estimating coding changes before we make DRG classification changes was that HCFA should conduct a detailed review of individual medical records every year. This review would ensure a more accurate estimate of case weights and would reduce the potential for eliminating changes in real case-mix growth.

Review of patient records from a prior period would provide empirical evidence to determine the extent to which certain diagnoses and procedures are, in fact, present in the Medicare patient records but were not coded either because of lack of space on the bill or because they did not affect DRG assignment. This approach would help ensure that the new DRG weights would be correctly estimated before the reclassified DRGs are implemented and any resulting increase in case mix could be assumed to be attributable to legitimate changes in the types of cases treated by hospitals.

Response: Although the commenters have identified a mechanism to estimate the potential for coding improvement, we are uncertain that a review of patient records as a part of our analysis prior to making DRG classification changes is feasible. The process of collecting and reabstracting from actual medical records is a time-consuming process. We believe that using this method would delay any potential DRG changes while the reabstraction is taking place. It may be more appropriate as a method to determine retroactively how much of observed case-mix increase is attributable to real case-mix increase. This approach was taken by RAND Corporation in its research for HCFA under cooperative agreement 18–C–98489/9–01 to examine changes in case mix between 1981 and 1984. ("The Medicare Case-Mix Index Increase: Medical Practice Changes, Aging, and DRG Creep;" Grace M. Carter, Paul Ginsberg; June 1985.) In either event, reabstracting medical records would improve our ability to predict changes only to the extent that the information is already in the medical record and simply not reported on the bill. It would not help measure the coding changes that will result from improvements in recording information in the medical record in response to our DRG changes.

Comment: The commenters believe that, in the interest of fairness and equity, HCFA should publish the specifications for any new methodology for improved forecasting of coding changes due to reclassified DRGs in a notice of proposed rulemaking so that the hospital community has the opportunity to comment upon its potential effectiveness and feasibility.

Response: As has always been our practice in the past concerning the prospective payment system, we will publish any changes we make in proposed rule format for public comment.

Comment: One commenter asserted that a 1 percent increase in the average case weight does not necessarily translate into a 1 percent increase in Medicare inpatient hospital payments. If a higher proportion of cases classify to relatively higher-weighted DRGs than had previously been the case, and these cases do not generate the same proportion of additional dollars in outlier payments as they do in basic DRG payments, then the aggregate prospective payment system expenditures will rise more slowly than the increase in the average case weight.

Response: We agree with the commenter that the effect of DRG changes in a given year on total program payments should take into account the effect on outlier payments in that year. As discussed below in section V.A of this preamble, we believe that the DRG changes that we made in FY 1991 were largely responsible for the outlier underpayment in that year and the estimated outlier underpayment for FY 1992. However, it is important to note that under our current recalibration methodology, the DRG changes have only a 2-year effect on outlier payments and a permanent effect on total program payments. Outlier payments are re-estimated each year, so that once the effect of the DRG changes is reflected in the MEDPAR file used to estimate outlier payments, any outlier underpayment resulting from those changes ceases. In contrast, the effect of the DRG changes on the case-mix index translates into a permanent increase in total program payments since the increase in the average case weight is built into the DRG relative weights through the normalization process. If we were to recalibrate to an average case weight of 1.0 each year, the DRG changes would have only a 2-year effect on both outlier payments and total payments.

III. 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 relative to 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. Contract labor and nonhospital direct wage 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. Wage Data Used in Determining the Hospital Wage Index for FY 1993

For discharges occurring on or after October 1, 1992, the wage index continues to be based solely on 1988 wage data. In determining the wage index for FY 1993, we incorporated all corrections of errors in the survey wage data that have been processed through August 15, 1992 since the construction of the wage index implemented for FY 1992. The final revised national average hourly wage is $13.9937 compared to $13.9752 used to establish the wage index values that were effective for discharges occurring on or after October 1, 1991.

The wage indexes for FY 1993 are shown in Tables 4a through 4c in the addendum to this final rule.

C. Revisions to the Wage Index Based On Hospital Reclassifications

Under section 1886(d)(8)(B) of the Act, for discharges occurring on or after October 1, 1988, hospitals in certain rural counties adjacent to one or more Metropolitan Statistical Areas (MSAs) are considered to be located in one of the adjacent MSAs if certain standards are met.

Under 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.

In determining the wage index values, the wage data for hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act is combined with the wage data for hospitals that were reclassified to the same MSA 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 wage index value for the redesignated hospitals cannot be reduced below 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 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 final rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. It should be noted that for some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one area are included in the group of redesignated hospitals, and one or more hospitals (usually a rural hospital), receive the Statewide rural wage index value rather than the wage index value otherwise applicable to the redesignated hospitals.

The FY 1993 wage index values incorporate all geographic reclassification decisions that will be effective for FY 1993. The wage index values published in this final rule are different from those proposed in the June 4, 1992 proposed rule as a result of changes in the decisions made by the MGCRB since the publication of the proposed rule that resulted from hospital appeals, discretionary review by the Administrator, withdrawals of reclassification requests, and wage index corrections. The reclassification changes affected not only the wage index values for specific geographic areas, but also whether redesignated hospitals receive the wage index value of the area to which they are redesignated or a combined wage index that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index values for the areas from which the hospitals were redesignated were also affected. A hospital that requested to withdraw its application may not request that the MGCRB decision be reinstated after publication of the prospective payment rates in this final rule.

Comment: Some commenters pointed out that the wage index for urban hospitals remaining in their original wage area is calculated exclusive of the wage data of those hospitals reclassified out of the area and that while most urban areas are protected from having their area wage index fall below the Statewide rural floor, urban areas with wage index values already below the Statewide rural wage index prior to any reclassification are not protected from a further decline in their wage index values. Similarly, in two states, New Jersey and Rhode Island, where there is no Statewide rural wage index, hospitals in these urban areas are also not protected. It was suggested that we provide "hold harmless" protection to urban areas that would preclude their wage index value from falling below their original (prior to any reclassification) wage index. One commenter indicated that our interpretation of the "floor" provision for FY 1993, as reflected in Table 4c, appears to give only reclassified rural

hospitals the benefit of the rural wage index floor. The commenter stated that this interpretation is contrary to the statute, which requires that the floor provision applies to any county whose wage index value falls below the Statewide rural value.

Response: Our rationale for not establishing a new "hold harmless" provision for urban areas whose wage index values are below the statewide rural wage index prior to reclassification and decline as a result of reclassifications is discussed thoroughly in the August 30, 1991 final rule (56 FR 43221). Section 1886(d)(8)(C)(iii) of the Act specifically precludes the reclassification of hospitals under sections 1886(d)(8)(B) and 1886(d)(10) of the Act from resulting in "the reduction of a county's wage index to a level below the wage index for rural areas in the State in which the county is located." The statute establishes a floor that applies only when a hospital's wage index value falls from above the Statewide rural wage index value to below the Statewide rural wage index value.

The statutory requirement of budget neutrality specifically applies only to reclassifications and wage index recomputations that occur as prescribed under statute. The statute is very specific with respect to the treatment of the wage index values for geographic areas from which and to which hospitals have been reclassified. We do not believe it is appropriate to establish a new "hold harmless" rule that would result in a significant change in the scheme constructed by Congress. Therefore, even if the change is warranted, we believe that it should be made through legislation.

With respect to our application of the provisions of section 1886(d)(8)(C)(iii) as reflected in Table 4c, we note that the rural floor applies not only to rural hospitals that were reclassified to an area where the wage index is less than the Statewide rural wage index for the area it came from, but also to urban hospitals whose wage index prior to reclassification is above the Statewide rural wage index value, and after being reclassified falls below the Statewide rural wage index value. The results for any area subject to this floor are incorporated in Table 4c. We note that for FY 1993, there are no urban areas for which the Statewide rural floor applies.

Comment: Two commenters asked that we use "real wage indexes" rather than the wage index calculated after the hospitals have been removed from the MSA as a result of reclassification. We received one comment suggesting that instead of our current practice of inserting the Statewide rural wage index for MSAs that become "empty" as a result of reclassification, it would be more appropriate to use the wage index that the MSA had prior to any reclassifications. In this way, hospitals would be better able to judge whether to withdraw their application for reclassification. The commenter also stated that it would be helpful if we indicated how many hospitals are used to calculate the wage index for each MSA and which MSAs are "empty" because all hospitals were reclassified out of the MSA.

Response: The law is very specific concerning how the wage index values should be calculated as a result of hospital reclassifications. Congress clearly contemplated that reclassified hospitals would not be considered part of their original labor market areas for purposes of computing the wage indexes for those areas. This is evidenced by section 1886(d)(8)(C) of the Act, which provides an exception to this requirement for those rural areas where reclassification of hospitals from those areas would reduce the rural wage index value. Accordingly, we believe the statute is clear that the wage index for each area would be computed exclusive of the data for the hospitals that have been granted reclassification from those areas.

Regarding the use of Statewide rural wage index values for MSAs that no longer have any hospitals as a result of reclassifications, we believe this comment has some merit in that hospitals would have difficulty determining whether to withdraw their applications in cases where the MSA is "empty." Therefore, in future proposed rules, where all the hospitals are tentatively reclassified out of the MSA, we will provide information on the wage index value for that area prior to any reclassifications. We will also indicate which areas no longer contain any hospitals. However, we will continue to assign the Statewide rural wage index value to the "empty" MSA. These values are needed in the event a new hospital or any other hospital that is not represented in the 1988 wage survey data furnishes services to Medicare beneficiaries during the fiscal year. In an empty MSA, all the hospitals that reported wages in 1988 are reclassified, so no hospitals currently exist for wage index purposes. We believe that any new hospital in the MSA should receive the Statewide rural wage index until such time that the new hospital's data is utilized in the calculation of an updated wage index. Since there is no rural Statewide average for New Jersey or Rhode Island, we will assign the wage index value before reclassification to any "empty" MSA in those States.

We see no purpose in publishing the number of hospitals used in calculating each MSA's wage index value. Since the average for each area is hour-weighted, rather than hospital-weighted, each hospital's influence on the area wage index is dependent on the number of hours of employment incurred by that hospital. For purposes of this final rule, the Statewide rural wage index was used for the following MSAs where all hospitals were reclassified from the MSA: Bloomington, IN; Bradenton, FL; Bremerton, WA; Cedar Rapids, IA; Danville, VA; Elkhart-Goshen, IN; Jacksonville, NC; Janesville-Beloit, WI; Lawrence, KS; Lewiston-Auburn, ME; Melbourne-Titusville, FL; New Bedford-Falls River-Attleboro, MA; Niagara Falls, NY; Pine Bluff, AR; Tacoma, WA; Trenton, NJ (pre-reclassification value); York, PA; Yuba City, CA.

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 midyear corrections has resulted in several problems related to the reclassification of hospitals by the MGCRB.

In the June 4, 1991 final rule with comment period concerning 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 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 reduced because of midyear 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 proposed eliminating midyear wage data corrections effective with requests for correction received on or after October 1, 1992. As discussed below, after consideration of all comments received on this issue, we are implementing this provision as proposed.

Under this provision, only those requests for wage data corrections for 1988 calendar year data, that are submitted with supporting documentation and received by the fiscal intermediary no later than September 30, 1992 will be implemented as a midyear wage index change. Changes based on those corrections will be made on a prospective basis in FY 1993 in accordance with our current policy. The specific requirements are as follows:

- A hospital that wishes to make a correction to its reported 1988 calendar year 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 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.

Comment: Several commenters, including some of the major hospital associations, indicated that they believed the sunset provision for submitting midyear wage index corrections based on the 1988 wage survey data is reasonable. There were two commenters who indicated that hospitals should be able to continue to submit corrections and that we should not eliminate midyear corrections. In addition, one of these commenters indicated that we should make retroactive changes to the wage index if a correction results in a revision of 1 percent or more to the area wage index.

Response: A prudent hospital would have ensured that data submitted for the 1988 wage survey was complete and accurate. Since the survey was completed in 1990, we believe that hospitals have had sufficient opportunity to review the wage data, and to submit corrections where appropriate. Moreover, because the wage index data will be updated annually, problems with any data errors will no longer be perpetuated from year to year. Therefore, effective October 1, 1992, fiscal intermediaries will no longer accept any requests for corrections to the 1988 wage survey data. In the near future, we will issue instructions to the intermediaries for reviewing, verifying and submitting completed requests to HCFA. It is our intention that all corrections to the 1988 data be completed on or before January 1, 1993, so that the latest, corrected wage data will be available to the MGCRB when deliberating on geographic reclassification requests effective for FY 1994.

With respect to retroactive corrections to the wage data, it has been our longstanding policy to make any corrections to the wage index on a prospective basis only. Our policy for applying prospective corrections to the wage index was originally set forth in the preamble to the January 3, 1984 final rule (49 FR 258) implementing the prospective payment system and was later codified at § 412.63 as part of the September 4, 1990 final rule (55 FR 36042). Under the policy, if a correction of a data error changes the wage index value for an area, the revised wage index is effective prospectively from the date the data correction is approved. This policy was established so as not to disadvantage hospitals in areas where a wage data error was detected by waiting until the beginning of the next fiscal year to recognize the correction.

Congress has twice visited this issue and has failed to require that we make wage data corrections retroactively. In section 9103 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99–272), Congress eliminated the provision of section 2316 of the Deficit Reduction Act of 1984 (Pub. L. 98–369) that would have required retroactive application of the new HCFA wage index that was implemented May 1, 1986. Congress provided that the revised wage index be applied prospectively, which is consistent with the prospective only rule established in January 1984. Congress again addressed this issue in Pub. L. 101–239. In section 6003(h) (5) of Pub. L. 101–239, Congress did require the Secretary to make retroactive adjustments in the 1984 wage data to account for errors, but only under very limited circumstances. The fact that Congress severely limited the application of this provision, not only with respect to the specific database,

but also with respect to a specific situation using such database, indicates Congressional intent that the provision have no further applicability beyond the situations specified in the statute. We should also point out that when corrections were made in these very limited cases, the hospitals who committed the errors in reporting the original data did not receive any benefit of the retroactive wage index corrections.

Comment: We received a number of comments concerning perceived problems with the wage data currently being collected through the Medicare cost report that will be used to formulate future wage index updates. Specifically, the commenters stated that the instructions for fringe benefit and contracted services should be further defined and clarified. One commenter suggested that contracted labor be expanded to include all contracted services rather than only those directly related to patient care. Also, each commenter on this issue expressed concern that the current survey instrument (the worksheet S–3, Part II of the HCFA–2552) does not allow hospitals to remove wages associated with non-hospital salaries that are included in the overhead of the other cost centers.

Response: These comments do not directly apply to the proposed wage index changes for FY 1993; rather, they address issues related to the calculation and formation of future wage indexes. We have already taken steps to revise the cost reporting instructions accompanying the worksheet S–3, Part II with respect to fringe benefits. This revision will be included in the latest cost report revisions (HCFA 2552–92), which will be effective for cost reporting periods beginning on or after October 1, 1991. The revised instructions will enable hospitals to more accurately determine appropriate fringe benefit costs to be reported for purposes of the wage index calculation.

Regarding the expansion of the contracted services definition to include all contracted services, we continue to believe it is not appropriate to include contract services other than those directly related to patient care for a number of reasons. First, many contracts, especially those that are not for direct patient care services, include items that are not merely labor costs. Frequently, these costs include supplies and equipment that may be provided by the contractor, and thus may not reflect current or local salary trends. Second, it is frequently difficult or impossible to ascertain the appropriate hours associated with the provision of some types of contracted services. Hospitals have consistently indicated problems with accurately determining these hours, especially for services such as contracted housekeeping and laundry. Finally, it is the contracted services such as those associated with nursing and technicians' services that hospitals must incur due to shortages of workers in those skilled areas that have most disadvantaged hospitals by not including these services in the wage index calculation. Since these services are directly related to hands-on patient care, hospitals can more readily maintain accurate records on hours worked in this context than in the case of other contracted services. If we did not limit the nature of contracted services included in the wage data, it is likely that the reliability of the data would be questionable (as in the case of the 1988 survey data) because of problems with accurately reporting contracted labor. Therefore, we believe it is appropriate to limit contract services to those directly related to patient care.

Regarding the exclusion of overhead costs associated with non-hospital services, we are taking measures to allocate overhead salaries to the excluded areas of the hospital. For the FY 1994 wage index update, we will be asking fiscal intermediaries to obtain data with respect to hours worked in the overhead (general service) cost centers and will develop a methodology to allocate overhead salaries to non-hospital cost centers that are excluded from the wage index computation. We note that the revised cost report (HCFA 2552–92) will include an additional line to capture these data in the future.

Comment: One commenter suggested that since we had allowed hospitals in Nebraska to make changes to their current wage survey data to carve out overhead wage costs related to excluded areas such as SNFs, all hospitals should have the same opportunity to revise their wage data.

Response: The premise of the commenter's suggestion is incorrect. No changes were made to any 1988 hospital wage survey data to remove overhead salary costs associated with non-hospital services. We have had several conversations with representatives of Nebraska hospitals on this issue. However, these discussions were related to future updates to the wage data using data submitted on the Medicare cost report (HCFA–2552, worksheet S–3, Part II). Because the data necessary to allocate overhead salaries to the excluded wage areas are not available for all hospitals, we do not believe it would be appropriate to allow individual hospitals to adjust their 1988 survey data to eliminate overhead salaries associated with those excluded areas.

Comment: One commenter indicated that it is very difficult to make corrections to the wage index data reported on the HCFA–2552, worksheet S–3, Part II since the data are transmitted electronically to HCFA using the Hospital Cost Report Information System (HCRIS). The commenter indicated that instructions are needed for fiscal intermediaries that would require them to transmit corrections to the wage survey data through HCRIS on a systematic basis. This would ensure that the most current and updated data are used to construct future wage indexes.

Response: We concur that it is important that fiscal intermediaries react timely to requests from hospitals to submit revisions to the HCFA–2552, worksheet S–3, Part II. Since we intend to update the wage index yearly based on the data reported through HCRIS, we will issue instructions to the fiscal intermediaries directing them to transmit all corrections to the wage form via HCRIS prior to our development of any revised wage index incorporating the cost report data.

Comment: We received one comment suggesting that we include contracted labor in the calculation of the current wage index.

Response: As we indicated in the final rule for FY 1992, the data submitted from hospitals for contracted services were incomplete and plagued with problems. As mentioned earlier, hospitals related numerous problems in determining what contracted services to include and in determining the hours associated with these services. A thorough discussion as to why contracted labor is not included in the current survey was included in the September 4, 1990 final rule (55 FR 36036).

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.

Because of significant delays in obtaining the necessary data from the Bureau of Census, OMB was unable to publish the revised MSA definitions by June 30, 1992, as originally planned. The delay in publication of the new MSA definitions has precluded the implementation of the revised MSAs in this final rule. 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 on a comparable schedule to implementation of the 1980 census data. Therefore, we intend to announce the revised MSAs and describe their effect on the wage index and geographic reclassifications in the FY 1994 proposed rule.

Comment: We received several comments indicating that even though OMB has not yet published the new MSA definitions based on the 1990 census data, we should recognize the new definitions. The commenters believe that the information concerning the revised MSA definitions is currently available and therefore should be used immediately because some hospitals may be adversely affected by the delay in implementation. In addition, we received comments asking that we provide an exception for hospitals in the Niagara Falls, NY and Buffalo, NY MSAs to allow those areas to combine into a singe large MSA on the premise that OMB will recognize those areas as a single MSA once the new definitions are issued. Some commenters stated that it is inappropriate to use the current definitions for MSAs for submitting applications to the MGCRB when new MSA definitions will be in effect when the decisions become effective in FY 1994.

Response: OMB has not yet issued its revised MSA designations based on 1990 census data. Until OMB makes its announcement, definitions are subject to change and are not final. We are aware of potential changes that OMB is considering, but we are required to use the current MSAs until the revised MSA definitions have been officially announced. We note that the Federal Executive Committee on Metropolitan Statistical Areas, which makes recommendations to OMB with respect to the MSA definitions, has not yet completed its deliberations, nor have any recommendations been made to OMB as of this date. It would be inappropriate to recognize some potential changes, while ignoring others, or to make changes based on preliminary information that is subject to change once OMB makes its final announcement. Therefore, as we indicated in the proposed rule, the delay in the publication of the new MSA definitions has precluded the implementation of revised MSAs in the final rule. We intend to announce the revised MSAs and describe their effect on the wage index and geographic reclassifications in the FY 1994 proposed rule.

IV. 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). 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 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 for purposes of their wage index or standardized amount or both. Hospitals may be reclassified as a group for purposes of both their wage index and standardized amount, but not solely for one of these measures.

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. 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 the incorporation of the geographic reclassifications under 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 reclassifications. 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 the reclassifications.

The first reclassification decisions issued by the MGCRB became effective on October 1, 1991 for discharges occurring in FY 1992. The August 30, 1991 final rule (56 FR 43196) setting forth the FY 1992 prospective payment system rules reflected 930 hospital reclassifications approved by the MGCRB and the HCFA Administrator effective for FY 1992. 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.

In the August 30, 1991 final rule (56 FR 43198), we also discussed public comments we had received concerning geographic reclassification issues raised in the June 3, 1991 proposed rule for the prospective payment system (56 FR 25178) and the June 4, 1991 final rule with comment period for the MGCRB (56 FR 25458). Many commenters addressed the impact of geographic reclassification on payment to hospitals. In response to the comments, we stated in the August 30, 1991, rule 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. In addition, we solicited public comments concerning those potential

revisions. We described the public comments we received in response to this request in the June 4, 1992 proposed rule (57 FR 23633).

B. Changes to the Regulations

Thus, as described above, the changes in the reclassification guidelines were formulated after multiple occasions for public comment. They were also based on our analysis of the FY 1992 reclassifications. We also took into account the effects of reclassifications, which, because they must be budget neutral, result in increased payments to one group of hospitals being offset by reduced payments to other groups. In light of this effect, we have an obligation to 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, we determined that a number of issues which have arisen concerning the reclassification guidelines warranted clarification.

Accordingly, as discussed in detail below, we proposed in our June 4, 1992 proposed rule to make several changes to the MGCRB guidelines. After considering all comments received in responses to the proposed rule, we are implementing the following changes to the MGCRB guidelines in this final rule. The changes will not affect reclassifications that will be effective for discharges occurring in FY 1993. However, given the 1-year time lag between the effective date of any changes to the MGCRB regulations and the effect of these changes on hospital reclassifications, we believe it is essential that the following changes be implemented in time to affect applications that will be processed by the MGCRB during FY 1993. Therefore, the new guidelines will be effective for applications submitted by October 1, 1992, for geographic reclassifications effective for discharges in FY 1994.

1. General Guidelines—Reclassifications for Individual Hospitals

a. *Reclassification to a Single Geographic Area (§ 412.230(a)(1)).* We are revising § 412.230(a)(1) to specify that a hospital 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 the area to which it wishes to be reclassified and must indicate that decision in its application.

Comment: One commenter stated that hospitals should not be limited to applying to only one area for both the wage index and the standardized amount. The commenter asserted that because the pattern of hospital expenditures for wages and salaries may be different from the pattern of expenditures for utilities and supplies, it would be appropriate for a hospital to reclassify to one area due to the comparability of labor costs and another area for its nonlabor costs.

Response: The standardized payment amount a hospital receives includes both labor and nonlabor payments. Moreover, more than 71 percent of the hospital's operating costs covered by the standardized amount are labor-related costs. Since payments for labor are reflected in both measures, we do not believe it is appropriate for a hospital to be reclassified to one area for its wage index and a different area for its standardized amount.

In addition, 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. Therefore, we believe that hospitals that meet the general proximity criteria should be reclassified to only one alternative geographic area. For the same reasons, we believe it also is appropriate to provide that sole community hospitals and rural referral centers may be reclassified to only one area using either the special access rule or the proximity rule, but not both.

b. *Individual Urban Hospital Reclassification to a Rural Area (§ 412.230(a)).* 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.

Comment: One commenter did not agree that urban to rural reclassifications should be disallowed. The commenter argued that a small MSA containing one hospital surrounded by rural counties is an example of a situation where an urban hospital would compete with rural hospitals.

Response: Section 1886(d)(8)(C)(i) of the Act, which addresses application of the wage index to reclassified hospitals, specifically references reclassifications of rural hospitals to urban areas and of urban hospitals to other urban areas. However, the statute does not require HCFA to provide for reclassification of urban hospitals to rural areas.

Moreover, we disagree that the situation described by the commenter demonstrates that a hospital should be allowed to reclassify from an urban area to a rural area. We believe the situation of hospitals located in small MSAs surrounded by rural areas is very different from a rural hospital near the border of another state. A lone hospital in an MSA already receives a wage index that is fully reflective of its own wage costs. As such, the hospital is not being unfairly disadvantaged by its wage index.

We recognize that an urban hospital in an MSA surrounded by rural areas may compete with a few rural hospitals in its vicinity. However, the rural labor market area is comprised of all rural hospitals in the State, and would be less representative of the hospital's labor market than an area comprised of hospitals in the same geographic vicinity. In fact, the most common criticism of the rural wage index is that it is an average of all the rural hospitals in a State and may not be representative of the wage costs in different regions of the State. It would be inappropriate to reclassify a hospital from a labor market area based on the data for geographically proximate hospitals to one based on hospitals dispersed throughout the State. This is in contrast to a rural to rural reclassification, which involves reclassification from one broad labor market to another. In that case, a rural hospital near the border of an adjacent State could be more like the hospitals in the next State than in its own State. It is for these reasons that, while not required by the statute, we decided to provide for rural to rural reclassifications and not to provide for urban to rural reclassifications.

c. *Special Access Rule for Rural Referral Centers and Sole Community Hospitals Seeking Reclassification (§ 412.230(a)(4)).* Consistent with the change we are making to § 412.230(a)(1), we are revising the regulations to specify that a sole community hospital or rural referral center may not be redesignated 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.

Comment: One commenter pointed out that under § 412.230(a)(4)(iii), HCFA neglected to recognize that a hospital designated as either a rural referral center or a sole community hospital or both would be allowed to reclassify to the nearest urban area or the nearest rural area.

Response: We have amended the regulations text to reflect the fact that these hospitals may reclassify to the nearest urban area or, if the hospital is closer to another rural area than an urban area, it has the option of requesting reclassification to that rural

area rather than the nearest urban area. Consistent with the guideline that allows rural hospitals to reclassify to another rural area, we believe the same type of reclassification should also be afforded to sole community hospitals and rural referral centers that apply for reclassification under the special access rule. The MGCRB has currently been allowing such reclassifications. However, consistent with the current requirement under the special access rule that the hospital must be reclassified to the nearest urban area, we believe such reclassifications should be allowed only in those situations where the hospital is closer to another rural area than an urban area. In that situation, the hospital would have the option of seeking reclassification to the nearest rural area, or to the nearest urban area.

Comment: One commenter pointed out that some hospitals may be in jeopardy of losing their rural referral center status as a result of triennial reviews that will begin October 1, 1992, if the existing "grandfather" provision for such status is not extended by legislation. Thus, hospitals that previously were able to qualify for reclassification based on the special access rules under § 412.230(a)(4) would no longer be able to do so. However, because of the uncertainty as to whether the grandfather provision will be extended, hospitals that would lose their status, absent grandfathering, may have to apply for reclassification under both the special access rule and the proximity rule. This commenter stated that the MGCRB should determine whether a hospital can qualify under the special access rule based on its status as of the date of the MGCRB's review.

Response: We agree with the commenter and are revising § 412.230(a)(4) to specify that any hospital that qualifies as a rural referral center or sole community hospital as of the date of the MGCRB's review of its application is eligible to request reclassification under the special access rule. This is consistent with current MGCRB policy that the wage data to be considered is the data available at the time of the MGCRB's review. We will provide the MGCRB on an ongoing basis with information on changes in hospital status. Hospitals should anticipate any change in their rural referral center status as a result of triennial reviews and apply for reclassification accordingly. A hospital that is uncertain whether its RRC status will be in effect as of the date of the MGCRB's decision may wish to apply under both the special access and, if it is eligible, proximity guidelines. At the time the MGCRB makes its decision, the hospital's reclassification request will be reviewed under the special access rule, if the hospital has retained its rural referral center status, or the proximity requirements, if the hospital has lost its rural referral center status. We note that any Administrator review of an MGCRB decision in such a case will be based on the hospital's status at the time of the MGCRB's decision.

d. *Guidelines for a Hospital Requesting Reclassification for Wage Index Purposes (§ 412.230(e)).* As proposed in our June 4, 1992 proposed rule, we are revising the wage index guidelines at § 412.230(e) to 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 national 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 provision also replaces 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 must 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 are adopting this change as an additional standard for wage index reclassifications. Thus, the revised wage index guidelines at § 412.230(e) will now specify that a hospital can be reclassified only if its average hourly wage is at 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).

We have included in section V of the addendum to this final rule new Tables 4d and 4e, which list the inflated average hourly wage for each labor market area before any geographic reclassifications. These tables can be used to make the average hourly wage comparisons for purposes of filing a wage index reclassification request. We note that the average hourly wages are subject to change once the final corrections to the 1988 wage data have been processed (see wage index discussion in section III of this document) and that the MGCRB will rely on the latest corrected wage data available at the time of its decision. As we indicated in the proposed rule, the hospital-specific data supplied to hospitals by HCFA during the application process already reflect the average hourly wage for the hospital's own labor market area. In addition, we are publishing the average hourly wage for each labor market area in Tables 4d and 4e. Therefore, we do not believe it is necessary to provide by rule an automatic extension for perfecting applications for FY 1994 reclassifications. However, we note that under § 412.256(c)(2), the MGCRB may, for good cause, grant a hospital that has submitted an application by October 1, an extension beyond October 1 to complete its application.

We received over 350 comments on the proposed change to the guidelines on reclassification for purposes of the wage index. These comments and our responses are presented below.

Comment: In general, hospitals located in large urban areas that have not benefited from geographic reclassification expressed strong support for the revised guideline that requires that, to be reclassified, a hospital's average hourly wage must be at least 108 percent of the average hourly wage of hospitals in the geographic area in which the hospital is located. They believe that the intent of the original legislation was to adjust payment levels in those special cases where a national payment rule could not appropriately address local circumstances. They stated that the original guidelines were too liberal to ensure that all qualifying hospitals were truly disadvantaged by their current geographic classification. As a result, the guidelines had an overly adverse impact on urban hospitals through the required reduction in the urban standardized amount to offset the cost of increased payments to reclassified hospitals. In addition, ProPAC supported the change stating that the "Commission believes the Secretary's solution strikes a reasonable balance between the need to provide relief to hospitals disadvantaged by their current geographic classification and the need to avoid inappropriate reclassifications."

In contrast, most of the commenters who strongly opposed the new

guidelines represent hospitals that are currently reclassified for purposes of the wage index. They believe that the 108 percent guideline is contrary to Congressional intent. Specifically, these commenters believe that neither the statutory requirements under section 1886(d)(10)(D) of the Act nor any other legislative directive indicates that Congress intended to limit the number of reclassified hospitals or contemplated the comparison of a hospital's wages to the average hourly wages in the area in which it is located. The commenters stated that the proposed guideline added a new factor to those that Congress intended that we consider. They expressed the opinion that the new guideline also reflected a change in focus from the previous MGCRB regulations, citing a recent court decision's affirmation of the proximity requirements based, in part, on the court's assessment that those requirements were consistent with the goal of the reclassification process "to adequately compensate hospitals that face increased costs due to competition with hospitals in geographic areas reimbursed at higher rates under the Medicare system." *Universal Health Services of McAllen, Inc.* v. *Sullivan,* 770 F. Supp. 704, 714 (D.D.C. 1991). The commenters believe the new threshold is an unreasonable obstacle to achieving this goal. Finally, many commenters expressed their belief that the new guideline was "arbitrary" and "outcome-oriented," that is, that HCFA selected the 108 percent threshold merely to achieve a satisfactory number of reclassifications. One commenter stated that this is evidenced by our failure to provide a similar guideline for the standardized amount since such a guideline would not affect as many hospitals.

Response: It is important to note from the outset that the Secretary's obligations under the prospective payment system extend beyond the implementation of section 1886(d)(10) of the Act. Specifically, under section 1886(d)(8)(D) of the Act, the Secretary is required to make a proportional adjustment in the standardized amounts for hospitals located in an urban area to assure that the provisions of sections 1886(d)(8) (B) and (C) or decisions issued pursuant to the MGCRB guidelines do not result in aggregate payments under the prospective payment system that are greater or less than those that would otherwise be made. The Secretary's obligation to effectuate this provision, commonly referred to as the "budget neutrality" provision, in a responsible manner is no less important than his duty to publish reclassification guidelines which are consistent with the purpose of section 1886(d)(10). In other words, the Secretary is equally responsible for assuring that hospitals meriting reclassification are afforded proper consideration and for protecting other hospitals against any effects of the budget neutrality adjustment which may result from inappropriate reclassifications. In recognition of both duties, the Secretary has repeatedly solicited public comment on the reclassification guidelines and has examined the results of reclassification to ensure that his guidelines are accomplishing their intended purpose. We believe that the inclusion of the 108 percent threshold in the guidelines fulfills this dual responsibility. It provides a reasonable standard for measuring one of the factors which should be considered to achieve appropriate reclassifications, i.e., how a hospital's own wage level compares to the wage level reflected in the wage index value for its current area.

Some commenters stated that the implementation of the new wage index guideline is contrary to the authority given the Secretary under the statute or contrary to legislative intent. We disagree. The Secretary has been given broad authority under the statute to determine the factors which should be considered in adjudicating applications for reclassification under section 1886(d)(10) of the Act. Section 1886(d)(10)(D)(i) provides that:

> The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:
>
> (I) Guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.
>
> (II) Guidelines for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area.
>
> (III) Guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services by medicare beneficiaries.
>
> (IV) Guidelines for considering the appropriateness of the criteria used to define New England County Metropolitan Areas.

A guideline that compares a hospital's wages to the wage level in its own area does not create a standard inconsistent with any of the four factors the Secretary has been directed to include in his guidelines. Moreover, a plain reading of the statute reveals that Congress did not intend to limit the guidelines to the four factors listed in section 1886(d)(10)(D)(i). In fact, the use of the word "include" indicates Congress' grant of authority to issue guidelines in addition to those expressly mentioned by the Act. In addition, nothing in that section or other relevant portions of the Act restricts the Secretary's authority to amend his initial guidelines for future application periods in consideration of additional factors.

There is nothing in the legislative history that indicates either that Congress intended the guidelines to be static or that suggests that promulgation of the 108 percent guideline is contrary to Congressional intent. In fact, the commenters have not pointed to any portion of the legislative history of section 6003(h)(1) of Public Law 101-239, the original legislation that created the MGCRB process, that contradicts the Secretary's authority to promulgate a threshold that compares the hospital's wage level to that of the area where it is located.

Moreover, although it included a number of revisions to section 1886(d)(10) of the Act, section 4002(h) of Public Law 101-508 did not change any of the reclassification criteria which the Secretary had published in September 6, 1990 interim final rule. We agree that this indicated that Congress generally endorsed the approach that the Secretary had outlined in his September 6, 1990 guidelines. However, section 4002(h) did not restrict the Secretary's authority to consider other factors or to further refine the reclassification guidelines at a later date.

However, some commenters have pointed to certain language in the Conference Committee report accompanying Public Law 101-508 to support their contention that we are adding a factor which Congress did not intend for us to consider. Specifically, they assert that the fact that Congress recommended a lower criterion for reclassification for purposes of the wage index is evidence that Congress would not now support this new guideline. We do not believe that the legislative history supports this contention.

The Conference Report which accompanied Public Law 101-508 reflects Congress' acknowledgement that the Secretary has the ultimate authority, absent explicit Congressional direction to the contrary, to assess the completeness and effectiveness of his guidelines and to make appropriate changes for future application periods. This conclusion is reflected in the manner in which Congress identified two areas of the original guidelines which it believed that the Secretary

should reconsider, i.e., group applications and the numeric threshold for the wage index guideline. With respect to group applications, the conferees stated that they believed that the omission in the September 6, 1990 interim final rule, of guidelines for urban hospitals to seek reclassification as a group was contrary to the intent of Congress and "should be rectified at the earliest possible date."

In the second area, concerning numeric guidelines, the report concluded:

> The conferees are also concerned that the thresholds for consideration of applications by the board may be set too high and would urge the Secretary to consider changing them. In particular, the Committee is concerned that the 85 percent criterion for average hourly wages is too high and that the Secretary should consider a threshold of 70 percent for this purpose."
>
> (H.R. Rep. No. 964, 101st Cong., 2nd Sess. 715 (1990))

It is axiomatic that Congress could have enacted both suggested changes by adding them to the legislation. Instead, it left any necessary rectification of the problems identified and the timing of the changes to the Secretary. Moreover, it left the ultimate evaluation of the appropriateness of the 85 percent threshold to the Secretary. Accordingly, we believe that the report establishes that Congress itself is aware that it has given broad authority to the Secretary to determine which guidelines are appropriate and to make corrective changes as necessary.

The Conference Committee report in no way suggests that the Secretary does not have the authority to continue to assess the effectiveness of the current guidelines or to promulgate the specific guideline at issue here. We also note that when the conferees issued their report, no reclassification applications had been adjudicated. Accordingly, the conferees concern that the 85 percent threshold might be too high was expressed before results of the original guidelines were available.

We also believe that the revisions to the wage index guidelines provided in this final rule are consistent with our previous assessment of the purpose of the statute. In our June 4, 1991 final rule with comment period we stated, in part, that we believe "that the geographic reclassifications should be limited to those hospitals which are disadvantaged by their current geographic classification because they compete with the hospitals that are located in the geographic area to which they seek to be reclassified." (56 FR 25469). We also stated in the same section of the final rule that:

> We believe that section 1886(d)(10) of the Act addresses those situations where a hospital competes in the same market with hospitals in an adjacent area; that is the hospital is more like the hospitals in an adjacent area than the hospitals in its geographic area. (56 FR 25469)

Both statements reflect our concern that a hospital that is not disadvantaged by its current classification should not be reclassified. In addition, the first indicates that in setting the 85 percent guideline we were establishing a minimum standard; no hospitals which did not compete with hospitals in another geographic area should be reclassified. The first statement also reflects our belief at that time that providing a guideline that provided an appropriate comparison of a hospital's wages to those of hospitals in the area to which it requested reclassification would be sufficient to achieve those goals.

However, from the outset, we have been concerned about the appropriateness of the guidelines. In issuing the September 6, 1990 interim final rule, we noted that we did not have the necessary data to estimate the impact on hospitals and that it was possible the provisions could create effects that were unintended or costly. We specifically requested comments on the reclassification criteria (55 FR 36765). However, the comments received on the interim final rule, which we responded to in the June 4, 1991 final rule with comment, were received before data were available on the impact of the guidelines. We also announced in the June 4, 1991 final rule with comment (56 FR 25470), and repeated in the August 30, 1991 final rule (56 FR 43202), that we planned to evaluate the extent and appropriateness of reclassifications under the original criteria and, if necessary, propose revisions to the guidelines for future application cycles. Thus, we recognized that the original guidelines may not have been sufficient to ensure appropriate reclassifications, and we have made public our intention to refine the criteria if they resulted in reclassifications inconsistent with the goal of the reclassification process.

Thus, we believe that we have not only the statutory authority but also an obligation to evaluate the reclassification criteria based on the latest available data and to refine them as necessary. The new reclassification guideline is "outcome-oriented" only in the sense that it is aimed at ensuring the overall fairness of the prospective payment system for all affected hospitals. The 108 percent threshold was not an arbitrary figure selected in order to achieve a preconceived number of reclassifications that HCFA deemed satisfactory. Rather, the 108 percent threshold is consistent with our view that, in order to qualify for reclassification, a hospital's wage level should be out-of-line with the level reflected in its current wage index and comparable with the average for the area to which it requests reclassification.

The 108 percent standard we are adopting is based on our analysis of hospitals reclassified for the wage index by the MGCRB in its first year of operation. Our analysis demonstrates 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. Our analysis indicates that hospitals may be reclassified under the current wage guidelines even though, as evidenced by the relationship between their average hourly wages and the wage index value for the area in which they are located, they may not be significantly disadvantaged by remaining in their original labor market area. Our goal is not to achieve a targeted number of reclassifications but instead to insure that hospitals which are reclassified are both significantly disadvantaged by their original labor market area, and similar to the area into which they are reclassified.

Comment: Several commenters stated that the statistical methods for determining the 108 percent threshold are unreasonable and based on potentially inaccurate assumptions. They believe that it is not appropriate to apply a national average standard to individual labor market areas. A few commenters suggested that we use area-specific standard deviations.

Response: These comments address two related, but different issues. The first issue is whether the qualifying standard should be national or area-specific, and the second is how the standard should be established statistically. Regarding the first issue, we believe that, since the geographic reclassification process is applied on a national basis, it is appropriate to develop a standard that can be applied to all hospitals in a consistent and uniform manner. A national standard based on the average variation in wages across all areas meets this objective; area-specific standards do not. The use of area-specific standards would mean that a hospital whose wages are only 3 percent higher than its area average

may qualify for reclassification, while a hospital in a different area whose wages are 10 percent higher than its area average may not qualify. Thus, we believe that a uniform national standard is required to avoid inequities across areas that would necessarily arise if area-specific standards were used.

Second, we developed the national standard threshold using the standard deviation, across all wage areas, of the ratio of a hospital's hourly wage to the average hourly wage for its area. The standard deviation depends in part on the number of hospitals used in its calculation. Area-specific standards would be much more sensitive to differences in the number of hospitals across labor market areas than is the national standard. We want to minimize the effect of variation across areas in the number of hospitals because it should not be a factor that influences the criteria for whether a hospital qualifies for reclassification. We believe that the national standard deviation addresses this issue appropriately.

In summary, in devising the national standard threshold, we wanted a threshold based on relevant data, that was not arbitrarily selected, and that could be applied uniformly to hospitals across all wage areas. The standard deviation, across all wage areas, of the ratio of a hospital's hourly wage to the average hourly wage for its area meets all of these objectives. It is based on data that compares a hospital's own wage level to the average for its area. To determine the actual threshold in a non-arbitrary manner, we used the standard deviation as a reasonable measure of divergence between a hospital's own wage level and the average for its area. Finally, we based the threshold on national data from all wage areas because we wanted a standard that could be applied uniformly to all hospitals. The use of the standard deviation, as well as the choice of the mean plus one standard deviation for the threshold, are based on the considerations described above and not on the basis of statistical inference.

Comment: Many commenters suggested that the hospital's own wages be excluded from the area average for purposes of making the 108 percent comparison. One statistician took issue with our methodology, stating "that comparing an individual measurement with summary statistics computed with that measurement deleted from the data set is more appropriate for determining whether it is out of line." Some commenters suggested that the 108 percent standard was inappropriate for single hospital MSAs because it would be impossible for the hospital to have an hourly wage that was 108 percent of itself.

Response: The purpose of the reclassification guidelines is to address only those situations in which a hospital is clearly disadvantaged by its wage index value under the existing labor market definitions. The 108 percent threshold is used to determine whether the average hourly wage that is used in calculating the wage index adjustment with which the hospital is currently being paid adequately represents the hospital's wage costs. Since that hospital's wages are included in the determination of the area wage index, it is appropriate that its wages be included in the area average in order to make a valid determination of whether the hospital is disadvantaged by its current wage index adjustment. Moreover, in establishing the 108 percent threshold, the comparison is not intended to measure whether a hospital's wage data are out of line with the wage data of other hospitals in the labor market area; instead, the comparison is intended to measure whether the hospital's wages are out of line with the wage level used to set the wage index for the hospital's labor market area. Therefore, the wages for the hospital requesting reclassification must be included in its labor market area when applying the 108 percent wage test.

With respect to single hospital MSAs, a hospital in such an MSA receives a wage index value that is based entirely on its own wage data and, therefore, its actual wage levels. Since such a hospital is clearly not disadvantaged by its inclusion in a labor market area where its wage index is determined based on its own wage levels, it is appropriate under this guideline that a hospital should not be reclassified if it is the only one in its area.

However, we note that a hospital that is the only hospital in its county may qualify for reclassification under the guidelines applicable to hospital groups. Since the guidelines for group appeals are based on demographic criteria as opposed to individual hospital guidelines, hospitals applying as a group are not required to meet the wage comparison to its own labor market area.

Comment: A commenter believes that the standard deviation should be taken to four decimal places (or, in percentage terms, two decimal places) in order to replicate the number of decimal places used in the wage index values.

Response: We do not believe that it is appropriate to use four decimal places in the standard deviation (and the mean to which it is added in order to develop the 108 percent guideline). We believe it is appropriate to use four decimal places in the wage index but not in the standard deviation because the wage index values are used for specific payment purposes to individual labor market areas whereas the standard deviation is a threshold applied to all areas. We also note that the standard deviation is 12.47 percent, and the mean is 96.04 percent; therefore, taking the values to four decimal places would only increase the standard from 108 percent to 108.51 percent. Any numerical standard will necessarily result in some hospitals just qualifying and others just missing qualification, regardless of the number of decimal points used.

Comment: Several commenters suggested using different numerical standards than 108 percent, with many suggesting using 100 percent of the original labor market area as the threshold. Another commenter suggested deleting the requirement that a hospital pay wages that are at least 108 percent of its original labor market area and instead requiring that a hospital must pay wages that are at least 100 percent of the area to which it requests reclassification.

Response: As discussed in the June 4, 1992 proposed rule (55 FR 23635), before proposing the 108 percent standard for the hospital's original labor market area, and the 84 percent standard for the area to which the hospital requests reclassification, we examined two other options. One of these options was to adopt a 100 percent standard for the hospital's original labor market area. We rejected this option because we believe that a hospital that receives a wage index adjustment based on 100 percent of its own wages is not significantly disadvantaged by its current classification. While the wage index value for those hospitals that pay more than 100 percent, but less than 108 percent, of the average wage levels of their original labor market area, does not fully represent their actual wages, our analysis indicates that these hospitals incur wage costs within the normal range of wage variation within a labor market area. Since the wage index value is based on average wages in an area, it is expected that some hospitals necessarily will have wages above the average but still within the normal range. We have defined the normal range as within one national standard deviation of the average hourly wage. We believe that the new criterion is necessary to ensure that only those hospitals disadvantaged by their current labor market area are reclassified.

Increasing the threshold for the comparison with the area to which a hospital is seeking reclassification and eliminating the comparison with the hospital's own labor market area does not achieve this goal.

Comment: A few commenters objected to the 108 percent guideline because they believe that it rewards inefficient hospitals that have not held their labor costs down. They believe that the new guideline will encourage hospitals that are close to the threshold to increase their labor costs in order to qualify for reclassification.

Response: The 108 percent threshold is not designed to reward inefficient hospitals, but rather to ensure that a significant difference in wages exists before reclassification is permitted. Because of the time lag between the data used to determine reclassification and the benefits of receiving reclassification, we do not believe that hospitals will raise their wages in order to qualify for reclassification. For example, we anticipate using 1990 cost report data to construct the wage index for FY 1994.

Comment: A number of commenters stated that the new wage index criterion applicable to individual wage index reclassifications should also be applied to group applications for reclassification.

Response: We did not propose applying the new wage criterion to group appeals because these applications involve the reclassification of all hospitals in a county to an alternative urban area. Since group applications are based on the interrelationship of geographic areas rather than the relationship of an individual hospital to a given labor market area, all hospitals in the area receive reclassification for all payment purposes, not just the wage index. This is similar to reclassifications provided under section 1886(d)(8)(B) of the Act where hospitals located in a rural county that meets certain specific geographic requirements are deemed urban and receive the urban standardized amount as well as the urban wage index.

For example, the requirements for rural to urban group reclassifications are that the county in which the hospitals are located must be adjacent to the area to which they seek reclassification; must comply with certain MSA guidelines related to commuting and population; and must demonstrate that, as a group, the hospitals pay wages that are at least 85 percent of the average for the area to which they request redesignation. Guidelines for urban to large urban group reclassifications have similar geographic and wage requirements with an additional standardized amount guideline.

Since group applications are primarily based on commuting and population requirements that apply to an entire area as opposed to individual hospitals in an area, and hospitals are reclassified for all prospective payment system purposes, we do not believe hospitals in a group appeal should be required to meet an additional criterion related to their current labor market area. The wage index criterion and, in the case of urban to urban group applications, the standardized amount criterion are intended to demonstrate that in addition to the county's geographic connection to the adjacent urban area, the hospitals in the county are also similar economically to hospitals in the adjacent urban area both in terms of its average wage levels and overall average hospital costs per discharge. Therefore, we are maintaining without modification the wage criterion for hospitals applying for reclassification as a group (that is, that the average hourly wage for the group must be at least 85 percent of the average for the area to which they are seeking reclassification). However, given the demographic nature of the group reclassification guidelines, we will review the appropriateness of those guidelines in light of any refined labor market area definitions that may be adopted in the future.

Comment: A number of commenters stated that the use of the 108 percent threshold without consideration of occupational mix is contrary to section 1886(d)(10)(D)(i)(I) of the Act, which states that the guidelines established by the Secretary shall include "guidelines for comparing wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified." These commenters believe that the language in the statute clearly precludes any wage comparison unless an occupational mix adjustment is also provided. The commenters believe that either the 108 percent threshold should be deleted or an occupational mix adjustment should be permitted when comparing the hospital with its own labor market area.

Response: We do not believe that the statute requires that any wage comparison included in the guidelines would be limited to those that include an occupational mix adjustment. Rather, we believe that Congress intended that, in devising the guidelines, the Secretary would consider taking into account a hospital's occupational mix, where appropriate. Further, we do not believe the statute precludes comparisons using the average hourly wage costs that are actually used to develop the wage index.

Consistent with our interpretation of Congressional intent, the initial guidelines for individual hospital reclassifications for purposes of the wage index provided for two bases of comparison: one on the basis of the hospital's average hourly wage cost and the other on the basis of the prices that the hospital pays for its labor. Recognizing that the variation in average hourly wages is greater than price level variation because of occupational mix differences, we set the threshold for a hospital that wishes to be compared on the basis of labor prices at a higher level than the threshold for a hospital that wishes to be compared on the basis of its average hourly wage. We set the threshold for the labor price comparison at 90 percent since we would expect the hospital to pay a comparable price for labor as hospitals in the area to which it is requesting reclassification.

Based on public comment, we have carefully considered the issue of whether the wage comparison with the hospitals in the original market area should also include an occupational mix adjustment. We believe that, if we were to institute such a provision, any hospital that requests reclassification based on an occupational mix adjustment in one labor market area should base its request on occupational mix adjustments for both labor market areas. For example, we considered whether to provide that a hospital electing the labor price comparison would be reclassified if its occupational-mix adjusted average hourly wage were at least 114 percent of the average hourly wage for its original labor market area and at least 90 percent of the average hourly wage for the area to which it requests reclassification. This provides the same 2 standard deviation band as for the labor cost comparison, since the range is 0.5 standard deviations below the mean to 1.5 standard deviations above. Just as is the case with the 90 percent threshold, we believe a more stringent threshold would be appropriate for a labor price comparison with the hospitals in the original labor market area because the occupational-mix adjusted average wage, which reflects only price differences, is being compared to an average hourly wage that reflects both price and occupational mix differences.

However, we have concluded that requiring an occupational mix adjustment to the wage comparison for a hospital that has elected the labor price comparison with the hospitals in

the area to which it seeks reclassification would not be appropriate because it would result in consequences that are contrary to the intent of the guideline.

Because a hospital's average hourly wage is a function of the mix of labor that it employs and the price it pays for that labor, two hospitals may have the same average hourly wage but one may have a more expensive occupational mix while the other may face higher price levels. Within the same labor market area, the hospitals with higher than average hourly wages tend to have the more expensive occupational mix. The effect of an occupational mix adjustment is to reduce the average hourly wage for hospitals with a more expensive skill mix and to increase the average hourly wage of hospitals that have a less expensive occupational mix.

The 90 percent threshold allows a hospital to qualify for reclassification that has a lower occupational mix than the hospitals in the area to which it is requesting reclassification. Although a hospital requesting reclassification based on a labor price comparison would have a lower occupational mix than the hospitals in the area to which it is requesting reclassification, the hospital would not necessarily have a lower occupational mix than the hospitals in the area in which it is located. If an occupational mix adjustment were applied in making the wage comparison for purposes of the 108 percent threshold, a hospital that is significantly disadvantaged by the wage index for its area because of factors that include a higher occupational mix, may no longer qualify. Instead, a hospital with a lower occupational mix whose average hourly wage is within the normal range of wage variation within a labor market area may qualify.

The following example illustrates this in greater detail. Hospital A and Hospital B both have average hourly wages of $11.95, but they have different occupational mixes and wage rates. Both are currently located in area X, which has an average hourly wage of $11.04. Both seek reclassification to MSA Y, which has an average hourly wage of $14.42. Since 84 percent of $14.42 is $12.1128, both hospitals must use the occupational mix guidelines to reclassify for wage index purposes. The occupational mix and wage rates of the hospitals are illustrated below:

Employment category	Hospital A		Hospital B	
	Occupational mix (percent)	Wage rate	Occupational mix (percent)	Wage rate
Administration	5	$32.00	2	$50.00
Registered nurses	30	18.00	8	25.63
LPNs and therapists	30	10.00	30	15.00
Clerical	15	5.00	20	8.00
Other	20	6.00	40	7.00

The wages of the two hospitals, adjusted to the occupational mix of MSA Y, are as follows:

Employment category	Hospital A					Hospital B				
	MSA occ. mix (percent)	×	Hospital wage rate	=		MSA occ. mix (percent)	×	Hospital wage rate	=	
Administration	7	×	$32.00	=	$2.24	7	×	$50.00	=	$3.50
Registered nurses	35	×	18.00	=	6.30	35	×	25.63	=	8.97
LPNs and therapists	40	×	10.00	=	4.00	40	×	15.00	=	6.00
Clerical	8	×	5.00	=	0.40	8	×	8.00	=	0.64
Other	10	×	6.00	=	0.60	10	×	7.00	=	0.70
Total					$13.54					$19.81

Since 90 percent of MSA Y's average hourly wage is $12.98, both hospitals satisfy the 90 percent threshold for reclassification to MSA Y for wage index purposes. One hundred eight percent of the average hourly wage for area X is $11.9232. Both hospitals would therefore qualify to be reclassified for wage index purposes to MSA Y. If, however, we added the requirement that any hospital that uses occupational mix to qualify for reclassification to a new labor market area also must use occupational mix to prove that its wages are significantly different from its original labor market area, only hospital B would qualify:

Employment category	Hospital A					Hospital B				
	Area X occ. mix (percent)	×	Hospital wage rate	=		Area X occ. mix (percent)	×	Hospital wage rate	=	
Administration	4	×	$32.00	=	$1.28	4	×	$50.00	=	$2.00
Registered nurses	16	×	18.00	=	2.88	16	×	25.63	=	4.10
LPNs and therapists	40	×	10.00	=	4.00	40	×	15.00	=	6.00
Clerical	15	×	5.00	=	0.75	15	×	8.00	=	1.20
Other	25	×	6.00	=	1.50	25	×	7.00	=	1.75

Employment category	Hospital A				Hospital B			
	Area X occ. mix (percent)	×	Hospital wage rate	=	Area X occ. mix (percent)	×	Hospital wage rate	=
Total				$10.41				$15.05

Since 114 percent of the Area X's average hourly wage is $12.5856, only Hospital B would qualify. As a result, two hospitals in the same labor market area with the same average hourly wage would be treated differently under an occupational mix guideline for the home labor market area average hourly wage.

We believe it is more important for the hospital that is significantly disadvantaged by its wage index to qualify for reclassification than one that is not. The hospital with the less expensive labor mix is already receiving, through its wage index value, the benefit of being included with hospitals that have average wages that reflect a higher skill mix of employees. We concluded that an occupational mix adjustment would be counter to the purpose of the guideline, which is to identify those hospitals that are significantly disadvantaged by their wage index value. Therefore, we have decided not to add an occupational mix adjustment to the threshold for a hospital that has elected a labor price comparison with the hospitals in the area to which it requests reclassification.

Comment: Several commenters addressed the impact of the budget neutrality adjustment. Some commenters suggested limiting the impact of the budget neutrality adjustment on urban hospitals by obtaining additional funding from Congress to pay for the reclassifications. Other commenters suggested limiting the budget neutrality adjustment to the MSAs directly involved in urban to urban reclassifications, and computing the budget neutrality adjustment on a State-by-State basis.

Response: While we share the commenters' concern about the impact of the budget neutrality adjustment on urban hospitals, we do not agree that the reclassifications granted by the MGCRB require additional funds. Each year Congress establishes an update to the standardized amount to Health Subcommittee voted to approve the revised guidelines in H.R. 5502, the Health Care Cost Reduction and Reform Act of 1992, which would institute the new guidelines for FY 1993.

Response: Absent final legislative action and Congressional grant of authority, we may not make retroactive changes to the MGCRB regulations. Moreover, absent Congressional direction to make a retroactive change, we do not believe that it would be appropriate in this instance to apply the new threshold retroactively. FY 1993 reclassifications have been duly granted by the MGCRB based on guidelines in effect at the time decisions were made and therefore should be implemented.

Comment: Some commenters suggested a 2-year phase-in of the new wage guideline.

Response: The commenters did not explain what they intended by a 2-year phase-in. One type of phase-in would be to spread the payment redistribution effect of the reclassification change over 2 years. We do not believe we have authority to provide for this type of phase-in because hospital payments are based on geographic location. Unless a hospital receives reclassification to another area, we do not have the authority to provide additional payments to non-reclassified hospitals.

Another type of phase-in would be to move from a 100 percent threshold in the first year to a 108 percent threshold in the next. However, this would not phase in the redistribution effect for a reclassified hospital since it would allow one group of hospitals to continue to be inappropriately reclassified for an additional year and not allow other hospitals to do so. In our view, a hospital is either appropriately reclassified or it is not, and payment should be made accordingly. It would not be appropriate to provide additional payments to hospitals that are inappropriately reclassified through the reduced payments to urban hospitals. Moreover, since the new guideline will not affect hospital payments until FY 1994, we believe the delayed implementation date is sufficient to allow hospitals to adapt to the change.

Comment: Some commenters suggested that instead of instituting the 108 percent wage test, we should simply limit the number of hospitals eligible for reclassification by restricting the program to rural hospitals or by allowing urban hospitals to reclassify for wage index purposes only. Other commenters suggested giving special consideration to certain types of hospitals such as rural hospitals with over 225 beds One hospital suggested "grandfathering in" hospitals already reclassified and applying the new threshold only to new applications. One commenter suggested that we limit reclassifications only to those hospitals where the payment effect was greater than 3 percent.

Response: Under the statute, we do not have the authority to deny both wage index and standardized amount reclassifications to any prospective payment system hospital because of its location if it otherwise meets the required guidelines. Section 1886(d)(10)(C)(i) of the Act requires that the MGCRB consider the application of any prospective payment hospital that requests that the Secretary change the hospital's geographic classification for purposes of determining the hospital's standardized amount or wage index. Therefore, an urban hospital should not be limited to reclassification for its wage index only.

We do not believe it is appropriate to institute special wage guidelines for certain classes of hospitals, such as large capacity rural hospitals, nor to limit the types of hospitals that can be reclassified. Further, it would be inappropriate to "grandfather" hospitals that cannot meet the revised guideline. The statute is clear in the requirement that reclassifications are for a period of 1 year, and there is no implication that reclassification would be permanent. Moreover, as discussed above, we announced in previous **Federal Register** documents that we intended to reevaluate the reclassification guidelines and revise them if necessary. Accordingly, we believe it would be unfair to use two different standards for reclassification decisions, depending upon whether a hospital applied in a prior year. To do so would conflict with the purpose of the MGCRB provisions by allowing some hospitals to be reclassified even though they are not significantly disadvantaged by their current wage index.

Comment: Some commenters believe that the proposed 108 percent standard does not reflect the statutory directive to develop guidelines for considering information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services to

Medicare beneficiaries. The commenters maintained that Congress intended that the special access provision result in special consideration for rural referral centers and sole community hospitals, which the 108 percent standard does not provide.

Other commenters recommended that sole community hospitals and rural referral centers be exempt from the 108 percent standard because they must compete with metropolitan hospitals for labor, or alternatively, that they should be subject to a wage threshold of 100 percent rather than 108 percent.

Response: Section 1886(d)(10)(i)(III) of the Act requires that the guidelines include criteria for considering information provided by a hospital with respect to the effect the hospital's geographic classification has on access to inpatient hospital services for Medicare beneficiaries. In drafting the MGCRB guidelines, we gave special consideration to sole community hospitals and rural referral centers with respect to the issue of access to inpatient hospital services for Medicare beneficiaries by waiving the proximity and adjacency requirements for those hospitals. As we stated in our September 6, 1990 interim final rule (55 FR 36762), we believe that the intent of this provision is to ensure continued access to care where a hospital is the sole source of inpatient hospital care or is the only provider of needed tertiary services in rural areas.

We believe that by waiving the proximity and adjacency test for sole community hospitals and rural referral centers we have complied with the directive in the statute to recognize the issue of maintaining access to patient care that these types of hospitals provide. The current access provisions recognize that these types of hospitals, because of their locations in isolated rural areas, may have wages and costs more similar to hospitals in urban areas. Therefore, because of the need to maintain access to inpatient care in those areas, we do not require these hospitals to meet the proximity guidelines. We do not, however, believe it would be appropriate to provide a lower wage standard for sole community hospitals and rural referral centers than for other hospitals applying for reclassification. The issue of whether a hospital is disadvantaged by its current labor market area is equally relevant to sole community hospitals and rural referral centers as it is to other types of hospitals. If a hospital does not pay wages that are out of line with its original labor market area, it is not disadvantaged by its current wage index value. We see no justification for providing a different threshold for sole community hospitals and rural referral center with respect to the 108 percent comparison. As is the case with the other thresholds applicable to both wage index and standardized amount reclassifications, we believe the 108 percent threshold should be applied consistently to all hospitals.

We remind hospitals that voluntarily terminated their sole community hospital status in favor of geographic reclassification and that anticipate losing that status as of the start of the next or any Federal fiscal year (that is, October 1) that they must reapply for sole community status under the provision of § 412.92(b)(4). Although § 412.92(b)(4)(iii)(A) states that at least one full year must have passed between the effective date of cancellation of sole community status and any future reclassification to that status, we note that all the affected hospitals will meet this criterion as of the date they lose their geographic reclassification. However, § 412.92(b)(2) provides that sole community status is effective 30 days after the date of HCFA written approval. To avoid any loss in special payment status, we encourage hospitals in this situation to reapply for sole community status 3 months prior to the date they anticipate losing geographic reclassification (that is, July 1 of the applicable year). Assuming that a hospital requalifies as a sole community hospital under the current criteria at § 412.92(a), the HCFA regional office will approve the hospital's request effective October 1 contingent upon the hospital reverting to rural status on that date. Although regional offices will process applications as quickly as possible for these hospitals, those that do not submit an application to requalify for sole community hospital status by July 1 may experience a delay in obtaining sole community status.

Comment: One commenter stated that the proposed 108 percent standard would endanger the viability of health care in rural America. The commenter also stated that a rural hospital reclassified only for its wage index would not receive the urban standardized amount, and therefore would still be paid less than an urban hospital. Also, even when the single rate standardized amount payment is adopted, rural hospitals still would have been penalized for several years.

Response: We note that approximately 30 percent of all rural hospitals were reclassified by the MGCRB in FY 1993 for purposes of the wage index. Our analysis indicates that 10 percent of rural hospitals will still be able to qualify for reclassification based on the new wage guideline. Therefore, only 20 percent of all rural hospitals will be impacted by the change. Since 80 percent of all rural hospitals will not be affected by the change, either because they never qualified for reclassification or are still eligible for reclassification, we do not believe that the revised guidelines will have a significant impact on the financial viability of rural hospitals as a group.

Moreover, we note that the benefit of reclassification is diluted for those hospitals that are significantly disadvantaged by their wage index because the wage index value for hospitals reclassified to a given area is reduced as a result of inappropriate reclassifications. For FY 1993, there are 15 reclassified areas listed in table 4c that will be receiving the Statewide rural wage index value because the wage index for their reclassified areas fell below the rural value. Clearly, inappropriate reclassification of hospitals with relatively lower wages is limiting the benefit of reclassification for those hospitals that are disadvantaged by their current labor market area.

We also note that of the hospitals reclassified for FY 1992 by the MGCRB, a higher percentage of the urban hospitals will be affected by this change than rural hospitals. Our analysis indicates that 90 percent of all urban hospitals that were reclassified for their wage index will no longer qualify for reclassification.

Since the inception of the prospective payment system, many programs have been initiated to ensure that the payment system is not biased against rural hospitals. Congress has passed many special provisions to help rural hospitals, such as the gradual phase out of separate standardized amounts, higher annual updates for rural hospitals, and higher disproportionate share payments for sole community hospitals and rural referral centers to provide equity between urban and rural hospitals.

An analysis of hospital profit margins indicates that the differences in profit margins for prospective payment hospitals based on PPS–7 cost report data for urban and rural hospitals has begun to narrow. We expect this trend to continue under current law with the elimination of the differential between the urban and rural standardized amounts.

Comment: Some commenters stated that Medicare policy should encourage a stable payment system from year to year. They believe that instituting

changes to the MGCRB guidelines for FY 1993 applications, and then instituting the revised MSA definitions and potential changes to labor market definitions for FY 1994, is inconsistent with that goal. Commenters suggested that the change in the guidelines be delayed until the revised labor market areas and new MSA definitions are implemented and updated wage data are available. One commenter suggested that HCFA implement the revised MSA definitions for MGCRB decisions in FY 1993 affecting reclassifications in FY 1994.

Response: Since the effects of reclassifications must be budget neutral, increased payments to one group of hospitals are offset by reduced payments to other groups. Accordingly, we believe that we have an obligation to ensure that reclassifications are granted only to those hospitals that truly warrant such reclassification because they are disadvantaged by their original labor market designation. Since our analysis clearly indicated that the current guidelines have resulted in the reclassification of some hospitals that are not disadvantaged by their original labor market designation, we have a responsibility to revise the guidelines in order to improve payment equity across all hospitals. Because the reclassification process is budget neutral, inappropriate reclassifications result not only in increased payments to hospitals that are not disadvantaged, but also in reduced payments to the hospitals that must fund the reclassifications.

We recognize that the revised guidelines may create difficulties for those hospitals that have altered their operations in anticipation of continued reclassification. While we are sympathetic to the impact that the revised guidelines will have on their financial condition, we believe it would be inappropriate to defer any revisions until next year. Since the revised guidelines will not affect payment until FY 1994, hospitals will have time to adjust to their loss of reclassification status. The benefits of providing additional adjustment time to these hospitals must be balanced against continuing to disadvantage non-reclassified hospitals through the budget neutrality adjustment. While we agree that payment stability is important, we have made it clear from the outset that it was our intention to examine the guidelines and propose any changes that were warranted.

Given these considerations, we do not believe it would be appropriate to delay implementing the new wage guidelines until the revised MSAs and/or labor market area definitions are also implemented. As we indicated in the June 4, 1992 proposed rule, the revised MSA definitions based on the 1990 census will be implemented in FY 1994 at the same time that the MGCRB reclassifications based on revised guidelines will take effect. Updated wage data will be incorporated into the FY 1994 wage index and it is also possible that refinements to the labor market areas will also be implemented at the same time that the MSA definitions are revised. Since these changes will coincide with the implementation of the revised guidelines for payment purposes, they may mitigate the adverse effect on hospitals that no longer qualify for reclassification. Some rural areas will become urban under the revised MSA definitions. In addition, the more recent wage data will help hospitals located in areas where wage levels have risen more rapidly than the national average. Finally, we believe that the revised guidelines will have relevance to any refined labor market area definitions.

Because the revised definitions have not yet been announced by OMB, we cannot adopt the revised MSA definitions in time for the MGCRB's review of reclassification requests during FY 1993. It is not simply a question of recognizing the new MSAs but also a question of reconfiguring the wage data to match those MSAs. However, we note that the new MSAs will be taken into account when we issue the proposed rule for FY 1994. As we stated in the proposed rule (57 FR 23637), 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.

Comment: A few commenters were concerned about the proportion of labor to non-labor costs in the standardized amounts. These commenters stated that the labor portion of the standardized amount was greater for rural hospitals than urban hospitals and was not consistent with 71.40 percent labor portion stated in the proposed rule (57 FR 23688). These commenters believed that any changes in the MGCRB guidelines should be delayed until the computation of the standardized amount is reevaluated.

Response: The comments reflect a misunderstanding of how the standardized amounts were computed. The urban and rural adjusted standardized amounts were developed from actual cost data as reported by hospitals on their Medicare cost reports for fiscal years ending in calendar year 1981. We described this methodology at great length in both the September 1, 1983 interim final rule (48 FR 39752) and the January 3, 1984 final rule (49 FR 234). The difference in the proportion of labor versus nonlabor between the urban and rural standardized amounts is a result of the standardization process that occurs after the percentage of the labor-related share is determined based on the hospital market basket. In the current market basket, 71.40 percent of hospital costs are considered to be labor-related. The labor/nonlabor portions derived from the hospital market basket are applied to hospital costs before the standardization adjustments for area wage differences are made. As a result, the labor/nonlabor proportions of the final urban and rural standardized amounts will vary. As described in the rules mentioned above, the labor portion of a hospital's costs is standardized by dividing those costs by the area wage index. The individual standardized costs are combined to derive a single urban or rural standardized amount. Because rural hospitals generally have wage index values less than 1.0 and urban hospitals generally have values greater than 1.0, during the standardization process, the rural labor portion of the standardized amount increases while the urban labor portion decreases. Therefore, while the labor portions of the standardized amounts appropriately reflect the market basket labor component (that is, 71.40 percent of costs), the proportions for the urban and rural rates will vary.

e. *Guidelines for a Hospital Seeking Reclassification for Purposes of its Standardized Amount.* As discussed in the June 4, 1992 proposed rule (57 FR 23636), we did not propose changing the guideline for individual hospital reclassifications for purposes of the standardized amount.

f. *Application of Numeric Standards.* In order to ensure consistency throughout the MGCRB 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. No comments were received on the rounding issue, but, as discussed below, we received one comment on the broader issue of numeric standards.

Comment: Some commenters recommended that an exceptions process be established regarding the numeric criteria applied by the MGCRB. They argued that any set of numerical

criteria is arbitrary and that an exceptions process would allow hospitals that do not meet the criteria, but have a justifiable case, to be considered for reclassification.

Response: To fairly assess the merits of reclassification requests, the MGCRB must base its decisions on a consistent, reliable set of criteria that can be applied equally in every case. We believe that objective criteria are necessary to ensure that all hospitals are treated fairly and consistently. Moreover, given the volume of applications, a determination process based on subjective guidelines, such as those necessarily associated with an exceptions process, would likely be very time-consuming and would therefore make it less feasible for the MGCRB to meet the March 30 deadline for issuing decisions. Given the subjective nature of an exceptions process, it would be very difficult for the MGCRB to make individual case-by-case determinations in a consistent and equitable manner. Therefore, we are not providing for an exceptions process at this time. However, we will continue to evaluate the reclassification process to determine if further revisions are appropriate in order to better target reclassifications to those hospitals that warrant reclassifications.

2. Implementation of FY 1994 Hospital Reclassifications

a. *Appropriate Wage Data.* We are revising §§ 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.

Comment: Several commenters indicated that they do not believe it is appropriate that hospitals are being asked to submit their applications for FY 1994 reclassification based on 1988 wage data. They argue that the 1988 wage data will determine if they qualify for reclassification, while the wage index that will be effective for FY 1994 payments will be based on 1990 wage data and revised labor market areas. Many of the commenters referred to this as the "Blind Leap Rule" because hospitals must make reclassification decisions based on data that will not be a factor when the reclassifications take effect. In addition, one commenter wanted the 1990 wage data to be used if there has been a change of ownership since 1988. Another commenter asked for clarification as to what data will be used for the FY 1994 wage index update. Some of these commenters noted that rural hospitals were disadvantaged by the exclusion of contract labor from the 1988 wage data and suggested that the revised guidelines be deferred until contract labor is incorporated into the average hourly wages.

Response: We anticipate using FY 1990 hospital wage data to construct the updated wage index for FY 1994. While this data is currently being submitted to HCFA through the HCRIS system, a complete database will not be available by October 1, 1992, when the MGCRB begins to consider applications for FY 1994 reclassifications. Moreover, the data currently available on the HCRIS system has not yet been tabulated, edited or reviewed. As we evaluate the data and as additional cost reports are submitted, we expect the data to continue to change until such time that the final wage index for FY 1994 is developed. In addition, the wage data will need to be reconfigured to conform to the revised MSA definitions and any refinements that we make in the FY 1994 labor market areas after proposed rulemaking. Therefore, complete and accurate 1990 wage data consistent with the FY 1992 labor market areas will not be available for use in making wage comparisons with respect to applications considered during FY 1993. The very nature of the reclassification process, which requires hospitals to apply 1 year before the reclassification takes effect, precludes the use of data in the application process that coincide with those that will be used to make payments after reclassifications are implemented. Once the wage data is updated annually beginning in FY 1994, there will necessarily 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. Accordingly, the MGCRB will continue to use 1988 wage data and FY 1993 labor market areas to determine if a hospital qualifies for a wage index reclassification for FY 1994. These data represent the latest complete database on which valid comparisons can be made across areas.

The issue of contract labor costs is discussed in section III above. However, we note that the reported 1988 contract labor data had such varied and significant problems that to rely upon it would have arbitrarily advantaged some areas and disadvantaged others. Since the 108 percent threshold will compare a rural hospital to other rural hospitals, it is not clear that the omission of contract labor from the wage index will affect the ability of most rural hospitals to meet this guideline.

Comment: Several commenters were concerned about the process of reclassification for merged hospitals that were previously single entities during the 1988 survey process and suggested that post-merger wage data be used.

Response: Merged hospitals that have been assigned a single provider number must apply jointly to the MGCRB. In recognition of this situation, the MGCRB has a process whereby merged facilities may be considered for reclassification. If both facilities are located in the same geographic area, this is accomplished by combining the wage and/or cost data for the two facilities. The wage survey data is combined by adding the inflation-adjusted salaries and hours of the two facilities together and then dividing the total combined salaries by the total combined hours to obtain a new average hourly wage. Cost data also may be combined by adding the required data of the two facilities together to achieve a combined cost per discharge. The adjustment factor such as case-mix index can be combined based on the discharge-weighted average of the two facilities.

On the other hand, if the hospitals continue to operate as separate providers, a separate reclassification decision will be made for each facility. In either case, the 1988 wage data must be used. There is no provision for adjustment of any wage data for events occurring subsequent to the survey period.

b. *Revised Labor Market Areas.* As noted in section III.E. of this preamble and the response to a previous comment, 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. 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. 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).* We are revising § 412.273 to specify that a hospital's request for withdrawal of an application must be submitted to the MGCRB. Additionally, we are adding a new paragraph (c) to § 412.273 to provide appeal rights for a hospital whose request for withdrawal has been denied by the MGCRB. 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. We received no comment on this specific change and we are adopting the proposed change with a revision to clarify that the 15-day deadline applies to the date of receipt; that is, the hospital's request for review must be received within 15 days of the date of the notice of denial. However, we received one comment concerning the withdrawal process which we address below.

Comment: One commenter noted that hospitals have 45 days from publication of the annual prospective payment system proposed rule to withdraw their applications for reclassification. The commenter asserted that since changes may occur in the wage index values between the publication of the proposed rule and the final rule, hospitals should be permitted to withdraw their applications within 30 days of the publication of the final rule.

Response: We believe that the proposed rule constitutes the latest feasible resource for providing hospitals with the necessary information to decide whether to withdraw requests for reclassification. We recognize that the proposed wage index values will change slightly in the final rule to take into account the impact of any withdrawal requests and the effect of any decisions by the MGCRB or the Administrator that were not issued in time to be taken into account in the proposed rule. We cannot extend the 45-day deadline, however, because doing so would not provide reasonable time to take withdrawals into account in the development of the final wage index and prospective payment system rates.

We note that although hospitals are permitted to withdraw their applications for reclassification at any time during the 45-day period, even if an MGCRB decision has already been made, a hospital that requests that its application be withdrawn may not request that the MGCRB decision be reinstated after publication of the prospective payment system final rule.

b. *Reopening.* We are adding 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. 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. An example of a facial error would be a decision that includes incorrect identifying information for the affected hospital(s). 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 is final and is not subject to judicial review. In accordance with these changes, we are also revising § 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).

Comment: One commenter apparently misinterpreted the republishing of current § 412.278 of the regulations text in the proposed rule as proposing a new provision concerning judicial review of the Administrator's decisions.

Response: In the proposed rule, we republished § 412.278 of the regulations text to correct technical errors in the CFR. The provisions concerning Administrator review were subject to the notice and comment rulemaking process in the September 6, 1990 interim final rule (55 FR 36754) and the June 4, 1991 final rule with comment period (56 FR 25458) and, with the exception of the new reopening provision, have not been materially altered in this rule. We note that section 1886(d)(10)(C)(iii)(II) of the Act specifies that with regard to appeals of MGCRB decisions, "the decision of the Secretary shall be final and shall not be subject to judicial review." Our regulations are consistent with that provision.

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 revising § 412.278(f)(1) 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 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 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.

2. 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). 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.

Based on a study by the RAND Corporation and our own analysis which indicated the significant potential for improvements in payment equity across types of outlier cases (see 57 FR 23640), we proposed in the June 4, 1992 rule to revise the day outlier payment policy effective for discharges occurring on or after October 1, 1992. We proposed revising § 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, for each DRG 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 will 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 costs for hospitals receiving hold harmless payments, and 100 percent for hospitals receiving 100 percent of the Federal rate.)

For cost outlier cases, we pay 75 percent of the charges adjusted to cost 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×.75) for day outlier cases. As stated in the proposed rule, we considered adopting a 2-year phase-in of this policy by implementing 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 proposed 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.

After consideration of all comments received on this issue, as discussed below, we are implementing the changes to the outlier payment methodology as proposed.

Comment: Several commenters supported our proposed change in the day outlier payment methodology. ProPAC agreed that this change would result in better targeting of outlier payments to those cases that impose the largest financial burden on hospitals. Other commenters opposed the change, or advocated a 2-year phase-in of the change in order to mitigate its impact on those hospitals with a relatively high proportion of day outlier cases. A few commenters advocated further reductions in payments to day outlier cases by adopting a .40 marginal cost factor for FY 1993, while others suggested that we wait to assess the impact of these changes before contemplating additional reductions. One commenter requested that we publish the information used to determine the reduction in the marginal cost factor for day outlier payments.

Response: As discussed in the June 4, 1992 proposed rule (57 FR 23640), research by the RAND Corporation shows that hospitals receiving day outlier payments are paid more than the marginal costs of caring for these patients during the outlier portion of their stay. As a result, payments for the most costly outlier cases are a smaller proportion of the costs of treating these cases than they would be in the absence of the excessive day outlier payments. The results of the study [3] indicate that the change in the calculation of the per diem payment for day outliers will more accurately reflect the marginal cost of treating patients during the outlier portion of their stay. In addition, we note that the hospitals that are most affected by this policy change, those in Region II (hospitals in New York, New Jersey, and Pennsylvania), will continue to have the highest payment-to-cost

[3] A technical paper describing the study and the results, Carter, G.M. and Rumpel, J.D., "Payment Rates for Unusual Medicare Hospital Cases", is available from HCFA.

ratio for outlier cases of any payment region after the change is implemented.

We believe that making this change on a phased-in basis would be inappropriate because it would result in continued overpayment for day outlier cases during the phase-in period. Also, it would be extremely difficult to achieve an even phase-in of the redistributional effect of the policy change. Because the change to the arithmetic mean length of stay provides the bulk of the change in distribution of outlier payments, an even transition would require pricing of bills under the old and new payment systems and then averaging the payments. This would be administratively difficult and costly, and would lead to problems in the definition of day and cost outliers, since a case which qualified as a day outlier under the old methodology might qualify as a cost outlier under the new methodology.

We agree that it would be inappropriate to establish further modifications in day outlier policy until we can assess the results of the changes implemented in this final rule. However, we will continue to evaluate possible changes to outlier policy in order to improve our ability to protect hospitals from significant financial loss in individual cases.

Comment: Several commenters believe that the proposed change to the day outlier per diem would result in unfairly shifting payments from major teaching (IME) and disproportionate share (DSH) hospitals to proprietary hospitals. In addition, they stated that there are serious methodological flaws in the cost outlier payment formula that should be corrected before shifting funds from day outlier cases to cost outlier cases. Specifically, the commenters asserted that the use of a single hospital-wide cost-to-charge ratio distorts cost outlier payments. They provided an example that purports to show that departmental cost-to-charge ratios would increase payments to IME and DSH hospitals.

Response: The change in outlier payment policy does not result in the shifting of payments from most major teaching or disproportionate share hospitals. Estimates of the impact of the proposed change indicate that, with the exception of hospitals in Region II, the hospitals receiving DSH or IME payments in no other region will experience a major decline in payments, and most will experience modest increases in total payments. Overall, hospitals in Region II show the largest total payment declines as a result of the change, but they maintain the highest payment-to-cost ratios for outlier cases even after the proposed change. The effects on the IME/DSH hospitals in that Region are similar. If the outlier change resulted in payment decreases for high DSH hospitals, we would expect it to result in payment decreases for government-controlled hospitals, which tend to provide a relatively large proportion of care to low income patients. However, this is not the case. Overall, the impact on government-controlled hospitals is a 0.0 percent change in total payments (See appendix A to this final rule, Table 1).

The cost-to-charge ratios are determined on a hospital-specific basis, and we do not believe the use of departmental cost-to-charge ratios in lieu of an overall cost-to-charge ratio would have a significant effect since any differential mark-up policies should be captured in the overall cost-to-charge ratios. We believe that the example submitted by the commenters on the effects of using departmental cost-to-charge ratios is based on distorted cost-to-charge data, and that a different methodology would better show the effect of using departmental cost-to-charge ratios on cost estimation. We used the average cost-to-charge ratios for ancillary and routine services as presented by the commenters to develop our analysis. We examined the costs for the same type of case at two hospitals where the total costs were the same when calculated using separate ancillary and routine cost-to-charge ratios. Our analysis showed that the only difference between the costs estimated using the overall cost-to-charge ratio and those estimated using separate routine and ancillary cost-to-charge ratios is due to rounding. However, we plan to analyze the use of separate cost-to-charge ratios for calculating cost outlier payments in time for consideration of the results in developing the FY 1994 proposed rule.

Comment: One commenter suggested that any savings realized through changing the per diem payment calculation for day outliers be used to lower the thresholds for day outliers, rather than lowering the cost outlier threshold.

Response: In establishing the FY 1993 thresholds, we reduced both the day and cost outlier thresholds so that the percentage of cases that qualify as day outlier cases remains about the same. However, a larger portion of these cases will now be paid as cost outliers instead of day outliers. We believe that the payment-to-cost ratios for day outlier cases and for cost outlier cases should be approximately the same. As discussed in detail in the June 4, 1992 proposed rule, we calculated the payment-to-cost ratios of different types of outlier cases under the current policy and under the proposed policy (57 FR 23641). Under the day outlier policy change, the payment-to-cost ratios are more equal across types of outlier cases, with a range of 0.4891 (for those cases that qualify only as cost outliers) to 0.5667 (for those cases that qualify as both types of outliers and are paid under the day outlier methodology). Under the current policy of using the geometric mean length of stay and a 0.60 marginal cost factor, the range is 0.4773 to 0.6549, for the same types of cases. Even under the new policy, the type of case with the highest payment-to-cost ratio will be paid under the day outlier formula. Thus, we believe that it is appropriate to redistribute some outlier funds from cases paid under the day outlier methodology to cases paid under the cost outlier methodology, since it is these cases that experience greater losses.

Comment: One commenter asserted that the research upon which the revised policy is based is potentially flawed, and urges that we delay implementation of any policy change until the results are confirmed by another researcher. This commenter is concerned with the construction of the cost data used in the study, with the standardization procedure used to remove the effects of the payment adjustments from the costs, and with several statistical issues. These issues include the choice of a linear model in the primary regressions, the use of a single day outlier payment multiplier (equivalent to the marginal cost factor) when a wide range is reported across DRGs in the study, and sample selection issues and sensitivity analysis. Another commenter urged that we use more current data to confirm the results of the RAND study, which was based on FY 1990 charge data and FY 1988 and 1989 cost report data.

Response: We are confident that the research done by the RAND Corporation is accurate and that the policy change is appropriate. The method for calculating the costs of a given case has been used by RAND in numerous studies for HCFA, ProPAC, and independent research purposes, and we believe that it provides accurate results. The standardization procedure is based on the total cost regressions performed for the August 30, 1991 final rule that implemented the prospective payment system for capital-related costs, as explained in detail at 56 FR 43369. Thus, we believe that the standardization process used by RAND represents the appropriate relationships between the payment adjustment factors and the total cost per case. RAND chose the

particular linear specification only after ascertaining that it produced an accurate description of how costs per case increase with the number of outlier days. In addition to an examination of plots of data within individual large DRGs, several alternative specifications were tested as described in the RAND report. A spline formulation was used to determine whether costs increase at different rates in different portions of the outlier part of the stay. As described in the report, the larger coefficient in the spline formulation was only 0.025 higher than the average coefficient. Using the arithmetic mean length of stay rather than the geometric mean length of stay did not affect average estimated cost per outlier day. Medical and surgical DRGs groups have only modestly different coefficients. Thus, the simple linear specification with the arithmetic mean length of stay provides a very close approximation to the cost data. Although RAND reported the R-square for each model, it was not used by RAND to choose among models. Rather, the RAND study shows that the estimate of how costs increase with length of stay is robust across a large variety of model specifications.

As the commenter noted, the RAND study found a range of day outlier payment multipliers across DRGs. However, approximately two-thirds of the DRGs had multipliers between 0.40 and 0.70, or within 27 percent of 0.55 (these figures are calculated using the arithmetic mean length of stay). Although the use of DRG-specific marginal cost factors may be a potentially more accurate method of paying for day outliers, we did not contemplate such a step for reasons of administrative complexity. A finding that a few DRGs had day outlier payment multipliers that are significantly different from 0.55 does not, we believe, contradict the choice of an appropriate single marginal cost factor based on the results of the RAND research. A few DRGs have day outlier payment multipliers significantly different from 0.60, the current factor, as well.

Regarding the issue of sample selection and sensitivity analysis, we believe that the authors of the RAND study have shown that their results are valid in this respect. On page 22 of their study, Table 3.3 shows that the coefficient used to determine the day outlier cost multiplier is almost identical when using the current method of paying cost outliers and when using the alternative fixed loss methodology (that is, a case qualifies as a cost outlier if its standardized costs exceed the DRG payment amount by a fixed dollar amount, regardless of DRG). The difference between the fixed loss methodology and the current cost outlier methodology is a much larger change in cost outlier policy than any movement in the cost outlier thresholds under the current cost outlier policy that we would contemplate in concert with the day outlier policy change. Therefore, we do not believe that the definition of cost outlier cases under alternative policies could cause a sample selection problem or bias the results of this study.

We have confirmed the results of the RAND study using more recent data. The analysis in the proposed rule at 57 FR 23640 of the payment-to-cost ratios of different types of outlier cases was completed using the FY 1991 charge and hospital-specific data. As we expected, we again found that the payment-to-cost ratios of different types of hospitals and different types of outlier cases become more equal after the policy change. In fact, since our confirmation of the results of the RAND study occurred using a completely different structure (that is, looking at the payment-to-cost ratios of FY 1991 cases under the alternative policies, rather than at the variables examined in the RAND study), we are even more confident of the validity of its results than if we had merely replicated the methodology and results.

Comment: Two commenters opposed the change in outlier policy based on their understanding that cost outlier payments are made only if the day outlier threshold has not been passed. Therefore, they believe that, under the new policy, cases with long lengths of stay would receive lower day outlier payments, and not be eligible for cost outlier payments.

Response: Beginning in FY 1989, all cases are eligible for cost outlier payments if their charges, adjusted to cost, exceed the cost outlier threshold. If a case has also passed the length of stay threshold for day outlier cases, it is paid under the method that yields the higher outlier payment. Therefore, the policy change does not penalize hospitals that have long lengths of stay, since their costly cases with long lengths of stay will continue to be eligible for cost outlier payments.

Comment: A commenter requested that we make available, as quickly as possible, the actual impact of the policy change so that the new payment methodology can be assessed.

Response: We will make every attempt to monitor the results of the policy change, and will make those results public as they become available.

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

As we stated in the proposed rule, 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 actual outlier payments (based on the latest FY 1991 billing data) were 4.24 percent of total standard DRG payments (exclusive of DSH and IME) instead of the estimated 5.1 percent, there was no reduction in total standard DRG payments between the payment per case estimated in the August 30, 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	$4,414.13	$4,543.57
Average outlier payment	237.36	216.35
Total standard DRG payment per case	4,651.49	4,759.92

The average total payment per case increased 2.3 percent over the amount estimated in the FY 1991 final rule. We would expect some 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 (see Section II.D.), 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 increase in payment per case of 2.3 percent exceeds our estimate that real case-mix change was between 1.0 and 1.25 percent.

Comment: Several commenters asserted that section 1886(d)[5](A)(iv) of the Act requires that actual outlier payments for any fiscal year be between 5 and 6 percent of total DRG payments estimated to be made in that fiscal year. Other commenters stated that we should pay retroactively for any difference between actual and estimated outlier payments. One of these commenters suggested that the adjustment be made

prospectively as part of the update framework. Another commenter disputed our statement that we do not make any retroactive adjustments, since the variables that are the basis for the IME, DSH, and capital payments are subject to change at cost report settlement. Finally, ProPAC opposed any retroactive adjustment, stating its belief that such an adjustment would be contrary to the intent of a prospective payment system.

Response: The statutory requirement under section 1886(d)(5)(A)(iv) of the Act, requires that outlier payments be between 5 and 6 percent of the total payments "projected or estimated to be made" based on DRG prospective payment rates for discharges in that year. This statutory language plainly directs the Secretary to establish outlier payments based on projections and estimates. This is what we did. Of course, amounts that are based on projections may differ, at times, from actual amounts that are determined after the operative events have passed. But Congress did not direct that outlier payments be based on actual amounts of total payments but rather on the projected amounts. Thus, we have met this requirement, for FY 1992 and for all other prospective payment system years, through our estimation process as described in the June 4, 1992 proposed rule. We have met our statutory obligations by making every effort to ensure that we have the best possible data to make our estimate.of total DRG and outlier payments when setting the outlier thresholds for a given year.

As ProPAC suggests, the commenters' argument that actual payments must be between 5 and 6 percent of total payments is inconsistent with the nature of a prospective payment system. The adjustment to outlier payments that the commenters propose must be considered in the broader context of the prospective payment system. Moreover, we note that the retroactive adjustments suggested by the commenters could also result in reductions in payments to hospitals in years where the outlier percentage was too high. However, we did not make adjustments in outlier payments in those years that we paid out more in outlier payments than anticipated.

We always use the most current data available at the time we set the outlier thresholds. Sometimes, as in FY 1991, the estimates based on that data result in outlier payment percentages being too low. At other times, the actual outlier payment percentages were too high. Such imprecision is inherent in a system that is required by statute to use estimates.

Thus, in light of the nature of a prospective payment system, and our attempts to estimate outlier payments as accurately as possible, we believe that we have satisfied the statute and that no retroactive adjustment is warranted.

We recognize that some hospital-specific data, such as the ratios used to determine the IME and DSH adjustments and the capital costs used to determine the payment methodology and hospital-specific rate under the capital prospective payment system, are corrected at cost report settlement. However, we do not correct the basic outlier payment amount determined for cost outliers (based on the standardization of charges to costs using the cost-to-charge ratios and IME and DSH adjustments available) at cost report settlement, but maintain the amounts determined based on the adjustment factors and cost-to-charge ratios available at the time the outlier payment was calculated. That is, while the various hospital-specific adjustments are adjusted at cost report settlement, the basic outlier and DRG payment amounts are not. We note that we could not correct the outlier cost standardization process or the thresholds at cost report settlement without repricing all discharges, because some cases that were paid under the day outlier methodology might switch to the cost outlier methodology (and vice-versa), and some cases that did not previously qualify as outliers might do so under revised thresholds or vice versa. We see no contradiction between correcting hospital-specific data relating to the payment adjustments at cost report settlement and not correcting system-wide elements, such as the standardized amounts and outlier thresholds. We agree with ProPAC that retroactive adjustment of the system wide elements would be contrary to the nature of the prospective payment system.

Comment: A commenter urged that we consider the decline in length of stay as a result of technological advancements when setting the outlier thresholds.

Response: The average length of stay, after declining at the beginning of the prospective payment system, has levelled out in recent years. We do not believe that it is advisable to make predictions about changing lengths of stay when setting the outlier thresholds.

4. FY 1992 Outlier Payments

As we stated in the June 4, 1992 proposed rule, we anticipate that FY 1992 outlier payments will be less than the 5.1 percent that we originally estimated when we set the outlier thresholds (57 FR 23645). This is due, in part, to the fact that 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 analyzing the FY 1992 outlier payments are similar to those involved in analyzing the FY 1991 outlier payments.

Using the FY 1991 cases and the FY 1992 payment data, we currently estimate that FY 1992 operating outlier payments will be approximately 3.84 percent of FY 1992 total DRG payments, and that FY 1992 capital outlier payments will be approximately 3.72 percent of capital DRG payments. (If indirect teaching and disproportionate share payments are included in the calculation, the estimated operating outlier percentage is 4.00 percent.) The 3.84 percent estimate for FY 1992 is lower than the 4.24 actual outlier percentage for FY 1991 largely because of changes in the payment adjustment factors.

Comment: Several commenters stated that we should institute a midyear correction of the FY 1992 outlier thresholds, given our estimate in the proposed rule that FY 1992 outlier payments would equal 3.6 percent of total FY 1992 DRG payments. These commenters also believe that we should institute a midyear monitoring process in order to make corrections to the thresholds in the event that we discover a difference between the estimated and actual outlier percentages.

Response: Section 1886(d)(5)(A)(iv) of the Act requires that outlier payments in a fiscal year be between 5 and 6 percent of the total payments "projected or estimated to be made" based on DRG prospective payment rates for discharges in that year. As explained in an earlier response, this statutory language directs the Secretary to make outlier payments based on estimates. In implementing this provision, we consider the projected total amount of DRG payments for all cases and set the outlier thresholds accordingly.

As ProPAC suggests, we believe that the commenters' argument that actual payments must be between 5 and 6 percent of total payments is inconsistent with the nature of a prospective payment system. This is necessarily a prospective process and the estimates upon which payments are based may prove to be inaccurate. We currently anticipate that FY 1992 outlier payments will fall short of the 5.1 percent level

that we originally estimated when setting the FY 1992 outlier thresholds. Moreover, while our current estimate of FY 1992 outlier payments is approximately $516 million lower than the estimate of FY 1992 contained in the August 30, 1991 final rule, our estimate for standard payments (DRG payments plus outlier payments) is approximately $2.1 billion higher and our estimate for total prospective payments is approximately $2.4 billion higher. However, in other years, the estimates on which outlier payments are based resulted in outlier percentages which were too high.

We used the most recent Medicare discharge and hospital-specific data available to estimate total payments and outlier payments. We do not believe that Congress envisioned we would revise in mid-year any of the estimates of factors used to set prospective payment rates for a given Federal fiscal year. These factors include not only the outlier thresholds, but the market basket rate of increase used to establish the update factors, the recalibration of the DRG rates, and the various required budget neutrality provisions. The market basket rate of increase has been overestimated for the past two fiscal years, but we have not made reductions in the standardized amounts during the year as new estimates of the market basket rate of increase became available. Further, our most recent estimate of the FY 1992 market basket rate of increase is 3.6 percent, or 0.8 percentage points lower than that used to establish the FY 1992 standardized amounts. This represents an additional $480 million in payment. In addition, although we now have evidence that the DRG recalibration resulted in a 1.0 percent increase in FY 1991 program payments, we have not contemplated a retroactive adjustment in the DRG weights or the recalibration of the budget neutrality adjustment factor. Since these increased payments are built into the DRG weights, FY 1992 payments are $600 million higher than they would have been if we had not made the changes (prior to taking into account the lower outlier payments). Even taking the estimated outlier shortfall into account, the net difference due to the level of the DRG weights and budget neutrality factors is an increase in payments. Another example is the FY 1992 budget neutrality adjustment to the capital prospective payment system. Based on the most current data available we estimate that in FY 1992 capital payments will be 92.8 percent (instead of the statutorily mandated 90 percent) of Medicare inpatient capital costs. Taking the phase-in of the capital prospective payment system into account, this represents an additional $90 million in program payments. Taken together, these differences between the original estimates and our most recent projections net to more than $570 million in excessive Medicare payments for FY 1992.

We do not believe it would be appropriate to make these mid-year corrections given the requirements under sections 1886(d)(6) and 1886(e)(5)(B) of the Act that we publish annual prospective payment rates and update factors by September 1 of each year. First, this provision is meant to provide hospitals with advance notice of the rates that will be in effect for the fiscal year. Second, as a practical matter, any mid-year correction to the prospective payment rates and adjustment factors would have to remove any anticipated payments in excess of our total payment target in order to maintain budget neutrality. Of necessity, any midyear correction would also rely on estimated data that may not be representative of the entire fiscal year. We note, for example, our estimate of FY 1992 outlier payments is based on FY 1991 MEDPAR data and has increased from 3.6 to 3.84 percent between the June 4, 1992 proposed rule and this final rule.

While we do not believe midyear corrections are appropriate, we will explore whether there are methodological changes that we could make in the rate-setting process that would improve the accuracy of our payment projections in the future. One area we will examine is whether it would be feasible and appropriate to incorporate more recent claim data into our projections. Although these data would be limited using available data from the fiscal year immediately preceding the fiscal year for which the rates are effective may improve the projections by capturing more quickly the effects of changes in case mix on payments. If we determine that using limited data from a more recent period would improve the rate calculations, we would propose methodological changes through the rulemaking process. Any changes would be effective no earlier than FY 1994.

Comment: A few commenters stated that our observation that FY 1992 DRG payments are projected to be higher than originally expected is irrelevant when determining whether or not to adjust the FY 1992 thresholds. The commenters believe that we have not demonstrated that the higher DRG payments were inappropriate, and that overall budget neutrality does not ensure that individual hospitals will not be harmed.

Response: While we are unable to isolate the effect that coding improvements in response to the FY 1991 DRG classification changes had on outlier payments, we are confident that at least a portion of the difference between actual and estimated outlier payments is due to the classification changes. If we had been able to predict the effect of the coding improvements on the distribution of cases across DRGs, we would have taken that effect into account when setting the outlier thresholds and budget neutrality factors. Similarly, we believe that at least a portion of the difference between estimated and actual payments at the individual hospital level was in fact a result of increases in payments based on the standardized amount. Cases that would have received an outlier payment in FY 1990 received higher standardized payments instead. The observation that FY 1992 DRG payments will be higher than originally estimated is not irrelevant. Since total payments to hospitals are higher than anticipated, hospitals as a whole are not harmed by the difference between our original and current estimates of FY 1992 outlier payments.

Comment: A commenter urged that we make available all data from all years of the prospective payment system that would enable the public to analyze any differences between estimated and actual outlier and total payments.

Response: We presented comparisons between estimated and actual outlier payments in the June 4, 1992 proposed rule, at 57 FR 23644. We believe that this is sufficient data to analyze differences between estimated and actual outlier payments under the prospective payment system.

5. FY 1993 Outlier Thresholds

For FY 1993, we proposed 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 that we are establishing in this final rule are: for day outliers, the geometric mean length of stay for each DRG plus the lesser of 23 days or 3 standard deviations, and for cost outliers, the greater of 2.0 times the prospective payment rate for the DRG or $35,500. The thresholds we would have implemented in this final rule 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 27 days or 3 standard deviations, and for cost outliers, the greater of 2.0 times the prospective payment rate for the DRG or $39,000.

The FY 1993 outlier thresholds will result in a slight increase in the proportion of outliers paid as cost outliers relative to those paid as day outliers. We estimate that 57.8 percent of cases will be paid using the cost outlier methodology and 42.2 percent will be paid using the day outlier methodology, compared to 57.8 percent of cases being paid using the cost outlier methodology without the FY 1993 day outlier payment change. Cases that meet the day outlier threshold but that will be paid using the cost outlier methodology, because it yields the higher payment, will increase from 13.9 percent to 17.4 percent of all outlier cases under the final policy. Our simulation of FY 1993 outlier payments based on FY 1991 MEDPAR data indicates that the percentage of outlier cases that will qualify as day outliers is about 75.2 percent under this final policy. The cases qualifying as day outliers will receive 77.2 percent of operating outlier payments in FY 1993. An estimated 24.8 percent of outlier cases will be cost-only outlier cases, which will receive about 22.8 percent of operating outlier payments under this final 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	46.6	48.6	24.6	19.7	24.4	19.8	24.6	19.7
Meets day and cost thresholds, paid using day methodology	11.2	9.2	21.1	14.2	20.9	14.3	21.0	14.2
Meets day and cost thresholds, paid using cost methodology	13.9	17.4	31.8	43.2	30.4	41.4	31.6	43.0
Subtotal—All cases meeting day threshold	71.8	75.2	77.5	77.2	75.8	75.5	77.3	77.0
Meets cost threshold only	28.2	24.8	22.5	22.8	24.2	24.5	22.7	23.0
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 resulted in a slightly lower percentage of outlier payments for capital-related costs as for operating costs. We estimate the final thresholds for FY 1993 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.0 percent of capital payments based on the Federal rate.

The final outlier adjustment factors that will be 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
0.944598	0.978420	0.9496

6. Other Changes Concerning Outliers

We proposed 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 proposed to remove § 412.82(d). This provision was implemented to conform our regulations to section 4008(d)(1)(A) of Public Law 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 factors we used to calculate day and high cost outlier payments for other types of cases. Section 4008(d)(1)(A) 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 proposed to delete § 412.82(d) since it is no longer applicable in determining day outlier payments. We received no comments on these changes and are implementing both of them in the final rule.

Because of the change to the calculation of day outlier payments, we are now including the arithmetic mean length of stay in Table 5 of section IV of the addendum to this final rule. When we recalibrate DRG weights, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight and geometric mean length of stay. DRGs that do not have at least 10 cases are considered to be low volume DRGs. For the low volume DRGs, we use the original geometric mean lengths of stay. In order to calculate day outlier payments for cases in DRGs that contained fewer than 10 cases in FY 1991, we are using the original geometric mean length of stay, because no arithmetic mean length of stay was calculated based on the original data.

Table 8a in section IV of the addendum to this final rule contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. Effective October 1, 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. These average ratios will be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.311473 or greater than 0.632770 and capital cost-to-charge ratios lower than 0.013573 or greater than 0.259693. 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 1993.

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 followed the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value included all urban hospitals nationwide and the proposed regional values are the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105).

The values in the proposed rule were 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 proposed 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 must 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. (See table set forth in the June 4, 1992 proposed rule at 57 FR 23647.)

Based on the latest data available (through June 1992), the final national case-mix index value is 1.2760 and the median case-mix values by region are as follows:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.1852
2. Middle Atlantic (PA, NJ, NY)	1.1878
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.2838
4. East North Central (IL, IN, MI, OH, WI)	1.2063
5. East South Central (AL, KY, MS, TN)	1.2125
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	1.1985
7. West South Central (AR, LA, OK, TX)	1.2561
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3256
9. Pacific (AK, CA, HI, OR, WA)	1.2816

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 final rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

We received no comments on this issue.

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 proposed to update the regional standards. The final 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 proposed 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 the lesser of—

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See table set forth in the proposed rule at 57 FR 23647.)

Based on the latest discharge data available, the final median numbers of discharges for urban hospitals by census region are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,405
2. Middle Atlantic (PA, NJ, NY)	8,250
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	6,922
4. East North Central (IL, IN, MI, OH, WI)	7,581
5. East South Central (AL, KY, MS, TN)	5,676
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	5,696
7. West South Central (AR, LA, OK, TX)	4,961
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,753
9. Pacific (AK, CA, HI, OR, WA)	5,636

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.

We received no comments on this issue.

3. Retention of Referral Center Status

The Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) was enacted on December 19, 1989. Section 6003(d) of that Act states 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 proposed rule, we stated that, with the expiration of the requirement of section 6003(d) of Public Law 101–239 on October 1, 1992, we would implement 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 will 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 for at least 2 of the last 3 years or for the current year a hospital meets 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 that 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 in effect for either its cost reporting period beginning July 1, 1993 or for two out of the three past periods. For example, to meet 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 equalled 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 equalled 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)(1), (b)(1)(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.

Comment: Several commenters suggested delaying implementation of the rural referral center triennial review procedure indefinitely or postponing it for at least 2 years when there will no longer be separate other urban and rural standardized amounts. The commenters stated that this would allow current rural referral centers to continue to receive the payments that they have been receiving and prevent those hospitals that would lose their rural referral center status from having to modify services because of a temporary reduction in their Medicare payments. One other commenter, noting that proposed legislation extending the grandfathering provision is pending in Congress, requested that we postpone implementation of the triennial reviews until Congress adjourns in October.

Response: We continue to believe that it is equitable and reasonable to review periodically rural referral centers' compliance with the criteria in the statute and regulations to ensure that only those hospitals that are truly functioning as rural referral centers receive the special adjustment. Some hospitals qualified as rural referral centers based on their case-mix index values and number of discharges from 1981 and have not met the criteria since that time. We believe that the special payment provision extended to rural referral centers should be limited to hospitals that truly warrant such designations based on current conditions. Many hospitals received their classification as a referral center based on conditions that existed many years ago. Thus, we do not agree with the commenters who suggested that we either not implement the triennial review procedures or that we delay implementation for 2 years. Therefore, effective with cost reporting periods beginning on or after October 1, 1992, rural referral centers that do not qualify for an extension will lose their special status. With regard to proposed legislation that would extend the grandfathering provision, we cannot set policy or delay implementing provisions of the regulations based on pending legislation that may be enacted in any one of several forms or may not be enacted at all. If legislation that has an impact on our policy concerning rural referral centers is enacted, we will comply with it as rapidly as possible.

Comment: We received one comment suggesting that since the change in the rural referral center policy will have an impact on payments to hospitals, it should be implemented in a budget-neutral fashion. That is, the money saved from no longer paying these hospitals at the other urban rate should be used to increase the standardized amounts.

Response: It has not been our practice to make budget neutrality adjustments to reflect increases or decreases in aggregate payments due to changes in hospital status for special payment

provisions except when we have been required to do so by the statute. For example, we made a budget neutrality adjustment as required by section 9302(d)(3) of Public Law 99–509 when the rural referral center case-mix index criterion was revised to exclude teaching hospitals effective for cost reporting periods beginning on or after October 1, 1986; however, we did not make subsequent adjustments to the payment rates for additional payments made to newly qualifying referral centers after that date and before the bed-size criterion was lowered, effective April 1, 1988 by section 1886(d)(5)(C)(i)(I) of the Act. Therefore, we do not believe we should adjust the rates when hospitals no longer qualify. We have also taken this position for disproportionate share hospitals, which must qualify annually for additional payments under the disproportionate share hospital provision.

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.

The Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) and the National Board of Medical Examiners Examination (NBMEE), examinations that a foreign medical graduate must pass in order for a hospital to receive direct graduate medical education payments for that resident, 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 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 proposed to revise § 413.86(h) to reflect this change in the examination requirements.

We received one comment supporting the proposed change, and we are adopting the change without revision in this final rule.

We note that section 1886(h) references only the FMGEMS. As stated in the proposed rule, 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. Changes to Capital Prospective Payment System Rules

In the June 4, 1992 proposed rule, we proposed to make a number of minor policy changes and clarifications in the capital prospective payment system rules. Several commenters indicated that in general the proposed changes were reasonable and did not comment on specific changes. The proposals and the specific comments that we received on them are discussed below.

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. The first cost reporting period beginning at least 1 year after the hospital accepts its first patient is the hospital's base year for purposes of determining its hospital-specific rate. 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 stated in the June 4, 1992 proposed rule, we believe that 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. Therefore, we proposed 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.

Also, we proposed that a hospital that replaces its entire facility (with or without a change of ownership) would 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.

Therefore, we proposed 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 proposed 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, its hospital-specific rate would be based on the hospital's old capital costs per discharge in its first 12-month cost reporting period (or a combination of cost reporting periods covering at least 12-months) ending after December 31, 1990.

We also proposed 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 first 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 did not explicitly contain this provision. We proposed 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.

After evaluating the comment discussed below, we are adopting the proposed changes in the new hospital capital payment provisions with one addition. In this final rule, we are clarifying that if a hospital has such low Medicare utilization in its original base period that it is not required to file a cost report, its hospital-specific rate will be based on the hospital's old capital costs per discharge in its first 12-month cost reporting period for which a cost report is filed.

Comment: One commenter expressed concern that the proposed clarification of the new hospital definition at § 412.300(b) is too broad in scope and would prohibit many newly operating facilities from obtaining the new hospital exemption. The commenter indicated that restrictions on what would constitute a new hospital are premature based on limited program experience to date under the capital prospective payment system and suggested that if restrictions are necessary, HCFA should revise the new hospital definition to allow case-by-case determinations of whether a replacement facility qualifies as a new hospital. The commenter recommended that the determination be based on considerations such as the distance between the facilities and changes in the patient population, the medical staff, and patient care services.

Response: We believe that it is appropriate to proceed expeditiously to clarify the new hospital definition so that hospitals that are planning to replace their existing plant will know in advance how the replacement facility will be treated under the capital prospective payment system. It is particularly important to do so because the new hospital definition under the capital prospective payment system is not identical to the definitions used in other areas of the Medicare program, such as the new hospital definition for purposes of determining if a new provider agreement is needed or for purposes of determining eligibility for a new hospital exemption to the rate-of-increase limits applicable to hospitals that are excluded from the prospective payment system. Thus, we need to clarify the new hospital definition for capital prospective payment purposes to eliminate any confusion on this point.

Further, we believe it is appropriate to restrict the new hospital exemption under the capital prospective payment system to new entrants into the hospital field that do not have a historic asset base. As we pointed out in the preamble of the June 4, 1992 proposed rule (57 FR 23649), it would be inappropriate to provide special payment protection to a hospital simply because the hospital experiences a significant increase in its asset base. 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 a hospital to replace existing plant instead of renovating or expanding its current facility. If the capital prospective payment system is to be effective in encouraging prudent capital spending, payment policies must be neutral with respect to decisions concerning whether to renovate or replace existing assets. Consistent with the need to provide neutral incentives, the proposed changes in the new hospital definition clarify that existing hospitals that move, realign, or replace the physical assets from which they operate will not qualify as a new hospital regardless of the mode through which such capital changes are effected.

In our view, criteria related to operational aspects of a hospital, such as those suggested by the commenter, should not apply to a determination affecting capital payments. A hospital could undergo the operational changes with little or no change in its asset base. Regardless of whether new patient care services, staff, patient demographics or other operational factors are involved or even form the basis for a substantial change in hospital assets, the determining factor in deciding whether a hospital is new for purposes of making capital payments should be directly related to a hospital's assets rather than its operations. Further, operational criteria would require a comparison of the hospital's operations before and after the replacement facility is opened; if such criteria were used in determining eligibility for the new hospital exemption, a hospital would not know with certainty at the planning stage for a replacement facility how the new assets would be treated under the capital prospective payment system. This uncertainty would not be desirable given the magnitude of the capital expenditure.

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

In the June 4, 1992 proposed rule, we proposed to establish a general principle to follow in situations where nonreimbursable cost centers in the base year subsequently become allowable cost centers (57 FR 23650). Specifically, we proposed 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 non-reimbursable 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, we proposed that 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. After consideration of the comment discussed below, we are adopting the proposed rule with a revision to clarify that only those costs that would otherwise qualify as old capital will be recognized as old capital costs if the non-reimbursable cost center is put in use for patient care.

Comment: One commenter requested that a building's "shelled in space" should be cited as an example of old capital cost and that costs associated with bringing such space into inpatient care use should be classified as old capital.

Response: We assume that by the term "shelled-in space" the commenter means partially completed construction that has never been put in use for patient care. If the "shelled-in space" was part of an asset that was used to provide hospital patient care as of December 31, 1990 (for example, a partially constructed floor of a building with other floors that are in use for patient care), the costs for the "shelled-in space" as of December 31, 1990 that otherwise meet the criteria for recognition of old capital would qualify as old capital costs when it is put into use for patient care. However, additional costs that are incurred after December 31, 1990 to bring the asset into patient care use would be classified as new capital because the hospital was not obligated to incur those costs as of December 31, 1990. If the "shelled-in space" is not part of an asset that was in hospital patient care use as of December 31, 1990 (for example, if the "shelled-in space" is a separate building), it would

not qualify as old capital. We do not believe it is necessary to identify specific types of costs that would be recognized under the proposed change. However, we are revising the proposed change to clarify that the costs for the non-reimbursable cost center will be recognized as old capital when it is put in use only to the extent the remaining criteria for recognition of old capital are also met.

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). In the June 4, 1992 proposed rule, we proposed a clarification of our policy in this area (57 FR 23650).

We proposed 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 proposed to 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 lease became effective. Any lease costs above that limitation would be paid for as new capital cost. Without the proposed change, all lease costs would have been recognized as new capital since there was no lease obligation as of December 31, 1990. The proposed policy would affect only those hospitals eligible for capital prospective payments on the basis of the hold-harmless methodology.

As noted in the June 4, 1992 proposed rule, 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).

No comments were received on the proposed change and we are adopting it without revision in this final rule.

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

We received one comment associated with the general requirement for obligated capital that was not directly related to any of the proposed changes discussed below.

Comment: Obligated capital costs for moveable equipment is recognized under the regulations if there was a binding contractual agreement that was executed before December 31, 1990. The comment suggests that HCFA clarify that the definition of legally obligated capital includes purchase orders that are issued by hospitals.

Response: As we stated in the preamble to the final regulations implementing the capital prospective payment system (56 FR 43392), in most cases the determination of the existence of a binding enforceable agreement will be a relatively straightforward matter that can be made by the intermediary based on the documentation submitted by the hospital. To address issues concerning whether particular documents establish a binding agreement and create an enforceable obligation under State law, we are establishing an internal process for legal review of such evidence. We provided for this approach because we are aware, based on previous program experience, that we must look to State law when there is no controlling federal statute on a matter. This approach is particularly applicable in cases where the issue arises of whether a purchase order represents a binding agreement under State law in light of the fact that most States have adopted the Uniform Commercial Code with little or no change and the code provides that an order may represent an invitation to contract for goods and not an absolute obligation in many cases. Since the obligated capital regulation requires that a contract between two unrelated parties must be formed no later than December 31, 1990, the requirements of that provision clearly may not be met unless the supplier of the goods or services indicates acceptance (i.e., delivery, invoice, receipt of payment, etc.) or is required to perform by the regulatory deadline under State law even in the absence of evidence of acceptance. When this evidence is not submitted, we do not believe that we can recognize the purchase order alone as unquestionable evidence of a binding contract under any State's law. When there is an issue of acceptance of a purchase order, or automatic requirement for performance due to the simple issuance of a purchase order under State law, we will employ the internal legal review process referred to in the preamble to the final regulations for the capital prospective payment system. As a result we are retaining the current regulatory language regarding binding agreements at § 412.302(c)(1).

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, 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 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 October 1, 1994 deadline for putting an asset in use to no later than September 30, 1996.

Current regulations do not establish a process for granting an extension in the October 1, 1994 deadline. Therefore, we proposed requiring 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 180 days after 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.

Based on public comments supporting the proposed change, we are adopting it in this final rule without revision.

Comment: A commenter requested that we describe the requirements and timeframe for a hospital to appeal a decision regarding an extension in the deadline for putting a project into patient care use.

Response: There is no separate appeals process for decisions regarding whether an extension in the deadline for completing a project is warranted by extraordinary circumstances. Instead, as provided in §§ 412.328(g)(2)(iii) and 412.344(d)(2), the final determinations for the hospital-specific rate and the hold-harmless payment affected by such decisions are subject to administrative and judicial review under Chapter 42, part 405, subpart R. Thus, if a hospital is

denied an extension in the deadline, the decision is not subject to formal appeal until the first cost reporting period affected by the decision, that is, the first cost reporting period during which the asset has been put in use and is classified as new capital. The intermediary's determination of capital payments for that cost reporting period is subject to the normal appeal procedures for intermediary cost report determinations. In the interim, if the hospital has additional information that would affect the determination, it may appeal the decision informally to HCFA through 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.

To avoid disadvantaging hospitals that may not have understood the importance of making a timely submission to the intermediary, we proposed revising § 412.302(c)(1)(v) to extend the deadline for submission of obligated capital cost documentation. We proposed 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.

Consistent with the extension of the notification deadline for the hospital, we also proposed to extend the deadline for the intermediary's notification to the hospital of its obligated capital determination. We proposed that the intermediary would have 1 year from the date the hospital submits its complete documentation to advise the hospital of the intermediary's decision. Based on further consideration, we are revising the proposed changes to require that the intermediary notify the hospital of its determination by the later of the end of the hospital's first cost reporting period under the capital prospective payment system or 9 months from the date the hospital submits its complete documentation.

Comment: Several commenters specifically indicated that the proposed change was reasonable. Noting that hospitals are at different stages of complying with the notification requirement based on when they became subject to the capital prospective payment system, one commenter recommended that the date for notifying the intermediary of obligated capital be extended to 90 days after the publication of this final rule.

Response: We believe that the proposed change represents a reasonable deadline for all affected hospitals. In general, we believe that 90 days after a hospital becomes subject to the capital prospective payment system is sufficient time for a hospital to notify its intermediary of obligated capital. Since hospitals with cost reporting periods beginning in late FY 1992 have had more advance warning on the notification requirements and their implications than hospitals with cost reporting periods beginning in early FY 1992, an extension in the deadline is unnecessary for these hospitals. Morever, an additional 90 day extension would limit the amount of information on obligated capital that we would have available in developing the proposed rule for FY 1994 capital payment policies and rates. As complete information as possible is needed not only to refine the capital acquisition model used for budget neutrality purposes but also to monitor the impact of the capital prospective payment system and determine if any policy changes would be appropriate. Based on these considerations, we are extending the notification deadline in this final rule as proposed.

After further consideration, we are also shortening the deadline for the intermediary's determination. The current rules provide that the intermediary will have until the end of the hospital's first cost reporting period under the capital prospective payment system, or 9 months if the hospital notified the intermediary on the 90 day deadline. In the June 4, 1992 proposed rule, we proposed to allow the intermediary one year to make its determination. In view of both the hospital's and HCFA's need to know the obligated capital determination as soon as possible, we are revising the intermediary's deadline to the later of the end of the hospital's first cost reporting period under the capital prospective payment system or 9 months from the date the hospital submits its complete documentation on obligated capital to the intermediary.

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 will qualify under the general rule for obligated capital. However, as discussed in the June 4, 1992 proposed rule, some states grant CON approvals that are conditional upon the hospital fulfilling certain requirements (57 FR 23652).

Because the August 30, 1991 final rule did not address conditional approvals, we proposed amending § 412.302(c)(2)(i)(B) to provide that if a hospital received conditional CON approval for a project, the intermediary will assess the nature of the conditions and determine whether the hospital received sufficient approval for the project to proceed 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.

We received several comments that were supportive of the proposed change and we are adopting it without revision in this final rule. As discussed below, we received other comments on the provisions relating to obligated capital for hospitals subject to a lengthy certificate-of-need process that were not directly related to the proposed change.

Comment: We received several comments from individual hospitals and associations requesting revision to the provisions related to obligated capital costs for hospitals subject to a lengthy certificate-of-need (CON) process. Citing problems and delays frequently encountered throughout the process, such as a requirement for separate CON approvals for each phase of a multi-phase project that are contingent on completion of earlier phases, the

commenters suggested that the policies be revised to:

- Allow later phases of a staged construction project to be deemed part of the originally approved obligation for purposes of meeting the December 31, 1989 deadline.
- Extend the deadline for putting the project into patient care use by up to 3 years.
- Allow a 10-year transition for each phase under the hold-harmless methodology.

We also received comments suggesting that the expenditure threshold for recognition of obligated capital was too stringent for small hospitals. Some of the commenters suggested that we lower the initial expenditure threshold to the lowest of $750,000, 10 percent of the estimated cost or 1 percent of inpatient operating cost (excluding capital costs), and extend the deadline for incurring the expenditures from December 31, 1990 to December 31, 1991.

Response: In developing the capital prospective payment policies set forth in the August 30, 1991 final rule, we were aware that some hospitals would be undertaking major capital projects during the transition from reasonable cost-based payments to prospective payments based solely on the Federal rate. We are monitoring the implementation of the capital prospective payment system closely. As we obtain additional information on those hospitals undertaking major projects that have been delayed by the CON process but do not qualify as obligated capital, we will reassess our transition payment policies. However, any reassessment will be made within the policy framework used to establish the initial transition payment policies.

In establishing the special provision for hospitals that are subject to a lengthy CON process, we recognized that such hospitals should not be disadvantaged if they reasonably anticipated the CON approval process in their capital planning but were unable to meet the December 31, 1990 cut-off date for obligated capital because timely CON approval was not received. Our intent was not to afford more favorable treatment for these hospitals than for other hospitals, but rather to make a reasonable and equitable allowance for the impact a lengthy CON process may have on the hospital's ability to meet the criteria for recognition of obligated capital costs as old capital in order to not disadvantage those hospitals that had already made a substantial financial commitment. Thus, the intent was to put these hospitals on a comparable footing with other hospitals.

We believe that it would be premature to make modifications in the CON provision at this time. We are sympathetic to the difficulties faced by some hospitals subject to a lengthy CON process. However, we believe that any modifications should be made only after we have sufficient information about the extent of potential problems unique to hospitals subject to the lengthy CON process as well as other hospitals that, for example, may meet all requirements for obligated capital other than the deadline for putting the project in use for patient care or have multi-phase projects, only the first stages of which will qualify as obligated capital. We wish to avoid ad hoc policy changes that might appear appropriate based on the specific circumstances of a few hospitals but which are not appropriate when the situations of other hospitals are also taken into account. Since the first three changes suggested by the commenters would not affect actual program payments until the capital projects are completed later in the transition, we believe it is not necessary to give them additional consideration before we complete a preliminary evaluation of how the capital prospective payment transition rules affect hospitals that are initiating major capital projects that do not meet the obligated capital requirements. To facilitate a systematic evaluation of this issue before next Spring, we welcome information from hospitals that are in this situation but have not already advised us of their circumstances. If we conclude that changes in our transition payment policies would be appropriate, we would include them in the proposed rule setting forth our FY 1994 capital payment policies and rates.

With regard to the recommendations by the commenters on the CON expenditure threshold, we note that we established the CON provision to protect hospitals with major capital projects that had made a significant financial commitment as of December 31, 1990 (the cut-off date for obligated capital), but would not be able to meet the obligated capital provision because of a lengthy CON process (56 FR 43393). If the hospital had not made a substantial financial investment, there is no indication that it was fully committed to proceeding with a project regardless of the capital prospective payment system nor would the hospital suffer financial loss if it decided not to proceed with the project. In the August 30, 1991 final rule, we established the threshold, based on comments received to the proposed rule, at the lesser of $750,000 or 10 percent of the estimated project cost, to ensure that it would be proportionate to the size of the project without being unreasonably high for large projects. We believe that the threshold is a reasonable standard to identify whether a substantial financial commitment had been made on a major capital project. Also, we believe it is appropriate to require that the commitment be made as of the same deadline for legally obligated capital. To provide otherwise would be to give hospitals subject to a lengthy CON process more favorable treatment than that afforded other hospitals. Based on the foregoing considerations, we are retaining the current expenditure thresholds.

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

Sections 412.328(b)(3) and (c) provide for transfer adjustment factors to the discharge count and case-mix index used to calculate each hospital's hospital-specific rate. (See 57 FR 23652 for details.)

In the August 30, 1991 final rule, we provided for only the transfer adjustment factors for the initial base year period. In the June 4, 1992 proposed rule, we proposed 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 a base period in the case of a new hospital or a hospital-specific rate redetermination. For later base periods beginning before October 1, 1991, we proposed to 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 factors provided in Table 9 of the June 4, 1992 proposed rule would be considered final values. We stated that we would publish values for cost reporting periods ending after June 30, 1991 through December 31, 1991 in this final rule. We proposed that 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.

Since no specific comments were received on the proposed change, we are making the change as proposed in this final rule. The transfer adjustment factors for cost reporting periods ending after June 30, 1991 through December 31, 1991 are in Table 9 of this **Federal Register** document.

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).

We proposed to amend § 412.328(f)(1)(i) to clarify that a redetermination is permitted only when there is an increase in the hospital's total old capital costs. We proposed to 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.

Also, 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 proposed 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.

Last, 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 proposed revising § 412.328(f)(1)(iii) to require 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. 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 proposed 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.

After consideration of the comments discussed below, we are modifying one proposed change. In this final rule, we are providing that if a redetermined hospital-specific rate is lower than the hospital's current hospital-specific rate, the intermediary will deny the hospital's request instead of providing the hospital with an opportunity to withdraw the request.

Comment: Several commenters disagreed with our clarification that only an actual increase in total old capital costs will be recognized as a basis for a redetermination of the hospital-specific rate and that a change in utilization would not be recognized. One commenter argued that other events, such as loss of physician staff, have a critical impact on a hospital's capital costs per case, especially for small rural hospitals. The commenter noted that since capital costs are fixed, they cannot be reduced as readily as operating costs in response to lower utilization. Another commenter requested clarification regarding how a utilization change would be taken into account when the hospital-specific rate is recalculated based on an increase in total old capital costs. Finally, a commenter noted that if the hospital's discharges in the new base period were used in redetermining the hospital-specific rate, hospitals with an increase in total old capital costs but reduced utilization would have an advantage over hospitals with no increase in total old capital costs but reduced utilization. The commenter suggested that no adjustment be made for any utilization change when the hospital-specific rate is redetermined; instead, the hospital-specific rate should be adjusted by the percentage increase in old capital costs.

Response: As we pointed out in the preamble of the June 4, 1992 proposed rule (57 FR 23653), the proposed limitation on hospital-specific rate redeterminations is not a change from our original policy but a necessary clarification because of confusion over the original language of the regulation (56 FR 43454). We further explained that the redetermination provision was incorporated into the final rule in order to provide for recognition of obligated capital costs comparable with the provision for hospitals paid under the hold-harmless payment methodology. There was no intention to provide protection from utilization declines through the hospital-specific rate redetermination policy. We reiterate that one of the primary purposes for moving to a per discharge payment was to enable the Medicare program to provide incentives for efficiency by ending subsidies for under-utilized capacity. We believe that to expand the basis for redetermination to utilization changes, regardless of the cause or the fact that capital-related costs are more difficult for providers to control, would undermine the balance we have obtained with this policy. We believe that the minimum payment levels that we have established through the exceptions policy are adequate protection for hospitals that suffer a drop in utilization or other adverse conditions that are often experienced in the normal course of hospital operations. We do not find the rationale presented by the commenters to be a sufficient basis to revise our original policy intent in this matter.

Once a hospital qualifies for a hospital-specific rate redetermination based on an increase in total old capital costs, the hospital-specific rate will be redetermined based on the hospital's Medicare old capital costs and discharges in the new base period. As one commenter pointed out, using the discharges in the new base year could in some cases give the hospital that experiences a decline in utilization an advantage over hospitals with declining utilization that do not qualify for a redetermination. Although this may occur in some cases, we would expect that most hospitals with significant obligated capital will experience an increase in utilization when the project is completed and put in use for patient care. If we were to simply adjust the hospital-specific rate by the percentage increase in total old capital costs, we would not be accounting for the increased utilization or any change in Medicare's share of old capital costs resulting from the obligated capital. Since payment is on a per discharge basis, the Medicare program would in effect be paying the hospital twice for the increased costs attributable to utilization increases: Once through the higher hospital-specific rate and again through the increased number of admissions. Therefore, we are not adopting the commenter's recommendation.

Comment: Instead of notifying a hospital that a redetermination request would result in a lower hospital-specific rate and allowing 60 days for the hospital to withdraw its request, one commenter suggested that the intermediary should reject the request for redetermination.

Response: Our intent in requiring the hospital to withdraw its request was to

make the hospital an active and responsible participant in the redetermination process and to avoid unnecessary requests. As pointed out in the preamble to the June 4, 1990 proposed change (57 FR 23653), the hospital must recognize the significance of requesting a redetermination for increased old capital costs. However, upon further consideration, we believe that the requirement that the hospital demonstrate an increase in its hospital-specific rate is sufficient to reduce the incidence of unwarranted requests. To avoid establishing an unnecessary administrative burden, we are adopting the commenter's suggestion in this final rule.

Comment: One commenter requested that the deadline for requesting a hospital-specific rate redetermination be set at 120 days from the end of the cost reporting period to allow a hospital time to analyze its capital costs.

Response: We believe that the proposed change will allow a hospital adequate time to analyze its costs and provide the necessary documentation for a hospital-specific rate redetermination at the same time the cost report is due. Since the revised cost reports will provide for separate reporting of old capital costs, the hospital will be able to compare its old capital costs per discharge for the cost reporting period with those for the original base year. Moreover, since the redetermination request is in part a request for a retroactive change in the basis for the capital payment determination for the cost reporting period, it is most appropriately filed as part of the cost report submission. This will allow the intermediary to take the request into consideration during tentative settlement and avoid in many cases the administrative burden of an additional retroactive adjustment prior to final settlement of the cost report. Since the hospital-specific rate redetermination and the cost report settlement process are so closely linked, we are adopting the proposed change without revision in this final rule.

Comment: One commenter stated that HCFA has not addressed when retroactive and prospective payments would be made to a hospital reflecting the redetermined hospital-specific rate and suggested that provision be made for interim payment adjustments so that hospitals will not have to wait a significant length of time before receiving the additional payments. The commenter also indicated that no deadlines are set for responses to hospital requests for a hospital-specific rate redetermination.

Response: Payments to providers, including interim payments, are addressed comprehensively in regulations at part 413, subpart E. These rules provide intermediaries with adequate flexibility to adjust payments on the basis of appropriately documented changes in capital costs during a cost reporting period. We believe they are as appropriate for capital payment purposes as they are for all other hospital payment provisions.

Based on an initial redetermination of the hospital-specific rate, the intermediary has discretionary authority to make a retroactive adjustment in the tentative settlement for any closed cost reporting periods affected by the redetermined hospital-specific rate. In addition, the intermediary may adjust the interim payments for a current cost reporting period to take into account the initial redetermined hospital-specific rate. The intermediary's decision to make these payment adjustments will be based on its assessment of the accuracy and adequacy of the documentation supporting the redetermination request. The final redetermination of the hospital-specific rate cannot be made until there has been a final settlement of the new base period cost report and the transfer-adjusted discharge and case-mix data needed to compute the rate are available. Since redetermination requests may be filed at different stages of the cost report cycle, a standard deadline for intermediary adjudication of a redetermination request and the resulting payment adjustments cannot be established. However, full retroactive application of the redetermined hospital-specific rate to the beginning of the new base period is clearly protected by § 412.336(c).

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.

Therefore, we proposed to add § 412.331 to incorporate the guidelines provided in the preamble to the final rule of August 30, 1991 for mergers or consolidations that meet the criteria under § 413.134(k) and to establish rules for dealing with situations where a hospital separates into two or more hospitals. We also proposed 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 proposed to 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.

We also proposed 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 will 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).

Comment: One commenter suggested that merged facilities should have the same opportunities to apply for

redetermination as other hospitals. In particular, the commenter noted that if the hospitals merged after the deadline for requesting a hospital-specific rate redetermination, they may be disadvantaged if one of the hospitals had been paid under the hold-harmless methodology and had not had a hospital-specific rate determination when obligated capital was put in use.

Response: The proposed change would not preclude a hospital that results from a merger of two or more previously independent hospitals from obtaining a redetermination of its old capital costs (as determined in the base year audits for the previously separate entities) if it is otherwise eligible for such a redetermination of the hospital-specific rate pursuant to the provisions at section 412.328(f). However, the commenter is correct that under current rules the resulting hospital would not qualify for a redetermination if the request is not filed timely. As a general rule, we do not believe that payment rules that are appropriately applied at the time should be reversed for subsequent events. At the same time, we can envision situations such as the one pointed out by the commenter where the result may be inequitable. We will examine the issue raised by the commenter and if we determine that any policy changes would be appropriate, we will propose them in a future rulemaking document.

Comment: A commenter questioned the preamble clarification that unless the asset acquisition meets the requirements stipulated for hospital merger or consolidation in the proposed § 412.331, those asset's costs would be treated as old or new capital under the rules provided at § 412.302 of the final capital prospective payment system regulations. The question arises because the writer understood that old capital costs always retain their identity as old capital.

Response: We provided discussion in the preamble of the June 4, 1990 proposed rule (57 FR 23653–23654) to call attention to the fact that old capital determinations are hospital-specific determinations and do not follow the asset if ownership of the asset is transferred to another hospital, except in the case of certain specified conditions. We believe that our descriptions of the limits on old capital have been adequate to alert hospitals that the purchase or sale of assets, even between facilities, will affect the treatment of the asset's costs unless a particular regulatory provision attaches to the type of transaction or asset involved.

If there is a change in the ownership of the hospital, the old capital determination made in the base year is retained by the hospital and its new owner(s). Similarly, we have extended this old capital protection to mergers and consolidations that are recognized under § 413.134(k). However, when Hospital A simply purchases the assets of Hospital B, even if it is the entire hospital (for example, when the latter hospital has filed for bankruptcy protection and its assets are being auctioned), those assets represent new capital assets to the purchaser (Hospital A) even if they were determined to be old capital assets when Hospital B was a participating Medicare provider. When there is no finding of merger or consolidation under Medicare program provisions, a simple asset acquisition is involved and the assets would be recognized as new capital costs if they were acquired after December 31, 1990 and no obligation to acquire them was in effect as of that date.

We believe these distinctions are necessary and appropriate so that no special incentives are created under the capital prospective payment system for hospitals to acquire assets that carry a potential advantage of being identified as old capital assets. We will make this distinction as clear as possible in our program instructions on the capital prospective payment system when those instructions are issued, as well.

Comment: One commenter asserted that HCFA should explicitly explain issues regarding change of ownership such as the limitations on recognition of old capital costs for new owners under the limits on valuation of assets when there is a change of ownership under section 1861(v)(1)(o) of the Social Security Act.

Response: The cost limitations on old capital assets when there is a change of ownership was addressed in the preamble to the August 30, 1991 final rule implementing the capital prospective payment system (56 FR 43405). Issues that arise from application of that limitation on an ongoing basis are addressed in program correspondence and will be included in program manual instructions that will be issued shortly.

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. A hospital must apply to the HCFA Regional Office servicing its area within 180 days of the extraordinary circumstance causing the unexpected expenditures in order to qualify for exceptions payments. We proposed 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 decision to extend the deadline for obligated capital notifications discussed above, we proposed changing the deadline for extraordinary circumstances applications to the later of October 1, 1992 or within 180 days of the occurrence of the extraordinary circumstances.

No comments were received on this proposal, and we are therefore adopting it without change in this final rule.

I. Special Payment Protections

1. Hospitals with High Medicare Usage

As discussed in detail in the June 4, 1992 proposed rule (57 FR 23654–23656), we believe it would not be approriate to institute a payment adjustment or any special exceptions provisions for high Medicare utilization hospitals at this time. Our analyses found that the Medicare market shares for high Medicare utilization hospitals are not appreciably different from those of other prospective payment system hospitals. Their capital costs per case, and their total costs per case, are not higher than other hospitals, once we control for payment adjustments, occupancy, and the capital age and financing variables. Finally, there is no evidence that the older patients high utilization Medicare hospitals treat require more intensive resource use that would warrant a payment adjustment. As stated in the June 4, 1992 proposed rule, we will continue to monitor the characteristics of high Medicare hospitals, particularly once the data on their capital payment status is available.

Comment: One commenter believes that we did not adequately address several issues in our discussion of hospitals with high Medicare usage in the proposed rule (57 FR 23654). In particular, the commenter believes that we have not considered the role of seasonal population shifts in defining hospital market share, especially with regard to high Medicare utilization hospitals in Florida. The commenter also believes we should consider the extent to which the alternative sources of hospital care for Medicare beneficiaries are higher cost facilities or facilities that receive higher Medicare payments. In

addition, the commenter believes we should examine the extent to which care received at alternate hospitals relates to specialized services not available at the high Medicare facility. The commenter notes that we have not previously applied a market share test for other facilities which receive special payment protection. The commenter further notes that high Medicare hospitals have never claimed to have higher costs per case than other hospitals, but rather that they receive insufficient payments per case. Finally, the commenter is concerned that facilities with high Medicare usage show a lower increase in payments per case than other facilities in the impact analysis published in the proposed rule.

Response: In general, payment adjustments have two justifications: a classification that shows systematically higher Medicare costs of treating patients, such as the disproportionate share and indirect medical education adjustments, or a classification that raises systematic access concerns, such as sole community status and the special exceptions provisions for high disproportionate share hospitals under the capital prospective payment system. Since high Medicare hospitals do not have higher costs per case than other hospitals that treat Medicare beneficiaries, we turned to the market share information as a method of testing the importance of access issues with regard to high Medicare hospitals. With regard to the use of market share in determining the appropriateness of any payment adjustment for high Medicare hospitals, one method of qualifying for rural sole community hospital (SCH) status is to show that a hospital's market share meets various criteria. Urban SCHs must show that alternative sources of care are at least 35 miles away, which is evidence of limited access to care.

Our analysis indicated rural high Medicare hospitals that are not a SCH have a market share that is similar to other non-SCH rural hospitals. While it is true our analysis indicates that urban high Medicare facilities have higher market shares for medical discharges than their non-high Medicare counterparts, it is also true that a variety of alternative sources of patient care are available in their market area. According to research by Brigid Goody ("Medicare Dependent Hospitals: Who Depends on Whom?" Health Care Financing Review, forthcoming), on average more than four other hospitals currently serve the residents of the market areas of urban high Medicare hospitals, and there are on average over 11 other hospitals within a 15 mile radius of a high Medicare hospital. This research shows that access is not a significant concern for Medicare patients of urban high Medicare hospitals.

The fact that payments to high Medicare hospitals are lower than payments to other hospitals does not lead to a conclusion that the high Medicare hospitals should receive a payment adjustment. High Medicare facilities treat less resource-intensive patients and are less likely to receive teaching and disproportionate share adjustments. As explained below in our response to ProPAC's comments regarding the level of the indirect teaching and disproportionate share adjustments, we believe that these adjustments are too high for operating payments, and that the lower adjustment levels set for capital PPS are appropriate for both capital and operating payments. However, we do not believe that the excessive operating teaching and disproportionate share adjustments to other hospitals support a payment adjustment for high Medicare hospitals that is not warranted by their costs.

It is unclear how seasonal migration could affect the market share analysis discussed in the proposed rule. The market share is defined as the share of Medicare discharges from all ZIP codes in a hospital's market area. The market area is defined as those ZIP codes, ranked in order of importance, that provide at least 75 percent of a hospital's discharges. It is extremely unlikely that a ZIP code from another State would contribute enough discharges to be included in a hospital's labor market area. In order for the effect of seasonal migrants to distort the market share analysis, seasonal migrants would have to have different hospitalization rates than residents. Moreover, a forthcoming article in Health Services Research by William Buczko ("Factors Affecting Interstate Use of Inpatient Care by Medicare Beneficiaries") demonstrates that the vast majority of interstate patient flow is due to beneficiaries seeking specialized care not available in their market area, rather than seasonal migration. In fact, 7.7 percent of admissions of Florida residents occur in other States (Buczko, page 303), while 9.1 percent of admissions occurring in Florida are residents of other States (Buczko, page 301), so the net migration effect is small.

Given that the standardized costs of high Medicare hospitals are lower than non-high Medicare hospitals, and that there does not seem to be an access issue to alternative sources of care for the beneficiaries that use urban high Medicare facilities (those high Medicare hospitals with a significantly higher market share), we continue to believe that it would be inappropriate to establish any special payment protection for high Medicare hospitals at this time. We will continue to monitor their situation, however. In this regard, we note that the relatively lower average payment increases indicated in the impact analysis of this final rule for high Medicare hospitals is largely attributable to the elimination of the Medicare-dependent hospital provision effective for cost reporting periods ending after March 31, 1993.

2. Financially Distressed Hospitals that Serve Low Income Patients

As we noted in the proposed rule of June 4, 1992 (57 FR 23656), 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.

In the proposed rule, we noted that organizations representing financially distressed hospitals had suggested a number of changes in the capital prospective payment system that were similar to suggestions made in the public comments that we considered in developing the August 30, 1991 final rule. We indicated that we believe it would be premature to modify the policies in that rule until we have had an opportunity to assess their impact.

Comment: Several commenters expressed general concern over the impact that the capital prospective payment system might be having on hospitals that do not have capital reserves and need to undertake major capital projects and stressed the need to monitor their situation closely. Specific

suggestions made by commenters included: payment adjustments for capital cycle and reliance on debt; special exceptions payments; and permanently maintaining the capital payment level at 80 percent of reasonable costs for high disproportionate hospitals and extending this provision for 10 years beyond the transition period.

Response: As we stressed in the proposed rule, we are concerned that financially distressed hospitals that provide needed services receive adequate payments under the capital prospective payment system. However, we believe that it is premature to modify the original policies after less than one year into the transition and before we have had an opportunity to assess the impact of those initial policies and evaluate whether they provide sufficient payment protections.

We note that we do not have evidence that indicates that the capital prospective payment system has had an immediate adverse impact on financially distressed hospitals that would warrant changes in our payment policies for FY 1993. To the extent a financially distressed hospital has recently completed or will be completing a major capital project within the year, the higher capital costs should be accounted for by the hold-harmless payment policies for old capital. Those with older plants and equipment should benefit from receiving a blend of their hospital-specific rate and Federal rate that is at or above their historical cost per case level. Moreover, the minimum payment level for urban disproportionate share hospitals with at least 100 beds will remain at 80 percent in FY 1993. The issue of adequate payments to financially distressed hospitals with new capital needs is closely related to issues involving hospitals that are undertaking major capital projects that do not qualify as obligated capital. In our earlier response to comments on the obligated capital policies, we noted that we will undertake a preliminary evaluation of how the capital prospective payment transition rules affect hospitals that are initiating major capital projects that do not meet the obligated capital requirements in time to consider policy changes beginning in FY 1994. In our evaluation, we intend to pay particular attention to financially distressed hospitals that serve low income patients. If we conclude that changes in our capital payment policies would be appropriate, we would include them in the proposed rule setting forth the FY 1994 capital payment policies and rates. We may find, however, that the problems faced by these hospitals cannot be addressed through change in the Medicare capital prospective payment system, but that special legislation may be required to assure that these hospitals have access to needed capital.

We are also interested in the effect of the capital prospective payment system on rural areas. We solicit comments on whether there are unique capital problems of rural hospitals in meeting the needs of their Medicare populations, and, if so, how those problems might be addressed appropriately.

J. Minor Technical Corrections

We are making the following technical changes to the regulations:

- Section 412.113(a)(2)(E) will 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) will be corrected to change the last reference for capital prospective payment system purposes to § 412.344(a)(2).
- Section 412.302(c)(1)(ii) will be revised to clarify that the qualifying criterion for obligation of moveable equipment is that a binding contract for lease or purchase of the equipment was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990.

In addition, we proposed 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.

Comment: One comment was received requesting that HCFA clarify the obligated capital provision for moveable equipment due to its ambiguity in the final rule issued August 30, 1991 (56 FR 43450).

Response: We believe that the correction proposed to section 412.302(c)(1)(ii) (57 FR 23657) resolves the concern raised in this comment. We are, therefore, adopting the technical corrections made in the proposed rule without change in this final rule.

VII. 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 (§§ 412.22 and 412.25)

Since the inception of the prospective payment system for operating costs of hospital inpatient services in October 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 the status of a hospital or unit (that is, whether it is subject to, or excluded from, the prospective payment system) will 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 will 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 specifically address cases 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 recognized at times other than the start of a cost reporting period.

We proposed revising §§ 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 that is added to a hospital during the hospital's cost reporting period.

We also proposed revising § 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.

After consideration of the following comments, we are adopting the proposed changes without revision.

Comment: One commenter expressed support for the concept of making changes in the status of a hospital only for entire cost reporting periods. However, other commenters objected to this policy, stating that it unnecessarily penalizes hospitals for factors beyond their control, such as construction delays, that it discourages hospitals from making changes in their programs to meet community needs, or that it can place undue workload demands on regulatory agencies during certain time periods.

Response: We understand these commenters' concerns, and are particularly appreciative of the concern expressed regarding the workloads of regulatory agencies. However, we note that the current policies do not prohibit hospitals from making changes in their operations, nor do they result in denial of payment for the hospitals' services, since all the types of care furnished by hospitals that are excluded from the prospective payment system are also payable under the prospective payment system. We also believe that regulatory agencies, hospitals, and the public generally will benefit from policies that are clearly stated, can be easily understood by both hospitals and intermediaries, and can be simply administered. Recognizing changes in status only at the beginning of cost reporting periods is consistent with these goals, while recognizing changes in the middle of cost reporting periods would introduce added complexity to the administration of the exclusion provisions. Therefore, we are not revising the proposed changes based on these comments.

Comment: Several commenters objected to our concern that misallocations of cost could occur if changes in unit size or the opening of a new unit were recognized during cost reporting periods. One commenter stated that cost reporting techniques such as the use of weighted averages or short-term interim cost reports are available and could be used to allow changes in facility size or status during a cost reporting period without causing a misallocation of cost. Another commenter suggested that Medicare cost reporting rules be revised to allow such changes to be recognized.

Response: We recognize that cost reporting techniques such as the use of weighted averages or the introduction of short-term interim cost reports could be used to identify the cost of changes in facility size or status during a cost reporting period. However, these proposed solutions would introduce significant added complexity to the administration of the exclusion provisions. This is particularly true if hospitals would make size changes more than once in a cost reporting period.

We are also concerned about the effect that allowing such midyear changes would have on making payment to excluded rehabilitation units. Hospitals with such units are now allowed to add new beds to those units at the start of a cost reporting period, based on a certification that the patient population treated in the beds will meet the 75 percent rule (see §§ 412.23(b)(2) and 412.30(b)). The added beds are provisionally excluded from the prospective payment system, and a retroactive adjustment is made if the rule is not actually complied with. If we were to allow hospitals to add beds during a cost reporting period as well, the compliance of those beds with the 75 percent rule would have to be assessed separately. Again, multiple changes within a year would further complicate this situation.

Because of these considerations, we continue to believe that changes in the bed size of an excluded unit or the establishment of new units should be recognized only at the beginning of a hospital's cost reporting period.

Comment: Several commenters approved of the proposal to consider a fully equipped and staffed unit to be open even if the unit has not yet provided any care to patients. However, the commenters recommended that the term "fully staffed" be interpreted relative to the initial expected usage of the new unit, not to the level of utilization that might be expected over the long term after the unit's start-up period.

Response: We recognize that hospitals do not always keep enough personnel on staff to function at 100 percent of their licensed capacity, but instead hire staff to meet expected demand and maintain various contingency plans for calling in additional staff to deal with unexpected patient loads. Therefore, we agree that staffing levels should be realistic in relation to expected utilization. However, we do not believe any change in the regulations is needed to achieve this. We will clarify this point in instructions to individuals responsible for verifying compliance with the exclusion criteria.

Comment: One commenter stated that the term "fully equipped and staffed" could be subject to various interpretations, and recommended that we eliminate this test of whether a unit is open and instead allow a unit to be considered open if it admitted its first patient within 30 days of the start of its cost reporting period.

Response: We agree that some judgment will be required to determine whether a unit is fully equipped and staffed. However, the HCFA Regional Office staff responsible for implementing the exclusion provisions are also responsible for implementing Medicare health and safety requirements, and we believe they are well-suited to make these judgments. Moreover, the purpose of the judgment is not to decide whether the staffing levels are the best possible to deal with various patient loads, but to assure that a unit is actually a functional entity, rather than one which is set up to simulate compliance with the exclusion criteria and allow exclusion at the start of a particular cost reporting period, but is not capable of delivering patient care. We do not agree that the admission of at least one patient within 30 days would be a better indicator of whether a unit is actually functioning. The date of admission of the first patient may be beyond the hospital's control, and if no patient were admitted within the required time period, it would be necessary to reverse the exclusion of an otherwise qualified unit retroactively. Thus, we are not making the change recommended by this commenter.

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 operating 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 § 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 start-up 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 proposed 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. Under the proposal, 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 will 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 proposed 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 this proposal, 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 proposed that the combined total provisional exclusion period not exceed 25 months. We also proposed revising 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. However, the hospital itself would not be considered newly participating for purposes of exemption from the rate-of-increase limit because it has previously participated under the old ownership.

In this final rule, we are adopting the proposed changes as described above, with one revision. After further review of our proposal, we have concluded that provisional exclusion for the initial cost reporting period of a new rehabilitation hospital (or for the rehabilitation unit of a new hospital) that is other than 12 months in length should be no longer than 11 months, so that the total period of provisional exclusion for such a hospital or unit would be limited to 23 months, not to 25 months as we had proposed.

We are making this change in order to provide more uniform treatment of hospitals that begin at times other than the start of their regular 12-month cost report cycle relative to those whose opening coincides with the start of that cycle. As noted in the preamble to the June 4, 1992 proposed rule (57 FR 23658), current cost reporting instructions allow a new hospital to select an initial cost reporting period as short as 1 month, or as long as 13 months, to cover the period between the hospital's actual start-up date and the beginning of its preferred 12-month cost reporting cycle. If a hospital chooses an initial cost reporting period of 1 through 11 months, it will not have had a full 12-month cost reporting period of exclusion in which to show compliance with the 75 percent criterion. We therefore would allow it an additional 12-month period of provisional exclusion, in order to allow it the same qualifying period as a hospital that began operating at the start of its regular 12-month cost reporting period. However, a hospital that selects an initial cost reporting period of 13 months has a qualifying period that is longer than it would have had if it had started up at the beginning of its preferred 12-month cost reporting cycle, and there is no need to provide such a hospital with an additional 12-month period of provisional exclusion. Therefore, we have revised these final regulations to provide, in §§ 412.23(b)(8) and 412.30(a)(3), that the total period of provisional exclusion for a new rehabilitation hospital or for the rehabilitation unit of a new hospital is the first full 12-month cost reporting period plus any initial short cost reporting period which is not less than 1 month and not more than 11 months in length.

Comment: One commenter expressed approval of the proposal to revise the regulations to specify that a hospital that has had a change of ownership as defined under § 489.18 may establish a rehabilitation unit and (assuming the unit is otherwise qualified) have that unit excluded from the prospective payment system as a new unit. The commenter asked whether this provision would apply only when the hospital has not previously operated a rehabilitation unit, and whether the change of ownership would trigger establishment of a new TEFRA base year.

Response: Under § 412.30, an exclusion for a new unit is available only to a hospital that has not previously sought exclusion for any rehabilitation unit. This provision would apply if the owner of the hospital following the change of ownership had not sought a rehabilitation unit exclusion for a unit of the hospital. The change of ownership would not in itself trigger a new TEFRA base year.

Comment: One commenter stated that the kind of provisional exclusion available to new rehabilitation hospitals and units should also be made available to new long-term care hospitals, since those hospitals also could be disadvantaged by being paid under the prospective payment system.

Response: We do not agree that provisional exclusion is appropriate for new long-term care hospitals, nor do we believe the law would support such a policy. The statute, at section 1886(d)(1)(B) of the Act, confers broad discretion on the Secretary in determining whether a hospital or hospital unit may be excluded on the basis that it furnishes rehabilitation services. In accordance with the authority, we permit such exclusions on the basis of written certifications. However, section 1886(d)(1)(B) sets forth specific criteria for a hospital to be excluded as a long-term care hospital; a hospital may be excluded as a long-term care hospital only if the hospital has an average inpatient length of stay of greater than 25 days. We do not believe that the statute permits us to extend the

exclusion for long-term care hospitals to a hospital which has not demonstrated actual compliance with the statutory requirement. We note that qualification as a rehabilitation hospital or unit depends on the characteristics of the patients and the types of services that the facility furnishes; such criteria can be assessed at a given point in time. In contrast, the criterion for exclusion as a long-term care hospital (average inpatient length of stay greater than 25 days) can be assessed only over a period of time. Thus, a hospital cannot qualify as a long-term care hospital until it has been in operation for some period of time. Therefore, we did not adopt this comment.

Comment: One commenter recommended that retroactive payment adjustments not be limited to provisionally excluded rehabilitation hospitals and units but also be available for hospitals or units that convert from one exclusion category to another, such as former psychiatric units that qualify for exclusion as rehabilitation units.

Response: The purpose of the retroactive payment adjustment for improperly excluded hospitals and units is to allow facilities that have been granted excluded status on a provisional basis to have their payments adjusted retroactively to reflect their actual functioning in situations where they expressed the intention of functioning as excluded facilities but did not actually do so. There is no provision that would allow us to adjust payments to a facility that actually converted from one type of hospital or unit to another, in order to reflect the amounts the facility might have been paid if the conversion had not occurred. For example, if a hospital stops functioning as a psychiatric hospital and reconfigures itself as a rehabilitation facility in an attempt to qualify for a prospective payment system exclusion as a rehabilitation hospital, but does not actually meet the 75 percent requirement, there would be no legal basis on which we could continue to pay the hospital as a psychiatric hospital, nor would there be any justification for doing so. Instead, the hospital would be paid under the prospective payment system. Thus, we did not adopt this recommendation.

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 deleting §§ 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 proposed 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.

As explained in the June 4, 1992 proposed rule, we have found that in practice this policy is not followed in many situations involving exhaustion of Medicare benefits prior to discharge. We proposed to change our policy to conform to current practice. We proposed to 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.

We received several comments concerning the proposed definition of discharge. Many commenters supported the proposed change. After consideration of those comments and the comments discussed below, we are establishing the definition of discharge as proposed.

Comment: One commenter believes that the proposed definition of discharge may affect the comparability between a hospital's current cost per discharge and the hospital's base year cost per discharge. A hospital's TEFRA target rate is based on its inpatient operating costs divided by the number of Medicare discharges in the hospital's base year. The commenter stated that a hospital should be allowed to elect to rebase due to the change in definition of discharge regardless of whether it has a material effect on its TEFRA target rate, because a hospital may not be able to compute the effect due to the time that may have elapsed since its base year.

Response: We do not agree with the commenter. Even if a different discharge definition were used in the base period, we believe that there should be no distortion in the target amount. Although there may be situations in which benefits were exhausted in the base year but the patient was not counted as a discharge until a subsequent cost reporting period, it is just as likely that the base year cost report discharge count included patients who were discharged in that period but who exhausted benefits in an earlier cost reporting period. This is similar to the averaging that occurs with other discharges. That is, there are discharges early in the cost reporting period for which most costs were incurred in the previous cost reporting period and there are admissions later in the cost reporting period that will not be discharged until the subsequent cost reporting period. Therefore, there is no cause to adjust the target amount due to the new definition of discharge.

As we stated in the proposed rule, the revised discharge definition is necessary to conform the discharge count to current practice. Although the revised definition is effective with discharges (as defined in revised § 413.40(c)(2)) occurring on or after October 1, 1992, we do not intend to enforce the discharge definition in § 412.4 retroactively. Retroactive enforcement would require cost report reopenings because most Medicare cost reports have been settled based on the practice of counting a discharge when the patient exhausts benefits. If, contrary to common practice, the hospital's discharge count has been based on § 412.4 in prior cost reporting periods, the hospital should be advantaged by the revised discharge count. In this case, the first cost reporting period affected by the new policy (that is, the cost reporting period ending on or after October 1, 1992), the hospital's discharge count would include all patients that are discharged in that cost reporting period (and have not previously been counted as a discharge for that inpatient stay) and any patients who exhausted Medicare benefits in that or an earlier period but have not been discharged from the hospital. In no event will a patient be counted as a discharge more than once during an inpatient stay.

Comment: A commenter recommended that HCFA review its practice of establishing the count of discharges and establish in this final rule an approach to reconcile

differences in provider and intermediary discharge counts.

Response: The discharge count used by fiscal intermediaries in settling Medicare cost reports is derived from the PS&R. The PS&R is designed to capture all statistical and payment data through the claims processing system. Any differences between the hospital's records, which should reflect the same data as the claims to Medicare, should be easily reconciled to the data derived from the PS&R. Any discrepancies detected through an error in the PS&R will be corrected through modifications to the PS&R data in the same manner as other reconciliations are effected. Establishing a separate approach to reconcile the differences is not necessary since the PS&R is an interface system through the claims processing system and should tie into the hospital records.

C. New Hospital Exemption Applicable to Excluded Hospitals (§ 413.40 (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 2 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 proposed making 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. As discussed in the proposed rule (57 FR 23659), we believe that offering a hospital the choice of requesting or foregoing an exemption sometimes allowed new hospitals to obtain a competitive advantage over other hospitals. To remedy this situation, we proposed revising § 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.

Also, under current policy, a hospital may be in operation for 3 or more years before it is subject to the rate-of-increase limit. We believe that a hospital's second year of operation should be sufficiently representative to be used to establish the target amount. Therefore, we proposed reducing 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 policy concerned the issue of whether a participating facility that reorganizes (for example, from an excluded hospital to an excluded unit of an acute care hospital) or changes the basis of its participation in the Medicare program (for example, from a rehabilitation hospital to a long-term hospital) is a new hospital, even if it continues to provide the same services as it did before the reorganization. To preclude hospitals from qualifying for a new hospital exemption based solely on such operational reorganizations or changes in certification status, we proposed to revise § 413.40(f) to specify that a hospital would qualify as a new hospital only if it had not previously provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program.

As explained in the June 4, 1992 proposed rule (57 FR 23659–23660), a hospital undergoing a change in organizational structure does not incur the significant patient care cost distortions associated with being a new hospital. Any cost distortions that affect the comparability of cost reporting periods stem from a change in the organizational structure of the facility rather than in the type of services it provides to patients in the excluded portion of the facility.

However, we also recognized that the target amount that applied before the hospital's reorganization might not appropriately reflect costs after its reorganization. Therefore, to account for the effect of changes in the operational structure of the hospital or distinct-part unit (that is, a freestanding rehabilitation hospital becomes a distinct-part unit or vice versa) on operating costs per discharge, we proposed to revise § 413.40(b) to clarify that the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.

In contrast, the target amount would continue to reflect the costs of a hospital that changes the basis of its certification but does not experience a significant change in organizational structure or in the type of services provided. The potential new hospital exemption period for these hospitals would begin with the first day of the cost reporting period in which the hospital provided services consistent with its new certification status. An example would be a new hospital with an average length of stay exceeding 25 days that changes its certification from an acute care hospital to a long-term hospital after 1 year. Since the hospital served the requisite patient population from the outset, the base year would be the first cost reporting period beginning at least 12 months after the hospital accepted its first patient as an acute care hospital.

After consideration of the following comments, we are adopting the proposed changes without revision.

Comment: A commenter argued that there may be cases where the established base year under the new hospital provision does not reflect the hospital's per-case costs because it could take a longer period of time before the on-going cost structure for a new hospital is in place. In cases where it is subsequently determined that the base year's per-case rates are distorted, a permanent adjustment to the base year per case rate should be made, so that these hospitals do not have to seek a payment adjustment to their per-case rates each year.

Response: The situation described above is not unique to new hospitals. There are many circumstances that could cause cost distortions between the base year and subsequent periods. Regulations at § 413.40(g)(1) currently provide the mechanism by which hospitals may receive adjustments

under the cost per case limitations. One general basis for an adjustment is lack of comparability between the base period and subsequent periods. To the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, and separately identified by the hospital, an adjustment may be warranted. If the cause of the cost distortion is permanent, the adjustment will be made permanent as well.

Comment: A commenter asserted that the existing new hospital exemption process provides the most effective incentive to reduce health care costs. Increases in hospital spending could be more effectively controlled through the existing new hospital exemption rules. The new hospital exemption was implemented in order to provide a hospital with enough to establish a good base of operations.

Response: We do not agree with the commenter that the current new hospital exemption more effectively controls hospital spending. During the exemption period, a hospital has little incentive to control its costs. Under the current exemption policy, a hospital may choose, after the fact, whether it wants its base year to be its initial year of operation (even though it may not be representative of its on-going costs), or its third year. Since the hospital knows in advance that it may choose either the first or the third year of operation as its base period, it has an incentive in both years to increase its costs in order to raise the target amount that would be applicable to subsequent periods.

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. The first year of operation is commonly atypical. That is, there are normally start-up costs in the first year and utilization may be lower in that year. Since the first year is typically unrepresentative of the hospital's on-going operation, it should not be used as a base period. However, by the second year of operation, the hospital's operations should be well established. To provide an exemption beyond this period unnecessarily delays the incentives for cost containment imposed by the rate-of-increase limits.

Comment: A commenter suggested that in determining the base year per-case rate for a new hospital that is exempt from the prospective payment system, HCFA should select whichever cost reporting period, within two years after the hospital accepts its first patient, is most representative of the hospital's legitimate cost structure.

Response: We believe the commenter's suggestion would be problematic in that it would require including a subjective judgment in the selection of the base year. New hospitals that are exempt from the prospective payment system have an advantage over other hospitals already under the rate-of-increase ceiling since the new hospital knows in advance which period will be its base period and can react accordingly. One problem with the current provision is that the hospital has the flexibility to choose after the close of the potential base periods which period it wants as the base year. In some situations, hospitals have prematurely requested an exemption and later wanted to withdraw the request due to subsequent extenuating circumstances. Making the exemption automatic, and shortening its length, puts all new hospitals on the same footing with respect to the rate-of-increase ceiling. Any distortions after the base year can be addressed through the normal adjustment procedures.

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 will 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 period would not be appropriate for establishing a target amount for limiting cost increases in future periods. Therefore, we proposed revising § 413.40(g)(3)(iii) to specify the circumstances when HCFA may adjust the amount of operating costs. We proposed that these circumstances include, but 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).

After consideration of the following comments, we are adopting the proposed changes without revision.

Comment: Commenters recognized that there may be situations where it would be appropriate for HCFA to make adjustments to overcome distortions in the comparison of base year and current costs. However, they argued that the proposed unqualified wording ("certain adjustments" which "include, but are not limited to" those specified in the rule) invites arbitrary and inappropriate actions both in the determination of what constitutes a significant distortion and in the nature of the adjustment. Furthermore, there is currently no requirement that HCFA advise the hospital in advance or seek its participation in resolving a reputed distortion. The commenters recommended that HCFA expand the list of specific situations causing distortions, provide for HCFA's general adjustment authority in the context of regulatory language describing the nature of other possible situations that would constitute or result in significant distortions, and that HCFA be required to notify the affected hospital of the distortion that it intends to address, describe the proposed remedy, and permit the hospital to present its views and data in advance of HCFA making any adjustments.

Response: We do not believe the proposed language invites arbitrary and inappropriate actions. Although there may be similarities in some adjustment requests, each case presented for a determination, is to a certain extent, unique to the individual hospital. The examples cited in the proposed rule are cases we are aware of to date, but there may be other situations that have not come to our attention. It is almost impossible to develop an all-inclusive listing of circumstances that may warrant adjustments. Therefore, we believe it is important to permit some latitude in the adjustment process by addressing the most common circumstances in the regulation and allowing flexibility to address unknown circumstances. Anytime HCFA makes an adjustment, the decision is forwarded to the hospital's fiscal intermediary, which in turn notifies the hospital of the decision, including a full explanation of the grounds for the decision. The hospital has 180 days after the date of the intermediary's notice of the decision to appeal a determination.

E. Other Issues

We received two comments unrelated to the proposed changes. We considered the comments, but we do not intend to make any additional changes as a result of these comments.

Comment: Several commenters wanted to treat new distinct-part units that are exempt from the prospective payment system the same as new hospitals in terms of the initial exemption from the rate-of-increase ceiling and the determination of the base year.

Response: We proposed no changes to this provision of the Medicare regulations. However, we continue to believe that the new hospital exemption should not be extended to include newly established distinct-part units. The basic premises regarding the new hospital exemption are that new hospitals have incurred start-up costs to become operational and they need to build a relationship with the community. With respect to distinct-part units of a hospital, start-up costs should be minimal and the distinct-part unit, to some degree, has its own patient population already established through the acute care hospital. Thus, we believe the considerations which underlie the exemption to new hospitals do not apply to distinct-part units.

Comment: A commenter suggested that HCFA should allow the rebasing of any long-term hospital that can show that it is providing a significantly greater amount of routine and/or ancillary services per discharge or per day for medically necessary services. A significant segment of long-term hospitals' base years are distorted due to such factors as increases in Medicare utilization, increases in ancillary usage among Medicare patients, and changes in the PRO criteria since the base year.

Response: We did not propose any changes to the rebasing provisions of the regulations. The circumstances described by the commenter are already accounted for in the adjustment provision for comparability of cost reporting periods. One of the conditions of the assignment of a new base period is that the general TEFRA adjustment provisions would not result in recognition of the reasonable and necessary costs of providing inpatient services. Therefore, we do not agree that the change in rebasing provisions recommended by the commenter is necessary.

VIII. Other ProPAC Recommendations

As required by law, we reviewed the March 1, 1992 report submitted by ProPAC to Congress and gave its recommendations careful consideration in conjunction with the proposals set forth in the proposed rule. We also responded to the individual recommendations in the proposed rule. The comments we received on the treatment of the ProPAC recommendations are set forth below along with our responses to those comments. However, if we received no comments from the public concerning a ProPAC recommendation or our response to that recommendation, we have not repeated the recommendation and response in the discussion below. Recommendations 1, 2, and 11 concerning the update factors for inpatient operating costs are discussed in Appendix C to this document. The remaining recommendations on which we received comments 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.

Comment: ProPAC reiterated its recommendation that HCFA implement an update framework for fiscal year 1994 instead of using the 2-year average of historical cost-per-case increases.

Response: We present a preliminary discussion of an update framework for the prospective payment system for capital-related costs in Appendix D of this final rule. Section 412.308(c)(1) provides that HCFA will use a framework to determine the update factor beginning in FY 1996. We welcome comments on the preliminary concepts and methodologies for a capital update framework, and on the issue of whether framework update should be implemented before FY 1996 to determine the update factor.

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 in the Proposed Rule: 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.

Comment: ProPAC had several comments on our response in the proposed rule to this recommendation. First, ProPAC agreed with our ultimate objective of one IME adjustment and one DSH adjustment for both the operating and capital prospective payment systems, but thought separate adjustments for operating and capital were necessary in the interim. ProPAC disagreed with our assertion that the estimate of the effects of teaching should control for the costs of treating a disproportionate share of low-income patients. ProPAC's position is based on its perception that the DSH adjustment is not intended specifically to reflect cost differences, but instead fulfills a broader public policy objective to maintain access to care.

In response to our statement that total operating margins are not relevant to an examination of Medicare payment policy, ProPAC argued that total margins are a useful analytic tool. For example, based on the relatively worse overall financial condition of teaching hospitals that serve a disproportionate share of low-income patients, as seen from these hospitals' low total operating margins, ProPAC commented that the savings from a reduction in the IME payment adjustment should be returned to these hospitals.

Response: As we noted above in our response in the proposed rule and in our response to Recommendation 5, below, we believe the adjustments for the operating and the capital prospective payment systems should be uniform. We have not, however, proposed changing the IME or DSH operating adjustments for FY 1993. These adjustments are specified in the statute.

We have serious concerns about ProPAC's rationale for not controlling for the costs of treating a disproportionate share of low-income patients in the estimation of the teaching effect. Numerous analyses have illustrated the interactive effects of IME and DSH on costs. We believe the payment adjustments should, as precisely as possible, reflect the actual cost impacts of the factors for which they are targeted. We have consistently maintained that the appropriate level of the IME adjustment should be one that is based on a more recent statistical estimate of the effects of teaching on costs, separate from all other factors for which hospitals' prospective payments are adjusted.

This position would seem to be consistent with Congressional intent, based on recent legislation. Since the DSH adjustment was implemented effective with discharges occurring on or after May 1, 1986, Congress has repeatedly acted to link the level of the IME adjustment to the level of the DSH adjustment. When the DSH adjustment was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99–272), Congress simultaneously lowered the IME adjustment in section 9104(a) in recognition of the overlap of these two adjustments in terms of the hospitals receiving them. Similarly, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203) further reduced the IME adjustment (section 4003(a)) to correspond with changes to the DSH payment policy (section 4003 (b), (c), and (d)). Finally, the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) deleted the expiration date for the

DSH adjustment (section 4002(b)(1)(A)) and correspondingly deleted the provision to increase the IME adjustment upon the expiration of the DSH adjustment (section 4002(b)(3)(B)).

Regarding the use of total margins to evaluate Medicare payment policy, we believe that our position is consistent with our argument that the IME estimate should reflect only the effect of teaching costs because the prospective payment system should, as precisely as possible, pay hospitals for their costs of treating Medicare patients efficiently. As we have stated in the past, we recognize the important role that large, inner-city hospitals play in fulfilling larger public health needs. However, as we have also indicated, we 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 Medicare payments to all teaching hospitals. As we expressed in the proposed rule and above, the issue of equitably dealing with these larger social problems should be addressed within the context of health care reform.

Finally, as we have noted before, teaching hospitals that also receive DSH payments have consistently had Medicare payment-to-cost ratios above those of other hospital groups. Therefore, we disagree with ProPAC's recommendation that the savings from reducing the IME adjustment should be returned to teaching hospitals that also receive DSH payments.

Comment: One commenter supported our position that Medicare payment equity could be improved by returning at least a portion of IME savings to all hospitals. This commenter pointed out that the IME adjustment represents one component in the prospective payment system, and that savings from reducing IME payments should be used to close the gap between the Medicare operating margins of teaching hospitals and nonteaching hospitals. Another commenter expressed strong opposition to reducing the level of the IME adjustment until a within-DRG severity measure is developed.

Response: We take note of the first commenter's support for improving overall payment equity in conjunction with reducing the IME adjustment. Although we are concerned with the financial viability of large inner-city teaching and DSH hospitals, our responsibility in evaluating potential system changes includes the objective of overall payment equity. We believe this can best be achieved by ensuring that the payment adjustments accurately reflect the across-hospital variations in Medicare costs due to the factors for which we make adjustments. Consequently, in response to the second commenter, we repeat our belief that the appropriate level of the IME operating adjustment is the level currently paid in the prospective payment system for capital-related costs. Because this estimate was made by controlling for case-mix variation using the FY 1991 GROUPER, it reflects our ability to control for the cost effects of varying levels of within DRG severity. To the extent that teaching hospitals have higher costs due to more severely ill patients that are not explained by controlling for case-mix, those costs would be reflected in the IME estimate. Therefore, we disagree with the argument that any reduction to IME should be delayed pending the adoption of a refined severity measure.

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 in the Proposed Rule: 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 implement 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.)

Comment: In its comments on the proposed rule, ProPAC stated that it continues to believe that the IME and DSH adjustments to the operating and capital prospective payments should be consistent. Also, ProPAC argued that the measure of teaching intensity used for capital IME payments, that is, the ratio of residents to average daily census, rewards hospitals with low occupancy rates. ProPAC was unable to reproduce our finding that the average daily census ratio performed better in explaining differences in cost per case. ProPAC believes that our regression results were based on total costs per case, and that our findings were due to lower occupancy hospitals having higher capital cost per case. As a result, ProPAC asserted that the use of the resident-to-day ratio rewards hospitals that use capital inefficiently. Finally, ProPAC suggested that the operating DSH formulas and criteria should be applied to capital payments, because of the public policy goals reflected in them. One commenter supported our position that the operating DSH adjustment should be made equal to the capital DSH adjustment. Another commenter believed that the capital IME adjustment should be set equal to the current operating IME adjustment.

Response: We agree with ProPAC that the formulas and criteria of the operating and capital IME and DSH adjustments should be equivalent. However, we continue to believe that the appropriate level of the adjustments is that justified by the total cost regressions, as implemented in the capital prospective payment adjustments. As we stated above in our response to ProPAC's comments regarding Recommendation 4, we believe the payment adjustments should reflect the increase in the cost of treating Medicare beneficiaries due to increases in the resident-to-day ratio and the disproportionate share patient percentage, rather than any broader policy goals.

We disagree with ProPAC's position that the resident-to-day ratio rewards hospitals with low occupancy rates. ProPAC cites an example where two hospitals have the same numbers of residents and beds but different occupancy rates, so that the hospital with the lower average daily census would have a higher resident-to-day ratio. Focusing on occupancy rates obscures the fact that residents furnish services to patients and not beds. We believe it is intuitively appropriate to pay identical IME adjustments to hospitals with the same resident-to-day ratio but different resident-to-bed ratios, rather than the reverse. Therefore, although there would be a distributional effect of switching to the resident-to-day ratio for the operating prospective payment system, the result should more closely resemble the actual distribution of teaching costs. We also note that the capital IME adjustment formula results in a rising marginal rate of increase as teaching intensity rises. This would alleviate some of the distributional impact, since the current operating IME adjustment formula results in a declining marginal rate of change.

ProPAC indicates that it was unable to duplicate our findings of smaller standard errors and larger t-statistics in its regressions on operating costs using the resident-to-day ratio instead of the resident-to-bed ratio and assumes our findings are based on the combination of operating and capital costs as the dependent variable in our regressions. In fact, our analysis of a single standard rate operating prospective payment system yielded results similar to those for total costs. In that analysis, which focused solely on Medicare operating costs, the standard error of the log of the resident-to-bed ratio was .0467, and the standard error of the log of the resident-to-day ratio was .0315. The respective t-statistics were 9.643 and 9.705. We would be happy to discuss these findings with ProPAC.

We disagree with ProPAC's suggestion that the better performance of the resident-to-day ratio in the statistical analysis is due to the higher capital costs per case of low-occupancy teaching hospitals with relatively high resident-to-day ratios. Based on this belief, ProPAC states that the resident-to-day ratio in the capital prospective payment system rewards hospitals for the inefficient use of capital resources. In fact, in a regression on FY 1988 and FY 1989 capital costs that controlled for occupancy levels, the resident-to-day ratio was significant and positive while the resident-to-bed ratio was insignificant.

Finally, we disagree with the commenter who believes the capital IME adjustment should be set at a level equal to the current operating IME adjustment. As stated in the proposed rule and repeated several times above, we continue to believe that the appropriate level of the IME and DSH adjustments are those justified by regressions on hospitals' total (operating and capital) Medicare costs, and adopted for the capital prospective payment system.

D. 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 in the Proposed Rule: 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.

Comment: In its comments submitted in response to the proposed rule, ProPAC reiterated its concern about the equity of the current transfer payment policy. In defense of its recommendation to pay transfer cases using a graduated per diem up to the full DRG payment, ProPAC cited a study conducted by RAND that shows average daily costs to be highest during the first part of a patient's stay. ("How Services and Costs Vary by Day of Stay for Medicare Hospital Stays," RAND Report No. R-3870-ProPAC, March 1990.) ProPAC urged HCFA to undertake further analysis of its current policy, pointing out that the differences between the findings in the 1988 HCFA Report to Congress and its more recent analysis could be due to differences in accounting for the per diem payment for transfer cases.

Response: As noted in our response to this recommendation in the proposed rule, we have examined potential revisions to the current transfer payment methodology in the past without finding an acceptable replacement. We will continue to examine transfer payment alternatives and look forward to the release of ProPAC's technical report containing the results of its analysis of the current policy. However, until we review ProPAC's analysis, we can only speculate on the reason or reasons for the differences.

With regard to the analysis performed by RAND, we note that in its report RAND states that its sample "does not contain enough either small or rural hospitals for us to make reliable statements about this class of hospitals" (p. 19). The RAND report was not designed to evaluate transfer payment policy. In fact, the sample used by RAND is most representative of urban hospitals with 100 or more beds and is slightly overrepresentative of major teaching hospitals compared to the universe. In our 1988 Report to Congress on transfer policy, we reported that rural hospitals and urban hospitals with fewer than 100 beds tend to transfer larger proportions of their cases than do other classes of hospitals. In addition, our analysis in that report of the cost-to-charge ratios by length-of-stay focused solely on transfer cases, whereas RAND analyzed all cases discharged from the sample hospitals, including "true" discharges as well as transfer cases. These differences may explain some of the different findings. Treatment prior to release by a transferring hospital may be different than treatment provided by a hospital that treats the entire episode of care due to the unavailability of the often costly technology necessary to provide definitive treatment at the transferring hospital.

Comment: One commenter questioned our belief in the neutrality of the incentives of our current transfer policy, stating that the policy fails to distinguish between complex cases transferred for more sophisticated care, and cases transferred near the end of a treatment episode. The commenter described a systematic risk of underpayment to hospitals accepting a large number of patients that will ultimately require transfers, and a systematic overpayment to hospitals receiving transfer patients at the end of the treatment episode for recuperative care. Another point raised by this commenter in relation to the payment policy for transfer cases

concerned the exception to the policy made for DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility). The commenter believed the types of cases assigned to this DRG were too varied to ensure payment equity, ranging from newborns who receive very little care and die soon after birth to those who receive many days or even months of complex neonatal intensive care before death.

Response: We have no evidence that our current policy either systematically underpays for complex cases transferred out or systematically overpays for cases transferred in for recuperative care. A DRG is assigned to each hospital stay involved in a transfer situation based on the patient's principal and secondary diagnoses and treatment received. Therefore, the more complex needs of a patient during the early phase of a severe illness should be reflected by the DRG assignment. We reiterate, however, that we have devoted a good deal of effort to examining alternative methodologies in the past, and we remain interested in identifying refinements that could further reduce any financial disincentives to appropriately transferring patients for either a higher or lower level of care.

With regard to the commenter's second point, paying a per diem amount for DRGs 385 and 456 would result in an underpayment to the transferring hospital since the weighting factor for these two DRGs is based on the assumption that the patient will be transferred. Therefore, in the January 3, 1984 final rule, we provided for payment of the full prospective payment rate for transfer cases assigned to either of these two DRGs (49 FR 244). We note that, as shown in Table 7B of the addendum to this final rule, only 5 Medicare discharges were assigned to DRG 385 during FY 1991. Given this low volume of cases in the Medicare population, further differentiation would be impractical. Furthermore, hospitals are protected from inordinate losses for all transfer cases through cost outlier payments.

We note that this commenter represents a national association of children's hospitals, a group that is excluded from the prospective payment system. These hospitals are affected indirectly by the DRG classifications and weights through non-Medicare payers that model their classification and payment structure after Medicare's. As we note above in section II.B.6 of this preamble, given the low volume of pediatric patients covered by Medicare, this aspect of Medicare payment policy could produce anomalous results when applied directly to payments for services to non-Medicare populations.

E. 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 the Proposed Rule: 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.

Comment: We received three comments in response to our decision to discontinue the add-on payment for blood clotting factor administered to Medicare inpatients with hemophilia. The commenters all expressed concern that elimination of the add-on payment for blood clotting factor would result in significant underpayment to hospitals providing this service to Medicare inpatients with hemophilia who require blood clotting factor. These commenters believe that since the situation that led Congress to mandate a special payment for clotting factor remains unchanged, and the price of clotting factor remains high, eliminating the add-on payment must be expected to have an adverse financial impact on the hospitals that treat these patients. One commenter included data specific to his hospital that identified the magnitude of the differences between the cost of treating

hemophilia patients who require blood clotting factor and the Medicare payment received by the hospital for these cases.

Response: Since publication of the proposed rule, we have updated our evaluation of blood clotting factor administered to Medicare hemophilia inpatients. The most recent bill data contains all claims received through June 1992 from hospitals that administered blood clotting factor to hemophilia inpatients admitted between June 19, 1990 and December 19, 1991, the duration of the add-on payment. We compared the claims that contain codes for both a diagnosis of hemophilia (either as principal or secondary diagnosis) and revenue codes for blood clotting factor to all other hemophilia hospital inpatients for the same time period. As in our original analysis, we found that the costs experienced by hospitals administering blood clotting factor, while higher than the costs for all other hemophilia patients, are incurred by a small number of patients, and are distributed across hospitals in such a way that no one hospital is adversely affected in a significant way. Thus, results of our current review support the conclusions reached in our earlier data analysis, which was described in the proposed rule and repeated above. ProPAC continues to agree with HCFA that there is no need for an add-on payment for blood clotting factor.

Comment: Two commenters expressed concern that accounting for the cost of blood clotting factor in establishing the relative weights for all DRGs would be unlikely to yield adequate payment as the volume of cases is too small to have sufficient impact on the weights. One commenter believes including the charges in the relative weights would overcompensate hospitals generally without correcting the underpayment suffered by other hospitals.

Response: The DRG relative weights are based on total charges submitted by all prospective payment hospitals. Because we could not identify specifically the charges for blood clotting factor as distinguished from the aggregate charges for all hemophilia patients, these costs were not excluded from the calculation of the DRG weights when the add-on payment was instituted. Thus, these costs have always been included in the charges used for establishing the DRG weights. Therefore, the add-on payment did not affect the aggregate charges used in calculating DRG relative weights.

Comment: We received one comment acknowledging that, for the Medicare population, there may be few hospitals facing a systematic risk of higher costs in treating hemophilia patients. However, this commenter believes that for children's hospitals that are paid under a DRG-type system for other than Medicare patients, there is substantial systematic risk. Therefore, the commenter requested that HCFA advise other payers that the payment policy that is appropriate for Medicare may not be appropriate in the case of a system that includes children and young adults.

Response: We have in the past, and continue to, caution against the use of Medicare DRGs that are developed based on a Medicare population for use with other populations. However, it would not be suitable for HCFA to advise other payers as to what may or may not be appropriate payment policy for their specific needs and populations.

F. 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 in the Proposed Rule: 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	$8,867	$7,260	$7,440	$7,400
	(1,606)	(13,727)	(15,333)	(53,661)
25	$5,027	$3,901	$4,093	$3,977
	(1,173)	(5,700)	(6,873)	(22,386)
26	$4,070	$5,959	$5,848	$7,174
	(1)	(16)	(17)	(54)
All cases	$7,310	$6,274	$6,403	$6,393
	(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.

We received several comments concerning the DRG classification for patients with intractable epilepsy. These commenters all disagreed with our decision not to make any changes in the current structure of DRGs 24, 25, and 26. The specific comments and our responses follow.

Comment: Commenters objected to the findings of our data analysis, stating that the data failed to identify charges for intractable epilepsy patients admitted for comprehensive medical evaluations, did not sufficiently distinguish those patients receiving neurodiagnostic monitoring, and was not representative of the true cost of diagnosing and treating intractable epilepsy patients. Many commenters questioned why the results of our analysis differed from ProPAC's findings and requested that we reconsider our decision and implement ProPAC's recommendation. In its comments, ProPAC reiterated its recommendation to modify the current DRGs to recognize the increased costs of treating patients with intractable epilepsy.

The commenters urged us to reassess our data, citing the failure of the present DRGs to account for the complexity and scope of the multidisciplinary services provided by hospitals that treat intractable epilepsy patients. Commenters recognized that additional procedure or diagnostic codes might be necessary to identify correctly the patients and services applicable to a new or revised DRG. In addition to offers to provide information and to assist HCFA efforts in DRG restructuring, a few commenters included data specific to their hospitals to supplement and enhance the reliability and validity of our data analysis.

Response: Since publication of the proposed rule, we have reexamined our analysis of both intractable and nonintractable epilepsy cases using the latest update to the FY 1991 MEDPAR file (June 1992). Our reassessment of these data confirms our prior conclusion that, although intractable epilepsy patients, particularly those with video-telemetered monitoring, do incur higher charges than patients without intractable epilepsy or telemetry, those differences are not currently of significant magnitude to justify a new DRG or other modification to the existing DRGs for these cases.

In response to assertions that our data do not truly represent the cost of caring for intractable epilepsy patients, we note that the data we analyzed for this issue and the results presented in the proposed rule included charge and coding information from all the FY 1991 bills received in HCFA as of December 1991. Our updated analysis includes the additional FY 1991 bills received in the 6 months following that date. The MEDPAR file contains 100 percent of the fully-coded Medicare claims submitted by hospitals and includes both the total

and covered charges. Thus, it is the coding and charge data submitted by hospitals themselves that are used during our DRG classification analyses. Accordingly, our analysis of the cost of caring for intractable epilepsy patients is based on data submitted by hospitals.

We used ICD–9–CM procedure codes 89.10 (Intracarotid amobarbital test) and 89.19 (Video and radio-telemetered electroencephalographic monitoring) to identify the complex patient subset of the entire intractable epileptic population. With the expansion of space on the HCFA UB–82 claim for reporting inpatient services from three to six fields, future data should be more comprehensive and complete. In addition, we note that this same extra space could be used in delineating the complex intractable epilepsy patients from the less complex patients. In past years, attempts have been made to obtain better coding of the diagnostic components of the comprehensive medical evaluation of intractable epileptics. Procedure codes 89.10 and 89.19 are a result of these attempts. We believe that it may be possible to develop additional codes to identify these patients. Therefore, we plan to include this topic on the agenda for the next meeting of the ICD–9–CM Coordination and Maintenance Committee (December 3, 1992).

While we appreciate the resource-use data for intractable epilepsy patients from specific hospitals included with some of the comments, the use of MEDPAR data ensures standard, uniform, unbiased information across all Medicare hospitals. Hospital-specific data from the provider community are used to enhance our understanding of the problem under analysis, but cannot be used to determine payment policy. ProPAC agreed with our finding that more accurate codes for intensive services for intractable epilepsy patients may need to be implemented. We encourage hospitals to use accurate coding and to furnish HCFA with information that would help improve the codes that are available to reflect the treatment being administered. Although our conclusions differ from those of ProPAC, we did consider its recommendation and evaluated our data in light of the results obtained by the ProPAC study. However, based on the number of cases in the MEDPAR file and the relatively small difference in average charges between intractable epilepsy cases and all other cases in DRGs 24, 25, and 26, as well as our assessment of the impact these cases have on the specialty or high-volume hospitals, we continue to believe that there is insufficient evidence to justify a DRG revision at this time.

Comment: Many commenters stated that HCFA's analysis failed to take into account the level of care received by intractable epilepsy patients in highly specialized epilepsy treatment centers. These commenters believe that, in analyzing the data, HCFA did not differentiate between the highly specialized centers and general acute care hospitals treating epilepsy patients with shorter and less expensive lengths of stay. One commenter expressed concern that the sampling method used was inadequate, stating that the majority of patients in our analysis were treated at acute care general hospitals for an intermittent problem related to their intractable epilepsy and, therefore, incurred shorter lengths of stay. Some commenters compared the length of stay experienced by intractable epilepsy patients admitted to specialty centers (approximately 2 to 5 weeks) with the geometric mean lengths of stay printed in Table 5 of the addendum to the proposed rule. (The geometric mean lengths of stay in that table were 5.2, 3.4, and 3.9 days for DRGs 24, 25, and 26, respectively.) They stated that the current DRG system, which is based on average resource use, does not account for the higher number of severely ill intractable patients found in these centers. The commenters assert that, for these hospitals, the averaging process inherent in the DRG classifications and the prospective payment system as a whole does not work. One commenter is concerned that we did not consider differences in the level of care available at an individual hospital. To ensure appropriate, equitable payment, the commenters recommended establishing a new DRG or modifying the present DRG to accommodate the additional costs incurred by the level of service available at these specialty institutions.

Response: In our analysis of epilepsy data for the proposed rule and the updated analysis conducted for this final rule, we evaluated the performance of acute care general hospitals and epilepsy treatment centers both as a group and separately. In our analysis, we did not use a sample of these hospitals, but rather 100 percent of the FY 1991 discharges from all hospitals for all epilepsy patients, both intractable and nonintractable. In our analysis for all hospitals, we focused on the high volume providers, defined as those treating 10 or more patients with intractable epilepsy in a year. Our most recent findings are similar to those set forth in the proposed rule, with only 25 percent of the high-volume hospitals incurring average charges in excess of the mean charge for all intractable epilepsy cases.

As in our previous analysis, we examined the experience of the epilepsy treatment centers. Our current findings, however, are more comprehensive than those for the proposed rule, as we were able to identify 52 epilepsy centers (rather than 25 as in the proposed rule). For these 52 hospitals, 8 had no Medicare epilepsy discharges in FY 1991; of the remaining 44 hospitals, 42 treated at least one Medicare intractable epilepsy patient. The results of this analysis parallel those presented in the proposed rule. As was the case in the previous analysis, the epilepsy specialty centers did not necessarily treat a high volume of Medicare intractable epilepsy patients. The number of patients for FY 1991 at the 42 centers ranged from 1 to 38. Considering only the 42 specialty hospitals that treated intractable epilepsy cases in FY 1991, we identified 15 hospitals where the average charge for nonintractable epilepsy cases exceeded the average charge for treating patients with intractable epilepsy. As we also found in our original analysis, the charges for patients with intractable epilepsy were highly variable, with 13 (72 percent) of the 18 high-volume hospitals (those with 10 or more cases) reporting average charges below the mean for all intractable epilepsy patients.

Although length of stay is one indicator of resource use, it is not one of the factors used in establishing DRG weights. More to the point, the geometric mean length of stay is used by HCFA to establish the outlier threshold for day outlier cases and is not relevant to other payment issues. A more illustrative statistic for the commenters' purpose is the arithmetic mean (average) length of stay for a DRG. In fact, the arithmetic mean lengths of stay for DRGs 24 through 26 are somewhat higher than the geometric—7.2, 4.3, and 5.9 days, respectively. (See Table 7B of the addendum to this final rule.)

The prospective payment system methodology ensures that all cases are included in establishing the weight for the DRGs. As payment is based on averages rather than individual cases, there will be cases that fall below the average and others that fall above the average. Outlier payment is provided for cases incurring excessive lengths of stay or high costs. We recognize the commenters' concerns that the averaging process may fail to address the special populations at epilepsy treatment centers. We intend to continue to monitor this situation, and

will explore whether improved codes can be used to identify these cases and review the charges in the FY 1992 MEDPAR data.

Comment: Many commenters objected to our use of Medicare operating margins as supporting documentation for our decision not to modify the DRG classification system to account for intractable epilepsy patients. These commenters stated that analysis of profit margins was inappropriate in determining the DRG classification, and that the classification system should be based on a combination of the patient's diagnoses, condition, services provided, and resources used during the patient's hospitalization.

Response: We believe that using Medicare operating margins as one indicator of the financial impact of Medicare payment on individual hospitals is appropriate. This variable provides perspective on total hospital resource use and payment under the prospective payment system. As noted, above, payment under this system relies on an averaging process both within a given DRG, as well as across all DRGs. Thus, while some cases within a given DRG will receive payment in excess of costs while others will receive payment below costs, this is equally true for the hospital's cases as a whole. There are DRGs for which payment to a particular hospital exceeds costs, just as there are DRGs for which the hospital receives payment below the actual cost of delivering service. The incentive to the hospital is to manage its operations more efficiently by evaluating those areas in which increased efficiencies can be instituted without affecting the quality of care and by treating a mix of patients to balance costs and payments.

Assignment to a DRG is based on a combination of patient diagnoses, procedures, age, and discharge status. The resources used during a patient's hospitalization are measured by total charges, which are the basis for establishing the DRG relative weights. A hospital's profit margin is not a factor in determining DRG classification. However, when questions arise concerning whether a hospital's loss on a particular set of Medicare cases is undermining its ability to provide its services to the Medicare population overall, we believe that considering the hospital's Medicare operating margin is appropriate. The decision not to implement modifications to the DRGs for intractable epilepsy was based on our total evaluation of hospital experience in treating these patients, and not on the operating margin of the specialty or high-volume hospitals.

Comment: Several commenters referred to the age of their patient population, stating that most of the Medicare patients receiving comprehensive treatment for intractable epilepsy are under age 40. These commenters stated that a DRG modification assuring appropriate payment would be cost beneficial in the long run, providing a predominantly young population suffering from intractable epilepsy the treatment to allow them to assume productive lives.

Response: Medicare data confirm that the population of intractable epilepsy patients contains more patients under age 65 than is typical. However, a very high proportion of the patients in our data are in fact over 65 years of age. With an average age of 65 or greater at more than 50 percent of the hospitals, we do not believe it is feasible to use age as a criteria for assigning DRG classification for intractable epilepsy patients. Every effort is made to ensure that payment for Medicare patients encourages maximum benefit and does not impede access to care.

Comment: Some comments included references to surgical treatment for intractable epilepsy patients, citing specific examples of cases receiving surgical care and their successful outcomes. One hospital, which evaluates patients with intractable epilepsy for epilepsy surgery, stated that they were significantly underpaid under Medicare for these patients. Commenters requested an adjustment to the current payment system to accommodate these inequities between cost and payment.

Response: Patients diagnosed with a principal diagnosis of intractable epilepsy who have a surgical procedure performed during the same admission are classified to surgical DRGs, not to DRGs 24, 25, and 26. There were 351 discharges during FY 1991 with a principal diagnosis of intractable epilepsy and the performance of a surgical procedure. Of these, 79 percent were assigned to DRG 1 (Craniotomy Age > 17 Except for Trauma), which currently has a relative weight of 3.2322. We have received no indication that the DRG 1 payment does not adequately compensate hospitals for intractable epilepsy patients who have surgery and our discussions with representatives of the hospital community identified the payment for DRGs 24 through 26 as the area of concern. Therefore, we concentrated our analysis on medical treatment, particularly neurodiagnostic monitoring and comprehensive medical evaluation of intractable epilepsy patients.

G. 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 in the Proposed Rule: 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.

Comment: ProPAC suggested, as did some commenters in response to the proposed RPCH regulations published on October 25, 1991 (56 FR 55382), that the Secretary has broad authority under section 1820(j) of the Act to waive various provisions of the EACH program, as set forth in section 1820 of the Act, in order to induce eligible hospitals to participate.

Response: As explained in our response to this recommendation in the proposed rule (57 FR 23665), we are considering all public comments with regard to the EACH proposals. Because this issue is under consideration in developing the final EACH regulations, we do not believe it would be appropriate to respond to ProPAC recommendations regarding it at this time. However, we will respond fully to the comments on this issue in the preamble to the final EACH regulations.

H. 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 in the Proposed Rule: 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 requires ProPAC to examine the following factors: Hemodialysis and other 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. However, 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 concluded that this sample was not adequate to address the issues raised by Congress in Pub. L. 101–508 and that more extensive cost data was needed. 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.

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 are maintaining computer files of cost report data for independent renal facilities with fiscal years ending in 1989, 1990 and 1991, and for hospital renal facilities with fiscal years ending in 1990 and 1991. ProPAC is in the process of analyzing 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. Also, section 4201(a) of Pub. L. 101–508 limited the Secretary's authority to set rates. With respect to ProPAC's recommendation regarding audits, we believe that the audits should be conducted, and the results should be used to set payment rates. We believe that to conduct audits without using these results to set rates would result in inefficient use of government expenditures.

In this final rule, we are not republishing the tables included in the June 4, 1992 proposed rule (57 FR 23667) that contained patient data from the ESRD Facility Survey. The tables were included in that notice to summarize the number of patients on the different treatment modalities. The tables showed that 95 percent of dialysis patients are on either outpatient hemodialysis or continuous ambulatory peritoneal dialysis. We presented this information for ProPAC to consider in revising the payment methodology for dialysis services.

When the base rates were originally established, they were weighted using the cost experiences of small renal units, especially hospitals, which then dominated the dialysis industry. This resulted in overpaying the more efficient larger facilities. This imbalance could be eliminated by establishing different rates for the larger, more efficient renal facilities that benefit from economies of scale. For facilities that meet certain limited criteria, a different payment structure based on the characteristics of these facilities might be considered. For example, pediatric hospitals could have their own payment rate, and small rural facilities, with less than a defined number of treatments (for example, 4,000 treatments) could have their payment rates adjusted to reflect the financial disadvantages 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 exceptions to their payment rates.

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). The percentage of patients on hemodialysis and CAPD continues to grow. Any new rate structure should reflect this trend and account for the decrease in the number of intermittent peritoneal dialysis (IPD) and home hemodialysis patients.

Comment: ProPAC expressed its disappointment that HCFA does not play to audit a representative sample of cost reports.

Response: Conducting annual audits results in substantial expenditures of resources. Auditing not only affects government spending but also spending by intermediaries and renal facilities in the audit sample. Before deciding to conduct audits, it is critical to define the goal of these audits. This is important, since the last three sets of audits have not been used to revise payment rates; in fact, section 4201(a) of Publ. L. 101–508 prohibits HCFA from changing the current composite rates.

In lieu of conducting annual audits, we suggest that the same sample group of renal facilities be analyzed on an

annual basis. ProPAC and HCFA would initially select this group of facilities and would analyze these same facilities' cost reports on an annual basis. HCFA would audit a facility's cost report on a variable basis or when the data warranted one. This format would provide ProPAC, HCFA, and Congress audited historical data of the costs to furnish a dialysis treatment. Furthermore, using the same facilities' cost reports would track the Medicare costs of a dialysis treatment over time.

With the advent of facilities submitting their cost reports electronically, renal cost data are now available to satisfy the program's responsibility of gauging dialysis costs. At this time, we do not plan to audit these data on an annual basis.

Comment: One commenter was under the impression that HCFA's suggestions are recommendations that we are trying to implement.

Response: Our suggestions are only factors that we believe ProPAC should examine before making final recommendations to Congress as mandated by section 4201(b) of Pub. L. 101–508. This law requires ProPAC to examine the effect that size, location, type of facility, and mix of services has on the costs of furnishing a dialysis treatment.

Comment: One commenter stated that the 1988 audit sample was inadequate since it represented only a 5 percent sample, included a high proportion of large facilities, and consisted of old data.

Response: The 1988 audit sample was scientifically designed to determine the median cost of furnishing a maintenance dialysis treatment in an efficiently operated renal facility. We did not design the audit sample to determine the costs of dialysis treatments in different types of renal facilities. ProPAC realized the limitation of the audit sample and stated that it was not adequate for the type of study mandated by section 4201(b) of Pub. L. 101–508. Although ProPAC decided not to use the audit data for its study, they believed the audit data did not justify a rate increase.

The sample size of 5 percent was adequate for determining the median cost of a maintenance dialysis treatment. Selecting a larger sample size would have an insignificant statistical effect on the confidence level in estimating the median cost of a dialysis treatment.

We do not believe the age of the data is a critical problem. Based on the results of the prior three audits, using the more current audit data in the payment formula has consistently produced lower payment rates. These audits consistently showed a decrease in Medicare costs of independent renal facilities, while hospitals' costs showed little variation.

To conduct audits and prepare a **Federal Register** notice would take about 18 months. Using current year audited cost data would delay any final notice for at least 18 months. Using unaudited data would expedite the process of revising payment rates. With the advent of renal facilities submitting their cost reports electronically, revising the composite payment rate using more current data could be accomplished more timely. Of course, this can only happen if renal facilities complete their cost reports timely and accurately.

Presently, independent facilities submitting cost data do not adhere to all the Medicare reimbursement principles in completing their cost reports. Cost data submitted by hospital facilities show wide ranges in the cost per treatment by treatment modality. From our review of the data, it appears that some hospitals are not completing their cost reports properly, resulting in incorrect allocation of costs. Until the data become reliable, updating payment rates using the most current unaudited data is not prudent. To help ensure timely and accurate payment revisions, renal facility administrators should verify that their facility cost reports are correctly prepared.

Comment: Two commenters objected to our suggestion that ProPAC consider a payment method that establishes different rates for the larger more efficient facilities.

Response: We are not suggesting that ProPAC penalize the larger more efficient facilities. We merely emphasize that a payment methodology that matches payment with expenditures should be considered. The present composite payment rate formula combines the cost experiences of all renal facilities to establish a single payment rate. Such a methodology penalizes the small rural facilities, pediatric facilities and backup hospitals that furnish dialysis treatment to ESRD patients requiring more medical resources. This methodology also inflates the amount paid for a maintenance dialysis treatment by using the cost experiences of smaller facilities. We believe that the payment rates should reflect the fact that 57 percent of all dialysis facilities furnish 83 percent of all dialysis treatments, and should account for the cost experience of small facilities or inefficient facilities. As part of the study mandated by Congress, ProPAC will examine what effect size, location, type of facility and mix of services has on a facility's costs.

Comment: Two commenters stated that the case mix adjustment should apply to all facilities, not just hospitals. In the proposed rule, we had recommended that ProPAC consider a case-mix adjustment for hospitals only.

Response: There is no study that clearly documents that one type of facility treats a sicker ESRD patient population than another type of facility. To date there is no medical definition of an atypical ESRD patient population. Until there is a clear definition, we are limited to assumptions regarding atypical patient mix based on patient characteristics.

During the last three exception windows, no independent renal facility was granted a rate increase because of an atypical ESRD patient mix. Generally, patient characteristics of independent renal facilities are not aberrant when compared to national ESRD patient characteristics. Furthermore, independent renal facilities have the option to transfer a sicker patient to their backup facility when the patient's condition requires more intense medical services. ProPAC will examine the possibility of adjusting payment rates to reflect a case-mix index. Such an index would ensure a matching of revenues with medical resources consumed by ESRD patients.

Comment: One commenter proposed that ProPAC structure a new payment methodology similar to the hospital prospective payment system that includes payment for outliers and exceptions.

Response: HCFA is suggesting that ProPAC consider a payment system that is adjusted for a case-mix index and provides different payment levels for pediatric and small rural facilities. We do not believe it is appropriate to make the exception process more complex, since most facilities already believe this process is burdensome and costly.

Comment: One commenter agreed that there was a shift in treatment modalities but did not agree with the conclusion that the rate should be adjusted to reflect this trend. The commenter suggested that because of this shift blended costs of all dialysis treatments has increased compared to the data used to set the original base composite rates.

Response: The commenter incorrectly assumes that HCFA is recommending a rate reduction because of changes in the type of dialysis being furnished. HCFA only summarized patient data in the June 4, 1992 proposed rule to show the shift in treatment modalities. We made no recommendations to ProPAC that the composite payment rate should be

reduced because of this shift. We suggested that ProPAC should take into consideration the increase in CAPD and CCPD in any rate structure. We brought this to ProPAC's attention because most owners of renal facilities argue that these forms of dialysis are more costly.

Comment: Two commenters disagreed with our statement that if ProPAC recommends a separate home dialysis rate, only those facilities that have a significant home patient population should be used to establish the payment rate to reflect the economic efficiencies and training expertise of such programs.

Response: One commenter misunderstood our discussion of the costs of home dialysis. We are not suggesting that the payment methodology exclude hospital facilities in computing new rates. On the contrary, hospitals have a higher percentage of home dialysis patients than independent renal facilities. To use all home dialysis programs in setting a payment rate for home dialysis would result in small or inefficient programs overstating the costs to furnish home dialysis in an efficiently operated facility. Audited cost data reveal that renal facilities with large home programs (home costs in excess of $1 million) tend to report home costs properly. Renal facilities with small home programs generally fail to report or to allocate home dialysis costs properly. We suggest that ProPAC consider this in determining if a separate home dialysis payment rate is justified. If special circumstances exist because Medicare is the principal payer for dialysis, then ProPAC might consider adjusting the rate for small rural facilities or for other justified circumstances. Again, HCFA is not implementing these recommendations. Rather, we are expressing our concerns and are emphasizing those factors that ProPAC should consider in its recommendations to Congress.

Comment: One commenter recommended that CCPD reimbursement should be set at levels currently reimbursed to durable medical equipment suppliers.

Response: Section 1881(b) of the Act provides two distinct methods for reimbursing CCPD. Under Method I, payment for CCPD is made at the facility's composite payment rate. Under Method II, payment for CCPD supplies and related services is limited to the amount established by section 6203(b) of Pub. L. 101–239, which is 130 percent of the median hospital payment rate. The Method II payment limit applies only to suppliers and not to dialysis facilities.

I. 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 in the Proposed Rule: 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 analyzing 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.

Comment: ProPAC continues to recommend that ASCs be required to submit annual cost reports. Although they agree that the costs of outpatient data collection should be minimized, they believe that an annual cost report containing the minimum essential information might be less disruptive than a retrospective method that occurs at irregular intervals.

Response: We do not agree with ProPAC's recommendation that ASCs be required to submit annual cost reports. As we stated previously, to require annual cost reports of ASCs would be burdensome, expensive, and ultimately more costly to Medicare than the current system of rebasing ASC payment rates periodically, using audited survey data and making interim annual adjustments based on an inflationary measure such as the consumer price index for urban consumers (CPI–U).

J. 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 in the Proposed Rule: 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.

Comment: In its comments, ProPAC reiterated the proposal that a beneficiary's liability for hospital outpatient services should be based on 20 percent of the payment amount allowed by Medicare, rather than on 20 percent of charges.

Response: At this time, such a methodology cannot be applied with sufficient accuracy to that majority of hospital outpatient services that are paid on a full or partial cost basis. Costs for these individual services are not known at time of delivery. Rather, Medicare payment for these services depends on retroactive settlement of the hospital's cost report and is determined

in the aggregate, based on the type of service (that is, radiology services, ASC-approved surgeries), not on the individual service. Only charges are determined for each patient and are known when the patient is billed.

We are in the process of developing a prospective payment system that will supersede the current cost-based system. In this context, we are reviewing the issue of beneficiary liability. As we stated in our comments on this recommendation, we are working to come up with an approach that will be fair to beneficiaries, while minimizing the negative financial impact on the Medicare program.

K. 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 free-standing ambulatory surgical centers (ASCs) should be used to establish the payment groups.

Response in the Proposed Rule: 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.

Comment: ProPAC asserted that at the time the ASC patient groups were developed, cost data were not available for a number of ASC-approved services, and that the original ASC data were from a limited selection of 90 ASC sites. ProPAC also reiterated that combining hospital cost data with ASC data would result in a more accurate classification system. They believed that such an approach would not need to violate the statutory requirement that the average standard overhead payment amount established for the procedure in each group take into account the costs incurred by ASCs generally.

Response: ProPAC's concern about previous inaccuracies in payment group classifications of ASC procedures should be alleviated by the expanded scope and depth of data being collected through the Medicare Ambulatory Surgical Center Payment Rate Survey 1992 (Form HCFA–452).

We agree with ProPAC that there might be merit in ranking ASC procedures by their cost in a hospital outpatient setting to determine each procedure's position relative to other procedures, and then to compare that scale with a parallel ranking by cost when the same procedures are performed in an ASC. However, we reiterate our initial position with respect to ProPAC's recommendation that hospital cost data be combined with ASC data to produce a more accurate classification system. To add hospital cost data to ASC cost data for the purpose of determining ASC facility payment classifications would not be in compliance with section 1833(i)(2)(A) of the Act, as stated in our response in the proposed rule. In addition, we believe that an approach such as that proposed by the Commission could significantly inflate Medicare costs.

L. 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 in the Proposed Rule: 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.

Comment: ProPAC, in its comments, restated the recommendation that national prospective payment rates for ASC-approved ambulatory surgery and radiology services be adjusted to reflect differences in labor costs. More specifically, ProPAC suggested that the appropriate labor share of the hospital outpatient setting be taken into account, and that we study whether an outpatient specific wage index is necessary.

Response: We believe that we would be able to determine a reasonably accurate representation of the labor share of hospital outpatient services. However, we do not now have access to the data required to develop an outpatient-specific wage index. We have already commented on our belief that requiring the collection of such data might place an undue administrative burden on hospitals. One commenter, representing a number of hospitals, responded to the proposed rule by voicing the concern that "ProPAC's recommendation for further study of payment adjustments for hospital-provided ASC and radiology services would result in an unreasonable data collection burden on hospitals."

The commenter pointed out that hospitals would have to maintain records that would provide a breakdown of salaries and personnel hours attributable to inpatient and outpatient services. Unless a hospital maintains completely separate inpatient and outpatient surgery and radiology areas, this would be virtually impossible. In addition, ASC procedures are not limited to just an operating room area but can occur in other ancillary departments such as emergency rooms. Also, because of observation status, it is often difficult for a hospital to know whether it is treating an inpatient or an outpatient.

M. 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 in the Proposed Rule: 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.

Comment: ProPAC disagreed with the Secretary's decision to postpone the collection of data on SNF wages and the development of a SNF wage index until after the payment system is revised through legislation. They asserted that some of the differences between the hospital wage index and a SNF wage index might be eliminated through more uniform staffing requirements, which were mandated under sections 4201(b)(1) and 4211(b) of Pub. L. 100-203, and are currently being implemented. They acknowledged that because States may exceed Federal requirements, variation in staffing patterns across States is not likely to be completely eliminated. They stated that a SNF wage index would more appropriately reflect the impact of possible nursing shortages in nursing facilities. ProPAC indicated that it would be advisable to collect the appropriate wage data at this time.

Response: As previously indicated, we have no way of knowing what impact a SNF wage index would have on individual SNFs. Moreover, our prior attempt to develop a wage index for HHAs proved troublesome.

When we implemented the first HHA wage index based on data received from HHAs, we received many industry complaints concerning the burdensome requirements and the accuracy of the data. As a result, Congress passed legislation that repealed the mandate for the Secretary to develop the HHA wage index. Instead, section 4027(d) of Public Law 101-508 required the hospital wage index to be used for HHAs. This legislation had a retroactive effective date, so HCFA was required to issue new cost limits using the hospital wage index for a retroactive period and all future periods. As with HHAs, we believe SNFs will have difficulty maintaining the data needed for HCFA to develop an accurate SNF wage index.

ProPAC believes a SNF wage index would more appropriately reflect the impact of possible nursing shortages in nursing facilities. We believe a nursing shortage would impact all classes of providers including hospitals, as well as SNFs. Therefore, we believe the hospital wage index also would reflect a nursing shortage.

In summary, based on the uncertain impact a SNF wage index would have on individual SNFs and on program experience in the context of HHAs, we believe it would be inappropriate to develop a SNF wage index at this time. Instead, we believe it is advisable to continue using the hospital wage index for SNFs until the SNF payment system is totally revised through legislation.

IX. 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.

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 sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems. Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined. Subpart E 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 sets forth the methodology for determining additional payments for outlier cases. Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system for inpatient operating costs. Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system for inpatient operating costs. Subpart K describes how the prospective payment system for inpatient operating costs is implemented for hospitals located in Puerto Rico. Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation. Subpart M 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 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.

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(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:

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(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.

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(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.

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§ 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 furnished 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, 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 cost 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 11 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 system, 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 11 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. Section 412.60 is amended as follows:

a. In paragraphs (a) and (c) introductory text, the phrase "HCFA will establish" is revised to read "HCFA establishes";

b. In paragraph (b), the phrase "HCFA will assign" is revised to read "HCFA assigns";

c. 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. Section 412.62 is amended as follows:

a. The section heading and paragraph (a) are revised;

b. The heading in paragraph (b) is revised and the phrase "HCFA will determine" is revised to read "HCFA determines";

c. In the introductory text, in paragraph (c), the phrase "HCFA will update" is revised to read "HCFA updates";

d. In the introductory text, in paragraph (d), the phrase "HCFA will standardize" is revised to read "HCFA standardizes";

e. In the introductory text, in paragraph (e), the phrase "HCFA will compute" is revised to read "HCFA computes";

f. The heading and introductory text of paragraph (j) are revised.

§ 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 "considered 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 to 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 by the arithmetic mean length-of-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 hosptials, 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 adjust 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 may adjust 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 sanatorium'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 transplanation 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) *Hosptials 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 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 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 a 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 prospective payment systems. This amount is not adjusted for the DRG weighting factor.

* * * * *

6. In § 412.100, paragraph (a) is 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, paragraphs (a)(2) and (d)(1) are revised; 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"; and in paragraphs (d)(2)(i)(B) (*1*) and (*2*) the date "January 1, 1993" is revised to read "October 1, 1993", 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, paragraphs (c) introductory text and (d)(3) introductory text are revised; in paragraph (a)(1)(i) the reference "§ 412.118(b)" is revised to read "§ 412.105(b)"; and in paragraph (d)(3)(i)(B) the term "reimbursed" is revised to read "paid" 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 indirect medical education costs as determined 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 paragraph (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".

7. In § 412.130, in paragraphs (b)(1) and (b)(2), the phrase "prospective payment system" is revised to read "prospective payment system".

J. Subpart K is amended as follows:

1. The heading of subpart 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, 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 rate 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 paragraphs (d), the phrase, "for inpatient operating costs" is added 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), (a)(3) and (a)(4) introductory text and (a)(4)(iii) 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 system 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 and paragraph (e)(2)(ii)(A) are 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 be redesignated 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.* To be redesignated under the special rules in this paragraph, a hospital must be a sole community hospital or a rural referral center as of the date of the MGCRB's review.

* * * * *

(iii) If a hospital that is a rural referral center, a sole community hospital, or both qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital. If the hospital is closer to another rural area than to any

urban area, it may seek redesignation to either the closest rural or the closest urban area.

* * * * *

(v) A hospital that is redesignated under paragraph (a)(4) of this section may not be redesignated 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)(l)(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 the following:

(A) The average hourly wage in the area in which the hospital is located and the average hourly wage in the adjacent area. The wage data are 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. In § 412.232, paragraph (c) is revised; paragraphs (d)(2) introductory text and (d)(2)(ii) introductory text are republished; and paragraphs (d)(2)(i) 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 added 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 submitted 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 file an appeal of the MGCRB's denial of its request for withdrawal of an application to the Administrator. The appeal must be received 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, a heading is added to paragraph (f) and paragraphs (f)(1) and (f)(3) are revised; and a new paragraph (g) is 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 systems.

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 and the costs meet all other provisions for recognition of old capital costs contained in this section.

* * * * *

(c) *Obligated capital costs*—(1) *General rule.* * * *

(ii) *Moveable equipment.* Moveable equipment is recognized as old capital only if all of the conditions specified in paragraphs (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; 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 180 days after 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 by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after 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.

* * * * *

3. 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; 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 or does not have adequate Medicare utilization to file a cost report in a 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 of 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—

* * * * *

(4) *Denial by intermediary.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital that its request is denied and explains the basis for the denial.

* * * * *

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 period (or combination of 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 180 days after the extraordinary 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.

* * * * *

PART 413—[AMENDED]

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, 1395l (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 the capital-related costs of inpatient services 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 costs, 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 given 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 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 it 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 provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program, for less than two years.

* * * * *

(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 Programs No. 93.733, Medicare—Hospital Insurance; No. 93.744, Medicare—Supplementary Medicare Insurance)

Dated: August 24, 1992.

William Toby, Jr.,

Acting Deputy Administrator, Health Care Financing Administration.

Approved: August 24, 1992.

Louis W. Sullivan,

Secretary.

[**Editorial Note:** The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts Effective With Discharges on or After October 1, 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 hospital operating costs and Medicare inpatient hospital 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 for cost reporting periods ending on or before March 31, 1993 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 final rule are presented at the end of this addendum in section V.

II. 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 in 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 standardized amounts set forth in Tables 1a, 1b, and 1c of section V of this addendum were—

- Updated by 2.55 percent for urban hospitals (that is, the market basket percentage increase of 4.1 percent minus 1.55 percent); and 3.55 percent for rural hospitals (that is, the market basket percentage increase of 4.1 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 interim final rule (48 FR 39763) contains a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(9)(B)(i) of the Act 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 from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients.

Since the standardized amounts have already been adjusted for differences in case mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, no additional adjustments for these factors for 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) 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 final rule.

Table 1a contains the three national standardized amounts that continue to be applicable to most hospitals. Table 1b sets forth the 27 regional standardized amounts that 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 will update the large urban, other urban, and rural average standardized amounts using the applicable percentage increases specified in section 1886(b)(3)(B)(i). Section 1886(b)(3)(B)(i)(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, 2.55 percent) for hospitals located in urban areas.
- The market basket percentage increase minus 0.55 percentage points (that is, 3.55 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 4.1 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 published the report to Congress as Appendix C to the proposed rule. Our final recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix C to this final 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.

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 have identified those hospitals that are likely to lose their rural referral center status and determined the cost of paying them the urban standardized amount for the portion of FY 1993 that we estimate they will no longer qualify as a rural referral center. We have included 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 following adjustment factors were applied to the final standardized amounts:

Urban	Rural
.987471	.999433

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 reflected wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 30, 1992. The final budget neutrality adjustment factors reflect the effects of all reclassification decisions and changes in these decisions 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.

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 to this final rule, we normalized the recalibrated DRG weights by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. While this adjustment is intended to ensure that recalibration does not affect total payments to hospitals, our analysis indicates that the normalization adjustment does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals.

Section 1886(d)(3)(E) of the Act specifies that the hospital wage index must be updated based on new survey data no later than October 1, 1990 and on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the DRG reclassification changes and recalibration of the relative weights be budget neutral and the requirement in section 1886(d)(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 proposed 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.

The budget neutrality adjustment factor that was applied to the final standardized amount is .999851.

In addition, we are continuing 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 midyear corrections in the wage index and applying those corrections on a prospective basis effective with discharges occurring after the date the corrections are made. As described in that rule, when midyear corrections are made under the provisions of § 412.63(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 midyear 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 computed a retroactive budget neutrality adjustment factor of .999586 in

the proposed rule. 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. Based on the additional revised wage values that have been implemented since the proposed rule was issued, the final budget neutral adjustment factor is .999490. 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 to this final rule, we proposed 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 were as follows:

Urban standardized amount	Rural standardized amount	Capital federal rate
.944828	.976085	.9490

The final 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
.944598	.976420	.9496

We proposed to continue to set the outlier thresholds so as to result in estimated outlier payments equal to 5.1 percent of total prospective payments. 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 June 30, 1992 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 will be made by the intermediaries in determining the prospective payment rates as described in section II.D of this addendum. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Tables Ia, Ib, and Ic, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico.

1. Adjustment for Area Wage Levels

Sections 1886(d)(2)(H) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble to this final rule, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 4c of the 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 cost 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 to this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGS, and have developed relative weights for each DRG that are intended to reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs.

Table 5 of section V of this addendum contains the weighting factors that we will 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, Mediare-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 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 hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted if appropriate under Step 3).

Step 5—Multiply the final amount from Step 4 by the weighting factor corresponding to the appropriate DRG (see Table 5, section 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 on 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 increasing the hospital-specific rates by 4.1 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 will be calculated by multiplying a hospital's hospital-specific rate for the preceding cost reporting period by the applicable update factor (that is, 104.1 percent). In addition, the hospital-specific rate will be adjusted by the budget neutrality adjustment factor (that is, .999851) as discussed in section II.A.4.b of this addendum. This resulting rate will be used in determining under which rate a sole community 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 weighting 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 weighting 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. Changes to Payment Rates for Inpatient Capital-Related Costs for FY 1993

The prospective payment system for hospital inpatient capital costs was implemented 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 a Federal rate for capital and a decreasing proportion of a hospital's 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 the factors used for determining the Federal rate and the hospital-specific rate are changed. The rate changes will 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 costs. Accordingly, we compute a separate Federal rate specific to Puerto Rico hospitals using the same methodology used to compute the national rate for capital costs. The Federal rate for hospitals in Puerto Rico is based on 75 percent of the Puerto Rico rate and 25 percent of the national rate.

A. Determination of the FY 1993 Federal Rate for Capital Costs.

For FY 1992, the Federal rate was $415.59. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1993 Federal rate would be $416.36. In this final rule, we are establishing an FY 1993 Federal rate of $417.29.

In the discussion that follows, we explain the factors that determined the FY 1993 Federal rate. In particular, we explain why the Federal rate has increased only 0.41 percent over FY 1992. The major factor contributing to the modest increase in the Federal rate is the requirement that estimated payments each year from FY 1992 through FY 1995 for capital costs equal 90 percent of what would have been payable that year on a reasonable cost basis. Based on the most recent data, we now estimate that capital payments for FY 1992 will equal 92.85 percent of reasonable costs. The data thus indicates that the budget neutrality adjustment for FY 1992 was not sufficient to meet the 90 percent target. As a consequence, the Federal rate for FY 1992 was higher than it should have been on the basis of the current data. While we do not retroactively adjust the budget neutrality factor and the Federal rate for previous years to account for revised estimates, we do employ the most recent information to refine the budget neutrality adjustment for subsequent years. The result is a larger budget neutrality adjustment for FY 1993, which restricts the increase in the Federal rate to 0.41 percent.

Although the Federal rate for FY 1993 is only 0.41 percent higher than the FY 1992 Federal rate, we note that Federal rate payments (holding the proportion of payment based on the Federal rate constant) will increase by 2.0 percent before any increase in the case-mix index is taken into account. More importantly, we estimate that total capital payments per case will increase 6.21 percent in FY 1993.

If FY 1992 payments had not been excessive (that is, had equalled 90 percent of what would have been payable on a reasonable cost basis), total payments would increase 9.6 percent. We explain below in section III.A.6. why the rate of increase in the Federal rate will generally be lower than the rate of increase in payments. It is important to emphasize that the increase in capital payments is a much more important factor in gauging the adequacy of payment under the capital prospective payment system than changes in the Federal rate alone.

Finally, it should be noted that total payments to hospitals under the prospective payment system will be relatively insensitive to changes in the Federal rate even after the expiration of the budget neutrality provision in FY 1996. Since capital payments constitute about 10 percent of hospital payments, a 1 percentage point change in the Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

1. Standard Federal Rate Update Factor for Inflation

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 2-year moving average of actual increases in Medicare inpatient capital-related costs per discharge. The 2-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 3 and 4 years before the fiscal year in question.

We proposed that the FY 1993 update factor for the Federal rate would be 3.76 percent. In this final rule, we are providing that the final FY 1993 update factor for the Federal rate will be increased by 6.07 percent.

Comment: Several commenters argued that the proposed update factor of 3.76 percent was too low. Some of these commenters noted that the calculation of the average cost per case increases seemed to employ data from a larger set of hospitals than just prospective payment hospitals. These commenters contended that using data only from prospective payment hospitals would produce an update factor of 4.37 percent, or .61 of a percentage point higher than the proposed update factor. One commenter noted that the proposed update factor of 3.76 percent was significantly lower (2.21 percentage points) than the update factor projected at the time of the August 30, 1991 final rule implementing the capital prospective payment system (56 FR 43522).

Response: For FY 1993, the update factor 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 days 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 proposed that the FY 1993 update for the Federal rate would be 3.76 percent. The following chart shows how this figure was computed:

CAPITAL PER CASE INCREASE FROM COST REPORT DATA

FY	Number of hospitals	Capital cost per case [1]	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 (percent)	Average 2-year increase (percent)
1989	2.52	4.20	
1990	2.08	3.31	3.76

[1] These figures represent the capital cost per case, with adjustments for the anticipated effects of cost report audits and reopenings, based on data in the December 1991 update of the HCRIS file. Differences between these figures and the figures in other charts is due to revised data in successive HCRIS updates. For example, the figure for average cost per case used in setting the PPS-capital rate for FY 1992, $527.22, was the 1989 average cost per case, with adjustments for audits and reopenings, based on data from the June 1991 HCRIS update. The figure of $518.90 for FY 1989 in this chart was derived from data in the December 1991 HCRIS update, the latest update available before the publication of the NPRM.

As we noted when we published the June 4, 1992 proposed rule, some cost reports were not included in the HCRIS data we used to compute the proposed update (57 FR 23692). We believed at the time that the missing data was probably from cost reporting periods ending June 30, which include a relative high proportion of hospitals with higher capital costs.

In determining the budget neutrality target for FY 1993 in the proposed rule, we estimated that the final FY 1990 rate of increase in the average cost per case would be 9.6 percent rather than the 5.46 percent increase indicated by the available data on actual costs. Since the regulation provides that the capital update factor be computed as the 2-year average of actual increases in capital-related costs per case, we believed it was more appropriate to use the 5.46 percent supported by actual cost data rather than an estimated increase for FY 1990. (We did, however, use the estimated increase for budget neutrality purposes). As several commenters acknowledged, we made it clear in the proposed rule that we would recompute the average increase using the latest data, and that the results would not necessarily be the same. The latest FY 1990 cost per case rate of increase (8.45 percent) is, in fact, closer to our estimate for budget neutrality purposes than to the calculated rate of actual increase in the proposed rule. It is also similar to the projected FY 1990 rate of increase in the August 31, 1991 final rule.

We emphasize that even though we use cost report data as the basis for our estimates of FY 1993 capital costs, the budget neutrality target is determined by the estimate of FY 1993 capital costs, not by the 2-year average update factor applied to the FY 1992 Federal rate.

Furthermore, as the data on the HCRIS file continue to be updated for the effects of cost report audits, reopenings, and other factors, the FY 1989 increase in average capital cost per case has also risen to 8.55 percent. In this case, the rise in the rate of increase from FY 1988 to FY 1989 was primarily due to a relatively greater decline in the FY 1988 average capital cost per discharge compared to the FY 1989 decline reported in the HCRIS data.

We computed the final update factor of 6.07 percent from the data for all short-term acute care hospitals, including hospitals under alternative payment waivers. We used the group of all short-term acute care hospitals because these hospitals are all similar and the waivers could be terminated at some future date. Furthermore, we use all short-term acute care hospitals for related program purposes, such as determining DRG relative weights. (Since waivered hospitals will not be paid prospectively in FY 1993, we excluded them from the budget neutrality determination. We discuss this issue in section III.A.4 below.) Contrary to the assertions of some commenters, including hospitals excluded from the prospective payment system in the determination of the 2-year average rate of increase would have slightly increased the update factor by 0.13 percent.

The final update factor of 6.07 percent is actually 0.10 of a percentage point higher than the 5.97 percent projected for FY 1993 in the August 30, 1993 final rule, and 2.31 percentage points higher

than the FY 1993 update of 3.76 percent proposed in the June 4, 1992 proposed rule. Because the issues relating to the revised capital update factor in this final rule are so complex, we have developed the following more detailed chart to show how the final FY 1993 update factor was computed:

CAPITAL PER CASE INCREASE FROM COST REPORT DATA

FY	Number hospitals 1st HCR	Number hospitals 2nd HCR	Unadj-capital cost per case	Increase in cost per case (Unadj.)	Audit adjusted capital cost per case [2] (percent)	Increase in adjusted cost per case (percent)	Average two increase in adjusted cost per case (percent)	Observed CMI (percent)	Adj. to CMI (percent)	Adjusted CMI (percent)	Adjusted increase (percent)	Update (Average two year increase of CMI adjusted rate of increase) (percent)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1988	4,329	5,600	$467.50		$468.04							
1989	4,298	5,486	517.31	10.65	508.06	8.55		2.52		2.52	5.88	
1990	4,259	5,406	582.20	12.54	551.07	8.47	8.51	0.86	1.22	2.09	6.25	6.07

[1] Colums 1 and 2 represent the numbers of hospital cost reports used in developing the capital cost per case figure in colume 3. Since hospital cost reporting periods do not all coincide with the Federal fiscal year, data for a given Federal fiscal year must be derived from more than one hospital cost report, allocated proportionately to the Federal fiscal year. For example, for a hospital with a cost reporting period beginning January 1, one quarter of its cost report for the period ending December 31, 1987 would be allocated to Federal fiscal year 1988, and three quarters of its cost report for the period ending December 31, 1988 would be allocated to Federal fiscal year 1987. Column 1 represents the number of cost reports used that ended in the Federal fiscal year in question. Column 2 represents the number of cost reports used that began in the Federal fiscal year in question. Column 2 is greater than Column 1 because Column 2 includes cost reports for hospitals whose cost reporting period coincides with the Federal year along with cost reports for those hospitals whose cost reporting periods do not coincide with the Federal fiscal year. Column 1 includes only cost reports for hospitals whose cost reporting periods do not coincide with the Federal fiscal year.

[2] Figures in column 5 represent the capital cost per case, adjusted for the anticipated effects of cost report audits and reopenings, from the June 1992 update of HCRIS. This column is equivalent to the column labelled Capital Cost per Case in the previous chart showing the computation of the update factor in the June 4, 1992 proposed rule. Differences between the capital cost per case figures used in this chart and in previous charts are due to use of more recent HCRIS data. The following factors were used in adjusting the capital cost per case figures from column 3 for the effects of audits and reopenings:

Audit Adjustment Applied to As-Submitted Cost Reports

Cost reporting periods beginning in:

FY 1987—0.9276
FY 1988—0.9238
FY 1989—0.9212
FY 1990—0.9430

Audit Adjustment Applied to Settled Cost Reports

All years—1.0034

The cost per case figures that result after the application of these audit adjustments to submited and settled costs reports, respectively, are entered in Column 5.

We note that the effect of the update on the Federal rate is limited by the requirement of budget neutrality until FY 1996. Although the update is 2.31 percentage points higher than in the proposed rule, the final FY 1993 Federal rate has only increased 0.22 percent from the proposed FY 1993 rate. It is only 0.41 percent higher than last year's Federal rate, and 2.99 percent lower than the FY 1993 projection in the August 30, 1992 final rule. This is due primarily to the change in the budget neutrality adjustment factor required to assure that payments in FY 1993 will equal 90 percent of what we estimate would have been paid for capital-related costs on a reasonable cost basis. We discuss the change in this factor, and the reasons for that change, in III.A.3 below.

Comment: Some commenters requested clarification of the discrepancy between our estimates of the FY 1989 and FY 1990 increases in the average capital cost per case in the August 1991 projection and the June 1992 final rule.

Response: The following table summarizes the figures we have used at various times for the FY 1989 and FY 1990 rates of increase in capital cost per case.

RATES OF INCREASE IN CAPITAL COST PER CASE

	FY 1989 (percent)	FY 1990 (percent)
FY 1992 Final Rule	[1] 7.82	[2] 6.37
FY 1993 Proposed Rule	[1] 6.83	[1] 5.46
FY 1993 Final Rule	[1] 8.55	[1] 8.47

[1] Cost report caiculations with audit adjustments.
[2] Estimate.

As the chart shows, all the figures for the FY 1989 increases were calculated from cost report data with adjustments for the anticipated effects of audits. The FY 1990 figure in the August 30, 1991 final rule was an estimate; the other figures for FY 1990 were calculated from cost report data. The variation in the figures calculated from cost report data is due entirely to changes in that data from one HCRIS update to another. The effects of audits have varied from our adjustments for their projected effects. We base our audit adjustment on the reported effects of previous audits. If the effect of audits on cost reports that are audited later differs from the effect of cost reports audited earlier, then the audit-adjusted capital cost per case will also vary from one HCRIS update to the next.

Comment: One commenter requested an explanation of the 1.22 percent adjustment to case mix increase for FY 1990 used in the computation of the capital update in the June 4, 1992 proposed rule. The commenter noted that the update would have been 4.38 percent without this adjustment.

Response: As we explained in the final rule for FY 1990 (54 FR 36471), 1.22 percent of the total increase in case mix from FY 1987 to FY 1988 resulted from FY 1988 GROUPER changes and recalibration. In other words, 1.22 percent of the increase of case mix from FY 1987 to FY 1988 did not represent an increase in resource requirements that should be recognized in increased payments in subsequent years. To assure that this distortion was not continued into subsequent years, we reduced the FY 1990 weights to remove prospectively the 1.22 percent increase in the average case weight attributable to GROUPER changes and recalibration in FY 1988. In computing the capital update factor, we adjust the rate of increase in capital cost per case for each year used in determining the update for observed case mix increase in that year.

Since 1.22 percent was removed from the FY 1990 weights to adjust for the effects of administrative changes on the DRG weights in 1988, that reduction must be reincorporated into the FY 1990 case mix increase. Case-mix increases for this purpose must be determined with consistent measures of case mix in two comparison years. The 1.22 percent adjustment corrects this inconsistency in determining the appropriate FY 1990 rate of increase. Otherwise, the adjustment would not be based on total observed case-mix increase for FY 1990.

Comment: Two commenters recommended that an add-on adjustment be employed in setting the update factor to account for appropriate changes in new technology prior to the adoption of an analytical update framework in FY 1996.

Response: The present update factor is based on a two-year lagged average of actual costs. Since actual costs include spending for new technology, the cost of new technology is already accounted for in the update factor. A separate adjustment for new technology is therefore not appropriate (and would be double counting) as long as the update is determined by a lagged average of actual costs. The cost of appropriate new technology is one of the factors that we believe should be included in the analytical update framework that will be used beginning in FY 1996. As we discuss in appendix D, we are studying methodologies for incorporating appropriate changes of cost due to new technology along with other factors into the update framework for FY 1996 and beyond.

Comment: One commenter alleged that HCFA was violating its commitment to provide fair and just capital updates by playing budget games with the capital update factor.

Response: The computation of the proposed update factor for FY 1993 was not driven by budget considerations. We employed the methodology established in the August 30, 1991 final rule implementing the capital prospective payment system and the best data available to us at the time to compute the proposed FY 1993 rate. As explained above, the change in the final update factor for FY 1993 is due to more complete and accurate data than were available at the time when we computed the proposed update. As also explained above, the major constraint on the increase in the Federal rate in FY 1993 is the budget neutrality requirement. This requirement was established by statute and we have no discretion in applying it. The update factor is determined independently of the budget neutrality adjustment.

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 0.9497 to the Federal rate. In the June 4, 1992 proposed rule, we proposed an outlier reduction factor of 0.9490. Based on the thresholds as set forth in section VI of the preamble to this final rule, we estimate that outlier payments will equal 5.04 percent of inpatient capital-related payments based on the Federal rate in FY 1993. We are therefore applying an outlier adjustment factor of 0.9496 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 0.9496/.9497 or 0.9999. Thus, the higher outlier payment percentage in FY 1993 will reduce the FY 1993 Federal rate by an additional .01 percent (1−0.9999) 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 proposed to adjust the Federal rate to maintain budget neutrality for changes in DRG weight and the geographic adjustment factor by a factor of 0.9906. In this final rule, we are applying a factor of 0.9980 to meet this requirement.

Comment: One commenter observed that the application of the "new" factor to preserve budget neutrality for changes resulting from any annual recalibration and reclassification of the DRG weights and in the geographic adjustment factor accounted for almost 1 percentage point of the 3.21 percent difference between the projection of the FY 1993 Federal rate in the August 30, 1991 final rule and the proposed FY 1993 Federal rate.

Response: This adjustment factor is not new in the sense that provision was made for the adjustment in the August 30, 1991 final rule implementing the capital prospective payment system. Consistent with the prospective payment system for operating costs, we believe that changes in the DRG weights and geographic adjustment factor (including those resulting from geographic reclassifications) should be budget neutral. The adjustment is applied for the first time this year since it was designed to adjust for all changes in DRG weights and in the geographic adjustment factor after the initial year of the capital prospective payment system.

We use 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 use 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 then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the geographic adjustment factor. For FY 1993, we

estimated in the proposed rule that a budget neutrality factor of 0.9906 was necessary for this purpose. For the final rule, we have determined that a factor of 0.9980 is necessary. Appendix B contains a more detailed description of the methodology used to determine this factor. 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 of 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 from 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 Pub. L. 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 adjustment 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.

We proposed a budget neutrality adjustment factor of 0.9564. In this final rule, we are establishing a budget neutrality factor of 0.9162. One reason for the change in the budget neutrality factor since the June 4, 1992 proposed rule is a decline in the projected FY 1993 capital cost per case budget neutrality target. We develop this target from available data on the average Medicare capital cost per case of all short-term acute care hospitals subject to the capital prospective payment system (excluding waiver hospitals), which we update to FY 1993 on the basis of estimated rates of increase in Medicare capital costs per case. The FY 1993 capital cost per case budget neutrality target declined 3.12 percent from the June 4, 1992 proposed rule to this final rule. Two significant factors account for this decline. One factor is the decline in the Medicare capital cost per case reported in the HCRIS updates. We believe that this decline is due to actual audit reductions higher than we originally projected. The second factor is a decline in our latest estimates of the projected increases in Medicare capital costs per case.

For the June 4, 1992 proposed rule, we had data from the December 1991 HCRIS update on the average Medicare capital cost per case for all hospitals in FY 1989. We adjusted this figure for the effects of audits and developed a projected average Medicare capital cost per case for FY 1993 on the basis of estimated rates of increase in Medicare inpatient capital cost per case. We then used the projected FY 1993 average Medicare capital cost per case as the budget neutrality target for FY 1993, and computed the budget neutrality adjustment accordingly.

For this final rule, we have actual data for FY 1990 from the June 1992 HCRIS update. Therefore, we are able to use FY 1990 capital costs per case rather than FY 1989 costs per case as the basis for projecting a FY 1993 average capital cost per case budget neutrality target. In computing the final FY 1993 budget neutrality target, we adjusted the FY 1990 capital cost per case for the effect of audits as we had done in the June 4, 1992 proposed rule for the FY 1989 amount. We eliminated the data from excluded and waiver hospitals, so that the average capital cost per case is based only on short-term acute care hospitals subject to the capital prospective payment system. Eliminating the waiver hospitals from the budget neutrality determination has the effect of raising the capital cost per case by 0.7 percent (from $551.07 per case to $554.94 per case) compared to using all short-term acute case hospitals including those in waiver states. We also adjusted the FY 1990 average Medicare capital costs for expansion of the preadmission DRG window and for the effects of transfers on the total discharge count used to determine the Medicare cost per case. We made both these adjustments in calculating the FY 1989 Medicare inpatient cost per case in the August 30, 1991 final rule (56 FR 43368). We included these adjustments in the budget neutrality target computation for consistency. Finally, we applied revised estimates of the rate of increase in capital costs per case between FY 1990 and FY 1993 to arrive at a projected FY 1993 average Medicare capital cost per case.

In the June 4, 1992 proposed rule, we estimated there would be a 29.1 percent increase in Medicare inpatient capital costs per case, between FY 1990 and FY 1993. In this final rule, we estimate the increase over that period will be 26.9 percent. The following chart shows how the rate of increase estimates for FY 1991 through FY 1992 were calculated in the June 4, 1992 proposed rule and for this final rule:

COMPARISON OF FACTORS FOR MEDICARE INPATIENT CAPITAL COST PER CASE INCREASES: NPRM AND FINAL RULE

[In Percentages]

FY	(1) Total inpatient capital			(2) Medicare share			(1)×(2)=(3) Medicare inpatient capital			(4) Medicare enrollment			(5) Admissions incidence			(4)×(5)=(6) Medicare admissions			(3)/(6)=(7) Estimated increase in medicare inpatient capital cost per case		
	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change	NPRM	Final	Change
91	5.99	5.81	−0.17	2.94	2.34	−0.58	9.11	8.28	−0.76	2.19	2.19	−0.00	−0.72	−0.71	0.01	1.46	1.47	0.01	7.54	6.71	−0.77
92	8.00	8.00	0.00	3.00	3.00	0.00	11.24	11.24	0.00	1.99	2.22	0.23	−0.03	0.25	0.28	1.96	2.47	0.50	9.10	8.56	−0.50
93	9.00	9.00	0.00	3.30	3.30	0.00	12.60	12.60	0.00	1.73	2.11	0.37	0.56	0.62	0.06	2.30	2.75	0.44	10.07	9.58	−0.45

The chart shows the causes of the decline in the rate of increase projections. For FY 1991, the decline in the projected rate of increase is due to the 0.17 percent decline in the projected rate of increase of total Medicare capital and the 0.58 percent decline in the projected rate of increase of Medicare dayshare. Together these factors produced a 0.76 percent decline in the projected rate of increase of Medicare inpatient capital. Combined with a 0.01 percent rise in the projected rate of increase of Medicare admissions, this produced a 0.77 percent decline in the projected rate of increase of Medicare capital cost per case. For FY 1992 and FY 1993, the decline is due to higher projected rates of increase in Medicare admissions (0.50 percent and 0.44 percent respectively). These changes are due in turn to higher projected rates of increase for Medicare enrollment (0.23 percent for FY 1992 and 0.37 percent for FY 1993) and higher projected rates of increase for admissions incidence (0.28 percent for FY 1992 and 0.06 percent for FY 1993).

The revised figures employed in this final rule come from our regular midsession budget review. The revised figures for FY 1991 derive from actual data which differed from our projections. For FY 1992, we now have preliminary data that shows admissions are increasing. We expect these increases to continue into FY 1993. Accordingly, we have raised our estimates of the rate of increase in admissions for the rest of FY 1992 and for FY 1993. The higher rates of increase in enrollment are based on SSA data that have become available since the June 4, 1992 proposed rule and show an increase in the disability population.

The following chart shows the effect of the reduced rates of increase by comparing the projections from FY 1990 to FY 1993 in the proposed rule and in the final rule:

EFFECT OF REVISED RATE OF INCREASE ESTIMATES ON CALCULATION OF FY 1993 BUDGET NEUTRALITY TARGET

	Capital cost per case	Percent change in rate of increase	Percent change in capital cost per case
FY 1990:			
Proposed	$568.66 [1]		
Final	560.49 [2]	N/A	−1.44
FY 1991:			
Proposed 7.54%	611.54		
Final 6.71%	598.10	−0.77	−2.20

EFFECT OF REVISED RATE OF INCREASE ESTIMATES ON CALCULATION OF FY 1993 BUDGET NEUTRALITY TARGET—Continued

	Capital cost per case	Percent change in rate of increase	Percent change in capital cost per case
FY 1992:			
Proposed 9.10%	667.19		
Final 8.56%	649.30	−0.49	−2.68
FY 1993:			
Proposed 10.07%	734.38		
Final 9.58%	711.50	−0.45	−3.12
Cumulative		−1.70	

[1] FY 1990 estimate, based on December 1991 HCRIS data (audit-adjusted) for FY 1989 and estimated rate of increase of 9.59 percent.
[2] FY 1990 cost per case based on June 1992 HCRIS data, audit-adjusted, excluding waiver hospitals and PPS-excluded hospitals, and adjusted for preadmission DRG window and transfers.

The chart shows that the cumulative effect on the revised rates of increase is to lower the FY 1993 budget neutrality target by 1.70 percent. Together with the 1.44 percent decline due to updated HCRIS data, this accounts for the 3.12 percent reduction in the FY 1993 capital cost per case budget neutrality target.

In addition to the lower FY 1993 capital cost- per-case budget neutrality target, the other factor that contributes to the revised budget neutrality adjustment factor in this final rule is higher update factor for the Federal and hospital-specific rates. Even without a decrease in the budget neutrality target, the higher update factor would have produced high payments based on those rates that would have required a reduction in the budget neutrality adjustment factor.

One implication of the revised capital cost per case budget neutrality targets is that, based on current data, the budget neutrality adjustment for FY 1992 was not sufficient to meet the 90 percent target. As a consequence, the Federal rate for FY 1992 was higher than it should have been on the basis of the revised capital cost per case estimates. 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, in this final rule, we use the most recently available data to establish the budget neutrality adjustment for FY 1993. For FY 1993, we proposed to apply 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. In this final rule, the budget neutrality adjustment factor is 0.9162. This represents a net −4.58 percent adjustment (.9162/.9602 = .9542) to the FY 1992 Federal rate, and a net adjustment of −4.20 percent (.9162/.9564 = .9580) in the FY 1993 Federal rate proposed in the June 4, 1992 proposed 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 estimated in the June 4, 1992 proposed rule that exceptions payments would equal 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we proposed to apply an exceptions reduction factor of 0.9610 to determine the FY 1993 Federal rate. For this final rule, we are estimating that exceptions payments for FY 1993 will equal 2.44 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are therefore applying an exceptions payment reduction factor of 0.9756 to the Federal rate for FY 1993.

We expect exceptions payments to increase during the transition period as payments are increasingly based on the Federal rate. This accounts for the higher level of exceptions payments for FY 1993 compared to FY 1992. The lower level of exceptions payments in this final rule compared to the proposed rule is due to the lower projected FY 1993 capital costs per case, which has the effect of reducing the number of hospitals that qualify for an exception and the amount of the exception for those that do qualify.

The exceptions reduction factors are not built permanently into the rates; that

is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the net adjustment to the FY 1993 Federal rate is −0.58 percent (.9756/.9813, or 0.9942) in comparison to the FY 1992 Federal rate, and +1.52 percent (.9756/.9610 or 1.0152) in comparison to the proposed Federal rate.

6. Standard Federal Rate for FY 1993

For FY 1992, the Federal rate was $415.59. With the changes we proposed to the factors used to establish the Federal rate, we proposed that the FY 1993 Federal rate would be $416.36. In this final rule, we are establishing an FY 1993 Federal rate of $417.29. The final Federal rate for FY 1993 was calculated as follows:

- The FY update factor is 1.0607.
- The FY 1993 outlier adjustment factor is 0.9496.
- The FY 1993 budget neutrality factor applied to the standard Federal rate for changes in the DRG relative weights and in the geographic adjustment factor is 0.9980.
- 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 is 0.9162.
- The FY 1993 exceptions payment adjustment factor is 0.9756.

Since the Federal rate had 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 proposed 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.

Comment: We received 15 comments on the proposed FY 1993 capital Federal rate. All the commenters noted that the proposed FY 1993 rate represented only a small increase over the FY 1992 rate. Seven commenters noted that the proposed FY 93 Federal rate was 3.21 percent lower than the rate of $430.17 projected in the August 30, 1991 final rule (56 FR 43522). One commenter also noted that while reasonably accurate projections of the budget neutrality adjustment and the exceptions reduction factor were included in the August 30, 1991 final rule projection, the projection did not include an estimate of the effects of the budget neutrality adjustment for case-mix change and change in the geographic adjustment factor. The commenter noted that this accounted for 1 percentage point of the difference between the August 1991 projection and the proposed FY 1993 Federal rate.

Seven commenters expressed concern that the proposed increase in the Federal capital rate would not be adequate to meet hospitals' Medicare capital-related costs. Three commenters noted that the small increase in the proposed Federal capital rate had already made it more difficult or more costly for hospitals to borrow. One commenter noted that the investment community places great (perhaps symbolic) importance on the amount of the Federal rate over total per case capital payments in judging whether hospitals are likely to have adequate funds under the capital prospective payment system to meet debt service.

Response: We explain in detail below the reasons why the FY 1993 Federal rate is lower than the rate projected in the August 30, 1991 final rule. We believe it is important to keep in mind, however, that while the Federal rate has increased by only 0.4 percent, largely because of budget neutrality constraints, we estimate total capital payments will increase by 6.2 percent.

We are sensitive to the concerns of hospitals that there be predictability in the levels of their capital payments. We make our projections based on the best data available at the time, and we share them so that others will have the most current information on what we estimate capital payments will be over the next few years. At the same time, we have a statutory obligation to assure that payments equal 90 percent of what would have been available on a reasonable cost basis and to revise our estimates for rate-setting purposes as better data become available. When we published the projections for fiscal years 1993 through 1996 in the August 30, 1991 final rule, we cautioned that they were only estimates, and that they were subject to revisions resulting from continued methodological refinements, more recent data, and payment policy changes. Some difference between the projection and the proposed FY 1993 Federal rate were therefore only to be expected.

The chart below compares the final FY 1993 Federal rate with the August 1991 projection. As the chart shows, the final update factor of 6.07 percent is slightly higher (0.09 percent) than the August 1991 projection. While the final FY 1993 GAF/DRG budget neutrality factor and the final outlier reduction factor have the effect of slightly decreasing the Federal rate (0.20 percent and 0.01 percent, respectively) in comparison to the projection, the final exceptions reduction factor has the effect of increasing the Federal rate by 1.57 percent compared to the projection. Our August 30, 1991 projection did not include the DRG/GAF budget neutrality factor because we had no basis for predicting the additional FY 1993 geographic reclassifications. While we estimate exceptions payments will be higher in FY 1993 than they were in FY 1992, they will be lower than we projected in August, 1991. This is probably due to the lower FY 1993 capital cost-per-case budget neutrality target for FY 1993, as we explained in section III.A.5. above. Finally, the major cause for the decrease in the final FY 1993 Federal rate compared to the August 1991 projection is the budget neutrality adjustment factor. We have explained the effects of the lower FY 1993 budget neutrality target and the higher FY 1993 update factor on the determination of the final budget neutrality adjustment factor for FY 1993 in section III.A.4. above.

COMPARISON OF FEDERAL RATE CALCULATION AUGUST 1991 PROJECTION AND FINAL FY 1993 RATE

	Cost per discharge	Percent change from FY 93	Cumulative percent change
	Projection		
FY 89 cost per discharge	$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters	464.42		
Update factor:			
Projection: 1.0597	492.15		
Final FY 93: 1.0607	492.61	0.09	0.09
GAF/DRG budget neutrality factor:			
Projection: 1.0000	492.15		
Final FY 93: 0.9980	491.63	−0.20	−0.11

COMPARISON OF FEDERAL RATE CALCULATION AUGUST 1991 PROJECTION AND FINAL FY 1993 RATE—Continued

	Cost per discharge	Percent change from FY 93	Cumulative percent change
	Projection		
Outlier reduction factor:			
Projection: 0.9497	467.39		
Final FY 93: 0.9496	466.85	−0.01	−0.12
Exceptions reduction factor:			
Projection: 0.9605	448.93		
Final FY 93: 0.9756	455.46	1.57	1.45
Budget neutrality reduction factor:			
Projection: 0.9582	430.17		
Final FY 93: 0.9162	417.29	−4.38	−2.99
Net change:			
Projected FY 93 rate:	430.17		
Final FY 93 rate:	417.29	−2.99	

We provide below a comparison of the final 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 final rate for FY 1993. The cumulative percent change column shows the difference, to that point in the table, between the FY 1992 rate and the final FY 1993 rate.

The 1993 update increases the Federal rate 6.07 percent compared to the rate in FY 1992 while the DRG/GAF budget neutrality factor decreases the Federal rate by 0.20 percent. The exceptions reduction factor decreases the proposed Federal rate by 0.58 percent compared to the exceptions reduction for FY 1992. The budget neutrality adjustment factor reduces the FY 1993 rate by 4.58 percent compared to the budget neutrality reduction in FY 1992. The combined effect of all the changes is to increase the FY 1993 Federal rate by 0.41 percent over the FY 1992 Federal rate.

COMPARISON OF FEDERAL RATE CALCULATION FROM FY 1992 FINAL RULE TO FY 1993 FINAL RULE

	Cost per discharge	Percent change from FY 92 rate from FY 92 (percent)	Cumulative percent change
FY 89 cost per discharge	$527.22		
FY 89 cost per discharge updated to 92,-adjusted for transfers and payment parameters	464.42		
Update factor:			
FY 92	464.42		
FY 93: 1.0607	492.61	6.07	6.07
GAF/DRG budget neutrality factor:			
FY 92: 1.0000	464.42		
FY 93: 0.9980	491.63	−0.20	5.86
Outlier reduction factor:			
FY 92: 0.9497	441.06		
FY 93: 0.9496	466.85	−0.01	5.85
Exceptions reduction factor:			
FY 92: 0.9813	432.81		
FY 93: 0.9756	455.46	−0.58	5.23
Budget neutrality reduction factor:			
FY 92: 0.9602	415.59		
FY 93: 0.9162	417.29	−4.58	.41
Net change:			
FY 92 rate	415.59		
FY 93 rate	417.29	.41	

Below we are providing a chart that demonstrates how our final FY 1993 Federal rate differs from the proposed FY 1993 Federal rate. The final update factor has the effect of raising the Federal rate by 2.23 percent. The revised DRG/GAF budget neutrality adjustment and outlier reduction factor have the effect of increasing the Federal rate marginally, and the revised exceptions reduction factor has the effect of increasing the Federal rate by 1.52 percent. However, the revised budget neutrality adjustment factor has the effect of decreasing the Federal rate by 4.20 percent, thus producing an increase of only 0.22 percent in the FY 1993 Federal rate between the June 4, 1992 proposed rule and this final rule.

COMPARISON OF FY 1993 PROPOSED FEDERAL RATE TO FY 1993 FINAL FEDERAL RATE

	Cost per discharge proposed	Percent change from FY 93 proposed (percent)	Cumulative change from FY 93 (percent)
FY 89 cost per discharge	$527.22		
FY 89 cost per discharge updated to 92, adjusted for transfers and payment parameters	464.42		
Update factor:			
Proposed FY 93: 1.0376	481.88		
Final FY 93: 1.0607	492.61	2.23	2.23
GAF/DRG budget neutrality factor:			
Proposed FY 93: 0.9906	477.35		
Final FY 93: 0.9980	491.63	.75	2.99
Outlier reduction factor:			
Proposed FY 93: 0.9490	453.01		
Final FY 93: 0.9496	466.85	.06	3.06
Exceptions reduction factor:			
Proposed FY 93: 0.9610	435.34		
Final FY 93: 0.9756	455.46	1.52	4.62
Budget neutrality reduction factor:			
Proposed FY 93: 0.9564	416.36		
Final FY 93: 0.9162	417.29	−4.20	−.22
Net change:			
Proposed FY 93 rate	416.36		
Final FY 93 rate	417.29	.22	

We estimated in the June 4, 1992 proposed rule that capital payments per case would increase 7.7 percent in FY 1993. With the lower budget neutrality target in this final rule, we project that capital payments per case will increase 6.2 percent in FY 1993. It is to be expected that the rate of increase in the Federal rate will generally be lower than the rate of increase in payments. As capital costs per case increase, total capital payments per case will increase proportionately through FY 1995 because of the requirement that aggregate payments for capital-related costs equal 90 percent of what would have been payable on a reasonable cost basis. At the same time, the amount of exceptions payments will increase as the transition progresses. These higher exceptions payments must be offset in the Federal rate determination, which reduces the increase in the Federal rate. For FY 1993, we expect exceptions payments to be more than twice as much as in FY 1992. The increase in capital payments per case is a much more important factor in gauging the adequacy of reimbursement under the capital prospective payment system than changes in the Federal rate alone. We believe that the projected increase in capital payments per case of 6.2 percent should be sufficient to provide adequate payment to hospitals to cover their Medicare related costs. In this regard, we note that the 6.2 percent increase is in relation to FY 1992 payment levels that we now estimate will equal 92.85 percent of what would have been payable on a reasonable cost basis (instead of 90 percent as required by statute). If FY 1992 payments had not been excessive, the FY 1993 increase would be 9.6 percent.

7. Rate for Puerto Rico Hospitals

For FY 1992, the rate for Puerto Rico hospitals was $319.68. With the changes we proposed making to the factors used to determine the rate, the FY 1993 standard rate for Puerto Rico would have been $320.27. With the changes we are adopting in this final rule, the standard rate for Puerto Rico is $320.99.

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 proposed that the hospital-specific rate be updated by a factor of 1.0376. In this final rule, we are updating the hospital-specific rate by a factor of 1.0607.

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 estimated in the proposed rule that exceptions payments would be 3.9 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore proposed that the updated hospital-specific rate be reduced by a factor of 0.9610. In this final rule, we are applying an exceptions reduction factor of 0.9756 to the hospital-specific rate. 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 compared to FY 1992 would therefore be −.58 percent (.9756/.9813 or .9942).

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 proposed a budget neutrality factor of 0.9564. In the final rule, we are applying a budget neutrality factor of 0.9162 to the hospital-specific rate. 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 in comparison to

FY 1992 would therefore be −4.58 percent (.9162/.9602 or .9542).

4. Net Change to Hospital-Specific Rate

We are providing a chart below to show the 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 1.0062, which represents an increase of 0.62 percent to the hospital-specific rate. The FY 1993 hospital-specific rate for each hospital is determined by multiplying the FY 1992 hospital-specific rate by the cumulative net adjustment of 1.0062.

FINAL FY 1993 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update Factor:			
FY 92:			
FY 93:	1.0607	1.0607	6.07
Exceptions payment adjustment factor:			
FY 92:	0.9813		
FY 93:	0.9755	0.9942	−0.58
Budget neutrality adjustment factor:			
FY 92:	0.9602		
FY 93:	0.9162	0.9542	−4.58
Cumulative adjustments:			
FY 92:	0.9422		
FY 93:	0.9481	1.0062	0.62

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1993

Comment: One commenter expressed concern over HCFA's use of the hospital wage index to adjust the Federal rate for local cost variations (the geographic adjustment factor). The commenter maintained that the use of the area wage index for payment to hospitals for purchases of new equipment is inappropriate since the cost of equipment from national manufacturers is unrelated to a hospital's geographic location. The commenter thus recommended the development of a more accurate index.

Response: The formula for the geographic adjustment factor already accounts for the concern expressed in the comment. The adjustment factor equals the hospital wage index value applicable to a hospital raised to the .6848 power and is applied to 100 percent of the Federal rate. When the wage index is raised to the .6848 power, it has the effect, on average, of adjusting .6848 of the Federal rate by the wage index. This means that only the part of the Federal rate which is actually affected by local cost variations, rather than the part which is determined by uniform national costs for equipment, is adjusted by the wage index. The exponential form is used in order to apply one factor to the whole capital payment, rather than forming labor and nonlabor shares. The present formula still provides the most accurate adjustment available to account for local cost variation. As we explained in the preamble to the August 30, 1991 final rule for the capital prospective payment system (56 FR 43374), the use of the hospital wage index was justified by our regression analyses, and the formula was determined in accordance with the results yielded by those analyses. While we still believe that the hospital wage index is the most appropriate basis for the geographic adjustment factor that is currently available, we agree with the commenter that the issue warrants continued study and evaluation.

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 hospital's outlier payments is included in its payments.

The rules to establish outlier thresholds for FY 1993 are published in section V.A of the preamble to this final rule. For FY 1993, 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 of $35,500. 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. For hospitals not subject to capital PPS (such as new hospitals under section 412.300(b) of the regulations), the operating cost outlier threshold is the greater of 2.0 times the operating prospective payment rate or $32,500. This threshold is derived by apportioning $35,500 in operating cost using the national average operating and capital cost-to-charge ratios (.6328 and .0594, respectively). This method is the same one used to develop last year's operating only threshold, as described at 56 FR 43227.

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 to this final rule, we are clarifying 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 will extend for 8 years, even though the hold-harmless payments may extend beyond the normal transition period.

IV. 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, by an applicable target rate percentage. For cost reporting periods beginning on or after October 1, 1992 and ending 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 perspective payment system is 4.2 percent. Therefore, the applicable percentage increase is also 4.2 percent.

V. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1a, 1b, 1c, 3c, 4a, 4b, and 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 1d, 3c, 4a, 4b, 4c, 4d, 4e, 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 1991

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 4d—Average Hourly Wage for Urban Areas
Table 4e—Average Hourly Wage for Rural Areas
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, Arithmetic Mean Length of Stay, and Day Outlier Threshold 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 6/92 GROUPER V9.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 91 MEDPAR Update 6/92 GROUPER V10.0
Table 8a—Statewide Average Operating Cost-to-Charge Rations for Urban and Rural Hospitals (Case Weighted)
Table 8b—Statewide Average Capital Cost-to-Charge Rations 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
2588.38	1066.39	2547.40	1049.51	2621.30	844.54

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)	2718.22	1113.53	2675.18	1095.89	2906.21	1002.29
2. Middle Atlantic (PA, NJ, NY)	2442.07	1054.94	2403.41	1038.24	2783.27	947.50
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2606.83	973.59	2565.55	958.18	2660.69	821.62
4. East North Central (IL, IN, MI, OH, WI)	2749.57	1151.92	2706.04	1133.68	2694.30	913.15
5. East South Central (AL, KY, MS, TN)	2501.84	881.57	2462.22	867.62	2637.01	766.17
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2607.57	1049.59	2566.29	1032.98	2562.99	818.54
7. West South Central (AR, LA, OK, TX)	2592.57	967.00	2551.51	951.70	2458.00	752.76
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2500.91	1035.78	2461.31	1019.39	2485.70	865.78
9. Pacific (AK, CA, HI, OR, WA)	2432.68	1183.17	2394.18	1164.44	2417.56	975.34

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	2327.98	484.16	2291.12	476.50	1786.74	385.18
National	2581.80	1004.12	2581.80	1004.12	2581.80	1004.12

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

BILLING CODE 4120-03-M

	Rate
National	417.29
Puerto Rico	320.99

BILLING CODE 4120-03-C

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.2807	010065	01.2058	010130	01.1135	030011	01.3734	030084	01.1632
010004	00.9097	010066	00.9287	010131	01.2425	030012	01.2299	030085	01.3884
010005	01.1227	010068	01.2062	010134	00.8432	030013	01.2443	030086	01.1918
010006	01.3393	010069	01.1563	010136	00.9547	030014	01.4031	030087	01.6008
010007	01.1009	010072	01.1131	010137	01.2968	030016	01.2762	030088	01.2860
010008	01.0077	010073	00.8980	010138	00.9357	030017	01.3632	030089	01.2309
010009	01.0273	010078	01.1942	010139	01.5218	030018	01.5880	030091	00.8278
010010	01.1156	010079	01.1448	010143	01.1285	030019	01.2814	030092	01.4688
010011	01.3574	010080	00.9558	010144	01.3769	030022	01.4006	030093	01.2437
010012	01.1928	010081	01.8053	010145	01.2076	030023	01.2054	030094	01.2765
010015	01.0730	010083	01.0932	010146	01.0485	030024	01.6310	030898	00.7311
010016	01.0765	010084	01.2908	010148	00.9447	030025	01.0782	030899	00.6006
010018	00.9150	010085	01.2717	010149	01.3690	030027	01.0651	040001	01.0679
010019	01.1785	010086	00.9694	010150	01.0028	030030	01.6629	040002	01.1367
010020	01.0007	010087	01.5097	010152	01.2536	030033	01.3734	040003	01.0336
010021	01.2115	010089	01.1003	010153	00.8914	030034	01.0286	040004	01.2209
010022	00.9401	010090	01.4705	010155	01.1307	030035	01.2489	040005	01.0550
010023	01.2778	010091	01.0189	010898	00.6959	030036	01.2334	040007	01.5318
010024	01.2337	010092	01.3663	010899	00.5933	030037	01.8935	040008	01.0179
010025	01.2158	010094	01.1763	020001	01.4834	030038	01.4606	040010	01.1393
010027	00.8711	010095	01.0181	020002	01.1941	030040	00.9724	040011	00.9214
010029	01.4931	010096	00.9046	020004	01.0873	030041	00.9511	040013	00.9602
010031	01.2797	010097	01.0095	020005	00.8986	030043	01.1931	040014	01.1017
010032	00.9070	010098	01.0219	020006	01.0388	030044	01.1142	040015	01.0677
010033	01.9500	010099	01.0825	020007	00.8894	030046	00.9612	040016	01.4707
010034	01.0531	010100	01.1681	020008	01.0337	030047	00.9275	040017	01.2500
010035	01.1657	010101	01.0596	020009	00.8031	030049	00.9341	040018	01.2014
010036	01.1478	010102	00.9137	020010	00.9224	030051	01.0494	040019	01.1889
010038	01.2293	010103	01.5453	020011	00.9338	030054	00.9025	040020	01.4579
010039	01.5918	010104	01.5707	020012	01.1664	030055	01.1924	040021	01.2006
010040	01.2753	010108	01.1573	020013	00.8977	030059	01.3816	040022	01.7042
010043	00.9501	010109	01.0879	020014	00.9471	030060	01.1243	040024	01.0779
010044	00.9779	010110	00.9101	020017	01.3587	030061	01.4282	040025	00.9912
010045	01.0126	010112	01.1441	020018	00.8830	030062	01.2490	040026	01.4413
010046	01.3194	010113	01.5946	020019	00.9503	030064	01.5476	040027	01.2715
010047	00.9036	010114	01.1854	020020	00.8628	030065	01.4554	040028	01.0000
010049	01.0788	010115	00.9016	020021	00.9057	030067	01.0547	040029	01.0846
010050	00.9495	010117	01.1192	020024	01.0246	030068	01.0087	040030	00.9079
010051	00.8718	010118	01.1355	020025	01.0078	030069	01.2786	040031	00.9728
010052	00.9603	010119	01.1920	020026	01.1908	030071	00.9551	040032	00.9237
010053	01.0067	010120	00.9828	020027	00.8359	030072	00.8989	040035	00.9041
010054	01.1921	010121	01.1109	030001	01.3599	030073	01.0328	040036	01.2320
010055	01.3346	010122	00.9563	030002	01.7380	030074	01.0462	040037	01.1284
010056	01.2842	010123	01.2910	030003	01.3336	030075	00.9442	040039	01.0557
010057	01.0200	010124	01.2798	030004	00.9854	030076	01.0117	040040	00.9778
010058	00.9263	010125	01.0978	030006	01.5817	030077	00.7776	040041	01.1297
010059	00.9996	010126	01.0798	030007	01.2790	030078	01.1100	040042	01.3115
010061	00.9621	010127	01.5077	030008	01.8927	030079	00.7854	040044	00.9187
010062	00.9492	010128	00.8924	030009	01.2224	030080	01.5176	040045	00.9487
010064	01.6518	010129	01.0554	030010	01.4361	030083	01.3441	040047	01.0544

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

TABLE 3C : HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1991 PAGE 2 OF 23

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040048	01.2069	050007	01.4703	050073	01.2120	050135	01.3049	050208	01.1976
040050	01.1109	050008	01.3953	050074	01.0395	050136	01.3076	050211	01.3168
040051	01.0280	050009	01.6000	050075	01.2731	050137	01.2767	050212	01.1095
040053	01.0717	050013	02.1120	050076	01.4954	050138	01.7096	050213	01.3564
040054	00.9446	050014	01.0900	050077	01.6483	050139	01.2205	050214	01.5716
040055	01.3252	050015	01.4684	050078	01.3238	050140	01.3019	050215	01.4204
040058	00.9180	050016	01.1946	050079	01.5241	050143	01.4009	050217	01.2056
040060	00.9695	050017	01.9933	050080	01.2311	050144	01.4930	050219	01.3706
040062	01.3526	050018	01.2796	050081	01.6282	050145	01.2900	050220	01.2450
040063	01.4390	050019	00.7922	050082	01.4809	050146	01.3049	050222	01.5296
040064	00.8984	050021	01.2764	050084	01.4872	050147	00.7747	050224	01.6173
040066	01.0283	050022	01.5545	050087	01.7521	050148	01.1390	050225	01.3297
040067	01.0036	050024	01.3828	050088	01.1315	050149	01.3558	050226	01.4251
040069	01.0551	050025	01.6798	050089	01.3407	050150	01.2390	050228	01.2661
040070	00.9657	050026	01.4721	050090	01.2425	050152	01.3970	050230	01.3292
040071	01.4155	050028	01.2747	050091	01.2298	050153	01.6477	050231	01.4958
040072	01.0725	050029	01.3320	050092	00.9567	050154	01.2110	050232	01.8455
040074	01.1757	050030	01.2945	050093	01.5271	050155	01.1197	050233	01.2228
040075	01.0993	050032	01.2717	050095	01.8435	050158	01.6879	050234	01.2798
040076	01.0551	050033	01.3884	050096	01.0718	050159	01.3837	050235	01.4968
040077	00.9291	050034	01.3070	050097	01.4338	050161	01.5294	050236	01.3888
040078	01.2401	050036	01.7045	050099	01.6542	050166	01.0654	050238	01.5071
040080	01.0646	050038	01.4082	050100	01.8331	050167	01.3999	050239	01.4064
040081	00.8575	050039	01.6461	050101	01.3574	050168	01.6888	050240	01.4360
040082	01.2094	050040	01.1045	050102	01.2827	050169	01.4921	050241	01.2925
040084	01.1260	050041	01.2924	050103	01.4956	050170	01.3981	050242	01.3955
040085	01.1257	050042	01.2177	050104	01.3491	050172	01.3240	050243	01.4729
040088	01.2212	050043	01.5692	050107	01.3433	050173	01.2573	050245	01.4000
040090	00.9494	050045	01.2626	050108	01.4305	050174	01.6003	050248	01.1513
040091	01.1566	050046	01.1808	050109	02.0924	050175	01.4063	050251	01.1670
040093	01.0247	050047	01.6987	050110	01.1464	050177	01.2293	050254	01.1327
040095	00.8694	050049	01.5231	050111	01.2808	050179	01.2228	050256	01.6656
040100	01.1223	050051	01.1343	050112	01.4457	050180	01.4073	050257	01.1369
040105	01.0147	050053	01.3009	050113	01.1647	050181	01.2654	050258	01.2623
040106	01.1790	050054	01.2674	050114	01.4614	050183	01.1410	050260	00.9203
040107	01.0462	050055	01.2734	050115	01.4725	050186	01.3155	050261	01.1843
040109	01.1371	050056	01.3617	050116	01.4336	050188	01.3696	050262	01.7410
040114	01.7026	050057	01.4453	050117	01.2996	050189	00.9187	050263	01.2486
040115	01.0629	050058	01.4042	050118	01.1611	050191	01.3865	050264	01.4191
040116	01.3681	050060	01.4612	050121	01.2872	050192	01.1849	050267	01.5161
040118	01.1909	050061	01.2545	050122	01.4208	050193	01.3445	050269	01.1058
040119	01.1355	050063	01.3401	050124	01.2011	050194	01.3361	050270	01.3105
040122	01.0989	050065	01.5135	050125	01.2949	050195	01.5421	050272	01.3153
040124	01.0864	050066	01.2789	050126	01.3888	050196	01.2815	050274	00.9881
040126	00.9696	050067	01.2843	050127	01.2583	050197	01.9226	050276	01.1377
040132	01.4616	050068	01.1129	050128	01.5007	050199	01.2276	050277	01.3979
040898	00.6959	050069	01.5887	050129	01.5397	050201	00.9026	050278	01.4018
040899	00.5933	050070	01.2006	050131	01.2597	050204	01.4002	050279	01.2294
050002	01.2983	050071	01.3234	050132	01.4007	050205	01.2271	050280	01.4564
050006	01.2943	050072	01.2213	050133	01.1959	050207	01.2364	050281	01.2638

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050282	01.2764	050366	01.2921	050446	00.8826	050535	01.3147	050607	01.2286
050283	01.4280	050367	01.2409	050447	01.0450	050537	01.2327	050608	01.1835
050286	01.0233	050369	01.2777	050448	01.0844	050539	01.2008	050609	01.2928
050289	01.6775	050373	01.3694	050449	01.2900	050541	01.4822	050613	01.0774
050290	01.4695	050376	01.3023	050450	00.7796	050542	01.1170	050615	01.3840
050291	01.1753	050377	01.0017	050451	00.9616	050543	01.3723	050616	01.3271
050292	01.1735	050378	01.1711	050454	01.6680	050545	00.9442	050618	01.1788
050293	01.2844	050379	01.1440	050455	01.8541	050546	01.0840	050619	01.3645
050295	01.3270	050380	01.6147	050456	01.3843	050547	00.9517	050622	01.0719
050296	01.1094	050382	01.4271	050457	01.8021	050549	01.7820	050623	01.1541
050298	01.2238	050385	01.3200	050458	00.9161	050550	01.1195	050624	01.2614
050299	01.2460	050387	00.9345	050459	01.2542	050551	01.2659	050625	01.4711
050300	01.2902	050388	00.9735	050464	01.7916	050552	01.0667	050630	01.2409
050301	01.1886	050390	01.2351	050467	01.2338	050557	01.5124	050633	01.2249
050302	01.2718	050391	01.4169	050468	01.6306	050559	01.2622	050635	01.2970
050305	01.4733	050392	00.9526	050469	01.0978	050560	01.2600	050636	01.2824
050307	01.4248	050393	01.5023	050470	01.1282	050561	01.1617	050637	01.1655
050308	01.5479	050394	01.4670	050471	01.7538	050564	01.3177	050638	00.9996
050309	01.2945	050396	01.5851	050476	01.2720	050565	01.1404	050641	01.1266
050310	01.2309	050397	00.8711	050477	01.3886	050566	01.0255	050643	00.9122
050312	01.7654	050401	01.2004	050478	01.0122	050567	01.6058	050644	01.1533
050313	01.1759	050404	01.0486	050481	01.4772	050568	01.3335	050649	01.3011
050315	01.2783	050406	01.0865	050482	01.0200	050569	01.2108	050651	01.2654
050317	01.2021	050407	01.1093	050483	01.2346	050570	01.6917	050655	00.7806
050320	01.3141	050410	00.8373	050485	01.7340	050571	01.4062	050660	01.1276
050324	01.8384	050411	01.3077	050486	01.4179	050573	01.6324	050661	00.8980
050325	01.2875	050414	01.2610	050488	01.2117	050575	01.2198	050662	00.8531
050327	01.6197	050417	01.1623	050489	01.0758	050577	01.3010	050663	01.0998
050328	01.2457	050418	01.3068	050491	01.4430	050578	01.4718	050666	01.0160
050329	01.2419	050419	01.2804	050492	01.2782	050579	01.4533	050667	01.0146
050331	01.2892	050420	01.3684	050494	01.0816	050580	01.2570	050668	01.1530
050333	00.9827	050421	01.3509	050496	01.7974	050581	01.3633	050669	00.7468
050334	01.4737	050423	01.0531	050497	00.7612	050583	01.7158	050670	01.2287
050335	01.2454	050424	01.6926	050498	01.1493	050584	01.2698	050671	01.1563
050336	01.2361	050425	01.3158	050502	01.6792	050585	01.3702	050672	00.6888
050337	01.2209	050426	01.3721	050503	01.2945	050586	01.3415	050674	01.1883
050342	01.3019	050427	00.9574	050506	01.4774	050587	01.2528	050675	01.4658
050343	01.0393	050430	00.9684	050510	01.2988	050588	01.2727	050676	00.9970
050345	01.3581	050431	01.0790	050512	01.2488	050589	01.3571	050677	01.2970
050348	01.7297	050432	01.6124	050515	01.3300	050590	01.3116	050678	01.1937
050349	01.0154	050433	01.0497	050516	01.3384	050591	01.1255	050680	01.1983
050350	01.4030	050434	01.1028	050517	01.3959	050592	01.2906	050682	00.9421
050351	01.4762	050435	01.2959	050522	01.3347	050593	01.2581	050684	01.2137
050352	01.2563	050436	01.0197	050523	01.2541	050594	01.9573	050685	01.1519
050353	01.6556	050438	01.4790	050526	01.3647	050597	01.3686	050686	01.2866
050355	00.9737	050440	01.2119	050527	01.2051	050598	01.3490	050688	01.1387
050357	01.8314	050441	01.7417	050528	01.2103	050599	01.6809	050689	01.3519
050359	01.1263	050442	00.8889	050530	00.9029	050601	01.3015	050690	01.1989
050360	01.4353	050443	00.9006	050531	01.2892	050603	01.4256	050691	00.9397
050363	01.3328	050444	01.2331	050534	01.4080	050604	01.4158	050693	01.2522

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
050694	01.1504	060056	00.9128	070024	01.1917	100017	01.6857	100075	01.7358
050695	01.2129	060057	01.0869	070025	01.6621	100018	01.3536	100076	01.3036
050696	01.7837	060058	00.8806	070026	01.2454	100019	01.4866	100077	01.3088
050698	01.8389	060060	01.0304	070027	01.2121	100020	01.3013	100078	01.1500
050699	00.9356	060062	01.0017	070028	01.4917	100021	01.3728	100079	01.1615
050898	00.5377	060063	01.1875	070029	01.2268	100022	01.6069	100080	01.5864
050899	00.5820	060064	01.3938	070030	01.2659	100023	01.3255	100081	01.0953
060001	01.4537	060065	01.3386	070031	01.3098	100024	01.2636	100082	01.3671
060003	01.2156	060066	00.9333	070033	01.3505	100025	01.5104	100083	01.3273
060004	01.0675	060068	01.1729	070034	01.2995	100026	01.4232	100084	01.3030
060005	01.7613	060070	01.1757	070035	01.3659	100027	00.8912	100085	01.3484
060006	01.1670	060071	01.0883	070036	01.3503	100028	01.2919	100086	01.3038
060007	01.1839	060072	00.9143	070038	00.6890	100029	01.3180	100087	01.7270
060008	01.0556	060073	01.0004	070898	00.7101	100030	01.2712	100088	01.5078
060009	01.3432	060074	00.8741	070899	00.5820	100032	01.7888	100089	01.2650
060010	01.5297	060075	01.2896	080001	01.6203	100034	01.6040	100090	01.2979
060011	01.2223	060076	01.3983	080002	01.1631	100035	01.4681	100092	01.3276
060012	01.4471	060085	00.8803	080003	01.2607	100038	01.6042	100093	01.5344
060013	01.1505	060087	01.4024	080004	01.2434	100039	01.6060	100098	01.0275
060014	01.6559	060088	01.1060	080005	01.1994	100040	01.6511	100099	01.2759
060015	01.4645	060090	00.9483	080006	01.1651	100042	01.2671	100100	01.2614
060016	01.1601	060096	01.0273	080007	01.2389	100043	01.3738	100102	01.2038
060018	01.1688	060100	01.3751	080898	00.6959	100044	01.4134	100103	01.0159
060020	01.4505	060101	01.4004	080899	00.5933	100045	01.3916	100105	01.3785
060022	01.5681	060102	04.0098	090001	01.4328	100046	01.3301	100106	01.1512
060023	01.4604	060103	01.3774	090002	01.2079	100047	01.5569	100107	01.2535
060024	01.6057	060104	01.2517	090003	01.4379	100048	00.9520	100108	01.1000
060026	01.4023	070001	01.7942	090004	01.5412	100049	01.3465	100109	01.2367
060027	01.4827	070002	01.7811	090005	01.2648	100050	01.2139	100110	01.3966
060028	01.3210	070003	01.1671	090006	01.3040	100051	01.2870	100112	00.9408
060029	01.0007	070004	01.1326	090007	01.2714	100052	01.3188	100113	01.9451
060030	01.3095	070005	01.2834	090008	01.3726	100053	01.2674	100114	01.4609
060031	01.4289	070006	01.2723	090009	01.2361	100054	01.3822	100117	01.2920
060032	01.3471	070007	01.3703	090010	00.9757	100055	01.3528	100118	01.1792
060033	01.1387	070008	01.2363	090011	01.8891	100056	01.5788	100121	01.1110
060034	01.3456	070009	01.2980	090898	00.7231	100057	01.3448	100122	01.3070
060036	01.1428	070010	01.4681	090899	00.5933	100059	01.5171	100124	01.2997
060037	01.0125	070011	01.2013	100001	01.4000	100060	01.7764	100125	01.1738
060038	01.1306	070012	01.2408	100002	01.4215	100061	01.4974	100126	01.4667
060041	01.0393	070013	01.3397	100004	01.0157	100062	01.6824	100127	01.5839
060042	00.9483	070014	01.2906	100005	00.9150	100063	01.3069	100128	02.2763
060043	00.9035	070015	01.2409	100006	01.6171	100065	01.2932	100129	01.3774
060044	01.2137	070016	01.2973	100007	01.8788	100067	01.3951	100130	01.1935
060046	01.1133	070017	01.2895	100008	01.7281	100068	01.4310	100131	01.2139
060047	01.1518	070018	01.3003	100009	01.4251	100069	01.3909	100132	01.2988
060049	01.0767	070019	01.1693	100010	01.3952	100070	01.3160	100134	00.9937
060050	01.2072	070020	01.3936	100012	01.5525	100071	01.3930	100135	01.5132
060052	00.9865	070021	01.2032	100014	01.3344	100072	01.1687	100137	01.1308
060053	01.0330	070022	01.6768	100015	01.4048	100073	01.8207	100138	00.9779
060054	01.3048	070023	01.2600	100016	01.0734	100074	01.2304	100139	01.0598

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100140	01.1109	100211	01.2754	100271	01.5410	110046	01.1827	110111	01.1528
100142	01.1554	100212	01.6385	100273	01.1315	110048	01.1312	110112	00.9332
100143	01.2493	100213	01.6171	100275	01.2908	110049	01.0813	110113	00.9359
100144	01.2342	100217	01.1825	100276	01.3876	110050	01.0816	110114	01.1564
100145	01.3950	100218	00.8936	100277	00.9858	110051	01.0597	110115	01.5940
100146	01.0733	100219	01.3936	100278	00.7001	110052	00.9588	110117	01.0856
100147	01.0822	100220	01.6915	100279	01.2467	110054	01.2304	110118	01.0223
100150	01.4413	100221	01.5388	100898	00.6949	110055	00.8773	110120	01.0427
100151	01.7316	100222	01.2115	100899	00.6006	110056	01.0010	110121	01.1166
100152	01.2547	100223	01.4299	110001	01.1521	110059	01.3460	110122	01.3175
100154	01.6119	100224	01.3205	110002	01.2100	110061	00.9824	110123	00.8407
100156	01.0572	100225	01.3552	110003	01.2807	110062	00.9283	110124	01.0701
100157	01.4940	100226	01.3232	110004	01.2335	110063	01.0237	110125	01.1454
100159	01.0483	100227	00.9987	110005	01.4139	110064	01.2407	110127	00.9562
100160	01.2020	100228	01.2815	110006	01.2835	110065	01.0074	110128	01.1585
100161	01.4972	100229	01.4520	110007	01.3649	110066	01.2501	110129	01.5776
100162	01.3005	100230	01.2915	110008	01.1195	110069	01.1877	110130	00.9831
100164	00.9793	100231	01.7215	110009	01.0965	110070	00.9533	110132	01.1265
100165	01.1584	100232	01.3052	110010	01.9743	110071	01.0251	110133	00.8840
100166	01.4862	100234	01.3446	110011	01.1453	110072	01.0014	110134	00.8867
100167	01.3312	100235	01.3244	110013	00.9995	110073	01.2412	110135	01.1890
100168	01.3000	100236	01.3262	110014	01.0751	110074	01.2548	110136	01.0683
100169	01.7889	100237	02.0913	110015	01.0547	110075	01.2140	110140	00.8759
100170	01.4209	100238	01.4063	110016	01.2469	110076	01.3555	110141	00.9009
100172	01.3702	100239	01.4274	110017	00.9250	110078	01.5980	110142	01.1020
100173	01.5692	100240	00.8782	110018	01.1500	110079	01.2995	110143	01.2729
100174	01.3602	100241	00.9973	110020	01.1531	110080	01.0573	110144	01.2323
100175	01.0959	100242	01.3171	110023	01.1880	110082	02.0469	110146	00.9212
100176	01.9604	100243	01.3904	110024	01.3752	110083	01.4836	110149	01.0848
100177	01.3378	100244	01.3450	110025	01.2755	110085	01.1704	110150	01.2289
100179	01.7123	100246	01.3711	110026	01.0967	110086	01.0771	110151	00.9758
100180	01.4072	100248	01.6901	110027	01.0378	110087	01.2536	110152	01.0233
100181	01.3175	100249	01.2950	110028	01.5517	110088	00.9038	110153	01.0138
100183	01.3326	100252	01.3833	110029	01.2996	110089	01.0962	110154	00.9353
100185	01.2225	100253	01.3613	110030	01.1911	110091	01.2709	110155	01.0543
100186	01.3573	100254	01.6178	110031	01.3097	110092	01.0621	110156	00.9178
100187	01.3150	100255	01.3761	110032	01.1164	110093	00.9371	110157	01.0763
100189	01.3593	100256	01.7248	110033	01.3355	110094	01.0178	110161	01.2627
100191	01.3654	100258	01.6866	110034	01.4077	110095	01.3290	110162	00.8182
100194	01.2560	100259	01.4085	110035	01.3190	110096	01.1582	110163	01.3511
100196	01.2443	100260	01.4028	110036	01.6238	110097	01.0965	110164	01.3161
100199	01.1796	100262	01.3321	110037	01.0704	110098	00.9990	110165	01.1867
100200	01.3590	100263	01.4506	110038	01.3240	110100	01.0916	110166	01.3448
100203	01.0913	100264	01.3849	110039	01.3166	110101	01.0179	110168	01.6530
100204	01.5664	100265	01.2832	110040	00.9159	110103	00.9406	110169	00.7644
100206	01.3601	100266	01.3117	110041	01.0693	110104	01.1343	110171	01.3323
100207	01.3742	100267	01.2275	110042	01.0518	110105	01.1652	110172	01.1520
100208	01.5110	100268	01.2570	110043	01.5543	110107	01.6078	110174	00.8696
100209	01.5225	100269	01.4176	110044	01.1345	110108	00.9078	110176	01.1254
100210	01.6631	100270	00.9092	110045	01.0129	110109	01.1161	110177	01.3896

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
110178	01.2100	120899	00.5933	140008	01.4056	140070	01.2229	140132	01.5680
110179	01.1950	130001	01.1096	140010	01.3494	140072	01.1192	140133	01.3426
110181	00.8654	130002	01.3102	140011	01.0820	140074	01.1313	140135	01.2026
110183	01.3391	130003	01.2385	140012	01.2222	140075	01.3874	140137	00.9961
110184	01.1991	130005	01.3730	140013	01.3866	140077	01.2278	140138	01.0727
110185	00.9950	130006	01.6766	140014	01.0576	140079	01.2507	140139	01.0721
110186	01.2728	130007	01.4940	140015	01.2327	140080	01.8248	140140	01.0429
110187	01.1397	130008	00.8795	140016	00.9981	140081	01.1358	140141	00.9690
110188	01.3434	130009	00.9873	140018	01.4046	140082	01.2611	140143	01.0522
110189	01.0960	130010	00.9302	140019	00.9165	140083	01.2738	140144	00.9696
110190	01.1041	130011	01.3203	140024	00.9756	140084	01.1863	140145	01.0514
110191	01.1444	130012	01.0135	140025	01.1038	140086	01.1050	140146	00.9206
110192	01.3332	130013	01.2715	140026	01.1490	140087	01.3220	140147	01.1802
110193	01.2038	130014	01.2564	140027	01.0760	140088	01.4819	140148	01.5298
110194	00.9166	130015	01.0194	140029	01.3280	140089	01.2433	140150	01.3610
110195	01.0943	130016	00.8736	140030	01.5137	140090	01.3584	140151	01.0544
110198	01.3080	130017	00.9874	140031	01.0307	140091	01.6612	140152	01.0207
110200	01.7368	130018	01.5607	140032	01.2771	140093	01.2364	140154	01.2636
110201	01.2753	130019	01.1290	140033	01.2012	140094	01.2388	140155	01.2025
110202	00.9738	130021	00.8888	140034	01.1094	140095	01.2428	140158	01.4262
110203	01.0435	130022	01.1546	140035	01.0080	140097	00.9008	140159	01.1715
110204	00.9352	130024	01.1239	140036	01.1251	140098	01.3743	140160	01.1383
110205	00.9701	130025	01.0674	140037	00.9621	140100	01.2459	140161	01.1281
110206	02.6891	130026	01.1421	140038	01.0483	140101	01.0459	140162	01.4844
110207	00.9220	130027	00.8684	140039	00.9958	140102	00.9996	140164	01.2479
110208	00.9302	130028	01.2871	140040	01.2393	140103	01.3355	140165	01.0678
110898	00.7011	130029	00.9880	140041	01.0562	140105	01.2929	140166	01.2615
110899	00.5820	130030	00.9651	140042	01.0393	140107	00.9125	140167	01.0735
120001	01.6839	130031	00.9623	140043	01.1749	140108	01.1886	140168	01.2103
120002	01.1500	130034	00.9022	140045	00.9523	140109	01.1323	140170	00.9655
120003	01.0844	130035	00.9563	140046	01.1928	140110	01.2309	140171	00.8737
120004	01.2495	130036	01.1786	140047	01.0309	140112	01.0432	140172	01.5159
120005	01.2184	130037	01.4076	140048	01.2229	140113	01.3775	140173	01.0015
120006	01.2192	130039	01.1610	140049	01.3555	140114	01.2525	140174	01.3772
120007	01.5721	130040	01.0513	140051	01.2983	140115	01.1965	140176	01.2109
120009	00.8843	130043	00.9911	140052	01.2085	140116	01.2294	140177	01.2533
120010	01.5693	130044	00.9124	140053	01.7380	140117	01.2878	140179	01.2690
120011	01.2296	130045	00.9209	140054	01.3546	140118	01.4766	140180	01.4634
120012	00.9233	130048	01.0189	140055	00.9723	140119	01.6519	140181	01.3250
120014	01.1607	130049	01.1800	140058	01.0897	140120	01.1685	140182	01.3122
120015	00.9311	130051	00.9839	140059	01.0961	140121	00.9697	140184	01.1419
120016	00.9376	130054	00.9209	140061	01.0740	140122	01.3840	140185	01.4079
120018	01.0064	130056	00.9856	140062	01.2481	140123	01.1927	140186	01.2105
120019	01.1949	130058	00.9828	140063	01.3171	140124	01.1214	140187	01.4454
120021	00.9316	140001	01.2698	140064	01.1548	140125	01.2435	140188	00.9610
120022	01.5083	140002	01.2583	140065	01.3288	140126	01.6272	140189	01.1598
120025	00.9026	140003	00.9624	140066	01.2204	140127	01.2812	140190	01.1855
120026	01.2685	140004	00.9855	140067	01.6999	140128	01.1243	140191	01.4398
120027	01.3548	140005	00.9579	140068	01.1981	140129	01.0391	140192	01.1451
120898	00.7175	140007	01.2724	140069	01.0660	140130	01.1338	140193	00.9858

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140197	01.2882	140294	01.0919	150049	01.0924	150106	01.0668	160035	00.9368
140199	01.0106	140295	03.2098	150050	01.1859	150109	01.2650	160036	01.0395
140200	01.4366	140297	01.4210	150051	01.2452	150110	00.8976	160037	01.0143
140202	01.2227	140299	00.8993	150052	01.0428	150111	01.0917	160039	01.0458
140203	01.1278	140898	00.8924	150053	01.0452	150112	01.1969	160040	01.3641
140205	00.9527	140899	00.6352	150054	01.0374	150113	01.2254	160041	01.1105
140206	01.0917	150001	01.0872	150056	01.6681	150114	01.0604	160043	00.9607
140207	01.2752	150002	01.3396	150057	02.2248	150115	01.2862	160044	01.2347
140208	01.4301	150003	01.6335	150058	01.5514	150122	01.0811	160045	01.6083
140209	01.5796	150004	01.3049	150059	01.2200	150123	00.9500	160046	01.0233
140210	01.0418	150005	01.2120	150060	01.1691	150124	01.1757	160047	01.4117
140211	01.1430	150006	01.2427	150061	01.1915	150125	01.3902	160048	01.0463
140212	01.2923	150007	01.1958	150062	01.0878	150126	01.5391	160049	00.8896
140213	01.1891	150008	01.3471	150063	01.1266	150127	01.1255	160050	01.0356
140215	01.0481	150009	01.2883	150064	01.0547	150128	01.1864	160051	01.2980
140217	01.2404	150010	01.1807	150065	01.1110	150129	01.2685	160052	00.9752
140218	00.9903	150011	01.2480	150066	01.1229	150130	01.1040	160054	01.0605
140220	01.1380	150012	01.5707	150067	01.0802	150132	01.3875	160055	01.0045
140223	01.5097	150013	01.1969	150069	01.2349	150133	01.2524	160056	01.0432
140224	01.3237	150014	01.3615	150070	01.0952	150134	01.1594	160057	01.3604
140226	00.9496	150015	01.2205	150071	01.1539	150135	00.8998	160058	01.6167
140228	01.5284	150017	01.6692	150072	01.2502	150136	01.0712	160059	01.2381
140229	00.9591	150018	01.2400	150073	01.0557	150898	00.7260	160060	01.0618
140230	00.9458	150019	01.1684	150074	01.4864	150899	00.5933	160061	00.9854
140231	01.5632	150020	01.1266	150075	01.2370	160001	01.1451	160062	00.9270
140233	01.6567	150021	01.6148	150076	01.0498	160002	01.2223	160063	01.1758
140234	01.1265	150022	01.1076	150077	01.1775	160003	01.0648	160064	01.5209
140236	00.9971	150023	01.3818	150078	01.0640	160005	01.0807	160065	01.1123
140239	01.5826	150024	01.1843	150079	01.1552	160007	00.9657	160066	01.0604
140240	01.2535	150025	01.5039	150082	01.3845	160008	01.0890	160067	01.2617
140242	01.4080	150026	01.1843	150084	01.6812	160009	01.1263	160068	01.0580
140245	01.0274	150027	01.0029	150085	00.9948	160012	01.1684	160069	01.3498
140246	01.0311	150029	01.2353	150086	01.2483	160013	01.2530	160070	01.1060
140250	01.2363	150030	01.1539	150088	01.1363	160014	00.9618	160071	01.1144
140251	01.3085	150031	01.0706	150089	01.2738	160016	01.2818	160072	01.0518
140252	01.2863	150032	01.6930	150090	01.2715	160018	00.9819	160073	00.8924
140253	01.2931	150033	01.5659	150091	01.2111	160020	01.0939	160074	01.0304
140258	01.3979	150034	01.3002	150092	01.1645	160021	01.1478	160075	01.0603
140271	01.0344	150035	01.4019	150094	01.0414	160023	01.0621	160076	00.9634
140275	01.1770	150036	01.0040	150095	01.1058	160024	01.4469	160077	01.1095
140276	02.0385	150037	01.2103	150096	00.9957	160025	01.8041	160079	01.2857
140280	01.1551	150038	01.2428	150097	01.0367	160026	01.0311	160080	01.1228
140281	01.5138	150039	00.9885	150098	01.0378	160027	01.1356	160081	01.0751
140285	01.2667	150042	01.1889	150099	01.2905	160028	01.2583	160082	01.6686
140286	01.1118	150043	01.0630	150100	01.6108	160029	01.4707	160083	01.5523
140288	01.5938	150044	01.2287	150101	01.0723	160030	01.3123	160085	01.1194
140289	01.2903	150045	01.1566	150102	01.1110	160031	01.0370	160086	01.0224
140290	01.3760	150046	01.4038	150103	01.1377	160032	01.0520	160088	01.0071
140291	01.2686	150047	01.6561	150104	01.1765	160033	01.3371	160089	01.2042
140292	01.1829	150048	01.1894	150105	01.1899	160034	01.0069	160090	01.0612

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160091	01.1484	170001	01.1766	170060	01.0271	170119	00.9660	180014	01.5682
160092	00.9577	170003	01.1989	170061	00.9579	170120	01.2204	180015	01.1127
160093	01.1072	170004	01.0516	170062	00.8377	170121	00.7809	180016	01.2169
160094	01.1693	170006	01.2448	170063	00.9206	170122	01.7991	180017	01.2192
160095	01.0180	170007	01.1010	170064	01.1751	170123	01.6654	180018	01.1517
160097	01.1539	170008	00.9991	170066	00.9209	170124	00.9671	180019	01.1733
160098	00.9540	170009	01.1522	170067	01.0420	170125	00.9370	180020	01.0135
160099	01.1000	170010	01.1259	170068	01.2396	170126	00.9444	180021	00.8932
160101	01.1539	170011	01.3697	170069	00.8692	170128	00.9867	180023	00.8378
160102	01.4277	170012	01.4225	170070	01.0520	170131	01.1211	180024	01.1971
160103	00.9088	170013	01.2044	170072	00.9388	170133	01.1665	180025	01.1364
160104	01.1289	170014	01.0518	170073	01.1051	170134	00.9839	180026	01.1047
160106	01.0244	170015	01.0848	170074	01.1606	170137	01.1593	180027	01.1584
160107	01.1155	170016	01.5595	170075	00.8531	170139	00.9930	180028	00.9983
160108	01.1355	170017	01.1637	170076	01.1126	170140	01.0413	180029	01.2807
160109	00.9404	170018	01.0952	170077	00.9616	170142	01.2571	180030	01.1426
160110	01.5133	170019	01.1744	170079	00.9817	170143	01.0974	180031	01.0072
160111	01.1219	170020	01.2290	170080	00.9380	170144	01.4918	180032	00.9826
160112	01.3817	170021	00.8715	170081	01.1493	170145	01.1412	180033	01.0839
160113	01.0406	170022	01.1905	170082	00.9060	170146	01.3039	180034	01.0142
160114	00.9999	170023	01.3064	170084	00.9248	170147	01.2069	180035	01.4414
160115	01.0056	170024	01.1095	170085	00.9504	170148	01.3398	180036	01.1078
160116	01.1577	170025	01.4207	170086	01.6370	170150	01.1203	180037	01.2749
160117	01.3154	170026	00.9821	170087	01.3418	170151	01.0078	180038	01.3275
160118	00.9818	170027	01.1582	170088	00.9179	170152	00.9171	180040	01.9553
160119	00.8638	170030	00.9603	170089	01.0088	170159	00.9069	180041	01.0752
160120	01.0027	170031	00.8710	170090	00.9886	170160	00.9558	180042	01.0414
160122	01.2211	170032	01.0511	170092	00.8533	170164	01.0932	180043	01.0160
160123	01.0925	170033	01.2049	170093	01.0010	170166	01.0040	180044	01.0751
160124	01.1718	170034	00.9479	170094	01.0075	170168	00.8770	180045	01.1608
160126	01.1321	170035	00.8775	170095	01.1793	170170	00.8764	180046	01.0588
160129	01.1705	170036	00.9422	170097	00.9444	170171	01.1352	180047	01.0240
160130	01.2416	170037	01.1652	170098	01.0209	170172	01.0228	180048	01.2059
160131	01.1606	170038	01.0037	170099	01.3717	170173	00.8102	180049	01.3416
160133	01.2038	170039	01.1149	170100	00.8651	170174	00.9340	180050	01.3005
160134	00.8828	170040	01.4016	170101	00.9907	170175	01.2210	180051	01.2125
160135	01.0239	170041	01.0179	170102	00.9830	170176	01.4211	180053	01.1658
160138	01.1582	170043	01.0588	170103	01.2192	170898	00.7011	180054	01.0992
160140	01.0684	170044	01.2595	170104	01.4420	170899	00.5933	180055	01.0622
160141	00.9181	170045	01.0009	170105	00.9777	180001	01.1568	180056	01.0495
160142	01.1483	170049	01.3135	170106	00.8914	180002	01.1128	180058	00.9086
160143	01.1009	170050	00.9428	170108	00.8933	180004	01.1876	180059	00.9006
160145	00.9850	170051	00.9672	170109	01.0060	180005	01.0678	180060	00.9007
160146	01.3144	170052	01.1010	170110	00.9566	180006	00.9384	180062	00.8038
160147	01.2240	170053	00.8500	170112	00.9259	180007	01.4138	180063	01.0339
160151	01.1435	170054	01.0908	170113	01.0555	180009	01.1713	180064	01.0689
160152	01.0277	170055	01.0664	170114	01.0676	180010	01.7280	180065	00.9945
160153	01.5615	170056	00.9870	170115	01.0850	180011	01.1112	180066	01.1728
160898	00.6959	170057	01.0294	170116	01.1178	180012	01.2604	180067	01.8949
160899	00.5933	170058	01.0300	170117	00.9506	180013	01.3284	180069	01.0734

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 19--

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
180070	01.0604	190005	01.3286	190089	01.0615	190166	01.0025	200021	01.1379
180072	01.0944	190006	01.1351	190090	01.1961	190167	01.2923	200023	00.7985
180075	00.9469	190007	01.0395	190092	01.1582	190170	00.9991	200024	01.1779
180078	01.0119	190008	01.4417	190095	01.0340	190173	01.4355	200025	01.1393
180079	01.0166	190009	01.0851	190098	01.3985	190175	01.8435	200026	00.9960
180080	01.1256	190010	00.9175	190099	01.1843	190176	01.4068	200027	01.0935
180081	01.3824	190011	01.0666	190102	01.4389	190177	01.4835	200028	01.0334
180085	01.3287	190013	01.2161	190103	00.8983	190178	00.9782	200031	01.2861
180087	00.9932	190014	00.9911	190106	01.1573	190182	01.0127	200032	01.2792
180088	01.6306	190015	01.1926	190109	01.0888	190183	01.0827	200033	01.6831
180092	01.1195	190017	01.2253	190110	00.9559	190184	00.9057	200034	01.1662
180093	01.3949	190018	01.1571	190111	01.5694	190185	01.2344	200037	01.1597
180094	00.9899	190019	01.4998	190112	01.2864	190186	00.9483	200038	00.9975
180095	00.9747	190020	01.1555	190113	01.2797	190187	00.6412	200039	01.3035
180099	00.9687	190023	00.6808	190114	00.9308	190189	01.0911	200040	01.0475
180101	01.2636	190025	01.2536	190115	01.2953	190190	00.9922	200041	01.1668
180102	01.3971	190026	01.3165	190116	01.2228	190191	01.2162	200043	00.6671
180103	01.7927	190027	01.3975	190118	00.9961	190193	01.1742	200044	01.1565
180104	01.3910	190029	01.2529	190120	00.9064	190194	01.1284	200050	01.1171
180105	00.9748	190033	00.9707	190122	01.1329	190196	00.8243	200051	00.9904
180106	00.9035	190034	01.2313	190124	01.4467	190197	01.1989	200052	01.0218
180108	00.9010	190035	01.3875	190125	01.3914	190198	01.1858	200055	01.0384
180115	00.9740	190036	01.6287	190127	01.4598	190199	01.2694	200062	00.9684
180116	01.2751	190037	00.9902	190128	00.8313	190200	01.5712	200063	01.2180
180117	01.2463	190039	01.4272	190130	00.9233	190201	01.2069	200066	01.1416
180118	01.0101	190040	01.3613	190131	01.2752	190202	01.4032	200898	00.7186
180120	00.9151	190041	01.5707	190132	01.0494	190203	01.6151	200899	00.5933
180121	01.0529	190043	01.0441	190133	01.0812	190204	01.4464	210001	01.3187
180122	00.9415	190044	01.0906	190134	01.0061	190205	01.3525	210002	01.8268
180123	01.4435	190045	01.2700	190135	01.3432	190206	01.4626	210003	01.3868
180124	01.3284	190046	01.4261	190136	01.0332	190207	01.1786	210004	01.2835
180125	01.0292	190047	01.1475	190138	00.7637	190208	00.8766	210005	01.2017
180126	01.0501	190048	00.9763	190140	01.0116	190211	00.8754	210006	01.0687
180127	01.1553	190049	00.9837	190142	00.9468	190212	00.8972	210007	01.4397
180128	01.1060	190050	01.0296	190144	01.1462	190213	00.8023	210008	01.2563
180129	01.0536	190053	01.0184	190145	00.9264	200001	01.3043	210009	01.6435
180130	01.3800	190054	01.3946	190146	01.4517	200002	01.0658	210010	01.1370
180132	01.3111	190059	00.9436	190147	00.9622	200003	01.0435	210011	01.2905
180133	01.2224	190060	01.2386	190148	00.9443	200006	01.0569	210012	01.4621
180134	01.0785	190064	01.4479	190149	00.9865	200007	01.0301	210013	01.3075
180136	01.2725	190065	01.4536	190151	01.0819	200008	01.2185	210015	01.1962
180137	01.7633	190071	00.8966	190152	01.4090	200009	01.6646	210016	01.7570
180138	01.2008	190075	01.4380	190155	00.9290	200012	01.1761	210017	01.1492
180139	01.0218	190077	00.8858	190156	00.8485	200013	01.0999	210018	01.2185
180898	00.7011	190078	01.1560	190158	01.2945	200015	01.2713	210019	01.3370
180899	00.5933	190079	01.2140	190160	01.1171	200016	01.0251	210021	01.2287
190001	00.9031	190081	00.8842	190161	00.8602	200017	01.3000	210022	01.3076
190002	01.5748	190083	00.8864	190162	01.2684	200018	01.1012	210023	01.2875
190003	01.3824	190086	01.2301	190164	01.0616	200019	01.2191	210024	01.2470
190004	01.1594	190088	01.3339	190165	01.0990	200020	01.0770	210025	01.2665

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
210026	01.3399	220030	01.0759	220100	01.2685	230027	01.0726	230099	01.2165
210027	01.1915	220031	01.7720	220101	01.3751	230029	01.4937	230100	01.1909
210028	01.0603	220033	01.2325	220102	00.8471	230030	01.1900	230101	01.0486
210029	01.3483	220035	01.1796	220104	01.2517	230031	01.3663	230103	01.0063
210030	01.0737	220036	01.4857	220105	01.1727	230032	01.6988	230104	01.5840
210031	01.4343	220038	01.2594	220106	01.1047	230034	01.1813	230105	01.4848
210032	01.2017	220041	01.1651	220107	01.1484	230035	01.1610	230106	01.1158
210033	01.1315	220042	01.1582	220108	01.1408	230036	01.2927	230107	00.9927
210034	01.1957	220045	01.1922	220110	01.9242	230037	01.2618	230108	01.1927
210035	01.1516	220046	01.3649	220111	01.1749	230038	01.5814	230110	01.2233
210036	01.2090	220048	01.1731	220114	01.0691	230039	01.2706	230111	01.0531
210037	01.1963	220049	01.1770	220115	01.2586	230040	01.3094	230113	01.0332
210038	01.3690	220050	00.9935	220116	01.7808	230041	01.1244	230114	00.7155
210039	01.2111	220051	01.2231	220118	01.9184	230042	01.0922	230115	01.0247
210040	01.3483	220052	01.2324	220119	01.3480	230046	01.7778	230116	00.8996
210043	01.1912	220053	01.2759	220120	00.9897	230047	01.2132	230117	01.8012
210044	01.1947	220055	01.1790	220123	00.9544	230053	01.4582	230118	01.2633
210045	00.9711	220057	01.1952	220126	01.2221	230054	01.6087	230119	01.2036
210046	01.1133	220058	01.0110	220128	01.1054	230055	01.1378	230120	01.0488
210048	01.1709	220060	01.1410	220131	01.1603	230056	00.9746	230121	01.2042
210049	01.1592	220062	00.6506	220133	00.8198	230058	01.1557	230122	01.3546
210051	01.3069	220063	01.1302	220135	01.1201	230059	01.4298	230124	01.1293
210054	01.2430	220064	01.1842	220153	01.0533	230060	01.1575	230125	01.3861
210055	01.1873	220065	01.1730	220154	00.9739	230062	01.1168	230128	01.3852
210056	01.3827	220066	01.2844	220156	01.2135	230063	01.2740	230129	01.8948
210057	01.2412	220067	01.2421	220162	01.4141	230065	01.4458	230130	01.5769
210058	01.7326	220068	00.6158	220163	01.9524	230066	01.3086	230132	01.3555
210059	01.3338	220070	01.1448	220171	01.6218	230068	01.3535	230133	01.1355
210060	01.0691	220071	01.8433	220173	00.4926	230069	01.0882	230134	01.3103
220001	01.1452	220073	01.2256	220175	01.0281	230070	01.3145	230135	01.3091
220002	01.3378	220074	01.1306	220897	05.1063	230071	00.6451	230137	01.0714
220003	01.1019	220075	00.7660	220898	00.7055	230072	01.1737	230138	00.8905
220004	01.3471	220076	01.1958	220899	00.5933	230075	01.3005	230140	01.5729
220006	01.2662	220077	01.6055	230001	01.1368	230076	01.2066	230141	01.5224
220008	01.1510	220079	01.1158	230002	01.2313	230077	02.1526	230142	01.2201
220010	01.1982	220080	01.1925	230003	01.1349	230078	01.3371	230143	01.2272
220011	01.1712	220081	00.9674	230004	01.7077	230080	01.2354	230144	01.1998
220012	01.1800	220082	01.2243	230005	01.2118	230081	01.1767	230145	01.1053
220015	01.2004	220083	01.1209	230006	00.9919	230082	01.1676	230146	01.2260
220016	01.1906	220084	01.1424	230007	01.0868	230085	01.1435	230147	01.5011
220017	01.2497	220086	01.5547	230012	00.8113	230086	00.9529	230149	01.0477
220019	01.0969	220088	01.4865	230013	01.2918	230087	01.1429	230150	01.5926
220020	01.1520	220089	01.2757	230014	00.9400	230089	01.3407	230151	01.3913
220021	01.2291	220090	01.1721	230015	01.3911	230090	01.2163	230153	01.0626
220023	01.2605	220092	01.1975	230017	01.5372	230092	01.2598	230154	01.1020
220024	01.1963	220094	01.2036	230019	01.5695	230093	01.1943	230155	01.0461
220025	01.0212	220095	01.1863	230020	01.5820	230095	01.1378	230156	01.6427
220026	01.2735	220097	01.0102	230021	01.5274	230096	01.0961	230157	01.3922
220028	01.4023	220098	01.2922	230022	01.2625	230097	01.5044	230159	01.3484
220029	01.1179	220099	01.1357	230024	01.4735	230098	00.7519	230162	00.9254

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230165	01.7088	230259	01.0814	240050	01.1246	240111	01.0053	240173	00.9818
230167	01.1964	230264	01.3379	240051	00.8788	240112	01.0203	240175	00.8058
230169	01.3236	230266	01.3527	240052	01.2180	240114	01.0895	240176	00.8781
230171	01.1730	230269	01.2338	240053	01.4600	240115	01.5260	240179	00.9741
230172	01.1684	230270	01.2680	240056	01.3083	240116	00.9281	240180	00.9701
230173	01.4305	230273	01.4920	240057	01.7598	240117	01.1230	240183	01.1023
230174	01.2339	230275	00.7517	240058	00.9866	240119	00.9196	240184	01.0748
230175	01.0288	230276	01.0259	240059	01.1126	240121	00.9339	240187	01.1987
230176	01.1450	230277	01.1410	240061	01.4290	240122	01.0981	240192	00.9211
230178	01.1113	230278	01.4955	240063	01.5098	240123	01.1306	240193	01.0804
230179	00.8224	230898	00.7113	240064	01.2314	240124	01.0103	240196	01.3439
230180	01.1210	230899	00.6096	240065	00.9942	240125	00.9385	240200	00.8994
230184	01.1455	240001	01.5487	240066	01.3506	240127	01.0661	240201	01.0092
230186	01.0154	240002	01.6757	240069	01.1869	240128	01.1684	240205	00.8532
230188	01.1331	240003	01.2466	240071	01.1155	240129	00.9601	240206	00.8688
230189	00.9138	240004	01.4783	240072	00.9939	240130	01.0192	240207	01.1604
230190	00.9790	240005	00.9433	240073	01.0033	240132	01.2909	240210	01.2456
230191	00.9616	240006	01.1764	240075	01.2355	240133	01.1252	240211	01.3121
230193	01.3041	240007	01.1059	240076	01.1264	240134	01.0216	240898	00.7011
230194	01.2159	240008	01.0324	240077	01.0247	240135	00.8382	240899	00.5820
230195	01.3667	240009	01.0705	240078	01.3836	240136	00.8763	250001	01.5351
230197	01.2310	240010	01.8486	240079	01.0791	240137	01.1818	250002	00.8077
230199	01.1837	240011	01.0393	240080	01.3605	240138	00.8802	250003	00.9684
230201	00.9747	240013	01.2251	240082	01.1982	240139	00.9800	250004	01.4420
230204	01.2507	240014	01.1819	240083	01.2390	240140	00.8296	250005	00.9526
230205	01.1182	240016	01.3521	240084	01.2448	240141	01.0087	250006	00.9699
230207	01.2930	240017	01.1897	240085	00.8683	240142	01.0533	250007	01.1588
230208	01.0780	240018	01.2161	240086	01.0726	240143	00.9570	250008	00.8840
230211	00.9553	240019	01.3366	240087	01.0552	240144	00.9825	250009	01.0973
230212	01.0962	240020	01.2241	240088	01.4404	240145	00.9147	250010	01.0840
230213	01.0969	240021	01.0442	240089	01.0130	240146	00.9886	250012	00.9714
230216	01.3120	240022	01.0947	240090	01.0246	240148	00.9878	250015	00.9498
230217	01.0827	240023	01.0434	240091	00.9799	240150	00.9497	250016	00.8817
230219	01.0083	240025	01.1964	240093	01.2910	240152	00.9632	250017	00.9812
230221	01.2415	240027	01.0586	240094	00.9949	240153	00.9833	250018	01.0138
230222	01.3501	240028	01.1193	240096	01.0553	240154	00.9785	250019	01.2655
230223	01.2913	240029	01.1741	240097	01.0524	240155	00.9636	250020	01.0207
230227	01.3514	240030	01.3263	240098	00.9298	240156	01.0391	250021	00.8890
230228	01.1930	240031	00.9580	240099	00.9524	240157	01.0666	250023	00.8334
230230	01.3405	240036	01.4943	240100	01.3042	240158	00.9179	250024	00.9398
230232	01.0412	240037	01.0507	240101	01.2096	240160	00.9688	250025	01.0209
230235	00.9867	240038	01.4615	240102	01.0953	240161	00.9893	250027	00.9823
230236	01.3399	240040	01.2780	240103	01.1664	240162	01.0592	250029	00.9110
230237	01.0889	240041	01.2177	240104	01.2187	240163	00.9659	250030	00.8907
230239	01.1560	240043	01.1255	240105	00.8992	240166	01.1525	250031	01.2567
230241	01.2143	240044	01.1644	240106	01.3209	240167	00.8388	250032	01.2072
230244	01.3681	240045	01.1021	240107	00.9677	240169	00.9684	250033	01.0365
230253	01.1032	240047	01.3887	240108	00.9392	240170	01.0584	250034	01.4442
230254	01.2625	240048	01.2591	240109	00.9691	240171	01.0991	250035	00.8410
230257	00.9162	240049	01.6577	240110	01.0154	240172	01.0845	250036	00.9614

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
250037	00.8930	250101	00.8826	260021	01.2831	260089	01.0829	260176	01.4620
250038	00.9187	250102	01.4419	260022	01.3869	260090	01.4544	260177	01.3048
250039	01.0118	250104	01.3143	260023	01.2732	260091	01.5467	260178	01.4142
250040	01.2053	250105	00.9087	260024	01.0607	260092	01.1280	260179	01.5442
250042	01.1271	250107	00.9139	260025	01.3033	260094	01.0700	260180	01.5485
250043	00.8909	250109	00.9856	260026	00.9474	260095	01.3661	260182	01.0209
250044	01.0525	250112	00.9541	260027	01.5417	260096	01.4280	260183	01.4446
250045	01.1647	250113	00.9556	260029	01.1609	260097	01.1961	260186	01.1420
250046	01.0475	250117	01.0880	260030	01.1169	260100	01.1503	260188	01.1727
250047	00.9326	250119	00.9687	260031	01.4644	260102	00.9735	260189	00.9530
250048	01.3353	250120	01.0682	260032	01.6111	260103	01.3136	260190	01.1426
250049	00.9272	250122	01.2651	260033	01.2668	260104	01.6018	260191	01.2506
250050	01.1693	250123	01.1486	260034	01.0358	260105	01.9059	260193	01.2130
250051	00.8808	250124	00.8813	260035	01.0577	260107	01.3046	260195	01.1116
250057	01.0880	250125	01.2550	260036	01.0900	260108	01.6531	260197	01.2125
250058	01.1730	250126	00.9919	260037	01.2409	260109	00.9996	260198	01.2873
250059	01.0052	250127	00.8436	260039	01.2995	260110	01.6543	260200	01.1639
250060	00.8007	250128	00.9709	260040	01.4981	260111	00.9715	260202	01.3792
250061	00.9120	250129	01.1736	260042	01.1125	260112	01.4243	260898	00.6959
250062	00.9942	250131	00.9613	260044	01.0607	260113	01.1687	260899	00.5933
250063	00.8561	250134	00.9535	260047	01.3407	260115	01.0292	270002	01.2268
250065	00.9442	250136	00.7432	260048	01.3525	260116	01.2167	270003	01.2111
250066	00.9378	250137	00.9631	260049	00.9763	260119	01.1453	270004	01.6654
250067	01.0106	250138	01.3198	260050	01.0947	260120	01.1658	270006	00.8607
250068	00.8515	250139	00.9033	260051	01.2169	260122	01.2201	270007	00.9635
250069	01.2290	250140	00.8149	260052	01.1899	260123	00.9644	270009	01.0755
250071	01.0512	250141	01.1843	260053	01.0725	260127	01.1482	270011	01.1328
250072	01.2240	250142	00.7975	260054	01.3329	260128	01.0252	270012	01.3842
250073	00.9892	250143	00.9179	260055	01.2043	260129	01.0795	270013	01.2712
250076	00.9129	250898	00.7011	260057	01.1640	260131	01.3650	270014	01.6252
250077	00.9331	250899	00.5933	260059	01.0850	260134	01.2778	270016	00.8858
250078	01.3886	260001	01.5613	260061	01.1065	260137	01.2258	270017	01.1953
250079	00.8598	260002	01.3257	260062	01.1663	260138	01.8004	270019	00.9792
250081	01.2215	260003	00.9540	260063	01.1723	260141	02.0416	270021	01.0883
250082	01.2514	260004	01.0358	260064	01.3736	260142	01.2080	270023	01.3089
250083	00.8997	260005	01.3728	260065	01.6096	260143	01.1436	270024	01.0469
250084	01.1966	260006	01.3907	260066	01.0404	260146	01.3910	270026	00.9326
250085	01.0008	260007	01.2514	260067	00.9180	260147	01.0426	270027	01.0139
250086	00.9265	260008	01.1982	260068	01.7683	260148	01.0096	270028	01.0329
250088	01.0092	260009	01.2630	260070	01.0768	260158	01.1385	270029	01.0812
250089	00.9999	260011	01.5392	260073	00.9728	260159	01.1010	270030	00.9514
250091	01.0206	260012	01.0056	260074	01.1957	260160	01.1248	270031	00.8901
250093	01.1580	260013	01.1565	260077	01.3904	260162	01.0112	270032	01.1279
250094	01.2725	260014	01.6238	260078	01.1134	260163	01.2131	270033	00.8346
250095	01.0480	260015	01.1876	260079	01.0063	260164	01.0692	270035	01.0460
250096	01.1992	260016	01.2309	260080	01.1100	260165	00.9779	270036	00.9983
250097	01.1853	260017	01.2115	260081	01.4046	260166	01.2324	270039	00.9205
250098	00.8454	260018	00.9483	260082	01.1548	260172	01.0210	270040	01.0094
250099	01.2061	260019	01.0160	260085	01.4457	260173	01.0721	270041	00.9284
250100	01.1505	260020	01.6168	260086	01.0581	260175	01.1367	270044	01.1145

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
270046	00.9532	280031	01.1046	280092	00.9934	300008	01.2355	310032	01.2549
270047	00.9928	280032	01.1851	280094	01.1222	300009	01.2220	310034	01.1526
270048	01.1120	280033	00.9335	280097	00.8690	300010	01.2353	310036	01.2028
270049	01.5750	280034	01.2721	280098	01.0099	300011	01.2187	310037	01.2170
270050	01.0269	280035	00.9044	280101	01.1203	300012	01.2576	310038	01.6843
270051	01.1910	280037	00.9497	280102	00.8643	300013	01.1540	310039	01.2925
270052	01.0407	280038	01.0366	280104	00.9322	300014	01.3466	310040	01.2080
270053	00.9047	280039	01.0737	280105	01.2152	300015	01.0421	310041	01.2512
270055	00.6803	280040	01.5666	280106	01.0201	300016	01.2323	310042	01.1506
270057	01.1117	280041	00.9218	280107	01.0745	300017	01.2003	310043	01.2114
270058	00.9434	280042	00.9783	280108	01.0455	300018	01.2254	310044	01.2584
270059	00.8462	280043	01.1572	280109	00.8824	300019	01.2697	310045	01.2746
270060	00.9544	280045	01.1270	280110	00.9953	300020	01.1540	310047	01.2626
270063	00.8769	280046	01.0164	280111	01.1988	300021	01.1536	310048	01.2321
270067	00.9538	280047	01.1721	280114	00.9322	300022	01.1215	310049	01.2456
270068	00.8818	280048	01.0670	280115	00.9657	300023	01.2290	310050	01.1909
270072	00.8453	280049	01.0303	280117	01.0890	300024	01.2535	310051	01.2915
270073	01.2183	280050	00.9881	280118	01.0141	300028	01.1845	310052	01.1763
270074	00.8436	280051	00.9674	280119	00.9109	300029	01.2856	310054	01.2753
270075	00.9671	280052	01.0106	280123	00.9142	300033	01.0735	310056	01.1859
270076	00.8432	280054	01.1549	280898	00.7011	300034	01.7411	310057	01.2249
270079	00.9286	280055	00.9710	280899	00.5933	300898	00.7055	310058	01.1769
270080	01.1143	280056	00.9827	290001	01.5962	300899	00.5933	310060	01.2048
270081	00.9430	280057	01.0219	290002	00.9406	310001	01.6578	310061	01.1485
270082	00.9041	280058	01.2317	290003	01.6362	310002	01.8335	310062	01.1534
270083	00,9864	280060	01.4590	290005	01.1879	310003	01.2124	310063	01.3049
270084	00.9482	280061	01.2910	290006	01.0956	310005	01.2569	310064	01.2228
270898	00.7186	280062	01.1223	290007	01.7005	310006	01.1516	310067	01.2307
270899	00.5933	280064	01.0678	290008	01.2704	310008	01.3109	310069	01.1381
280001	01.1182	280065	01.1466	290009	01.5518	310009	01.1789	310070	01.2633
280003	01.8260	280066	01.1535	290010	01.0426	310010	01.2440	310071	00.9062
280005	01.4500	280068	00.9262	290011	01.0069	310011	01.2175	310072	01.2813
280009	01.4855	280070	00.9697	290012	01.3145	310012	01.5288	310073	01.4049
280011	00.9936	280073	00.9619	290013	01.0691	310013	01.2615	310074	01.2930
280012	01.1906	280074	01.1627	290014	00.9938	310014	01.5702	310075	01.2412
280013	01.9172	280075	01.2967	290015	01.0594	310015	01.5962	310076	01.3239
280014	00.9868	280076	00.9741	290016	01.2954	310016	01.2386	310077	01.5759
280015	01.0075	280077	01.2704	290018	01.0306	310017	01.3287	310078	01.2965
280017	01.1621	280078	00.9440	290019	01.2083	310018	01.2118	310081	01.1964
280018	00.9322	280079	00.9652	290020	01.0173	310019	01.6564	310083	01.2911
280020	01.4323	280080	01.0670	290021	01.5430	310020	01.1989	310084	01.2308
280021	01.1422	280081	01.4435	290022	01.6758	310021	01.2415	310085	01.2262
280022	01.0214	280082	01.4939	290027	00.9600	310022	01.2106	310086	01.1769
280023	01.3568	280083	00.9711	290029	00.7746	310024	01.2169	310087	01.1864
280024	00.8310	280084	00.9581	290032	01.4420	310025	01.1601	310088	01.2569
280025	00.9937	280085	00.9546	300001	01.2914	310026	01.2314	310090	01.2539
280026	01.0445	280088	01.6300	300003	01.8799	310027	01.2724	310091	01.2398
280028	00.8807	280089	01.0396	300005	01.3445	310028	01.1847	310092	01.3387
280029	01.0108	280090	00.9305	300006	01.1117	310029	01.8190	310093	01.0833
280030	01.7771	280091	01.0154	300007	01.1003	310031	02.7545	310096	01.7282

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
310105	01.0944	320067	00.8602	330053	01.0513	330127	01.2252	330201	01.4914
310108	01.3596	320068	00.8736	330055	01.3973	330128	01.4005	330202	01.2794
310110	01.2095	320069	01.0429	330056	01 4060	330132	01.1135	330203	01.4157
310111	01.2331	320070	00.9856	330057	01.5811	330133	01.2789	330204	01.2648
310112	01.2160	320072	01.5919	330058	01.3020	330135	01.1790	330205	01.0993
310113	01.2212	320074	01.0663	330059	01.4747	330136	01.2399	330208	01.1781
310115	01.1844	320076	01.1175	330061	01.3031	330140	01.6372	330209	01.2066
310116	01.2549	320079	01.0770	330062	01.0569	330141	01.2477	330211	01.2290
310118	01.1946	320898	00.7241	330064	01.2798	330142	01.3141	330212	01.2391
310119	01.5145	320899	00.5933	330065	01.1733	330144	01.0037	330213	01.1508
310120	01.0583	330001	01.1560	330066	01.2167	330148	01.0177	330214	01.7146
310121	01.0506	330002	01.4240	330067	01.3164	330151	01.1024	330215	01.1883
310898	00.7011	330003	01.3300	330072	01.3217	330152	01.4034	330218	01.2156
310899	00.5820	330004	01.3071	330073	01.1219	330153	01.3076	330219	01.5641
320001	01.4300	330005	01.6638	330074	01.2650	330154	01.3975	330221	01.2786
320002	01.2442	330006	01.3572	330075	01.0670	330155	01.1739	330222	01.2062
320003	01.1382	330007	01.3469	330078	01.3601	330157	01.3135	330223	01.0765
320004	01.1776	330008	01.1911	330079	01.1014	330158	01.3151	330224	01.2649
320005	01.2389	330009	01.3027	330080	01.2452	330159	01.2762	330225	01.1733
320006	01.1944	330010	01.2150	330082	01.2209	330160	01.4381	330226	01.2993
320009	01.3605	330011	01.1975	330084	00.9667	330161	01.0558	330229	01.1804
320011	00.9584	330012	01.5788	330085	01.3318	330162	01.2408	330230	01.4463
320012	00.9736	330013	02.0376	330086	01.2710	330163	01.1750	330231	01.2100
320013	01.0998	330014	01.3760	330088	01.0905	330164	01.3939	330232	01.2402
320014	00.9454	330015	00.8720	330090	01.7340	330166	00.9389	330233	01.5026
320016	01.2056	330016	00.9942	330091	01.3319	330167	01.5214	330234	01.8929
320017	01.2002	330019	01.3449	330092	00.9838	330169	01.3728	330235	01.1854
320018	01.2417	330020	00.9904	330094	01.3141	330171	01.2915	330236	01.3596
320019	01.3538	330022	01.0132	330095	01.2325	330174	00.7840	330238	01.1009
320021	01.6441	330023	01.2086	330096	01.1394	330175	01.0503	330239	01.1613
320022	01.2261	330024	01.6925	330097	01.1737	330176	00.8622	330240	01.3378
320023	01.1057	330025	01.1062	330100	00.6809	330177	01.0684	330241	01.7462
320030	01.0421	330027	01.4311	330101	01.6650	330179	00.9373	330242	01.2437
320031	00.9598	330028	01.3321	330102	01.2920	330180	01.2225	330244	01.0699
320032	00.9241	330029	01.1444	330103	01.1701	330181	01.2585	330245	01.3008
320033	01.0992	330030	01.1690	330104	01.3306	330182	02.2748	330246	01.1757
320035	01.0732	330033	01.1243	330106	01.5433	330183	01.4318	330247	00.6020
320037	01.2479	330034	01.0723	330107	01.2394	330184	01.2495	330249	01.1964
320038	01.2570	330036	01.2036	330108	01.2452	330185	01.1809	330250	01.2499
320046	01.0924	330037	01.0767	330110	01.0962	330186	00.9961	330252	00.9324
320048	01.2282	330038	01.1750	330111	01.1248	330188	01.1807	330254	00.9844
320056	00.9453	330039	00.8940	330114	00.9982	330189	00.8684	330258	01.3202
320057	01.0938	330041	01.3626	330115	01.2553	330191	01.2528	330259	01.3134
320058	00.8775	330043	01.2780	330116	01.0004	330193	01.3674	330261	01.2055
320059	01.0857	330044	01.2124	330118	01.5905	330194	01.7304	330263	01.0704
320060	00.9163	330045	01.2999	330119	01.5732	330195	01.6563	330264	01.2158
320061	01.2288	330046	01.5843	330121	01.0137	330196	01.3772	330265	01.2840
320062	00.8894	330047	01.2787	330122	01.2779	330197	01.0166	330267	01.2482
320063	01.2761	330048	01.2433	330125	01.7608	330198	01.3351	330268	01.1270
320065	01.1642	330049	01.3131	330126	01.2178	330199	01.2794	330270	01 8912

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330273	01.1818	330394	01.3836	340049	00.5900	340121	00.9534	350012	00.9745
330275	01.2036	330395	01.3399	340050	01.2019	340122	01.0402	350013	01.0994
330278	01.1937	330396	01.2195	340051	01.2279	340123	01.1942	350014	01.0561
330277	01.1679	330397	01.4256	340052	00.9710	340124	01.0969	350015	01.5097
330279	01.2534	330398	01.3058	340053	01.5724	340125	01.4446	350016	00.9590
330281	00.5845	330399	01.3674	340054	00.9793	340126	01.2844	350017	01.2594
330285	01.6000	330898	00.5377	340055	01.1561	340127	01.2259	350018	01.0383
330286	01.3285	330899	00.5933	340060	01.1859	340129	01.1190	350019	01.5307
330288	01.0172	340001	01.2439	340061	01.6056	340130	01.3969	350020	01.3376
330290	01.6601	340002	01.7820	340063	01.0220	340131	01.3435	350021	01.0483
330293	01.1152	340003	01.1432	340064	01.1011	340132	01.3657	350023	00.9208
330304	01.1618	340004	01.3930	340065	01.2382	340133	01.2081	350024	01.0031
330306	01.3793	340005	01.2186	340067	01.1095	340135	01.0705	350025	00.9630
330307	01.1383	340006	01.1747	340068	01.2600	340136	00.8650	350027	00.9789
330308	01.2434	340007	01.1159	340069	01.7413	340137	01.2023	350029	00.9882
330309	01.2846	340008	01.2221	340070	01.2915	340138	01.1161	350030	01.0583
330314	01.2954	340009	01.2706	340071	01.0893	340141	01.5263	350031	00.9835
330315	01.1883	340010	01.3135	340072	01.0470	340142	01.1674	350032	01.3053
330316	01.2443	340011	01.0800	340073	01.3473	340143	01.3674	350033	00.9688
330327	00.9478	340012	01.0754	340075	01.1885	340144	01.2598	350034	00.9734
330331	01.1957	340013	01.1941	340076	01.0245	340145	01.1897	350035	00.8348
330332	01.2665	340014	01.6266	340080	01.0938	340146	01.0141	350036	00.9224
330333	01.3099	340015	01.2265	340084	01.0217	340147	01.2841	350038	00.9552
330336	01.2740	340016	01.2028	340085	01.2478	340148	01.3166	350039	00.8885
330338	01.1616	340017	01.2021	340087	01.0869	340151	01.1652	350041	00.9925
330339	00.8648	340018	01.2130	340088	01.0748	340153	01.9099	350042	00.9260
330340	01.1313	340019	01.0666	340089	01.0036	340154	00.9800	350043	01.5731
330350	01.8946	340020	01.2499	340090	01.1399	340155	01.4954	350044	00.8569
330351	01.0933	340021	01.2157	340091	01.6623	340156	00.8579	350047	01.1519
330353	01.2145	340022	01.1448	340093	01.0485	340158	01.0443	350049	01.0629
330354	01.1615	340023	01.3133	340094	01.3397	340159	01.2070	350050	00.9960
330357	01.3723	340024	01.2259	340096	01.2118	340160	01.0404	350051	00.9419
330359	00.9412	340025	01.0964	340097	01.0040	340162	01.2682	350053	00.8935
330362	00.6536	340027	01.1215	340098	01.6166	340164	01.3371	350055	00.9582
330363	00.6845	340028	01.3883	340099	01.1462	340166	01.3205	350056	00.8781
330366	00.7261	340030	01.7642	340100	01.0987	340167	00.5762	350058	00.9941
330367	00.5681	340031	01.0764	340101	01.0661	340168	00.5394	350060	00.9295
330368	00.6233	340032	01.2951	340104	01.0037	340898	00.6959	350061	01.0154
330369	00.6711	340034	01.2774	340105	01.3337	340899	00.5704	350063	00.8245
330371	00.6549	340035	01.0880	340106	01.1051	350001	01.1012	350064	00.8353
330372	01.2391	340036	01.0849	340107	01.2960	350002	01.6350	350065	00.9904
330373	00.6795	340037	01.2492	340109	01.2881	350003	01.1388	350066	00.9846
330381	01.3061	340038	01.2031	340111	01.1685	350004	01.8746	350067	01.0297
330383	01.3768	340039	01.2352	340112	01.0075	350005	01.1909	350898	00.5196
330385	01.2000	340040	01.7179	340113	01.9528	350006	01.3931	350899	00.5200
330386	01.2119	340041	01.2312	340114	01.3849	350007	01.0256	360001	01.2208
330387	00.8627	340042	01.1518	340115	01.4475	350008	01.0437	360002	01.1442
330389	01.8157	340044	01.0104	340116	01.7306	350009	01.1634	360003	01.5880
330390	01.2245	340045	00.9701	340119	01.2109	350010	01.0859	360006	01.7210
330393	01.6510	340047	01.7865	340120	01.0633	350011	01.7361	360007	01.1485

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
360008	01.1885	360064	01.4600	360120	00.7106	360179	01.2535	370020	01.2583
360009	01.3042	360065	01.2015	360121	01.1847	360180	02.1065	370021	00.9723
360010	01.1622	360066	01.2308	360122	01.2237	360184	00.7100	370022	01.3410
360011	01.2673	360067	01.1829	360123	01.1505	360185	01.1692	370023	01.3165
360012	01.2772	360068	01.4427	360124	01.2238	360186	01.1560	370025	01.3100
360013	01.0931	360069	01.0316	360125	01.0834	360187	01.3206	370026	01.3143
360014	01.1689	360070	01.4018	360126	01.2596	360188	00.9687	370028	01.6147
360015	01.4481	360071	01.2758	360127	01.0204	360189	01.0651	370029	01.2188
360016	01.4685	360072	01.1559	360128	01.0601	360192	01.2783	370030	01.2113
360017	01.7324	360074	01.3153	360129	01.0463	360193	01.2608	370032	01.3442
360018	01.3731	360075	01.4178	360130	01.1047	360194	01.0646	370033	01.2104
360019	01.1745	360076	01.2600	360131	01.2733	360195	01.1869	370034	01.1218
360020	01.2387	360077	01.3972	360132	01.1794	360197	01.1575	370035	01.5126
360021	01.2084	360078	01.2704	360133	01.3232	360200	01.2071	370036	01.1042
360024	01.2724	360079	01.6191	360134	01.5318	360203	01.1218	370037	01.5306
360025	01.2127	360080	01.2267	360135	01.1194	360204	01.1640	370038	01.0635
360026	01.1237	360081	01.3315	360136	01.0698	360210	01.1851	370039	01.2286
360027	01.4963	360082	01.3182	360137	01.5094	360211	01.1710	370040	01.0324
360028	01.3266	360083	01.2132	360139	01.1154	360212	01.4200	370041	01.0246
360029	01.1008	360084	01.4106	360140	01.0630	360213	01.0973	370042	00.8843
360030	01.1579	360085	01.6739	360141	01.4123	360218	01.3145	370043	00.9562
360031	01.2545	360086	01.3417	360142	00.9861	360230	01.2830	370045	01.0659
360032	01.1178	360087	01.3150	360143	01.2290	360231	01.1230	370046	01.0201
360034	01.0803	360088	01.1521	360144	01.2917	360232	01.1335	370047	01.2533
360035	01.4548	360089	01.1109	360145	01.4940	360234	01.2280	370048	01.2083
360036	01.1750	360090	01.1711	360147	01.2193	360236	01.2063	370049	01.2957
360037	01.8293	360091	01.3045	360148	01.1836	360238	00.8516	370050	00.8128
360038	01.4265	360092	01.1612	360149	01.0868	360239	01.2051	370051	01.0003
360039	01.2393	360093	01.1582	360150	01.2099	360240	00.5398	370054	01.2476
360040	01.2684	360094	01.2206	360151	01.2817	360241	00.6470	370056	01.4618
360041	01.2353	360095	01.2945	360152	01.4955	360242	01.5841	370057	01.0880
360042	01.0930	360096	01.1047	360153	01.1568	360243	00.9016	370059	01.2278
360044	01.0944	360098	01.3047	360154	01.0441	360898	00.7055	370060	01.0457
360045	01.5035	360099	01.0450	360155	01.2076	360899	00.6006	370063	01.1852
360046	01.1259	360100	01.2811	360156	01.1317	370001	01.6630	370064	00.9042
360047	01.1087	360101	01.6026	360159	01.1440	370002	01.1831	370065	01.1241
360048	01.7146	360102	01.2225	360161	01.2195	370004	01.1904	370069	01.0116
360049	01.2561	360103	01.3406	360162	01.2199	370005	00.9163	370071	01.0079
360050	01.2480	360104	00.8989	360163	01.6523	370006	01.2095	370072	00.9698
360051	01.4791	360106	01.1637	360164	00.9753	370007	01.1117	370076	01.1117
360052	01.5950	360107	01.2072	360165	01.0777	370008	01.2182	370077	01.2633
360054	01.2983	360108	01.0218	360166	01.0321	370011	00.9381	370078	01.5373
360055	01.1899	360109	01.0370	360169	01.0140	370012	00.9169	370079	00.9247
360056	01.2907	360112	01.6095	360170	01.1557	370013	01.4016	370080	00.9494
360057	00.9616	360113	01.2408	360172	01.3402	370014	01.1517	370082	00.9971
360058	01.1008	360114	01.0511	360174	01.1523	370015	01.1269	370083	00.9946
360059	01.4813	360115	01.2479	360175	01.1492	370016	01.2491	370084	00.8590
360061	00.9603	360116	01.0275	360176	01.1366	370017	00.9861	370085	00.8928
360062	01.6108	360118	01.2524	360177	01.2603	370018	01.1800	370086	01.0952
360063	01.0531	360119	01.2161	360178	01.2593	370019	01.1325	370089	01.2511

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370091	01.5313	370179	01.0750	380056	01.0380	390023	01.2283	390078	01 0548
370092	01.0351	370180	01.0228	380059	00.9145	390024	00.7847	390079	01.6542
370093	01.6174	370183	01.0842	380060	01.3258	390025	00.8124	390080	01.1715
370094	01.2787	370185	00.6561	380061	01.6086	390026	01.2380	390081	01.2354
370095	00.9083	370186	00.9634	380062	00.9536	390027	01.7205	390083	01.1254
370097	01.2421	370189	00.9860	380063	01.2683	390028	01.6786	390084	01.1549
370099	01.1489	370190	01.3183	380064	01.3214	390029	01.6470	390086	01.0827
370100	01.0450	370898	00.7011	380065	01.0798	390030	01.1475	390088	01.3304
370103	00.9072	370899	00.5933	380066	01.1358	390031	01.1584	390090	01.7880
370105	01.8882	380001	01.3203	380068	01.0718	390032	01.2139	390091	01.1112
370106	01.3370	380002	01.2313	380069	01.1687	390035	01.2510	390092	01.2270
370108	01.0358	380003	01.1420	380070	01.0683	390036	01.2135	390093	01.2238
370110	00.9971	380004	01.8249	380071	01.2575	390037	01.2069	390095	01.2449
370112	00.9205	380005	01.2024	380072	00.9369	390039	01.0661	390096	01.2257
370113	01.0953	380006	01.1757	380075	01.3712	390040	00.9802	390097	01.3060
370114	01.5430	380007	01.7822	380078	01.1830	390041	01.2212	390098	01.5804
370117	01.3063	380008	01.0571	380081	01.0498	390042	01.2589	390100	01.7299
370121	01.1788	380009	01.6433	380082	01.2904	390043	01.0783	390101	01.2252
370122	00.9339	380010	01.1516	380083	01.1659	390044	01.5304	390102	01.2725
370123	01.1579	380011	01.1471	380084	01.2609	390045	01.2991	390103	01.0780
370125	00.9808	380013	01.2419	380087	00.9779	390046	01.4233	390104	01.0662
370126	01.0998	380014	01.3127	380088	00.9280	390047	01.4582	390106	01.0788
370131	00.9952	380017	01.7214	380089	01.2922	390048	01.1050	390107	01.1696
370133	01.1936	380018	01.8707	380090	01.3307	390049	01.5231	390108	01.3382
370138	01.1842	380019	01.2649	380091	01.1711	390050	01.8804	390109	01.2110
370139	01.0073	380020	01.3445	380094	01.1491	390051	02.0915	390110	01.3387
370140	01.0652	380021	01.2315	380096	01.1107	390052	01.1415	390111	01.7172
370141	01.4378	380022	01.2338	380898	00.6959	390054	01.1127	390112	01.1828
370146	01.0242	380023	01.2872	380899	00.5933	390055	01.6890	390113	01.2474
370148	01.2687	380024	01.2863	390001	01.2248	390056	01.0962	390114	01.0313
370149	01.2109	380025	01.2421	390002	01.1848	390057	01.2574	390115	01.2930
370153	01.0973	380026	01.4084	390003	01.1522	390058	01.3240	390116	01.1821
370154	01.0248	380027	01.2104	390004	01.2474	390059	01.3276	390117	01.1647
370156	01.0210	380029	01.1555	390005	01.0906	390060	01.1557	390118	01.1609
370157	00.9195	380030	00.8953	390006	01.6859	390061	01.2393	390119	01.3166
370158	01.0514	380031	01.0175	390007	01.1727	390062	01.1877	390121	01.2056
370159	01.1521	380033	01.6755	390008	01.1245	390063	01.6215	390122	01.0424
370161	01.1959	380035	01.1882	390009	01.4983	390064	01.4194	390123	01.2041
370163	00.8649	380036	01.0905	390010	01.1734	390065	01.2442	390125	01.2187
370165	01.1643	380037	01.2117	390011	01.2003	390066	01.2678	390126	01.2167
370166	01.1656	380038	01.2444	390012	01.1969	390067	01.5103	390127	01.1118
370169	00.9965	380039	01.3112	390013	01.1550	390068	01.2594	390128	01.1941
370170	00.8238	380040	01.3427	390014	00.8159	390069	01.2592	390130	01.0671
370171	00.9463	380042	01.1124	390015	01.1104	390070	01.1882	390131	01.2059
370172	00.8966	380047	01.5541	390016	01.1716	390071	01.1218	390132	01.1606
370173	01.0663	380048	00.9951	390017	01.1496	390072	00.9935	390133	01.4044
370174	00.9662	380050	01.3293	390018	01.2180	390073	01.4717	390135	01.2238
370176	01.2706	380051	01.4251	390019	01.1113	390074	01.2243	390136	01.1704
370177	00.9393	380052	01.1735	390021	01.0658	390075	01.3036	390137	01.1657
370178	01.0007	380055	01.1787	390022	01.2705	390076	01.2570	390138	01.2470

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. CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390139	01.4427	390197	01.2864	390277	01.4534	400111	01.2195	420036	01.2537
390142	01.7099	390198	01.2504	390278	00.8975	400112	01.2237	420037	01.2720
390143	03.1916	390199	01.2182	390898	00.6478	400113	01.2075	420038	01.2051
390145	01.2120	390200	01.0823	390899	00.5756	400114	01.0776	420039	01.1188
390146	01.1901	390201	01.3181	400001	01.1869	400115	01.0326	420040	01.2994
390147	01.1880	390203	01.2909	400002	01.2608	400117	01.1714	420042	01.0812
390148	01.1487	390204	01.2726	400003	01.1319	400118	01.1614	420043	01.1473
390149	01.2551	390205	01.2345	400004	01.1172	400120	01.3128	420044	01.1484
390150	01.1998	390206	01.2600	400005	01.1165	400121	01.0225	420048	01.1354
390151	01.2693	390209	00.9546	400006	01.1717	400898	00.7124	420049	01.0893
390152	01.0243	390211	01.1389	400007	01.0901	400899	00.5933	420051	01.5386
390153	01.2058	390213	01.0185	400008	01.1139	410001	01.2640	420053	01.0857
390154	01.1150	390215	01.1789	400009	00.9820	410002	01.2483	420054	01.1379
390155	01.2832	390217	01.1413	400010	00.9631	410004	01.4267	420055	01.0351
390156	01.3735	390219	01.1923	400011	01.1131	410005	01.2981	420056	01.0152
390157	01.1812	390220	01.1139	400012	01.0397	410006	01.1874	420057	01.0846
390158	01.2492	390222	01.2000	400013	01.0272	410007	01.5205	420059	01.0531
390159	01.3079	390223	01.5759	400014	01.3318	410008	01.1990	420061	01.2593
390160	01.1721	390224	00.9580	400015	01.0801	410009	01.3382	420062	01.2822
390161	01.0728	390225	01.2692	400016	01.2660	410010	01.0374	420064	01.0772
390162	01.2402	390226	01.6126	400017	01.1062	410011	01.1929	420065	01.3053
390163	01.2013	390228	01.1929	400018	01.2698	410012	01.5862	420066	01.0015
390164	01.8775	390229	01.4457	400019	01.3510	410013	01.1477	420067	01.1124
390165	01.0801	390231	01.3036	400021	01.3106	410898	00.7124	420068	01.1785
390166	01.1110	390232	01.0866	400022	01.2852	410899	00.5933	420069	01.0072
390167	01.2332	390233	01.2834	400024	01.0343	420002	01.3260	420070	01.2626
390168	01.1968	390235	01.8436	400026	00.9306	420004	01.9502	420071	01.3694
390169	01.2263	390236	01.2111	400027	01.0976	420005	01.1085	420072	01.0073
390170	01.6284	390237	01.4882	400028	01.0450	420006	01.5297	420073	01.2811
390171	01.0849	390238	00.9991	400029	01.0198	420007	01.4123	420074	00.9710
390172	01.1793	390242	01.2145	400031	01.0733	420009	01.2309	420075	01.0716
390173	01.1246	390244	00.8734	400032	01.1247	420010	01.0818	420076	01.2637
390174	01.5844	390245	01.3513	400037	00.5692	420011	01.0829	420078	01.5714
390176	01.2046	390246	01.2118	400038	00.9750	420014	01.1158	420079	01.5497
390178	01.3257	390247	01.1039	400044	01.2547	420015	01.2538	420080	01.1505
390179	01.2349	390249	00.9705	400048	01.1327	420016	01.2156	420081	00.7982
390180	01.3894	390252	00.9369	400061	01.7728	420018	01.6260	420082	01.3709
390181	01.0718	390256	01.6519	400079	01.1418	420019	01.1687	420083	01.1952
390183	01.1446	390258	01.2930	400087	01.2463	420020	01.1766	420084	00.8372
390184	01.1044	390260	01.2363	400088	00.7437	420022	00.9970	420085	01.2551
390185	01.1571	390261	01.8268	400089	01.0897	420023	01.2479	420086	01.3756
390186	01.0995	390262	01.6813	400094	00.9192	420026	01.8115	420087	01.5254
390187	01.0994	390263	01.4368	400098	01.2320	420027	01.3416	420088	01.1805
390189	01.1126	390265	01.2574	400102	01.0991	420028	01.0602	420089	01.2609
390191	01.0654	390266	01.1242	400103	01.4111	420029	01.8435	420898	00.6771
390192	01.0701	390267	01.2187	400104	01.2781	420030	01.1604	420899	00.5933
390193	01.1907	390268	01.2201	400105	01.2795	420031	00.9787	430004	01.0610
390194	01.0999	390270	01.3042	400106	01.1440	420032	00.8739	430005	01.3185
390195	01.5428	390272	00.6193	400109	01.5059	420033	01.1658	430007	01.1426
390196	01.2912	390275	00.5439	400110	01.1676	420035	00.8266	430008	01.2152

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
430009	01.0311	430084	01.0086	440059	01.1388	440146	01.3387	450014	01.1052
430010	01.0947	430085	00.9279	440060	01.2150	440147	00.7335	450015	01.5143
430011	01.3501	430086	00.8651	440061	01.1043	440148	01.1316	450016	01.6549
430012	01.3030	430087	01.0579	440063	01.4087	440149	01.1647	450018	01.6541
430013	01.2439	430088	00.9259	440064	01.0984	440150	01.2898	450019	02.8940
430014	01.1898	440001	00.9701	440065	01.1393	440151	01.1705	450020	01.0537
430015	01.0331	440002	01.5635	440067	01.1641	440152	01.5789	450021	01.7689
430016	01.7030	440003	01.1093	440068	01.1625	440153	00.9846	450023	01.4111
430017	01.0879	440006	01.3877	440069	01.0897	440154	00.7352	450024	01.2651
430018	00.9467	440007	01.0247	440070	00.9311	440156	01.4045	450025	01.4534
430022	00.9431	440008	00.9625	440071	01.3252	440157	01.0030	450027	01.1921
430023	00.9419	440009	01.0302	440072	01.3619	440159	01.2169	450028	01.4417
430024	01.0061	440010	00.9354	440073	01.2878	440160	01.0547	450029	01.3741
430025	01.0109	440011	01.2239	440074	00.8640	440161	01.5777	450031	01.1828
430026	00.8677	440012	01.3394	440078	01.0115	440162	01.0043	450032	01.2115
430027	01.6594	440014	00.8841	440079	00.8339	440166	01.2809	450033	01.6066
430028	01.0992	440015	01.4882	440081	01.1405	440168	01.0334	450034	01.4968
430029	00.9978	440016	00.9545	440082	01.8142	440170	01.3329	450035	01.4719
430031	00.9946	440017	01.4827	440083	01.2404	440173	01.4742	450037	01.4609
430033	00.9962	440018	01.2963	440084	01.0804	440174	00.9098	450039	01.1670
430034	01.0563	440019	01.4679	440087	01.0114	440175	01.1642	450040	01.6219
430036	01.0365	440020	01.2166	440090	01.0373	440176	01.2734	450041	00.9493
430037	00.9672	440022	01.0826	440091	01.3862	440177	00.9367	450042	01.6210
430038	01.0455	440023	00.9772	440095	01.0858	440178	01.1885	450043	01.4135
430039	01.0100	440024	01.1448	440100	01.0961	440180	01.0662	450044	01.5010
430040	00.9229	440025	01.1533	440102	01.0579	440181	00.9708	450046	01.3774
430041	00.9428	440026	01.2767	440103	01.2834	440182	00.9304	450047	01.0038
430042	01.0035	440029	01.2274	440104	01.4361	440183	01.4239	450050	01.2953
430043	01.1949	440030	01.0530	440105	01.3156	440184	01.2415	450051	01.6324
430044	00.9390	440031	01.0537	440109	01.0700	440185	01.0482	450052	01.0335
430047	01.0916	440032	00.9586	440110	01.0866	440186	01.1493	450053	01.1164
430048	01.1354	440033	01.0885	440111	01.2814	440187	01.0728	450054	01.6334
430049	00.9242	440034	01.3829	440114	00.9988	440189	01.4744	450055	01.0755
430051	00.9914	440035	01.1732	440115	01.1522	440192	00.9500	450056	01.6181
430054	00.9401	440038	00.9220	440120	01.4553	440193	01.0686	450057	01.1861
430056	00.8737	440039	01.5792	440121	01.0594	440194	01.2554	450058	01.5148
430057	00.9685	440040	00.8998	440125	01.4373	440196	00.9960	450059	01.2827
430060	00.9537	440041	00.8852	440128	00.9216	440197	01.3298	450060	01.3405
430062	00.8552	440046	01.0297	440130	01.1124	440200	01.0749	450063	00.9390
430064	01.0464	440047	00.9236	440131	01.1110	440203	00.9790	450064	01.4570
430065	00.9444	440048	01.5935	440132	01.0456	440205	00.9780	450065	01.1392
430066	01.0643	440049	01.6166	440133	01.4550	440898	00.6864	450068	01.6465
430073	01.1100	440050	01.1555	440135	01.3845	440899	00.6006	450070	01.1236
430076	01.0099	440051	00.9219	440136	01.2579	450002	01.3855	450072	01.1840
430077	01.4189	440052	01.1565	440137	01.0527	450004	01.0607	450073	01.1736
430079	01.0408	440053	01.1704	440141	00.9151	450005	01.0299	450074	01.1915
430080	00.8204	440054	00.9825	440142	01.0537	450007	01.3586	450076	01.2381
430081	01.0026	440056	00.9654	440143	01.0324	450008	01.2447	450077	00.9754
430082	00.8949	440057	00.9617	440144	01.1294	450010	01.2755	450078	00.9893
430083	00.8473	440058	01.1467	440145	00.9832	450011	01.5581	450079	01.4452

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450080	01.1702	450153	01.5808	450234	00.9339	450351	01.2629	450484	01.5176
450081	01.1807	450154	01.1220	450235	01.0289	450352	01.2194	450486	00.9476
450082	00.9919	450155	01.0564	450236	01.1313	450353	01.1300	450488	01.2052
450083	01.5521	450157	01.0128	450237	01.5059	450355	01.1050	450489	01.0417
450085	00.9963	450160	01.0277	450239	01.1964	450358	01.9688	450497	01.1283
450087	01.3391	450162	01.3390	450241	00.9570	450362	00.9602	450498	01.0559
450090	01.1520	450163	01.1107	450243	00.9256	450365	00.9674	450508	01.4144
450092	01.2884	450164	00.9291	450246	00.9993	450366	01.6512	450514	01.1391
450094	01.3869	450165	00.9342	450249	00.9333	450369	01.1976	450517	00.9456
450096	01.4927	450166	00.8710	450253	01.0894	450370	01.1805	450518	01.3298
450097	01.4102	450169	00.8654	450258	01.1207	450371	01.1090	450523	01.4783
450098	01.1212	450170	01.1030	450259	01.2272	450372	01.3069	450530	01.3074
450099	01.2182	450175	01.1695	450264	00.8619	450373	01.1578	450534	00.9581
450101	01.3864	450176	01.2791	450268	01.2150	450374	00.8738	450535	01.2197
450102	01.6956	450177	01.1028	450269	00.9470	450376	01.4582	450537	01.3805
450104	01.2475	450178	01.0727	450270	01.1469	450378	01.2817	450538	01.2929
450107	01.4170	450179	01.0314	450271	01.1899	450379	01.5651	450539	01.2635
450108	00.9755	450181	01.0091	450272	01.3336	450381	00.8685	450544	01.2441
450109	00.9858	450183	00.9973	450276	00.9935	450388	01.6342	450545	01.1621
450110	01.2221	450184	01.4694	450278	00.9019	450389	01.2288	450548	01.3549
450111	01.1780	450185	01.0479	450280	01.3141	450393	01.2912	450547	00.9694
450112	01.2148	450187	01.1956	450283	01.1470	450395	01.0765	450550	01.0390
450113	01.2870	450188	00.9714	450286	01.0916	450399	01.0324	450551	01.0309
450115	01.0676	450190	01.2586	450288	01.1421	450400	01.0697	450557	01.0522
450118	01.4149	450191	01.1034	450289	01.3842	450403	01.2084	450558	01.7843
450119	01.2402	450192	01.0860	450292	01.2537	450410	01.0562	450559	00.8868
450121	01.3731	450193	02.1589	450293	00.9902	450411	01.0614	450561	01.5104
450123	01.0640	450194	01.1285	450296	01.2171	450417	01.0327	450563	01.2053
450124	01.4598	450195	01.4252	450297	01.0690	450418	01.3688	450565	01.2918
450126	01.3117	450196	01.2384	450299	01.3459	450419	01.2443	450570	01.0129
450127	00.9705	450197	01.2032	450303	00.9486	450422	00.7583	450571	01.4388
450128	01.1501	450200	01.2931	450306	01.0436	450423	01.3455	450573	01.0348
450130	01.4654	450201	00.9801	450307	00.9979	450424	01.2620	450574	01.0248
450131	01.2387	450203	01.1710	450309	01.0402	450429	00.9315	450575	00.9941
450132	01.4478	450207	01.0962	450315	01.2236	450431	01.5019	450578	00.9649
450133	01.4367	450208	02.6823	450320	01.3066	450438	01.0544	450580	01.1793
450135	01.5678	450209	01.3417	450321	00.8834	450446	00.9118	450583	01.0090
450137	01.3454	450210	01.2006	450322	00.9486	450447	01.2783	450584	01.1749
450140	00.9018	450211	01.2561	450324	01.5258	450450	01.0858	450586	01.1145
450142	01.2795	450213	01.4343	450325	01.1917	450451	01.0106	450587	01.2594
450143	01.0184	450214	01.3070	450327	00.9892	450457	01.6706	450591	01.2424
450144	01.1376	450217	00.8680	450330	01.0898	450460	00.9721	450596	01.2329
450145	00.9723	450218	00.9966	450334	01.0666	450462	01.5906	450597	01.0384
450146	01.0127	450219	01.1242	450337	01.1856	450464	00.9138	450603	00.9644
450147	01.3529	450221	00.9881	450340	01.3507	450465	01.1064	450604	01.2342
450148	01.3120	450222	01.6916	450341	00.9360	450467	01.0551	450605	01 2250
450149	01.4242	450224	01.1342	450346	01.3101	450469	01.2731	450607	00.8998
450150	01.0191	450229	01.3599	450347	01.2250	450473	01.0851	450609	00.8576
450151	01.0829	450231	01.5954	450348	00.9782	450475	01.1437	450610	01.3851
450152	01.4143	450233	01.0909	450349	01.1459	450476	01.0202	450614	01.0259

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
. CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450615	00.9536	450691	01.1613	450766	01.6145	470001	01.1553	490043	01.1753
450617	01.3711	450694	01.2182	450768	01.0854	470003	01.9216	490044	01.2720
450620	01.0812	450696	01.0786	450769	00.9330	470004	01.1731	490045	01.1529
450623	01.1476	450697	01.4611	450770	00.9871	470005	01.1976	490046	01.3425
450626	00.9647	450698	00.9556	450771	01.4283	470006	01.2796	490047	01.1639
450628	00.9852	450700	00.9224	450773	01.1471	470008	01.2179	490048	01.3228
450630	01.6381	450702	01.2762	450775	01.1682	470010	01.0269	490050	01.3131
450631	01.6317	450703	01.2745	450898	00.5372	470011	01.1543	490052	01.4080
450632	00.9899	450704	01.2882	450899	00.5933	470012	01.2574	490053	01.2126
450633	01.5660	450705	00.8070	460001	01.6016	470013	01.1251	490054	01.0640
450634	01.3371	450706	01.2435	460003	01.4090	470015	01.2147	490057	01.3413
450637	01.3089	450709	01.1897	460004	01.7104	470018	01.1755	490059	01.4063
450638	01.4822	450711	01.6222	460005	01.2454	470020	01.0039	490060	01.0832
450639	01.5131	450712	00.7254	460006	01.3409	470023	01.2332	490063	01.5838
450641	00.8878	450713	01.2507	460007	01.3771	470024	01.1079	490066	01.1103
450643	01.1682	450715	01.3715	460008	01.3177	490001	01.1387	490067	01.2667
450644	01.6063	450716	01.2262	460009	01.7617	490002	01.0308	490069	01.3553
450646	01.4764	450717	01.2323	460010	01.9808	490003	00.6383	490071	01.2842
450647	01.9626	450718	01.1212	460011	01.3147	490004	01.2117	490073	01.2107
450648	01.1072	450723	01.2479	460013	01.4278	490005	01.4018	490074	01.2452
450649	01.0714	450724	01.1884	460014	01.0575	490006	01.1329	490075	01.2427
450651	01.8222	450725	00.9412	460015	01.2503	490007	01.9211	490077	01.1728
450652	00.9569	450726	00.8623	460016	00.9768	490008	01.1192	490079	01.2327
450653	01.2340	450727	00.9602	460017	01.2157	490009	01.6423	490083	00.7777
450654	00.9878	450728	00.8694	460018	00.9469	490010	01.1743	490084	01.1377
450656	01.2664	450729	00.9587	460019	00.9871	490011	01.2760	490085	01.2287
450658	00.9579	450730	01.3964	460020	00.9421	490012	01.0049	490088	01.1241
450659	01.4426	450732	01.1773	460021	01.2999	490013	01.1182	490089	01.0397
450660	01.6533	450733	01.3126	460022	00.9610	490014	01.5665	490090	01.1350
450661	01.2200	450734	01.2399	460023	01.1392	490015	01.4621	490091	01.1648
450662	01.4437	450735	00.8450	460024	01.0085	490017	01.2820	490092	01.1219
450665	00.9783	450737	00.8791	460025	00.8483	490018	01.0968	490093	01.2530
450666	01.2154	450742	01.3280	460026	00.9616	490019	01.1421	490094	01.0831
450668	01.5214	450743	01.4463	460027	00.9446	490020	01.0727	490095	01.2819
450669	01.3213	450745	00.8077	460029	00.9560	490021	01.3966	490097	01.1400
450670	01.2267	450746	00.8982	460030	01.1082	490022	01.2210	490098	01.2638
450672	01.5935	450747	01.3199	460032	00.9744	490023	01.1902	490099	00.9339
450673	01.0142	450749	01.0312	460033	00.9922	490024	01.6464	490100	01.2995
450674	00.8497	450750	00.9812	460035	00.9074	490027	01.0346	490101	01.1062
450675	01.3358	450751	01.3228	460036	00.9919	490028	01.2916	490104	00.8727
450677	01.3343	450753	00.8613	460037	00.9503	490030	01.3058	490105	00.7232
450678	01.4926	450754	00.8778	460039	00.9546	490031	01.0669	490106	00.8091
450681	01.5291	450755	01.0099	460041	01.2425	490032	01.6518	490107	01.2613
450682	01.2877	450757	00.9658	460042	01.3774	490033	01.2290	490108	00.8697
450683	01.2976	450758	01.4997	460043	01.2879	490035	01.3112	490109	00.8224
450684	01.2924	450759	01.1293	460044	01.1249	490037	01.1306	490110	01.2084
450685	01.2284	450760	01.3408	460046	00.9837	490038	01.2374	490111	01.1711
450686	01.3757	450761	00.9399	460047	01.6139	490040	01.3881	490112	01.5160
450688	01.3312	450763	01.0429	460898	00.7066	490041	01.1724	490113	01.2372
450690	01.3172	450765	01.0829	460899	00.5933	490042	01.2836	490114	01.0184

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

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
490115	01.1527	500048	00.9335	500123	01.0131	510050	01.2320	520031	01.1652
490116	01.1860	500049	01.2302	500124	01.3235	510053	01.0007	520032	01.1489
490117	01.0709	500050	01.2740	500125	00.9519	510055	01.1703	520033	01.2565
490118	01.7037	500051	01.6318	500127	01.0546	510058	01.2083	520034	01.1890
490119	01.3368	500052	01.2202	500129	01.6826	510059	01.3569	520035	01.2525
490120	01.3135	500053	01.2395	500132	00.8229	510060	01.1631	520037	01.6022
490122	01.2100	500054	01.8326	500134	00.7324	510061	01.0428	520038	01.2987
490123	01.1422	500055	01.0012	500135	01.1246	510062	01.1423	520039	01.0161
490124	01.2071	500057	01.2807	500137	00.8154	510063	01.0610	520040	01.4177
490126	01.1959	500058	01.3179	500138	07.0911	510065	00.9971	520041	01.1157
490127	01.0639	500059	01.1465	500139	01.3357	510066	01.1441	520042	01.0195
490129	01.1401	500060	01.1850	500140	00.9810	510067	01.2705	520044	01.3324
490130	01.2419	500061	01.1698	500141	01.2473	510068	01.1017	520045	01.6515
490131	00.9471	500062	00.9538	500143	00.5857	510070	01.1866	520047	00.9726
490898	00.6901	500064	01.5581	500898	00.6949	510071	01.2579	520048	01.3234
490899	00.5704	500065	01.2768	500899	00.6006	510072	01.0285	520049	01.8058
500001	01.3064	500068	01.1688	510001	01.6679	510076	00.9675	520051	02.0395
500002	01.4458	500069	00.9942	510002	01.2809	510077	01.1330	520053	01.0651
500003	01.2859	500071	01.4231	510004	00.9722	510080	00.9922	520054	01.1973
500005	01.7205	500072	01.1843	510005	00.9611	510081	01.0027	520056	01.2998
500007	01.3026	500073	00.9397	510006	01.2035	510082	01.0235	520057	01.1426
500008	01.9064	500074	01.1160	510007	01.3758	510084	00.9458	520058	01.1022
500009	01.3359	500075	01.1804	510008	01.1685	510085	01.1980	520059	01.2665
500011	01.2214	500076	01.3117	510009	01.0270	510086	01.0419	520060	01.2399
500012	01.4978	500077	01.2325	510012	01.0406	510087	00.7818	520062	01.1771
500014	01.6616	500078	01.2968	510013	01.1448	520002	01.2749	520063	01.1928
500015	01.2864	500079	01.2518	510015	00.9202	520003	01.1458	520064	01.5249
500016	01.3659	500080	00.9282	510016	01.0086	520004	01.2492	520066	01.2379
500019	01.2500	500084	01.0119	510018	01.1258	520006	01.0211	520068	01.0636
500021	01.3900	500085	01.0574	510020	01.0994	520007	01.0786	520069	01.1985
500023	01.1981	500086	01.3083	510022	01.6317	520008	01.2066	520070	01.3206
500024	01.3352	500088	01.3063	510023	01.0319	520009	01.4828	520071	01.1777
500025	01.9341	500089	01.0355	510024	01.3162	520010	01.1006	520074	01.1111
500026	01.2809	500090	00.9145	510025	00.9089	520011	01.0878	520075	01.3986
500027	01.5774	500092	01.1105	510026	00.9774	520012	00.9378	520076	01.1655
500028	00.9916	500093	01.1741	510027	01.0039	520013	01.3000	520077	01.0303
500029	00.9016	500094	00.9211	510028	01.0682	520014	01.1698	520078	01.3126
500030	01.3461	500096	01.0396	510029	01.2375	520015	01.1637	520081	01.2238
500031	01.2379	500097	01.1722	510030	01.1182	520016	00.9800	520082	01.2960
500033	01.1721	500098	00.8660	510031	01.2725	520017	01.1687	520083	01.5012
500034	00.9292	500101	00.9255	510033	01.2116	520018	00.9687	520084	01.0843
500035	01.3867	500102	00.9650	510035	01.0518	520019	01.2358	520087	01.4903
500036	01.2761	500104	01.2724	510036	01.0958	520021	01.1869	520088	01.2162
500037	01.1628	500106	00.9994	510038	01.0036	520024	00.9859	520089	01.4093
500039	01.3067	500107	01.1449	510039	01.2756	520025	01.1238	520090	01.1472
500041	01.2100	500108	01.6490	510040	00.9728	520026	01.0938	520091	01.2351
500042	01.3030	500110	01.2213	510043	01.0028	520027	01.1475	520092	01.1657
500043	01.1757	500118	01.1950	510046	01.2549	520028	01.3674	520094	01.1705
500044	01.9124	500119	01.2518	510047	01.1247	520029	00.9306	520095	01.3066
500045	01.1611	500122	01.2276	510048	01.1451	520030	01.5266	520096	01.4422

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
520097	01.2957	520173	01.0630						
520098	01.6973	520174	01.4653						
520100	01.2329	520176	00.8295						
520101	01.1682	520177	01.5402						
520102	01.1985	520178	01.1607						
520103	01.3448	520180	00.5761						
520104	00.9950	520898	00.7124						
520107	01.2347	520899	00.6006						
520109	01.0764	530001	01.2405						
520110	00.9832	530002	01.1456						
520111	01.0896	530003	00.9566						
520112	01.1216	530004	00.9964						
520113	01.2121	530005	01.0804						
520114	01.0560	530006	01.0912						
520115	01.2905	530007	01.0418						
520116	01.1972	530008	01.1467						
520117	01.0769	530009	00.9850						
520118	00.9365	530010	01.2582						
520120	01.0775	530011	01.1237						
520121	00.9657	530012	01.6087						
520122	01.0398	530014	01.1254						
520123	01.0393	530015	01.1318						
520124	01.1554	530016	01.1459						
520130	01.0636	530017	00.9856						
520131	01.0723	530018	01.0635						
520132	01.1596	530019	00.9848						
520134	01.1496	530022	01.1262						
520135	01.0653	530023	00.9055						
520136	01.4682	530024	00.9604						
520138	01.8465	530025	01.2472						
520139	01.1979	530026	01.0539						
520140	01.4135	530027	00.8637						
520141	01.0937	530029	00.8958						
520142	00.9855	530031	00.9951						
520144	01.0099	530032	01.2402						
520145	01.0208	530898	00.7113						
520146	01.1638								
520148	01.0991								
520149	01.0493								
520151	01.0604								
520152	01.1405								
520153	01.0127								
520154	01.1128								
520156	01.0859								
520157	01.0042								
520159	00.9120								
520160	01.7563								
520161	01.0644								
520170	01.3000								
520171	00.9913								

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH JUNE 1992

BILLING CODE 4120-03-C

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (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	0.9425	0.9603
Taylor,TX		
Aguadilla, PR	0.4566	0.5846
Aguada, PR		
Aguadilla, PR		
Isabella, PR		
Moca, PR		
Akron, OH	0.8917	0.9245
Portage, OH		
Summit, OH		
Albany, GA	0.8046	0.8617
Dougherty, GA		
Lee, GA		
Albany-Schenectady-Troy, NY	0.8953	0.9271
Albany, NY		
Greene, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Albuquerque, NM	1.0119	1.0081
Bernalillo, NM		
Alexandria, LA	0.8272	0.8782
Rapides, LA		
Allentown-Bethlehem-Easton, PA-NJ	0.8945	0.9265
Warren, NJ		
Carbon, PA		
Lehigh, PA		
Northampton, PA		
Altoona, PA	0.9235	0.9470
Blair, PA		
Amarillo, TX	0.8735	0.9115
Potter, TX		
Randall, TX		
*Anaheim-Santa Ana, CA	1.1751	1.1168
Orange, CA		
Anchorage, AK	1.4170	1.2696
Anchorage, AK		
Anderson, IN	0.9579	0.9710
Madison, IN		
Anderson, SC	0.7255	0.8027
Anderson, SC		
Ann Arbor, MI	1.1379	1.0925
Washtenaw, MI		
Anniston, AL	0.7928	0.8530
Calhoun, AL		
Appleton-Oshkosh-Neenah, WI	0.9219	0.9458
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
Arecibo, PR	0.3952	0.5295
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
Quebradillas, PR		
Asheville, NC	0.8735	0.9115
Buncombe, NC		
Athens, GA	0.7770	0.8413
Clarke, GA		
Jackson, GA		
Madison, GA		
Oconee, GA		
*Atlanta, GA	0.9592	0.9719
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	1.0604	1.0410
Atlantic, NJ		
Cape May, NJ		
Augusta, GA-SC	0.9397	0.9583
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Aurora-Elgin, IL	0.9459	0.9624
Kane, IL		
Kendall, IL		
Austin, TX	0.9595	0.9721
Hays, TX		
Travis, TX		
Williamson, TX		
Bakersfield, CA	1.0863	1.0583
Kern, CA		
*Baltimore, MD	1.0151	1.0103
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Hartford, MD		
Howard, MD		
Queen Annes, MD		
Bangor, ME	0.9060	0.9346
Penobscot, ME		
Baton Rouge, LA	0.9085	0.9364
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
Battle Creek, MI	0.9095	0.9371
Calhoun, MI		
Beaumont-Port Arthur, TX	0.9600	0.9724
Hardin, TX		
Jefferson, TX		
Orange, TX		
Beaver County, PA	1.0160	1.0109
Beaver, PA		
Bellingham, WA	1.0492	1.0334
Whatcom, WA		
Benton Harbor, MI	0.8163	0.8702
Berrien, MI		
*Bergen-Passaic, NJ	0.8370	0.8853
Bergen, NJ		
Passaic, NJ		
Billings, MT	0.9321	0.9530
Yellowstone, MT		
Biloxi-Gulfport, MS	0.8059	0.8626
Hancock, MS		
Harrison, MS		
Binghamton, NY	0.9256	0.9484
Broome, NY		
Tioga, NY		
Birmingham, AL	0.8766	0.9138
Blount, AL		
Jefferson, AL		
Saint Clair, AL		
Shelby, AL		
Walker, AL		
Bismarck, ND	0.8878	0.9217
Burleigh, ND		
Morton, ND		
Bloomington, IN	0.7833	0.8460
Monroe, IN		
Bloomington-Normal, IL	0.8655	0.9058
McLean, IL		
Boise City, ID	0.9753	0.9830
Ada, ID		
*Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1804	1.1203
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Boulder-Longmont, CO	1.0736	1.0498
Boulder, CO		
Bradenton, FL	0.8727	0.9110
Manatee, FL		
Brazoria, TX	0.8943	0.9264
Brazoria, TX		
Bremerton, WA	0.9631	0.9746
Kitsap, WA		
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1900	1.1265
Fairfield, CT		
Brownsville-Harlingen, TX	0.8597	0.9017
Cameron, TX		
Bryan-College Station, TX	0.9485	0.9644
Brazos, TX		
Buffalo, NY	0.8905	0.9237
Erie, NY		
Burlington, NC	0.7936	0.8536
Alamance, NC		
Burlington, VT	0.9354	0.9553
Chittenden, VT		
Grand Isle, VT		
Caguas, PR	0.4586	0.5863
Caguas, PR		
Gurabo, PR		
San Lorenz, PR		
Aguas Buenas, PR		
Cayey, PR		
Cidra, PR		
Canton, OH	0.8449	0.8910
Carroll, OH		
Stark, OH		
Casper, WY	0.8887	0.9224
Natrona, WY		
Cedar Rapids, IA	0.7528	0.8233
Linn, IA		
Champaign-Urbana-Rantoul, IL	0.8741	0.9120
Champaign, IL		
Charleston, SC	0.8328	0.8822
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
Charleston, WV	0.9688	0.9785
Kanawha, WV		
Putnam, WV		
*Charlotte-Gastonia-Rock Hill, NC-SC	0.9462	0.9628
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
Charlottesville, VA	0.9611	0.9732
Albermarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		

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
Chattanooga, TN-GA	0.9194	0.9441
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
Sequatchie, TN		
Cheyenne, WY	0.7773	0.8415
Laramie, WY		
*Chicago, IL	1.0513	1.0349
Cook, IL		
Du Page, IL		
McHenry, IL		
Chico, CA	1.0977	1.0659
Butte, CA		
*Cincinnati, OH-KY-IN	0.9817	0.9874
Dearborn, IN		
Boone, KY		
Campbell, KY		
Kenton, KY		
Clermont, OH		
Hamilton, OH		
Warren, OH		
Clarksville-Hopkinsville, TN-KY	0.7379	0.8121
Christian, KY		
Montgomery, TN		
*Cleveland, OH	1.0734	1.0497
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Medina, OH		
Colorado Springs, CO	0.9812	0.9671
El Paso, CO		
Columbia, MO	0.9502	0.9656
Boone, MO		
Columbia, SC	0.8937	0.9259
Lexington, SC		
Richland, SC		
Columbus, GA-AL	0.7368	0.8113
Russell, AL		
Chattanoochee, GA		
Muscogee, GA		
*Columbus, OH	0.9669	0.9772
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
Union, OH		
Corpus Christi, TX	0.8590	0.9012
Nueces, TX		
San Patricio, TX		
Cumberland, MD-WV	0.8184	0.8718
Allegany, MD		
Mineral, WV		
*Dallas, TX	0.9634	0.9748
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Kaufman, TX		
Rockwall, TX		
Danville, VA	0.7823	0.8452
Danville City, VA		
Pittsylvania, VA		
Davenport-Rock Island-Moline, IA-IL	0.8467	0.8923
Scott, IA		
Henry, IL		
Rock Island, IL		
Dayton-Springfield, OH	0.9727	0.9812
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
Daytona Beach, FL	0.8903	0.9235
Volusia, FL		
Decatur, AL	0.7484	0.8200
Lawrence, AL		
Morgan, AL		
Decatur, IL	0.8282	0.8789
Macon, IL		
*Denver, CO	1.0753	1.0510
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
Des Moines, IA	0.9167	0.9422
Dallas, IA		
Polk, IA		
Warren, IA		
*Detroit, MI	1.0822	1.0556
Lapeer, MI		
Livingston, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
Saint Clair, MI		
Wayne, MI		
Dothan, AL	0.7566	0.8261
Dale, AL		
Houston, AL		
Dubuque, IA	0.8371	0.8854
Dubuque, IA		
Duluth, MN-WI	0.9513	0.9664
St. Louis, MN		
Douglas, WI		
Eau Claire, WI	0.8484	0.8935
Chippewa, Wi		
Eau Claire, WI		
El Paso, TX	0.0.8710	0.9098
El Paso, TX		
Elkhart-Goshen, IN	0.7833	0.8460
Elkhart, IN		
Elmira, NY	0.8848	0.9196
Chemung, NY		
Enid, OK	0.8909	0.9239
Garfield, OK		
Erie, PA	0.9151	0.9411
Erie, PA		
Eugene-Springfield, OR	1.0159	1.0109
Lane, OR		
Evansville, IN-KY	0.9423	0.9601
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
Fargo-Moorhead, ND-MN	0.9702	0.9795
Clay, MN		
Cass, ND		
Fayetteville, NC	0.8292	0.8796
Cumberland, NC		
Fayetteville-Springdale, AR	0.7986	0.8573
Washington, AR		
Flint, MI	1.1539	1.1030
Genesee, MI		
Florence, AL	0.7714	0.8372
Colbert, AL		
Lauderdale, AL		
Florence, SC	0.8425	0.8893
Florence, SC		
Fort Collins-Loveland, CO	1.0234	1.0160
Larimor, CO		
*Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0352	1.0240
Broward, FL		
Fort Myers-Cape Coral, FL	0.9795	0.9859
Lee, FL		
Fort Pierce, FL	1.1036	1.0698
Martin, FL		
St. Lucie, FL		
Fort Smith, AR-OK	0.7928	0.8530
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
Fort Walton Beach, FL	0.8937	0.9259
Okaloosa, FL		
Fort Wayne, IN	0.8999	0.9303
Allen, IN		
De Kalb, IN		
Whitley, IN		
*Fort Worth-Arlington, TX	0.9743	0.9823
Johnson, TX		
Parker, TX		
Tarrant, TX		
Fresno, CA	1.0733	1.0496
Fresno, CA		
Gadsden, AL	0.8196	0.8726
Etowah, AL		
Gainesville, FL	0.8795	0.9158
Alachua, FL		
Bradford, FL		
Galveston-Texas City, TX	0.9424	0.9602
Galveston, TX		
Gary-Hammond, IN	0.9592	0.9719
Lake, IN		
Porter, IN		
Glens Falls, NY	0.9227	0.9464
Warren, NY		
Washington, NY		
Grand Forks, ND	0.9573	0.9706
Grand Forks, ND		
Grand Rapids, MI	0.9879	0.9917
Kent, MI		
Ottawa, MI		
Great Falls, MT	0.9987	0.9991
Cascade, MT		
Greeley, CO	0.9354	0.9553
Weld, CO		
Green Bay, WI	0.9581	0.9711
Brown, WI		
Greensboro-Winston-Salem-High Point, NC	0.9161	0.9418
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
Greenville-Spartanburg, SC	0.8919	0.9246
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
Hagerstown, MD	0.9154	0.9413
Washington, MD		
Hamilton-Middletown, OH	0.9149	0.9409
Butler, OH		
Harrisburg-Lebanon-Carlisle, PA	0.9914	0.9941
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
*Hartford-Middletown-New Britain-Bristol, CT	1.1905	1.1268

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
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
Hickory, NC	0.8663	0.9064
Alexander, NC		
Burke, NC		
Catawba, NC		
Honolulu, HI	1.1575	1.1053
Honolulu, HI		
Houma-Thibodaux, LA	0.7341	0.8092
Lafourche, LA		
Terrebonne, LA		
*Houston, TX	0.9931	0.9953
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
Huntington-Ashland, WV-KY-OH	0.9434	0.9609
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
Huntsville, AL	0.8831	0.9184
Madison, AL		
*Indianapolis, IN	0.9658	0.9765
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
Iowa City, IA	0.9524	0.9672
Johnson, IA		
Jackson, MI	0.8882	0.9220
Jackson, MI		
Jackson, MS	0.7730	0.8383
Hinds, MS		
Madison, MS		
Rankin, MS		
Jackson, TN	0.8325	0.8820
Madison, TN		
Jacksonville, FL	0.9047	0.9337
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
Jacksonville, NC	0.7936	0.8536
Onslow, NC		
Jamestown-Dunkirk, NY	0.6631	0.7548
Chatauqua, NY		
Janesville-Beloit, WI	0.8443	0.8906
Rock, WI		
Jersey City, NJ	1.0648	1.0439
Hudson, NJ		
Johnson City-Kingsport-Bristol, TN-VA	0.8665	0.9065
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
Johnstown, PA	0.8609	0.9025
Cambria, PA		
Somerset, PA		
Joliet, IL	1.0504	1.0342
Grundy, IL		
Will, IL		
Joplin, MO	0.7953	0.8548
Jasper, MO		
Newton, MO		
Kalamazoo, MI	1.1705	1.1138
Kalamazoo, MI		
Kankakee, IL	0.8485	0.8936
Kankakee, IL		
*Kansas City, KS-MO	0.9584	0.9713
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
Kenosha, WI	0.8851	0.9198
Kenosha, WI		
Killeen-Temple, TX	1.1290	1.0866
Bill, TX		
Coryell, TX		
Knoxville, TN	0.8689	0.9083
Anderson, TN		
Blount, TN		
Grainger, TN		
Jefferson, TN		
Knox, TN		
Sevier, TN		
Union, TN		
Kokomo, IN	0.9486	0.9645
Howard, IN		
Tipton, IN		
LaCrosse, WI	0.8952	0.9270
LaCrosse, WI		
Lafayette, LA	0.8223	0.8746
Lafayette, LA		
St. Martin, LA		
Lafayette, IN	0.8619	0.9032
Tippecanoe, IN		
Lake Charles, LA	0.8371	0.8854
Calcasieu, LA		
Lake County, IL	0.9404	0.9588
Lake, IL		
Lakeland-Winter Haven, FL	0.7939	0.8538
Polk, FL		
Lancaster, PA	0.9274	0.9497
Lancaster, PA		
Lansing-East Lansing, MI	1.0218	1.0149
Clinton, MI		
Eaton, MI		
Ingham, MI		
Laredo, TX	0.7275	0.8042
Webb, TX		
Las Cruces, NM	0.7906	0.8514
Dona Ana, NM		
Las Vegas, NV	1.0626	1.0425
Clark, NV		
Lawrence, KS	0.7443	0.8169
Douglas, KS		
Lawton, OK	0.8384	0.8863
Comanche, OK		
Lewiston-Auburn, ME	0.8324	0.8819
Androscoggin, ME		
Lexington-Fayette, KY	0.8443	0.8906
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Scott, KY		
Woodford, KY		
Lima, OH	0.8449	0.8910
Allen, OH		
Auglaize, OH		
Lincoln, NE	0.8952	0.9270
Lancaster, NE		
Little Rock-North Little Rock, AR	0.8416	0.8886
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
Longview-Marshall, TX	0.8688	0.9082
Gregg, TX		
Harrison, TX		
Lorain-Elyria, OH	0.8892	0.9227
Lorain, OH		
*Los Angeles-Long Beach, CA	1.2352	1.1556
Los Angeles, CA		
Louisville, KY-IN	0.9088	0.9366
Clark, IN		
Floyd, IN		
Harrison, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
Shelby, KY		
Lubbock, TX	0.8786	0.9152
Lubbock, TX		
Lynchburg, VA	0.8540	0.8976
Amherst, VA		
Campbell, VA		
Lynchburg City, VA		
Macon-Warner Robins, GA	0.8800	0.9162
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Madison, WI	1.0307	1.0209
Dane, WI		
Manchester-Nashua, NH	1.0126	1.0086
Hillsborough, NH		
Merrimack, NH		
Mansfield, OH	0.8389	0.8867
Richland, OH		
Mayaguez, PR	0.4769	0.6023
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
San German, PR		
McAllen-Edinburg-Mission, TX	0.7712	0.8370
Hidalgo, TX		
Medford, OR	1.0041	1.0028
Jackson, OR		
Melbourne-Titusville, FL	0.8727	0.9110
Brevard, FL		
Memphis, TN-AR-MS	0.9056	0.9344
Crittenden, AR		
De Soto, MS		
Shelby, TN		
Tipton, TN		
Merced, CA	1.0310	1.0211
Merced, CA		
*Miami-Hialeah, FL	0.9950	0.9966
Dade, FL		
*Middlesex-Somerset-Hunterdon, NJ	1.0405	1.0276
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		

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
Midland, TX	1.0372	1.0253
Midland, TX		
*Milwaukee, WI	0.9715	0.9804
Milwaukee, WI		
Ozaukee, WI,		
Washington, WI		
Waukesha, WI		
*Minneapolis-St. Paul, MN-WI	1.0813	1.0550
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	0.8241	0.8759
Baldwin, AL		
Mobile, AL		
Modesto, CA	1.1383	1.0928
Stanislaus, CA		
Monmouth-Ocean, NJ	0.9940	0.9959
Monmouth, NJ		
Ocean, NJ		
Monroe, LA	0.7860	0.8480
Ouachita, LA		
Montgomery, AL	0.7735	0.8387
Autauga, AL		
Elmore, AL		
Montgomery, AL		
Muncie, IN	0.8427	0.8894
Delaware, IN		
Muskegon, MI	0.9849	0.9896
Muskegon, MI		
Naples, FL	1.0320	1.0218
Collier, FL		
Nashville, TN	0.9393	0.9580
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford, TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
*Nassau-Suffolk, NY	1.2149	1.1426
Nassau, NY		
Suffolk, NY		
New Bedford-Fall River-Attleboro, MA	1.1708	1.1140
Bristol, MA		
New Haven-Waterbury-Meriden, CT	1.2090	1.1388
New Haven, CT		
New London-Norwich, CT	1.1566	1.1048
New London, CT		
*New Orleans, LA	0.8985	0.9293
Jefferson, LA		
Orleans, LA		
St. Bernard, LA		
St. Charles, LA		
St. John The Baptist, LA		
St. Tammany, LA		
*New York, NY	1.3455	1.2253
Bronx, NY		
Kings, NY		
New York City, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
*Newark, NJ	1.0734	1.0497
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Niagara Falls, NY	0.8398	0.8873
Niagara, NY		
*Norfolk-Virginia Beach-Newport News, VA	0.8511	0.8955
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	1.4128	1.2670
Alameda, CA		
Contra Costa, CA		
Ocala, FL	0.8611	0.9027
Marion, FL		
Odessa, TX	1.0835	1.0565
Ector, TX		
Oklahoma City, OK	0.9228	0.9465
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
Olympia, WA	1.0997	1.0672
Thurston, WA		
Omaha, NE-IA	0.8985	0.9293
Pottawattamie, IA		
Douglas, NE		
Sarpy, NE		
Washington, NE		
Orange County, NY	0.9193	0.9440
Orange, NY		
*Orlando, FL	0.9617	0.9736
Orange, FL		
Osceola, FL		
Seminole, FL		
Owensboro, KY	0.8148	0.8691
Daviess, KY		
Oxnard-Ventura, CA	1.1787	1.1192
Ventura, CA		
Panama City, FL	0.8629	0.9040
Bay, FL		
Parkersburg-Marietta, WV-OH	0.8536	0.8973
Washington, OH		
Wood, WV		
Pascagoula, MS	0.8767	0.9138
Jackson, MS		
Pensacola, FL	0.8620	0.9033
Escambia, FL		
Santa Rosa, FL		
Peoria, IL	0.8706	0.9095
Peoria, IL		
Tazewell, IL		
Woodford, IL		
*Philadelphia, PA-NJ	1.0947	1.0639
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
*Phoenix, AZ	1.0424	1.0288
Maricopa, AZ		
Pine Bluff, AR	0.6976	0.7815
Jefferson, AR		
*Pittsburgh, PA	1.0123	1.0084
Allegheny, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
Pittsfield, MA	1.0778	1.0526
Berkshire, MA		
Ponce, PR	0.4599	0.5875
Juana Diaz, PR		
Ponce, PR		
Portland, ME	0.9253	0.9482
Cumberland, ME		
Sagadahoc, ME		
York, ME		
*Portland, OR	1.1571	1.1051
Clackamas, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Portsmouth-Dover-Rochester, NH	1.0042	1.0029
Rockingham, NH		
Strafford, NH		
Poughkeepsie, NY	1.0443	1.0301
Dutchess, NY		
*Providence-Pawtucket-Woonsocket, RI	1.0291	1.0198
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
Provo-Orem, UT	1.0226	1.0154
Utah, UT		
Pueblo, CO	0.8718	0.9103
Pueblo, CO		
Racine, WI	0.9627	0.9743
Racine, WI		
Raleigh-Durham, NC	0.9461	0.9628
Durham, NC		
Franklin, NC		
Orange, NC		
Wake, NC		
Rapid City, SD	0.8396	0.8872
Pennington, SD		
Reading, PA	1.0267	1.0182
Berks, PA		
Redding, CA	1.0545	1.0370
Shasta, CA		
Reno, NV	1.1613	1.1078
Washoe, NV		
Richland-Kennewick, WA	0.9398	0.9584
Benton, WA		
Franklin, WA		
Richmond-Petersburg, VA	0.9413	0.9594
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		

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
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
*Riverside-San Bernardino, CA	1.1103	1.0743
Riverside, CA		
San Bernardino, CA		
Roanoke, VA	0.8281	0.8788
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
Rochester, MN	1.1025	1.0691
Olmsted, MN		
*Rochester, NY	0.9706	0.9798
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
Rockford, IL	0.9279	0.9500
Boone, IL		
Winnebago, IL		
*Sacramento, CA	1.2257	1.1495
Eldorado, CA		
Placer, CA		
Sacramento, CA		
Yolo, CA		
Saginaw-Bay City-Midland, MI	1.0479	1.0326
Bay, MI		
Midland, MI		
Saginaw, MI		
St. Cloud, MN	0.8915	0.9244
Benton, MN		
Sherburne, MN		
Stearns, MN		
St. Joseph, MO	0.9410	0.9592
Buchanan, MO		
*St. Louis, MO–IL	0.9384	0.9574
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	0.9833	0.9885
Marion, OR		
Polk, OR		
Salinas-Seaside-Monterey, CA	1.3035	1.1990
Monterey, CA		
*Salt Lake City-Ogden, UT	0.9928	0.9951
Davis, UT		
Salt Lake, UT		
Weber, UT		
San Angelo, TX	0.8136	0.8683
Tom Green, TX		
*San Antonio, TX	0.8448	0.8909
Bexar, TX		
Comal, TX		
Guadalupe, TX		
*San Diego, CA	1.1929	1.1284
San Diego, CA		
*San Francisco, CA	1.4521	1.2910
Marin, CA		
San Francisco, CA		
San Mateo, CA		
*San Jose, CA	1.4893	1.3136
Santa Clara, CA		
*San Juan, PR	0.4985	0.6208
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	1.1800	1.1200
Santa Barbara, CA		
Santa Cruz, CA	1.1814	1.1209
Santa Cruz, CA		
Santa Fe, NM	0.9158	0.9415
Los Alamos, NM		
Santa Fe, NM		
Santa Rosa-Petaluma, CA	1.2973	1.1951
Sonoma, CA		
Sarasota, FL	0.9777	0.9487
Sarasota, FL		
Savannah, GA	0.8324	0.8819
Chatham, GA		
Effingham, GA		
Scranton-Wilkes Barre, PA	0.8912	0.9242
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Monroe, PA		
Wyoming, PA		
*Seattle, WA	1.0866	1.0585
King, WA		
Snohomish, WA		
Sharon, PA	0.8910	0.9240
Mercer, PA		
Sheboygan, WI	0.8868	0.9210
Sheboygan, WI		
Sherman-Denison, TX	0.9085	0.9364
Grayson, TX		
Shreveport, LA	0.9295	0.9512
Bossier, LA		
Caddo, LA		
Sioux City, IA-NE	0.8500	0.8947
Woodbury, IA		
Dakota, NE		
Sioux Falls, SD	0.8829	0.9182
Minnehaha, SD		
South Bend-Mishawaka, IN	1.0179	1.0122
St. Joseph, IN		
Spokane, WA	1.0687	1.0466
Spokane, WA		
Springfield, IL	0.9292	0.9510
Menard, IL		
Sangamon, IL		
Springfield, MO	0.8079	0.8641
Christian, MO		
Greene, MO		
Springfield, MA	0.9614	0.9734
Hampden, MA		
Hampshire, MA		
State College, PA	0.9897	0.9929
Centre, PA		
Steubenville-Weirton, OH–WV	0.8708	0.9096
Jefferson, OH		
Brooke, WV		
Hancock, WV		
Stockton, CA	1.1784	1.1190
San Joaquin, CA		
Syracuse, NY	0.9912	0.9940
Madison, NY		
Onondaga, NY		
Oswego, NY		
Tacoma, WA	0.9631	0.9746
Pierce, WA		
Tallahassee, FL	0.9216	0.9456
Gadsden, FL		
Leon, FL		
*Tampa-St. Petersburg-Clearwater, FL	0.9244	0.9476
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
Terre Haute, IN	0.8823	0.9178
Clay, IN		
Vigo, IN		
Texarkana-TX-Texarkana, AR	0.7903	0.8512
Miller, AR		
Bowie, TX		
Toledo, OH	0.8710	0.9098
Fulton, OH		
Lucas, OH		
Wood, OH		
Topeka, KS	0.9299	0.9514
Shawnee, KS		
Trenton, NJ	1.0034	1.0023
Mercer, NJ		
Tucson, AZ	0.9616	0.9735
Pima, AZ		
Tulsa, OK	0.8573	0.8999
Creeks, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
Tuscaloosa, AL	0.8518	0.8960
Tuscaloosa, AL		
Tyler, TX	0.9833	0.9885
Smith, TX		
Utica-Rome, NY	0.8398	0.8873
Herkimer, NY		
Oneida, NY		
Vallejo-Fairfield-Napa, CA	1.2912	1.1913
Napa, CA		
Solano, CA		
Vancouver, WA	1.0706	1.0480
Clark, WA		
Victoria, TX	0.8990	0.9297
Victoria, TX		
Vineland-Millville-Bridgeton, NJ	0.9645	0.9756
Cumberland, NJ		
Visalia-Tulare-Porterville, CA	1.0388	1.0264
Tulare, CA		
Waco, TX	0.7811	0.8444
McLennan, TX		
*Washington, DC–MD–VA	1.0936	1.0632
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		

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
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Stafford, VA		
Waterloo-Cedar Falls, IA	0.8639	0.9047
Black Hawk, IA		
Bremer, IA		
Wausau, WI	0.9744	0.9824
Marathon, WI		
West Palm Beach-Boca Raton-Delray Beach, FL	1.0227	1.0155
Palm Beach, FL		
Wheeling, WV–OH	0.6923	0.7774
Belmont, OH		
Marshall, WV		
Ohio, WV		
Wichita, KS	0.9805	0.9866
Butler, KS		
Harvey, KS		
Sedgwick, KS		
Wichita Falls, TX	0.8169	0.8707
Wichita, TX		
Williamsport, PA	0.8861	0.9205
Lycoming, PA		
Wilmington, DE–NJ–MD	1.0880	1.0595
New Castle, DE		
Cecil, MD		
Salem, NJ		
Wilmington, NC	0.8708	0.9096
New Hanover, NC		
Worcester-Fitchburg-Leominster, MA	0.9682	0.9781
Worcester, MA		
Yakima, WA	1.0107	1.0073
Yakima, WA		
York, PA	0.8609	0.9025
Adams, PA		
York, PA		
Youngstown-Warren, OH	0.9862	0.9905
Mahoning, OH		
Trumbull, OH		
Yuba City, CA	1.0159	1.0109
Sutter, CA		
Yuba, CA		
Yuma, AZ	0.8743	0.9121
Yuma, AZ		

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7130	0.7932
Alaska	1.3492	1.2277
Arizona	0.8743	0.9121
Arkansas	0.6976	0.7815
California	1.0159	1.0109
Colorado	0.8412	0.8883
Connecticut	1.1900	1.1265
Delaware	0.8568	0.8996
Florida	0.8727	0.9110
Georgia	0.7770	0.8413
Hawaii	0.9614	0.9734
Idaho	0.9101	0.9375
Illinois	0.7696	0.8358
Indiana	0.7833	0.8460
Iowa	0.7528	0.8233
Kansas	0.7443	0.8169
Kentucky	0.7790	0.8428
Louisiana	0.7381	0.8122
Maine	0.8324	0.8819
Maryland	0.8058	0.8626
Massachusetts	1.1708	1.1140
Michigan	0.8882	0.9220
Minnesota	0.8305	0.8806
Mississippi	0.6960	0.7802
Missouri	0.7246	0.8020
Montana	0.8251	0.8766
Nebraska	0.6992	0.7827
Nevada	0.9698	0.9792
New Hampshire	0.9543	0.9685
New Jersey [1]		
New Mexico	0.8317	0.8814
New York	0.8398	0.8873
North Carolina	0.7936	0.8536
North Dakota	0.7715	0.8372
Ohio	0.8449	0.8910
Oklahoma	0.7399	0.8136
Oregon	0.9603	0.9726
Pennsylvania	0.8609	0.9025
Puerto Rico	0.4331	0.5638
Rhode Island [1]		
South Carolina	0.7657	0.8329
South Dakota	0.7165	0.7959
Tennessee	0.7337	0.8089
Texas	0.7592	0.8281
Utah	0.9040	0.9332
Vermont	0.9702	0.9795
Virginia	0.7823	0.8452
Washington	0.9631	0.9746
West Virginia	0.8484	0.8935
Wisconsin	0.8443	0.8906
Wyoming	0.8453	0.8913

[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	0.9425	0.9603
Akron, OH	0.8917	0.9245
Albany, GA	0.7894	0.8505
Albany-Schenectady-Troy, NY	0.8953	0.9271
Albany-Schenectady-Troy, NY (Rural Vermont Hospitals)	0.9702	0.9795
Albuquerque, NM	0.9938	0.9958
Alexandria, LA	0.8046	0.8617
Allentown-Bethlehem-Easton, PA–NJ	0.8945	0.9265
Altoona, PA	0.9235	0.9470
Amarillo, TX	0.8735	0.9115
Anaheim-Santa Ana, CA	1.1540	1.1031
Anchorage, AK	1.3995	1.2588
Ann Arbor, MI	1.1058	1.0713
Appleton-Oshkosh-Neenah, WI	0.8695	0.9087
Asheville, NC	0.8468	0.8924
Athens, GA	0.7214	0.7996
Athens, GA (Rural Georgia Hospitals)	0.7770	0.8413
Atlanta, GA	0.9474	0.9637
Augusta, GA–SC	0.9397	0.9583
Aurora-Elgin, IL	0.8870	0.9212
Baltimore, MD	1.0151	1.0103
Bangor, ME	0.8797	0.9160
Baton Rouge, LA	0.9085	0.9364
Battle Creek, MI	0.9095	0.9371
Beaver County, PA	0.9447	0.9618
Billings, MT	0.9045	0.9336
Biloxi-Gulfport, MS	0.7801	0.8436
Binghamton, NY	0.8864	0.9207
Birmingham, AL	0.8766	0.9138
Bismarck, ND	0.8878	0.9217
Bloomington, IN	0.7754	0.8401
Bloomington, IN (Rural Indiana Hospitals)	0.7833	0.8460
Boise City, ID	0.9554	0.9692
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.1561	1.1044
Boston-Lawrence-Salem-Lowell-Brockton, MA (Rural Massachusetts Hosp)	1.1708	1.1140
Brazoria, TX	0.8789	0.9154
Bremerton, WA	1.0361	1.0246
Buffalo, NY	0.8773	0.9143
Burlington, VT	0.9014	0.9314
Burlington, VT (Rural Vermont Hospitals)	0.9702	0.9795
Caguas, PR	0.4586	0.5863
Canton, OH	0.8062	0.8628
Canton, OH (Rural Ohio Hospitals)	0.8449	0.8910
Casper, WY	0.8769	0.9140
Champaign-Urbana-Rantoul, IL	0.8741	0.9120
Charleston, SC	0.8168	0.8706
Charleston, WV	0.9535	0.9679
Charlotte-Gastonia-Rock Hill, NC–SC	0.9281	0.9502
Charlottesville, VA	0.9370	0.9564
Chattanooga, TN–GA	0.8875	0.9215
Cheyenne, WY	0.7496	0.8209
Chicago, IL	1.0513	1.0349
Chico, CA	1.0845	1.0571
Cincinnati, OH–KY–IN	0.9817	0.9874
Cleveland, OH	1.0470	1.0320
Columbia, MO	0.9265	0.9491
Columbia, SC	0.8745	0.9123
Columbus, GA–AL	0.7368	0.8113
Columbus, OH	0.9515	0.9665
Dallas, TX	0.9634	0.9748
Davenport-Rock Island-Moline, IA–IL	0.8342	0.8833
Dayton-Springfield, OH	0.9727	0.9812
Daytona Beach, FL	0.8903	0.9235
Decatur, AL	0.7484	0.8200
Denver, CO	1.0753	1.0510
Des Moines, IA	0.9028	0.9324
Detroit, MI	1.0740	1.0477
Dothan, AL	0.7566	0.8261
Dubuque, IA	0.8117	0.8669
Dubuque, IA (Rural Wisconsin Hospitals)	0.8443	0.8906
Duluth, MN–WI	0.9390	0.9578
Eau Claire, WI	0.8484	0.8935
El Paso, TX	0.8710	0.9098
Elkhart-Goshen, IN	0.8868	0.9210
Elmira, NY	0.8655	0.9058
Erie, PA	0.9151	0.9411
Eugene-Springfield, OR	1.0159	1.0109
Evansville, IN–KY	0.9068	0.9352
Fargo-Moorhead, ND–MN	0.9312	0.9524
Fayetteville, NC	0.7892	0.8503
Fayetteville, NC (Rural North Carolina)	0.7936	0.8536
Fayetteville-Springdale, AR	0.7986	0.8573

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Flint, MI	1.1203	1.0809
Florence, AL	0.7714	0.8372
Florence, SC	0.8425	0.8893
Fort Collins-Loveland, CO	1.0027	1.0018
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0229	1.0156
Fort Myers-Cape Coral, FL	0.9795	0.9859
Fort Pierce, FL	1.0256	1.0175
Fort Smith, AR	0.7928	0.8530
Fort Walton Beach, FL	0.8937	0.9259
Fort Wayne, IN	0.8724	0.9108
Fort Worth-Arlington, TX	0.9743	0.9823
Fresno, CA	1.0619	1.0420
Galveston-Texas City, TX	0.9424	0.9602
Glens Falls, NY	0.8985	0.9293
Grand Forks, ND	0.9205	0.9449
Grand Rapids, MI	0.9879	0.9917
Great Falls, MT	0.9258	0.9486
Greeley, CO	0.8952	0.9270
Green Bay, WI	0.9274	0.9497
Greensboro-Winston-Salem-High Point, NC	0.8988	0.9295
Greenville-Spartanburg, SC	0.8772	0.9142
Hagerstown, MD	0.8754	0.9129
Hamilton-Middletown, OH	0.8431	0.8897
Harrisburg-Lebanon-Carlisle, PA	0.9386	0.9575
Hartford-Middletown-New Britain-Bristol, CN	1.1803	1.1202
Hickory, NC	0.8421	0.8890
Honolulu, HI	1.1575	1.1053
Houston, TX	0.9931	0.9953
Huntington-Ashland, WV-KY-OH	0.9251	0.9481
Huntsville, AL	0.8477	0.8930
Indianapolis, IN	0.9556	0.9694
Iowa City, IA	0.9323	0.9531
Jackson, MI	0.8822	0.9177
Jackson, MI (Rural Michigan Hospitals)	0.8882	0.9220
Jackson, MS	0.7590	0.8279
Jackson, TN	0.8069	0.8634
Jacksonville, FL	0.9047	0.9337
Johnson City-Kingsport-Bristol, TN-VA	0.8665	0.9065
Johnstown, PA	0.8335	0.8827
Johnstown, PA (Rural Pennsylvania Hosp)	0.8609	0.9025
Joliet, IL	1.0207	1.0141
Joplin, MO	0.7835	0.8461
Kalamazoo, MI	1.1189	1.0800
Kansas City, KS-MO	0.9584	0.9713
Knoxville, TN	0.8689	0.9083
Kokomo, IN	0.9115	0.9385
LaCrosse, WI	0.8743	0.9121
Lafayette, LA	0.8223	0.8746
Lafayette, IN	0.8619	0.9032
Lake Charles, LA	0.8371	0.8854
Lancaster, PA	0.9092	0.9369
Lansing-East Lansing, MI	1.0041	1.0028
Las Vegas, NV	1.0484	1.0329
Lawrence, KS	0.7501	0.8213
Lawton, OK	0.8282	0.8789
Lewiston-Auburn, ME	0.8454	0.8914
Lexington-Fayette, KY	0.8320	0.8817
Lincoln, NE	0.8458	0.8916
Little Rock-North Little Rock, AR	0.8204	0.8732
Longview-Marshall, TX	0.8517	0.8959
Lorain-Elyria, OH	0.8892	0.9227
Los Angeles-Long Beach, CA	1.2352	1.1556
Louisville, KY-IN	0.8965	0.9279
Lubbock, TX	0.8786	0.9152
Lynchburg, VA	0.8386	0.8864
Macon-Warner Robins, GA	0.8618	0.9032
Madison, WI	0.9787	0.9854
Manchester-Nashua, NH	1.0126	1.0086
Mansfield, OH	0.8389	0.8867
Mansfield, OH (Rural Ohio Hospitals)	0.8449	0.8910
Medford, OR	0.9880	0.9918
Memphis, TN-AR-MS	0.8769	0.9140
Merced, CA	1.0310	1.0211
Miami-Hialeah, FL	0.9950	0.9966
Middlesex-Somerset-Hunterdon, NJ	0.9923	0.9947
Midland, TX	1.0372	1.0253
Milwaukee, WI	0.9599	0.9724
Minneapolis-St. Paul, MN-WI	1.0813	1.0550
Mobile, AL	0.8241	0.8759
Modesto, CA	1.1383	1.0928
Monroe, LA	0.7860	0.8480
Montgomery, AL	0.7735	0.8387
Muncie, IN	0.8270	0.8780
Nashville, TN	0.9393	0.9580
New London-Norwich, CT	1.1290	1.0866
New Orleans, LA	0.8985	0.9293
New York, NY	1.3455	1.2253
Newark, NJ	1.0613	1.0416
Norfolk-Virginia Beach-Newport News, VA	0.8511	0.8955
Oakland, CA	1.4128	1.2670
Odessa, TX	1.0835	1.0565
Oklahoma City, OK	0.9228	0.9465
Olympia, WA	1.0386	1.0263
Omaha, NE-IA	0.8985	0.9293
Orange County, NY	0.9193	0.9440
Orlando, FL	0.9442	0.9614
Owensboro, KY	0.8148	0.8691
Oxnard-Ventura, CA	1.1787	1.1192
Panama City, FL	0.8629	0.9040
Panama City, FL (Rural Florida Hospitals)	0.8727	0.9110
Parkersburg-Marietta, WV-OH	0.8536	0.8973
Pascagoula, MS	0.8767	0.9138
Peoria, IL	0.8706	0.9095
Philadelphia, PA-NJ	1.0792	1.0536
Phoenix, AZ	1.0424	1.0288
Pine Bluff, AR	0.6976	0.7815
Pittsburgh, PA	0.9950	0.9966
Pittsfield, MA	1.0115	1.0079
Portland, ME	0.9106	0.9379
Portland, OR	1.1416	1.0949
Portsmouth-Dover-Rochester, NH	1.0042	1.0029
Poughkeepsie, NY	0.9960	0.9973
Providence-Pawtucket-Woonsocket, RI	1.0036	1.0025
Provo-Orem, UT	0.9997	0.9998
Pueblo, CO	0.8515	0.8958
Raleigh-Durham, NC	0.9193	0.9440
Rapid City, SD	0.8280	0.8788
Redding, CA	1.0401	1.0273
Reno, NV	1.1433	1.0960
Roanoke, VA	0.8163	0.8702
Rochester, NY	0.9560	0.9697
Rockford, IL	0.9091	0.9368
Sacramento, CA	1.2257	1.1495
Saginaw-Bay City-Midland, MI	1.0206	1.0141
St. Cloud, MN	0.8915	0.9244
St Louis, MO-IL	0.9236	0.9470
Salem, OR	0.9833	0.9885
Salinas-Seaside-Monterey, CA	1.2893	1.1901
Salt Lake City-Ogden, UT	0.9928	0.9951
San Angelo, TX	0.8136	0.8683
San Antonio, TX	0.8448	0.8909
San Diego, CA	1.1929	1.1284
San Francisco, CA	1.4521	1.2910
San Jose, CA	1.4715	1.3028
San Juan, PR	0.4985	0.6208
Santa Barbara-Santa Maria-Lompoc, CA	1.1631	1.1090
Santa Fe, NM	0.8852	0.9199
Santa Rosa-Petaluma, CA	1.2973	1.1951
Sarasota, FL	0.9442	0.9614
Scranton-Wilkes Barre, PA	0.8912	0.9242
Seattle, WA	1.0715	1.0484
Sharon, PA	0.8910	0.9240
Sheboygan, WI	0.8719	0.9104
Sherman-Denison, TX	0.8930	0.9254
Shreveport, LA	0.9295	0.9512
Sioux City, IA-NE	0.8320	0.8817
Sioux Falls, SD	0.8829	0.9182
South Bend-Mishawaka, IN	0.9684	0.9783
Spokane, WA	1.0687	1.0466
Springfield, IL	0.9189	0.9437
Springfield, MO	0.7912	0.8518
State College, PA	0.9324	0.9532
Steubenville-Weirton, OH-WV	0.8336	0.8828
Stockton, CA	1.1784	1.1190
Syracuse, NY	0.9510	0.9662
Tacoma, WA	0.9863	0.9906
Tallahassee, FL	0.8849	0.9197
Tampa-St. Petersburg-Clearwater, FL	0.9244	0.9476
Terre Haute, IN	0.8714	0.9100
Texarkana, TX-Texarkana, AR	0.7903	0.8512
Toledo, OH	0.8710	0.9098
Toledo, OH (Rural Michigan Hospitals)	0.8882	0.9220
Topeka, KS	0.9299	0.9514
Tucson, AZ	0.9616	0.9735
Tulsa, OK	0.8427	0.8894
Tuscaloosa, AL	0.8283	0.8790
Tyler, TX	0.9326	0.9533
Vallejo-Fairfield-Napa, CA	1.2716	1.1789
Vancouver, WA	1.0120	1.0082
Victoria, TX	0.8835	0.9187
Waco, TX	0.7811	0.8444
Washington, DC—MD—VA	1.0936	1.0632
Waterloo-Cedar Falls, IA	0.8639	0.9047
Wausau, WI	0.9093	0.9370
West Palm Beach-Boca Raton-Delray Beach, FL	1.0227	1.0155
Wichita, KS	0.9559	0.9696
Wichita Falls, TX	0.8169	0.8707
Williamsport, PA	0.8704	0.9093
Wilmington, NC	0.8296	0.8799
Worcester-Fitchburg-Leominster, MA	0.9682	0.9781
Yakima, WA	0.9981	0.9987
Youngstown-Warren, OH	0.9503	0.9657
Rural California	0.9997	0.9998
Rural Connecticut	1.1576	1.1054
Rural Georgia	0.7770	0.8413
Rural Illinois	0.7696	0.8358
Rural Indiana	0.7833	0.8460
Rural Iowa	0.7528	0.8233
Rural Kansas	0.7443	0.8169
Rural Kentucky	0.7790	0.8428
Rural Louisiana	0.7381	0.8122
Rural Michigan	0.8882	0.9220
Rural Minnesota	0.8305	0.8806
Rural Missouri	0.7246	0.8020
Rural New Hampshire	0.9543	0.9685
Rural New Hampshire (Rural Vermont Hosp)	0.9702	0.9795
Rural North Carolina	0.7936	0.8536
Rural Ohio	0.8449	0.8910
Rural Oklahoma	0.7399	0.8136
Rural Pennsylvania	0.8609	0.9025
Rural South Dakota	0.7165	0.7959
Rural Tennessee	0.7337	0.8089
Rural Texas	0.7592	0.8281
Rural Utah	0.9040	0.9332

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Rural Virginia	0.7823	0.8452
Rural Washington	0.9425	0.9603
Rural Washington (Rural Oregon Hosp)	0.9603	0.9726
Rural West Virginia	0.8484	0.8935
Rural Wisconsin	0.8443	0.8906
Rural Wyoming	0.8285	0.8791

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	12.8965
Aguadilla, PR	6.3891
Akron, OH	12.2791
Albany, GA	11.2600
Albany-Schenectady-Troy, NY	12.4806
Albuquerque, NM	14.1605
Alexandria, LA	11.5753
Allentown-Bethlehem-Easton, PA-NJ	13.7884
Altoona, PA	12.9225
Amarillo, TX	12.2235
Anaheim-Santa Ana, CA	16.9674
Anchorage, AK	19.8289
Anderson, IN	13.4045
Anderson, SC	10.1524
Ann Arbor, MI	15.9236
Anniston, AL	11.0938
Appleton-Oshkosh-Neenah, WI	12.8388
Arecibo, PR	5.5300
Asheville, NC	12.2240
Athens, GA	11.9635
Atlanta, GA	13.4224
Atlantic City, NJ	14.6966
Augusta, GA-SC	13.1493
Aurora-Elgin, IL	13.5186
Austin, TX	13.4267
Bakersfield, CA	15.2019
Baltimore, MD	14.2056
Bangor, ME	12.6780
Baton Rouge, LA	12.7130
Battle Creek, MI	13.2392
Beaumont-Port Arthur, TX	13.4335
Beaver County, PA	14.2180
Bellingham, WA	14.6826
Benton Harbor, MI	11.8274
Bergen-Passaic, NJ	14.4089
Billings, MT	13.0434
Biloxi-Gulfport, MS	11.2771
Binghamton, NY	12.9526
Birmingham, AL	12.2666
Bismarck, ND	12.3267
Bloomington, IN	12.0838
Bloomington-Normal, IL	12.1113
Boise City, ID	13.6480
Boston-Lawrence-Salem-Lowell-Brockton, MA	16.5188
Boulder-Longmont, CO	14.1963
Bradenton, FL	12.9557
Brazoria, TX	13.0281
Bremerton, WA	13.3376
Bridgeport-Stamford-Norwalk-Danbury, CT	16.8305
Brownsville-Harlingen, TX	12.0309
Bryan-College Station, TX	13.2727
Buffalo, NY	12.4609
Burlington, NC	11.1706
Burlington, VT	13.0898
Caguas, PR	6.2649

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Canton, OH	12.3253
Casper, WY	12.4361
Cedar Rapids, IA	12.4596
Champaign-Urbana-Rantoul, IL	12.2322
Charleston, SC	11.6535
Charleston, WV	13.5576
Charlotte-Gastonia-Rock Hill, NC-SC	13.2414
Charlottesville, VA	13.4492
Chattanooga, TN-GA	12.8660
Cheyenne, WY	11.0616
Chicago, IL	14.7119
Chico, CA	15.3604
Cincinnati, OH-KY-IN	13.7371
Clarksville-Hopkinsville, TN-KY	10.3256
Cleveland, OH	15.0210
Colorado Springs, CO	13.7311
Columbia, MO	13.2974
Columbia, SC	12.5055
Columbus, GA-AL	10.4663
Columbus, OH	13.5306
Corpus Christi, TX	12.0212
Cumberland, MD-WV	11.4529
Dallas, TX	13.4814
Danville, VA	10.4995
Davenport-Rock Island-Moline, IA-IL	11.8485
Dayton-Springfield, OH	13.5646
Daytona Beach, FL	12.5096
Decatur, AL	10.4723
Decatur, IL	11.5902
Denver, CO	15.0478
Des Moines, IA	12.8279
Detroit, MI	15.1409
Dothan, AL	10.5672
Dubuque, IA	11.7141
Duluth, MN-WI	13.3127
Eau Claire, WI	11.8584
El Paso, TX	12.1891
Elkhart-Goshen, IN	12.5172
Elmira, NY	12.3239
Enid, OK	12.4665
Erie, PA	12.8062
Eugene-Springfield, OR	14.2167
Evansville, IN-KY	13.1857
Fargo-Moorhead, ND-MN	13.5774
Fayetteville, NC	11.6037
Fayetteville-Springdale, AR	11.1760
Flint, MI	16.1469
Florence, AL	10.7414
Florence, SC	11.7898
Fort Collins-Loveland, CO	14.3206
Fort Lauderdale-Hollywood-Pompano Beach, FL	14.4860
Fort Myers-Cape Coral, FL	13.7065
Fort Pierce, FL	15.4435
Fort Smith, AR-OK	11.0943
Fort Walton Beach, FL	12.4721
Fort Wayne, IN	12.5931
Fort Worth-Arlington, TX	13.6344
Fresno, CA	15.0188
Gadsden, AL	11.4686
Gainesville, FL	12.3072
Galveston-Texas City, TX	13.1915
Gary-Hammond, IN	13.8130
Glens Falls, NY	12.9117
Grand Forks, ND	13.3966
Grand Rapids, MI	13.8241
Great Falls, MT	13.9760
Greeley, CO	13.0898
Green Bay, WI	13.4079
Greensboro-Winston-Salem-High Point, NC	12.8197
Greenville-Spartanburg, SC	12.4814
Hagerstown, MD	12.8093
Hamilton-Middletown, OH	13.1268
Harrisburg-Lebanon-Carlisle, PA	13.8739
Hartford-Middletown-New Britain-Bristol, CT	16.6679

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Hickory, NC	12.2271
Honolulu, HI	16.1983
Houma-Thibodaux, LA	10.2729
Houston, TX	13.8967
Huntington-Ashland, WV-KY-OH	13.2013
Huntsville, AL	12.3581
Indianapolis, IN	13.5158
Iowa City, IA	13.3273
Jackson, MI	13.5173
Jackson, MS	10.8165
Jackson, TN	11.0644
Jacksonville, FL	12.6601
Jacksonville, NC	10.0072
Jamestown-Dunkirk, NY	10.8192
Janesville-Beloit, WI	11.8416
Jersey City, NJ	14.7239
Johnson City-Kingsport-Bristol, TN-VA	12.1249
Johnstown, PA	12.5941
Joliet, IL	14.3772
Joplin, MO	11.1297
Kalamazoo, MI	16.3790
Kankakee, IL	11.8736
Kansas City, KS-MO	13.4119
Kenosha, WI	12.3859
Killeen-Temple, TX	15.7993
Knoxville, TN	12.1590
Kokomo, IN	13.2741
LaCrosse, WI	12.5272
Lafayette, LA	11.5076
Lafayette, IN	12.0615
Lake Charles, LA	11.7138
Lake County, IL	13.9788
Lakeland-Winter Haven, FL	11.6521
Lancaster, PA	12.9499
Lansing-East Lansing, MI	14.2990
Laredo, TX	10.1800
Las Cruces, NM	11.0633
Las Vegas, NV	14.8703
Lawrence, KS	12.5003
Lawton, OK	11.7329
Lewiston-Auburn, ME	12.6689
Lexington-Fayette, KY	11.8143
Lima, OH	11.2775
Lincoln, NE	12.5260
Little Rock-North Little Rock, AR	11.7777
Longview-Marshall, TX	12.1572
Lorain-Elyria, OH	12.5459
Los Angeles-Long Beach, CA	17.2810
Louisville, KY-IN	12.7172
Lubbock, TX	12.2947
Lynchburg, VA	11.9507
Macon-Warner Robins, GA	12.3144
Madison, WI	14.4229
Manchester-Nashua NH	14.3525
Mansfield, OH	11.7387
Mayaguez, PR	6.6740
McAllen-Edinburg-Mission, TX	10.7920
Medford, OR	14.0511
Melbourne-Titusville, FL	12.8679
Memphis, TN-AR-MS	12.6726
Merced, CA	14.4242
Miami-Hialeah, FL	14.2513
Middlesex-Somerset-Hunterdon, NJ	14.5485
Midland, TX	14.5148
Milwaukee, WI	13.5945
Minneapolis-St. Paul, MN-WI	15.1320
Mobile, AL	11.6369
Modesto, CA	16.1936
Monmouth-Ocean, NJ	13.8730
Monroe, LA	10.9996
Montgomery, AL	10.8242
Muncie, IN	11.7931
Muskegon, MI	13.3830
Naples, FL	14.4410
Nashville, TN	13.1448
Nassau-Suffolk, NY	18.0971
New Bedford-Fall River-Attleboro, MA	13.9910

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
New Haven-Waterbury-Meriden, CT	16.9179
New London-Norwich, CT	16.1857
New Orleans, LA	12.5738
New York, NY	18.8279
Newark, NJ	15.7113
Niagara Falls, NY	11.7272
Norfolk-Virginia Beach-Newport News, VA	11.9106
Oakland, CA	19.9782
Ocala, FL	12.0496
Odessa, TX	15.1305
Oklahoma City, OK	12.9135
Olympia, WA	15.3889
Omaha, NE-IA	12.5738
Orange County, NY	13.5021
Orlando, FL	13.4573
Owensboro, KY	11.3504
Oxnard-Ventura, CA	17.2175
Panama City, FL	12.0750
Parkersburg-Marietta, WV-OH	11.9450
Pascagoula, MS	12.2466
Pensacola, FL	12.0624
Peoria, IL	12.1828
Philadelphia, PA-NJ	15.3190
Phoenix, AZ	14.5873
Pine Bluff, AR	11.0111
Pittsburgh, PA	14.1661
Pittsfield, MA	15.0819
Ponce, PR	6.4363
Portland, ME	12.9972
Portland, OR	16.1919
Portsmouth-Dover-Rochester, NH	14.0996
Poughkeepsie, NY	14.6131
Providence-Pawtucket-Woonsocket, RI	14.8684
Provo-Orem, UT	14.3096
Pueblo, CO	12.2002
Racine, WI	12.3782
Raleigh-Durham, NC	13.2395
Rapid City, SD	11.7497
Reading, PA	12.3287
Redding, CA	14.7558
Reno, NV	16.2510
Richland-Kennewick, WA	13.1513
Richmond-Petersburg, VA	13.1726
Riverside-San Bernardino, CA	15.6107
Roanoke, VA	11.5877
Rochester, MN	15.4279
Rochester, NY	13.5825
Rockford, IL	12.9846
Sacramento, CA	17.1232
Saginaw-Bay City-Midland, MI	14.6188
St. Cloud, MN	13.1769
St. Joseph, MO	13.1676
St. Louis, MO-IL	13.1322
Salem, OR	14.6104
Salinas-Seaside-Monterey, CA	18.2410
Salt Lake City-Ogden, UT	13.8926
San Angelo, TX	11.3852
San Antonio, TX	11.8222
San Diego, CA	16.6930
San Francisco, CA	20.3365
San Jose, CA	20.8415

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
San Juan, PR	6.9756
Santa Barbara-Santa Maria-Lompoc, CA	16.4615
Santa Cruz, CA	17.8823
Santa Fe, NM	12.7832
Santa Rosa-Petaluma, CA	18.1542
Sarasota, FL	13.6812
Savannah, GA	11.6480
Scranton-Wilkes Barre, PA	12.5217
Seattle, WA	15.2062
Sharon, PA	12.6742
Sheboygan, WI	12.4098
Sherman-Denison, TX	12.7131
Shreveport, LA	13.0076
Sioux City, IA-NE	11.8949
Sioux Falls, SD	12.3553
South Bend-Mishawaka, IN	14.2436
Spokane, WA	14.9550
Springfield, IL	13.0023
Springfield, MO	11.3051
Springfield, MA	14.4511
State College, PA	13.8497
Steubenville-Weirton, OH-WV	12.1860
Stockton, CA	16.2434
Syracuse, NY	13.8711
Tacoma, WA	14.4318
Tallahassee, FL	12.8971
Tampa-St. Petersburg-Clearwater, FL	12.9357
Terre Haute, IN	12.3463
Texarkana-TX-Texarkana, AR	11.0389
Toledo, OH	14.1229
Topeka, KS	13.0121
Trenton, NJ	14.0413
Tucson, AZ	13.4151
Tulsa, OK	11.9967
Tuscaloosa, AL	11.9195
Tyler, TX	13.7607
Utica-Rome, NY	11.9069
Vallejo-Fairfield-Napa, CA	18.4685
Vancouver, WA	15.1047
Victoria, TX	12.5802
Vineland-Millville-Bridgeton, NJ	13.6515
Visalia-Tulare-Porterville, CA	14.5366
Waco, TX	10.9308
Washington, DC-MD-VA	15.3037
Waterloo-Cedar Falls, IA	12.0885
Wausau, WI	13.6355
West Palm Beach-Boca Raton-Delray Beach, FL	14.1762
Wheeling, WV-OH	11.2840
Wichita, KS	13.7212
Wichita Falls, TX	11.4308
Williamsport, PA	12.3992
Wilmington, DE-NJ-MD	15.2032
Wilmington, NC	12.1861
Worcester-Fitchburg-Leominster, MA	15.1431
Yakima, WA	14.1430
York, PA	12.6185
Youngstown-Warren, OH	13.8000
Yuba City, CA	14.3528
Yuma, AZ	12.4286

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	9.9782
Alaska	18.7800
Arizona	12.2352
Arkansas	9.7615
California	14.2158
Colorado	11.7715
Connecticut	16.6527
Delaware	11.9902
Florida	12.2119
Georgia	10.8640
Hawaii	13.4534
Idaho	12.5228
Illinois	10.7702
Indiana	10.9616
Iowa	10.5352
Kansas	10.4157
Kentucky	10.9009
Louisiana	10.3290
Maine	11.6490
Maryland	11.2762
Massachusetts	16.3011
Michigan	12.4296
Minnesota	11.6218
Mississippi	9.7401
Missouri	10.1393
Montana	11.5467
Nebraska	9.7847
Nevada	13.5711
New Hampshire	13.3536
New Jersey [1]	
New Mexico	11.6391
New York	11.7524
North Carolina	11.1061
North Dakota	10.7966
Ohio	11.8238
Oklahoma	10.3540
Oregon	13.4376
Pennsylvania	12.0476
Puerto Rico	6.0612
Rhode Island [1]	
South Carolina	10.7144
South Dakota	10.0267
Tennessee	10.2677
Texas	10.6238
Utah	12.5646
Vermont	12.6386
Virginia	10.9323
Washington	13.4773
West Virginia	11.8723
Wisconsin	11.8155
Wyoming	11.8294

[1] All counties within the State are classified urban.

BILLING CODE 4120-03-M

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	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
1	01	SURG		CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.2324	11.3	15.8	34
2	01	SURG		CRANIOTOMY FOR TRAUMA AGE >17	3.1311	10.8	15.1	34
3	01	SURG	*	CRANIOTOMY AGE 0-17	2.9627	12.7	12.7	36
4	01	SURG		SPINAL PROCEDURES	2.3612	8.8	12.8	32
5	01	SURG		EXTRACRANIAL VASCULAR PROCEDURES	1.5504	5.2	6.5	28
6	01	SURG		CARPAL TUNNEL RELEASE	.5437	2.0	3.0	22
7	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC	2.6363	11.1	21.5	34
8	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	.7944	2.9	4.5	26
9	01	MED		SPINAL DISORDERS & INJURIES	1.2786	6.4	10.0	29
10	01	MED		NERVOUS SYSTEM NEOPLASMS WITH CC	1.2884	7.4	10.9	30
11	01	MED		NERVOUS SYSTEM NEOPLASMS W/O CC	.7649	4.3	6.2	27
12	01	MED		DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9550	6.9	9.9	30
13	01	MED		MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.8336	6.5	8.2	30
14	01	MED		SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.2160	7.0	9.8	30
15	01	MED		TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.6662	4.1	5.2	27
16	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.1086	6.6	9.0	30
17	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6424	4.4	5.7	27
18	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC	.9170	5.8	7.7	29
19	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.5958	3.9	5.4	27
20	01	MED		NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.0042	8.6	12.6	32
21	01	MED		VIRAL MENINGITIS	1.4505	7.2	9.5	30
22	01	MED		HYPERTENSIVE ENCEPHALOPATHY	.7261	4.2	5.4	27
23	01	MED		NONTRAUMATIC STUPOR & COMA	.8202	4.2	6.0	27
24	01	MED		SEIZURE & HEADACHE AGE >17 WITH CC	.9714	5.2	7.2	28
25	01	MED		SEIZURE & HEADACHE AGE >17 W/O CC	.5282	3.4	4.3	26
26	01	MED		SEIZURE & HEADACHE AGE 0-17	1.0516	4.0	5.9	27
27	01	MED		TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3744	4.3	8.2	27
28	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC	1.2208	5.9	9.3	29
29	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.5885	3.3	4.6	26
30	01	MED	*	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3593	2.0	2.0	17
31	01	MED		CONCUSSION AGE >17 WITH CC	.7707	4.4	6.4	27
32	01	MED		CONCUSSION AGE >17 W/O CC	.4454	2.7	3.6	25
33	01	MED	*	CONCUSSION AGE 0-17	.2494	1.6	1.6	9
34	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	1.1442	5.9	8.5	29
35	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5590	3.6	4.9	27

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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 TRANSFER CASES.
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NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG		RETINAL PROCEDURES	.6238	1.9	2.3	11
37	02	SURG		ORBITAL PROCEDURES	.7883	2.8	4.2	26
38	02	SURG		PRIMARY IRIS PROCEDURES	.3584	2.1	2.8	16
39	02	SURG		LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.4858	1.5	1.9	8
40	02	SURG		EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.5150	2.0	3.2	25
41	02	SURG	*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3713	1.6	1.6	7
42	02	SURG		INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.5968	1.9	2.5	14
43	02	MED		HYPHEMA	.4026	3.6	4.8	27
44	02	MED		ACUTE MAJOR EYE INFECTIONS	.5767	5.2	6.2	28
45	02	MED		NEUROLOGICAL EYE DISORDERS	.5989	3.5	4.4	26
46	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W CC	.7217	4.3	6.3	27
47	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4156	2.9	4.1	26
48	02	MED	*	OTHER DISORDERS OF THE EYE AGE 0-17	.4079	2.9	2.9	26
49	03	SURG		MAJOR HEAD & NECK PROCEDURES	1.6029	5.0	7.3	28
50	03	SURG		SIALOADENECTOMY	.6594	2.0	2.5	12
51	03	SURG		SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.6278	2.1	2.9	19
52	03	SURG		CLEFT LIP & PALATE REPAIR	.7859	2.2	2.9	19
53	03	SURG		SINUS & MASTOID PROCEDURES AGE >17	.7237	2.0	3.1	24
54	03	SURG	*	SINUS & MASTOID PROCEDURES AGE 0-17	.6994	3.2	3.2	22
55	03	SURG		MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	.5469	1.7	2.4	15
56	03	SURG		RHINOPLASTY	.6168	1.9	2.6	17
57	03	SURG		T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.8845	3.3	5.1	26
58	03	SURG	*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3145	1.5	1.5	4
59	03	SURG		TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.4273	1.5	2.0	10
60	03	SURG	*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2655	1.5	1.5	4
61	03	SURG		MYRINGOTOMY W TUBE INSERTION AGE >17	.8613	2.5	4.6	26
62	03	SURG	*	MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3136	1.3	1.3	5
63	03	SURG		OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.0429	3.7	5.5	27
64	03	MED		EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1039	5.1	8.8	28
65	03	MED		DYSEQUILIBRIUM	.4922	3.3	4.1	23
66	03	MED		EPISTAXIS	.4885	3.3	4.3	25
67	03	MED		EPIGLOTTITIS	.8424	4.1	5.2	27
68	03	MED		OTITIS MEDIA & URI AGE >17 WITH CC	.7216	4.7	5.8	28
69	03	MED		OTITIS MEDIA & URI AGE >17 W/O CC	.5000	3.6	4.3	22
70	03	MED		OTITIS MEDIA & URI AGE 0-17	.6126	3.2	4.4	26

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED		LARYNGOTRACHEITIS	.7664	4.0	5.1	27
72	03	MED		NASAL TRAUMA & DEFORMITY	.5844	3.3	5.0	26
73	03	MED		OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7522	4.1	5.9	27
74	03	MED	*	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	.3480	2.1	2.1	20
75	04	SURG		MAJOR CHEST PROCEDURES	3.0400	11.2	13.6	34
76	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3973	10.5	14.6	34
77	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.0208	4.3	6.5	27
78	04	MED		PULMONARY EMBOLISM	1.4350	8.5	10.0	31
79	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC	1.7510	9.0	11.8	32
80	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	.9617	6.4	7.9	29
81	04	MED	*	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.1200	6.1	6.1	29
82	04	MED		RESPIRATORY NEOPLASMS	1.2809	6.7	9.6	30
83	04	MED		MAJOR CHEST TRAUMA WITH CC	.9490	6.0	7.9	29
84	04	MED		MAJOR CHEST TRAUMA W/O CC	.4783	3.4	4.3	26
85	04	MED		PLEURAL EFFUSION WITH CC	1.1969	6.8	9.0	30
86	04	MED		PLEURAL EFFUSION W/O CC	.6711	4.0	5.3	27
87	04	MED		PULMONARY EDEMA & RESPIRATORY FAILURE	1.3597	5.8	8.0	29
88	04	MED		CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9941	5.8	7.2	29
89	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.1581	7.0	8.6	30
90	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.7090	5.2	6.1	28
91	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.7985	4.7	5.8	28
92	04	MED		INTERSTITIAL LUNG DISEASE WITH CC	1.1975	6.8	8.7	30
93	04	MED		INTERSTITIAL LUNG DISEASE W/O CC	.7723	4.8	6.0	28
94	04	MED		PNEUMOTHORAX WITH CC	1.2774	7.1	9.3	30
95	04	MED		PNEUMOTHORAX W/O CC	.5973	4.3	5.3	27
96	04	MED		BRONCHITIS & ASTHMA AGE >17 WITH CC	.9369	5.8	7.0	29
97	04	MED		BRONCHITIS & ASTHMA AGE >17 W/O CC	.6191	4.3	5.1	24
98	04	MED		BRONCHITIS & ASTHMA AGE 0-17	.8924	4.7	6.3	28
99	04	MED		RESPIRATORY SIGNS & SYMPTOMS WITH CC	.7623	3.8	5.0	27
100	04	MED		RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5049	2.5	3.1	17
101	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC	.9135	5.0	6.7	28
102	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5426	3.3	4.3	26
103	05	SURG		HEART TRANSPLANT	12.5568	23.7	32.3	47
104	05	SURG		CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.7521	17.2	20.1	40
105	05	SURG		CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.8291	11.9	14.3	35

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.6583	13.3	14.9	36
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.2348	10.2	11.4	33
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.8725	12.3	15.1	35
109			NO LONGER VALID	.0000	.0	.0	0
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES WITH CC	4.0823	9.9	13.3	33
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2979	7.3	8.4	30
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9874	4.5	6.0	28
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.7789	14.0	18.8	37
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.5957	8.9	12.3	32
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	3.6092	11.3	13.6	34
116	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GEN PROC	2.4604	5.3	7.1	28
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.2264	3.7	5.4	27
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5858	2.5	3.9	26
119	05	SURG	VEIN LIGATION & STRIPPING	.9650	3.5	6.0	26
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9906	7.2	12.3	30
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	1.6114	7.8	9.5	31
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE	1.1532	5.7	6.8	29
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4090	2.9	5.3	26
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.2029	4.2	5.7	27
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	.7587	2.2	3.1	22
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.8464	15.5	20.3	39
127	05	MED	HEART FAILURE & SHOCK	1.0150	5.9	7.6	29
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7873	7.2	8.2	30
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.2831	2.4	4.7	25
130	05	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	.9106	6.1	7.9	29
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5861	4.7	6.0	28
132	05	MED	ATHEROSCLEROSIS WITH CC	.7591	4.0	5.4	27
133	05	MED	ATHEROSCLEROSIS W/O CC	.5312	2.9	3.8	24
134	05	MED	HYPERTENSION	.5655	3.8	4.8	27
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 WITH CC	.8625	4.6	6.4	28
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	.5266	3.1	4.2	24
137	05	MED	* CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.6411	3.3	3.3	26
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC	.8110	4.3	5.7	27
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5020	2.9	3.6	21
140	05	MED	ANGINA PECTORIS	.6219	3.6	4.4	24

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.6998	4.2	5.5	27
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5048	3.1	3.8	22
143	05	MED	CHEST PAIN	.5164	2.7	3.3	18
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0650	5.0	7.0	28
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6240	3.1	4.1	26
146	06	SURG	RECTAL RESECTION WITH CC	2.5394	11.9	13.6	35
147	06	SURG	RECTAL RESECTION W/O CC	1.5192	8.2	9.0	31
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	3.1353	13.0	15.6	36
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4948	8.3	9.0	28
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.5484	11.3	13.7	34
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.1885	6.3	7.7	29
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.7736	8.8	10.4	32
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0426	6.5	7.1	25
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 WITH CC	4.0491	14.0	17.9	37
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 W/O CC	1.4617	7.2	8.5	30
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8510	6.0	6.0	29
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	.9575	4.5	6.2	27
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.4975	2.3	3.0	17
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 WITH CC	1.0747	4.7	6.1	28
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	.6168	2.7	3.3	19
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 WITH CC	.7820	3.2	4.4	26
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.4651	1.8	2.2	11
163	06	SURG	HERNIA PROCEDURES AGE 0-17	.4843	2.3	2.7	14
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.1607	9.5	11.2	32
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2080	6.3	7.0	25
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.3251	5.9	7.0	29
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.7495	3.6	4.1	15
168	03	SURG	MOUTH PROCEDURES WITH CC	.9902	3.4	5.5	26
169	03	SURG	MOUTH PROCEDURES W/O CC	.5788	2.1	2.8	18
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7310	10.7	15.6	34
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.0898	5.0	6.7	28
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.2990	7.1	10.4	30
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6346	3.5	5.2	27
174	06	MED	G.I. HEMORRHAGE WITH CC	.9794	5.3	6.8	28
175	06	MED	G.I. HEMORRHAGE W/O CC	.5506	3.6	4.3	22

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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	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED	COMPLICATED PEPTIC ULCER	1.0331	5.8	7.5	29
177	06	MED	UNCOMPLICATED PEPTIC ULCER WITH CC	.7931	5.0	6.1	28
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.5720	3.7	4.4	22
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.1044	7.0	9.1	30
180	06	MED	G.I. OBSTRUCTION WITH CC	.9279	5.7	7.4	29
181	06	MED	G.I. OBSTRUCTION W/O CC	.5007	3.8	4.5	25
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 WITH CC	.7721	4.8	6.1	28
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	.5296	3.4	4.2	24
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.5625	3.0	4.1	25
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	.7854	4.4	6.2	27
186	03	MED	* DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	.4174	2.9	2.9	23
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.5650	2.6	3.8	26
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 WITH CC	.9971	5.2	7.3	28
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.4804	2.8	3.8	26
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.6796	4.1	5.3	27
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES WITH CC.	4.4652	15.3	19.9	38
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7051	7.7	9.5	31
193	07	SURG	BILIARY TRACT PROC W CC EXCEPT ONLY CHOLECYST W OR W/O CDE .D.E	3.0376	13.7	16.4	37
194	07	SURG	BILIARY TRACT PROC W/O CC EXCEPT ONLY CHOLECYST W OR W/O C.D.E	1.6333	7.9	9.8	31
195	07	SURG	CHOLECYSTECTOMY W C.D.E. WITH CC	2.2744	10.4	12.0	33
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.4039	7.2	8.0	30
197	07	SURG	CHOLECYSTECTOMY W/O C D.E. WITH CC	1.6916	6.2	8.3	29
198	07	SURG	CHOLECYSTECTOMY W/O C.D.E. W/O CC	.8757	2.6	3.6	26
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3376	11.0	14.3	34
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.7205	9.0	13.4	32
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.5221	10.0	14.4	33
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.2996	7.0	9.6	30
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.2158	6.8	9.7	30
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1158	6.0	7.8	29
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA WITH CC	1.2249	6.5	9.1	30
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6113	3.6	5.0	27
207	07	MED	DISORDERS OF THE BILIARY TRACT WITH CC	.9814	5.3	6.9	28
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.5564	3.1	4.0	25
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - LOWER EXTREMITY	2.3686	9.4	10.4	32
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC	1.9077	10.7	12.5	34

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.3307	8.3	9.3	31
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.0345	4.2	6.1	27
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.7686	9.2	12.8	32
214	08	SURG	BACK & NECK PROCEDURES WITH CC	1.8686	8.1	10.1	31
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.0905	5.1	6.0	28
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.0429	10.0	14.5	33
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	3.0601	13.6	21.3	37
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 WITH CC	1.4186	6.8	8.8	30
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	.8956	4.2	5.1	26
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	.9382	5.3	5.3	28
221	08	SURG	KNEE PROCEDURES WITH CC	1.7828	7.3	10.6	30
222	08	SURG	KNEE PROCEDURES W/O CC	.9544	3.7	5.2	27
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	.8087	3.0	3.8	22
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	.6538	2.4	2.9	14
225	08	SURG	FOOT PROCEDURES	.8212	3.3	5.0	26
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3241	5.7	8.7	29
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6767	2.8	3.8	23
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	.7961	2.5	3.5	25
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5539	1.9	2.6	15
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.9179	3.9	6.0	27
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	1.1044	3.9	6.3	27
232	08	SURG	ARTHROSCOPY	1.1792	3.6	6.6	27
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC	1.8579	8.3	11.6	31
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	.8957	3.9	5.3	27
235	08	MED	FRACTURES OF FEMUR	1.0209	6.8	11.2	30
236	08	MED	FRACTURES OF HIP & PELVIS	.8128	6.2	8.6	29
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5496	4.2	5.5	27
238	08	MED	OSTEOMYELITIS	1.5435	10.2	13.7	33
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0415	7.4	9.9	30
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.1468	6.8	9.2	30
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.5782	4.3	5.6	27
242	08	MED	SEPTIC ARTHRITIS	1.1864	7.8	10.3	31
243	08	MED	MEDICAL BACK PROBLEMS	.6834	5.0	6.7	28
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7353	5.2	7.0	28
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5043	3.8	5.3	27

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED		NON-SPECIFIC ARTHROPATHIES	.5706	4.2	5.3	27
247	08	MED		SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	.5682	3.7	5.0	27
248	08	MED		TENDONITIS, MYOSITIS & BURSITIS	.6750	4.5	6.0	28
249	08	MED		AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.6965	4.1	6.2	27
250	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 WITH CC	.7047	4.5	6.5	28
251	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	.4395	2.6	3.5	25
252	08	MED	*	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.3549	1.8	1.8	15
253	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 WITH CC	.7774	5.5	7.8	29
254	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	.4231	3.4	4.6	26
255	08	MED	*	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4709	2.9	2.9	26
256	08	MED		OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	.6505	3.7	5.2	27
257	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY WITH CC	.8950	4.2	4.9	23
258	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7002	3.2	3.6	14
259	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC	.8774	3.6	5.4	27
260	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.5659	2.1	2.5	12
261	09	SURG		BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	.7183	2.2	2.8	14
262	09	SURG		BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.5345	2.1	3.1	22
263	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS WITH CC	2.5403	14.3	20.2	37
264	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.2662	8.2	11.3	31
265	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.3939	6.0	9.5	29
266	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	.6978	3.0	4.3	26
267	09	SURG		PERIANAL & PILONIDAL PROCEDURES	.6245	2.7	4.1	26
268	09	SURG		SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	.7519	2.6	4.4	26
269	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE WITH CC	1.6956	8.0	12.0	31
270	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST PROCEDURE W/O CC	.6343	2.8	3.9	26
271	09	MED		SKIN ULCERS	1.1970	8.4	11.2	31
272	09	MED		MAJOR SKIN DISORDERS WITH CC	1.0477	7.1	9.2	30
273	09	MED		MAJOR SKIN DISORDERS W/O CC	.6583	5.2	6.7	28
274	09	MED		MALIGNANT BREAST DISORDERS WITH CC	1.1572	6.7	10.8	30
275	09	MED		MALIGNANT BREAST DISORDERS W/O CC	.5957	3.0	4.8	26
276	09	MED		NON-MALIGANT BREAST DISORDERS	.6085	4.0	5.4	27
277	09	MED		CELLULITIS AGE >17 WITH CC	.9036	6.8	8.2	30
278	09	MED		CELLULITIS AGE >17 W/O CC	.5941	5.1	6.0	28
279	09	MED	*	CELLULITIS AGE 0-17	.7479	4.2	4.2	24
280	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC	.6807	4.6	6.3	28

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
281	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4270	3.1	4.1	26
282	09	MED	*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.3476	2.2	2.2	19
283	09	MED		MINOR SKIN DISORDERS WITH CC	.7558	5.2	7.1	28
284	09	MED		MINOR SKIN DISORDERS W/O CC	.4450	3.5	4.7	26
285	10	SURG		AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.7519	14.7	21.1	38
286	10	SURG		ADRENAL & PITUITARY PROCEDURES	2.3944	9.0	11.1	32
287	10	SURG		SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.1744	12.5	18.3	36
288	10	SURG		O.R. PROCEDURES FOR OBESITY	2.0378	6.9	10.1	30
289	10	SURG		PARATHYROID PROCEDURES	1.0252	3.7	5.3	27
290	10	SURG		THYROID PROCEDURES	.7448	2.6	3.2	16
291	10	SURG		THYROGLOSSAL PROCEDURES	.4896	1.7	2.0	9
292	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.8428	12.0	17.7	35
293	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1284	5.3	7.5	28
294	10	MED		DIABETES AGE >35	.7491	5.6	7.1	29
295	10	MED		DIABETES AGE 0-35	.7721	4.3	5.7	27
296	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.9410	5.9	8.1	29
297	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5271	3.9	5.0	27
298	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.4777	2.6	3.4	21
299	10	MED		INBORN ERRORS OF METABOLISM	.8392	4.5	6.7	28
300	10	MED		ENDOCRINE DISORDERS WITH CC	1.1251	6.9	9.2	30
301	10	MED		ENDOCRINE DISORDERS W/O CC	.5811	3.9	5.3	27
302	11	SURG		KIDNEY TRANSPLANT	3.8885	13.5	15.7	37
303	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6532	10.9	13.1	34
304	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.4103	9.9	13.3	33
305	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1548	5.0	6.4	28
306	11	SURG		PROSTATECTOMY WITH CC	1.2744	6.5	8.6	30
307	11	SURG		PROSTATECTOMY W/O CC	.6889	3.7	4.5	20
308	11	SURG		MINOR BLADDER PROCEDURES WITH CC	1.4315	6.0	8.9	29
309	11	SURG		MINOR BLADDER PROCEDURES W/O CC	.7287	2.9	3.9	26
310	11	SURG		TRANSURETHRAL PROCEDURES WITH CC	.8880	3.8	5.4	27
311	11	SURG		TRANSURETHRAL PROCEDURES W/O CC	.5153	2.1	2.7	14
312	11	SURG		URETHRAL PROCEDURES, AGE >17 WITH CC	.8082	3.7	5.2	27
313	11	SURG		URETHRAL PROCEDURES, AGE >17 W/O CC	.4623	2.1	2.7	17
314	11	SURG	*	URETHRAL PROCEDURES, AGE 0-17	.4389	2.3	2.3	25
315	11	SURG		OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0362	6.6	12.0	30

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED		RENAL FAILURE	1.2896	6.2	9.1	29
317	11	MED		ADMIT FOR RENAL DIALYSIS	.5075	2.8	3.9	26
318	11	MED		KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.1244	6.0	9.0	29
319	11	MED		KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5069	2.5	3.7	26
320	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	.9807	6.5	8.1	29
321	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	6252	4.8	5.7	27
322	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6389	4.6	5.6	28
323	11	MED		URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY	.7381	3.1	4.2	26
324	11	MED		URINARY STONES W/O CC	.3858	2.1	2.5	13
325	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	.6551	4.2	5.7	27
326	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4152	2.8	3.6	22
327	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.7038	4.9	6.5	28
328	11	MED		URETHRAL STRICTURE AGE >17 WITH CC	.6363	3.6	4.8	27
329	11	MED		URETHRAL STRICTURE AGE >17 W/O CC	.4113	2.1	2.9	18
330	11	MED	*	URETHRAL STRICTURE AGE 0-17	2830	1.6	1.6	9
331	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	.9765	5.3	7.4	28
332	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5347	3.0	4.4	26
333	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.9590	5.2	7.6	28
334	12	SURG		MAJOR MALE PELVIC PROCEDURES W CC	1.7728	8.2	8.9	28
335	12	SURG		MAJOR MALE PELVIC PROCEDURES W/O CC	1.3597	6.9	7.3	19
336	12	SURG		TRANSURETHRAL PROSTATECTOMY WITH CC	.8704	4.6	5.5	24
337	12	SURG		TRANSURETHRAL PROSTATECTOMY W/O CC	.6066	3.4	3.8	12
338	12	SURG		TESTES PROCEDURES, FOR MALIGNANCY	.9386	3.9	6.1	27
339	12	SURG		TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.7572	3.1	4.5	26
340	12	SURG	*	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.4401	2.4	2.4	13
341	12	SURG		PENIS PROCEDURES	.9681	3.3	4.2	25
342	12	SURG		CIRCUMCISION AGE >17	.5766	2.5	3.7	25
343	12	SURG	*	CIRCUMCISION AGE 0-17	.3845	1.7	1.7	6
344	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0568	3.9	5.2	27
345	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.7521	3.2	4.6	26
346	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	.9906	5.7	8.5	29
347	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5120	2.9	4.4	26
348	12	MED		BENIGN PROSTATIC HYPERTROPHY WITH CC	.6815	4.0	5.5	27
349	12	MED		BENIGN PROSTATIC HYPERTROPHY W/O CC	.3952	2.3	3.0	20
350	12	MED		INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6707	4.8	5.8	28

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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	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
351	12	MED	*	STERILIZATION, MALE	.3384	1.3	1.3	5
352	12	MED		OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	5801	3.2	4.7	26
353	13	SURG		PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.9031	9.2	11.1	32
354	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.3686	6.8	7.8	30
355	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.8493	4.7	5.0	12
356	13	SURG		FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	7030	3.8	4.2	15
357	13	SURG		UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.3097	10.0	12.3	33
358	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1 1066	5 6	6.3	22
359	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.7723	4.2	4.5	11
360	13	SURG		VAGINA, CERVIX & VULVA PROCEDURES	.8024	4.0	5.0	27
361	13	SURG		LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.9767	3.5	5.5	27
362	13	SURG	*	ENDOSCOPIC TUBAL INTERRUPTION	.5057	1.4	1.4	5
363	13	SURG		D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6251	3.0	4.1	24
364	13	SURG		D&C, CONIZATION EXCEPT FOR MALIGNANCY	.5659	2.6	3.8	26
365	13	SURG		OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7093	7.1	10.4	30
366	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.2158	6.5	10.1	29
367	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.4808	2.7	3.8	26
368	13	MED		INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8820	5.8	7.3	29
369	13	MED		MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5321	3.1	4.5	26
370	14	SURG		CESAREAN SECTION W CC	.8916	5.3	6.8	27
371	14	SURG		CESAREAN SECTION W/O CC	6461	4.0	4.2	11
372	14	MED		VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4619	2.9	3.6	19
373	14	MED		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3182	2.1	2.4	8
374	14	SURG		VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6297	2.8	4 0	24
375	14	SURG	*	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6921	4.4	4.4	27
376	14	MED		POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3247	2.3	2 9	17
377	14	SURG		POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	.8392	3.6	5.1	27
378	14	MED		ECTOPIC PREGNANCY	.7694	3.3	3.7	13
379	14	MED		THREATENED ABORTION	.2743	2.0	2.9	20
380	14	MED		ABORTION W/O D&C	.3430	1.9	2.8	20
381	14	SURG		ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.4326	1.7	2.4	14
382	14	MED		FALSE LABOR	.1486	1.3	1.4	5
383	14	MED		OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3947	3.2	4.3	26
384	14	MED		OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.2701	2.0	2.7	18
385	15	MED	*	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.2418	1 8	1.8	25

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
386	15	MED	*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.7035	17.9	17.9	41
387	15	MED	*	PREMATURITY W MAJOR PROBLEMS	1.8545	13.3	13.3	36
388	15	MED	*	PREMATURITY W/O MAJOR PROBLEMS	1.1747	8.6	8.6	32
389	15	MED	*	FULL TERM NEONATE W MAJOR PROBLEMS	1.4229	4.7	4.7	28
390	15	MED		NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1340	3.8	6.1	27
391	15	MED	*	NORMAL NEWBORN	.2252	3.1	3.1	11
392	16	SURG		SPLENECTOMY AGE >17	3.1287	11.0	14.0	34
393	16	SURG	*	SPLENECTOMY AGE 0-17	1.5437	9.1	9.1	32
394	16	SURG		OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.5966	5.6	10.0	29
395	16	MED		RED BLOOD CELL DISORDERS AGE >17	.7881	4.6	6.3	28
396	16	MED		RED BLOOD CELL DISORDERS AGE 0-17	.6802	2.0	3.2	24
397	16	MED		COAGULATION DISORDERS	1.1905	5.3	7.4	28
398	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.2091	6.4	8.2	29
399	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.8735	4.0	5.2	27
400	17	SURG		LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.5572	8.9	13.3	32
401	17	SURG		LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.3497	10.2	15.0	33
402	17	SURG		LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	.8536	3.5	5.1	27
403	17	MED		LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6827	8.1	12.0	31
404	17	MED		LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.7428	4.0	5.6	27
405	17	MED	*	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0565	4.9	4.9	28
406	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7669	11.0	15.3	34
407	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1999	5.0	8.5	28
408	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.3279	4.9	8.4	28
409	17	MED		RADIOTHERAPY	.9886	6.1	8.9	29
410	17	MED		CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	.6095	2.8	3.5	20
411	17	MED		HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4256	2.4	3.3	23
412	17	MED		HISTORY OF MALIGNANCY W ENDOSCOPY	.4257	2.0	2.9	20
413	17	MED		OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.3335	7.3	10.7	30
414	17	MED		OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.6857	4.1	6.0	27
415	18	SURG		O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5162	14.6	20.5	38
416	18	MED		SEPTECEMIA AGE >17	1.5222	7.4	10.3	30
417	18	MED		SEPTECEMIA AGE 0-17	.8974	4.4	5.5	27
418	18	MED		POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9879	6.4	8.1	29
419	18	MED		FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9500	5.7	7.3	29
420	18	MED		FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6510	4.4	5.3	27

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					RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED		VIRAL ILLNESS AGE >17	.6882	4.3	5.4	27
422	18	MED		VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.7629	4.8	6.2	28
423	18	MED		OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.5976	7.9	11.0	31
424	19	SURG		O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4058	13.8	23.4	37
425	19	MED		ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.7045	4.5	6.2	27
426	19	MED		DEPRESSIVE NEUROSES	.6023	5.1	7.2	28
427	19	MED		NEUROSES EXCEPT DEPRESSIVE	.6322	5.1	7.6	28
428	19	MED		DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7703	6.4	10.5	29
429	19	MED		ORGANIC DISTURBANCES & MENTAL RETARDATION	.9460	7.6	11.4	31
430	19	MED		PSYCHOSES	.9040	8.6	12.3	32
431	19	MED		CHILDHOOD MENTAL DISORDERS	.5980	5.1	7.3	28
432	19	MED		OTHER MENTAL DISORDER DIAGNOSES	.7113	4.5	6.9	27
433	20	MED		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3545	2.9	4.4	26
434	20	MED		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC	.7494	5.4	7.4	28
435	20	MED		ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC	.4818	4.5	6.3	27
436	20	MED		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.9869	14.8	17.9	38
437	20	MED		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	1.0888	14.2	16.7	37
438				NO LONGER VALID	.0000	.0	.0	0
439	21	SURG		SKIN GRAFTS FOR INJURIES	1.2126	5.6	9.2	29
440	21	SURG		WOUND DEBRIDEMENTS FOR INJURIES	1.8359	8.1	12.9	31
441	21	SURG		HAND PROCEDURES FOR INJURIES	.7321	2.3	3.5	25
442	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES WITH CC	1.9106	5.9	9.7	29
443	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.7518	2.6	3.7	26
444	21	MED		TRAUMATIC INJURY AGE > 17 W CC	.7643	5.2	7.2	28
445	21	MED		TRAUMATIC INJURY AGE > 17 W/O CC	.4649	3.3	4.3	26
446	21	MED	*	TRAUMATIC INJURY AGE 0-17	4869	2.4	2.4	22
447	21	MED		ALLERGIC REACTIONS AGE >17	4919	2.5	3.4	24
448	21	MED	*	ALLERGIC REACTIONS AGE 0-17	3523	2.9	2.9	17
449	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC	7889	4.0	5.7	27
450	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4325	2.3	3.2	22
451	21	MED	*	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.5268	2.1	2.1	17
452	21	MED		COMPLICATIONS OF TREATMENT WITH CC	.8550	4.2	6.1	27
453	21	MED		COMPLICATIONS OF TREATMENT W/O CC	.4175	2.7	3.5	23
454	21	MED		OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC	.8873	4.3	6.8	27
455	21	MED		OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC	.4130	2.3	3.1	21

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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	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
456	22	MED	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.7285	4.6	8.8	28
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	2.0147	3.6	8.8	27
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.8787	16.0	22.7	39
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	1.8906	10.2	14.9	33
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0032	6.3	9.1	29
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	.8808	2.5	5.1	26
462	23	MED	REHABILITATION	1.7805	13.9	17.9	37
463	23	MED	SIGNS & SYMPTOMS W CC	.7277	4.8	6.6	28
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4567	3.1	4.1	26
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.3531	1.9	2.8	20
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.5328	2.4	4.4	25
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4469	2.7	5.4	26
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.4195	13.1	19.0	36
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0	0
470		**	UNGROUPABLE	.0000	.0	.0	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.8976	11.9	13.7	35
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	11.7093	16.1	29.9	39
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4402	9.7	17.1	33
474	04		NO LONGER VALID	.0000	.0	.0	0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.5965	9.6	14.1	33
476			PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2014	13.6	16.9	37
477			NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.4337	6.0	10.2	29
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.1645	6.8	10.2	30
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.2718	4.1	5.5	27
480		SURG	LIVER TRANSPLANT	20.1614	26.9	40.3	50
481		SURG	BONE MARROW TRANSPLANT	15.2244	41.2	45.7	64
482		SURG	TRACHEOSTOMY W MOUTH, LARYNX OR PHARYNX DISORDER	3.4826	13.7	18.0	37
483		SURG	TRACHEOSTOMY EXCEPT FOR MOUTH, LARYNX OR PHARYNX DISORDER	16.6590	43.9	57.2	67
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.5706	14.9	23.3	38
485	24	SURG	LIMB REATTACH., HIP AND FEMUR PROCS FOR MULTI SIGN TRAUMA	3.1669	13.0	16.4	36
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8231	10.6	17.4	34
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9406	7.5	11.3	31
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.1539	16.5	23.1	39
489	25	MED	HIV W MAJOR RELATED CONDITION	1.9151	9.3	14.1	32
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1285	5.4	8.8	28

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				RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS	OUTLIER THRESHOLD
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES - UPPER EXTREMITY	1.5676	5.3	6.3	28
492	17	MED	CHEMOTHERAPY WITH ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	2.7815	8.5	14.3	32

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BILLING CODE 4120-03-C

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	350
			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 [1]
			25	489
112.85	Candidiasis of the intestine	Y	06	182, 183, 184
			15	387, 389 [1]
			25	489
320.81	Meningitis due to anaerobic bacteria	Y	01	20
			15	387, 389 [1]
320.82	Meningitis due to gram-negative bacteria, not elsewhere classified	Y	01	20
			15	387, 389 [1]
320.89	Meningitis due to other specified bacteria	Y	01	20
			15	387, 389 [1]
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
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

TABLE 6a.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
482.30	Pneumonia due to unspecified Streptococcus	Y	04	89, 90, 91
			15	387, 389 [1]
			25	489
482.31	Pneumonia due to Streptococcus, Group A	Y	04	89, 90, 91
			15	387, 389 [1]
			25	489
482.32	Pneumonia due to Streptococcus, Group B	Y	04	89, 90, 91
			15	387, 389 [1]
			25	489
482.39	Pneumonia due to other Streptococcus	Y	04	89, 90, 91
			15	387, 389 [1]
			25	489
482.81	Pneumonia due to anaerobes	Y	04	79, 80, 81
			15	387, 389 [1]
			25	489
482.82	Pneumonia due to Escherichia coli [E. coli]	Y	04	79, 80, 81
			15	387, 389 [1]
			25	489
482.83	Pneumonia due to other gram-negative bacteria	Y	04	79, 80, 81
			15	387, 389 [1]
			25	489
482.89	Pneumonia due to other specified bacteria	Y	04	79, 80, 81
			15	387, 389 [1]
			25	489
483.0	Pneumonia due to Mycoplasma pneumoniae	Y	04	89, 90, 91
			15	387, 389 [1]
483.8	Pneumonia due to other specified organism	Y	04	89, 90, 91
			15	387, 389 [1]
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, 187
			—	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	Alvelolar 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 (urethra) sphincter deficiency [ISD]	N	11	331, 332, 333
599.83	Urethral instability	N	11	331, 332, 333
599.84	Other specified disorders of urethral	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

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
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	N	08	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	387, 389 [1]
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	487 [2]
864.15	Injury to liver with open wound into cavity, unspecified laceration	Y	07	205, 206
			24	487 [2]
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	391 [3]
			23	467
V29.1	Observation and evaluation of newborns and infants for suspected neurological condition not found.	N	15	391 [3]
			23	467
V29.8	Observation and evaluation of newborns and infants for other specified suspected condition not found.	N	15	391 [3]
			23	467
V29.9	Observation and evaluation of newborns and infants for unspecified	N	15	391 [3]
			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, 359
66.02	Salpingostomy	Y	13	354, 355, 357, 358, 359
68.9	Other and unspecified hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375
81.97	Revision of joint replacement of upper extremity	Y	08	233, 234
			21	442, 443
			24	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, 184
008.6	Enteritis due to specified virus	N	06	182, 183, 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
099.4	Other nongonococcal urethritis	N	12	350
			13	358, 359, 368
320.8	Meningitis due to other specified bacteria	Y	01	20
			15	387, 389 [2]

TABLE 6C.—INVALID DIAGNOSIS CODES [1]—Continued

Diagnosis code	Description	CC	MDC	DRG
346.0	Classical migraine	N	01	24, 25, 26
346.1	Common migraine	N	01	24, 25, 26
346.2	Variants of migraine	N	01	24, 25, 26
346.8	Other forms of migraine	N	01	24, 25, 26
346.9	Migraine, unspecified	N	01	24, 25, 26
440.2	Atherosclerosis of arteries of the extremities	N	05	130, 131
482.3	Pneumonia due to Streptococcus	Y	04	89, 90, 91
482.8	Pneumonia due to other specified bacteria	Y	04	79, 80, 81
483	Pneumonia due to other specified organism	Y	04	89, 90, 91
524.0	Major anomalies of jaw size	N	03	185, 186, 187
524.1	Anomalies of relationship of jaw to cranial base	N	03	185, 186, 187
596.5	Other functional disorders of bladder	N	11	331, 332, 333
599.8	Other specified disorders of urethra and urinary tract	N	11	331, 332, 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, 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	148, 149
			17	400, 406, 407
			21	442, 443
			24	486
66.0	Salpingotomy	Y	13	354, 355, 357, 358, 359
69.11	Removal of intraligamentous ectopic pregnancy	Y	13	354, 355, 357, 358, 359
89.49	Artificial pacemaker slew rate check	N	14	375

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, 404
200.10	Lymphosarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
200.20	Burkitt's tumor or lymphoma, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
200.80	Other named variants, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.00	Hodgkin's paragranuloma, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
201.10	Hodgkin's granuloma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.20	Hodgkin's sarcoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.40	Lymphocytic-histiocytic predominance, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
201.50	Nodular sclerosis, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.60	Mixe cellularity, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.70	Lymphocytic depletion, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
201.90	Hodgkin's disease, unspecified, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
202.00	Nodular lymphoma, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.10	Mycosis fungoides, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.20	Sezary's disease, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.30	Malignant histiocytosis, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.40	Leukemic reticuloendotheliosis, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
202.50	Letterer-Siwe disease, unspecified site, extranodal and solid organ sites	Y	17	406, 407, 408, 413, 414

TABLE 6e.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	DRG
202.60	Malignant mast cell tumors, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
202.80	Other lymphomas, unspecified site, extranodal and solid organ sites	Y	17	400, 401, 402, 403, 404
202.90	Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites.	Y	17	400, 401, 402, 403, 404
481	Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia]	Y	04	89, 90, 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, 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.	Y	14	370, 371, 372, 373, 374, 375
665.11	Rupture of uterus during labor, delivered, with or without mention of antepartum condition.	Y	14	370, 371, 372, 373, 374, 375
665.12	Rupture of uterus during labor, delivered, with mention of postpartum complication.	Y	14	370, 371, 372, 373, 374, 375
665.14	Rupture of uterus during labor, postpartum condition or complication	Y	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 delivery.	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 cesarean 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	442, 443
			24	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
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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
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436	78001	78001	78001	78001	78001	78001	78001
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*80336	*80372	*80406	*80442	*80476	*85104	*85140	*85174
78001	78001	78001	78001	78001	78001	78001	78001
*80339	*80373	*80409	*80443	*80479	*85105	*85141	*85175
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*80340	*80374	*80410	*80444	*80480	*85106	*85142	*85176
78001	78001	78001	78001	78001	78001	78001	78001
*80341	*80375	*80411	*80445	*80481	*85109	*85143	*85179
78001	78001	78001	78001	78001	78001	78001	78001
*80342	*80376	*80412	*80446	*80482	*85110	*85144	*85180
78001	78001	78001	78001	78001	78001	78001	78001
*80343	*80379	*80413	*80449	*80483	*85111	*85145	*85181
78001	78001	78001	78001	78001	78001	78001	78001
*80344	*80380	*80414	*80450	*80484	*85112	*85146	*85182
78001	78001	78001	78001	78001	78001	78001	78001
*80345	*80381	*80415	*80451	*80485	*85113	*85149	*85183
78001	78001	78001	78001	78001	78001	78001	78001
*80346	*80382	*80416	*80452	*80486	*85114	*85150	*85184
78001	78001	78001	78001	78001	78001	78001	78001
*80349	*80383	*80419	*80453	*80489	*85115	*85151	*85185
78001	78001	78001	78001	78001	78001	78001	78001
*80350	*80384	*80420	*80454	*80490	*85116	*85152	*85186
78001	78001	78001	78001	78001	78001	78001	78001
*80351	*80385	*80421	*80455	*80491	*85119	*85153	*85189
78001	78001	78001	78001	78001	78001	78001	78001
*80352	*80386	*80422	*80456	*80492	*85120	*85154	*85190
78001	78001	78001	78001	78001	78001	78001	78001
*80353	*80389	*80423	*80459	*80493	*85121	*85155	*85191
78001	78001	78001	78001	78001	78001	78001	78001
*80354	*80390	*80424	*80460	*80494	*85122	*85156	*85192
78001	78001	78001	78001	78001	78001	78001	78001
*80355	*80391	*80425	*80461	*80495	*85123	*85159	*85193
78001	78001	78001	78001	78001	78001	78001	78001
*80356	*80392	*80426	*80462	*80496	*85124	*85160	*85194
78001	78001	78001	78001	78001	78001	78001	78001
*80359	*80393	*80429	*80463	*8500	*85125	*85161	*85195
78001	78001	78001	78001	78001	78001	78001	78001
*80360	*80394	*80430	*80464	*8501	*85126	*85162	*85196
78001	78001	78001	78001	78001	78001	78001	78001
*80361	*80395	*80431	*80465	*8502	*85129	*85163	*85199
78001	78001	78001	78001	78001	78001	78001	78001
*80362	*80396	*80432	*80466	*8503	*85130	*85164	*85200
78001	78001	78001	78001	78001	78001	78001	78001
*80363	*80399	*80433	*80469	*8504	*85131	*85165	*85201
78001	78001	78001	78001	78001	78001	78001	78001
*80364	*80400	*80434	*80470	*8505	*85132	*85166	*85202
78001	78001	78001	78001	78001	78001	78001	78001
*80365	*80401	*80435	*80471	*8509	*85133	*85169	*85203
78001	78001	78001	78001	78001	78001	78001	78001
*80366	*80402	*80436	*80472	*85100	*85134	*85170	*85204
78001	78001	78001	78001	78001	78001	78001	78001
*80369	*80403	*80439	*80473	*85101	*85135	*85171	*85205
78001	78001	78001	78001	78001	78001	78001	78001
*80370	*80404	*80440	*80474	*85102	*85136	*85172	*85206
78001	78001	78001	78001	78001	78001	78001	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
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*80381	*80415	*80451	*80485	*85113	*85149	*85183	*85219
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*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

7800	7800
*85242	*85316
7800	7800
*85243	*85319
7800	7800
*85244	*85400
7800	7800
*85245	*85401
7800	7800
*85246	*85402
7800	7800
*85249	*85403
7800	7800
*85250	*85404
7800	7800
*85251	*85405
7800	7800
*85252	*85406
7800	7800
*85253	*85409
7800	7800
*85254	*85410
7800	7800
*85255	*85411
7800	7800
*85256	*85412
7800	7800
*85259	*85413
7800	7800
*85300	*85414
7800	7800
*85301	*85415
7800	7800
*85302	*85416
7800	7800
*85303	*85419
7800	7800
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*85315	

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28876	15.9617	4	7	11	19	32
002	6031	15.1069	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5300	13.0400	3	5	9	16	27
005	53888	6.7762	2	3	5	8	13
006	868	3.2857	1	1	2	3	7
007	5961	22.0765	2	6	11	23	47
008	2772	4.6032	1	1	3	6	10
009	1731	10.3039	2	4	7	12	21
010	20406	10.9344	2	4	7	14	22
011	3565	6.3719	1	2	4	8	13
012	21663	10.6732	2	4	7	12	19
013	5723	8.5598	3	4	7	10	15
014	342315	10.0711	3	4	7	12	19
015	135323	5.4583	2	3	4	6	10
016	11124	9.3788	3	4	7	11	18
017	2966	5.8736	2	3	4	7	10
018	13951	8.0095	2	4	6	9	15
019	6986	5.4705	1	2	4	7	10
020	7578	12.6498	3	5	9	16	25
021	1032	9.6909	3	4	7	12	19
022	9831	5.5487	2	3	4	7	10
023	3143	6.2685	1	2	4	7	12
024	54473	7.3996	2	3	5	9	14
025	22879	4.4291	1	2	3	5	8
026	61	5.9344	1	2	3	8	14
027	2808	8.2942	1	2	4	10	19
028	8249	9.5305	2	3	6	11	19
029	3690	4.8705	1	2	3	6	10
030	2	1.0000	1	1	1	1	1
031	3757	7.0186	2	2	4	8	13
032	2713	3.6922	1	2	3	4	7
034	13703	8.9718	2	3	6	10	17
035	3837	5.2434	1	2	4	6	10
036	20529	2.3437	1	1	2	3	4
037	2746	4.6555	1	1	3	5	10
038	784	2.9426	1	1	2	3	5
039	9719	1.9414	1	1	1	2	3
040	3422	3.4278	1	1	2	4	8
042	20598	2.5786	1	1	2	3	5
043	207	5.5266	1	2	4	6	10
044	1996	6.2856	2	4	5	7	11
045	2641	4.4623	1	2	4	6	8
046	2904	6.3402	1	2	5	8	12
047	1891	4.4093	1	1	3	5	8
048	2	7.0000	5	5	9	9	9
049	2965	7.5400	2	3	5	9	15
050	4928	2.6331	1	1	2	3	4
051	534	2.8614	1	1	2	3	6
052	175	3.1886	1	1	2	3	6
053	6507	3.4372	1	1	2	3	8

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DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3659	2.7349	1	1	1	2	6
056	1151	2.7958	1	1	2	3	6
057	710	5.3620	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	185	2.1568	1	1	1	2	4
060	1	18.0000	18	18	18	18	18
061	385	5.0026	1	1	2	6	12
063	4945	5.6977	1	2	4	7	11
064	4372	8.9318	1	2	6	11	20
065	32587	4.1850	1	2	3	5	8
066	7860	4.3564	1	2	3	5	8
067	437	5.2014	2	3	4	6	9
068	11729	6.0495	2	3	5	7	11
069	3772	4.2858	2	2	4	5	8
070	18	4.3889	1	2	2	5	9
071	136	5.1176	2	3	4	6	10
072	685	5.7460	1	2	3	6	9
073	6685	6.0432	1	2	4	7	12
074	2	11.0000	9	9	13	13	13
075	32193	13.7943	6	8	10	16	26
076	40220	14.8394	4	7	11	18	28
077	3502	6.5580	1	2	5	9	14
078	26963	10.0607	4	7	9	12	16
079	140699	11.8842	4	6	9	14	22
080	9304	7.9451	3	4	7	10	14
081	1	7.0000	7	7	7	7	7
082	70711	9.5833	2	4	7	12	19
083	7420	8.1515	2	4	6	10	15
084	1879	4.4050	1	2	3	6	8
085	17755	9.0945	2	4	7	11	17
086	1757	5.3199	1	2	4	7	10
087	61415	8.1182	2	4	6	10	15
088	166636	7.3926	3	4	6	9	13
089	380530	8.7583	3	5	7	11	15
090	46157	6.2364	3	4	5	8	10
091	48	6.1042	2	3	5	7	11
092	9095	8.7428	3	4	7	11	16
093	1504	6.0632	2	3	5	8	11
094	9730	9.5251	3	4	7	11	18
095	1324	6.1284	2	3	4	7	10
096	181510	7.1153	3	4	6	8	12
097	32577	5.1442	2	3	4	6	9
098	18	6.2778	2	3	5	6	10
099	31096	5.1861	1	2	4	6	10
100	11482	3.1253	1	2	2	4	6
101	19157	6.8025	2	3	5	8	13
102	3754	4.3207	1	2	3	5	8
103	282	33.8262	10	14	21	40	68
104	17814	20.3496	9	12	17	25	35
105	16203	14.4966	7	9	11	16	25
106	76162	15.2542	8	10	13	17	24

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SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
107	52857	11.7523	7	8	9	13	18
108	8959	15.2274	7	9	12	18	28
110	51947	13.5024	3	8	11	16	25
111	6304	8.4123	3	6	8	10	13
112	131484	6.0934	2	3	5	8	12
113	37250	19.0177	6	8	14	23	37
114	8226	12.4919	3	5	9	15	24
115	8518	13.9283	5	8	11	17	24
116	65949	7.2686	2	3	6	9	14
117	3402	5.5091	1	2	3	7	12
118	8487	3.9126	1	1	2	4	8
119	3237	6.3031	1	2	3	7	15
120	35546	12.2367	2	3	8	15	27
121	146199	9.6359	4	6	8	11	16
122	100359	6.8565	2	4	7	9	11
123	56218	5.3458	1	1	3	7	13
124	125726	5.7739	1	2	5	7	11
125	89536	3.1482	1	1	2	4	7
126	4302	20.4328	5	10	16	29	41
127	612827	7.7476	2	4	6	9	14
128	23541	8.4050	4	5	7	10	13
129	6269	4.7437	1	1	1	6	12
130	71880	8.1132	2	4	7	10	14
131	26526	5.9725	1	3	6	8	10
132	12394	5.5501	1	2	4	7	11
133	4077	3.9146	1	2	3	5	7
134	29162	4.9837	2	2	4	6	9
135	6400	6.5938	2	3	5	8	13
136	1424	4.2507	1	2	3	5	7
138	188352	5.8759	2	3	4	7	11
139	72186	3.6766	1	2	3	5	7
140	346480	4.4712	2	2	4	5	8
141	77799	5.7258	2	3	4	7	10
142	37177	3.9232	1	2	3	5	7
143	117399	3.3738	1	2	3	4	6
144	56530	7.0916	1	3	5	9	14
145	8425	4.1858	1	2	3	5	8
146	7640	13.8241	7	9	11	15	23
147	1590	8.9233	5	7	9	11	13
148	143851	15.9248	7	9	12	19	28
149	18122	9.0774	6	7	8	10	13
150	21960	13.9135	5	8	11	17	25
151	4781	7.7473	3	4	7	10	13
152	4605	10.6725	5	7	9	12	18
153	2059	7.0515	4	5	7	8	10
154	37694	18.0724	7	9	14	22	34
155	4202	8.5626	4	5	7	10	14
157	13356	6.5860	2	3	4	8	13
158	9999	3.0529	1	1	2	4	6
159	16539	6.3772	2	3	5	8	12
160	12946	3.3294	1	2	3	4	6

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SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
161	24227	4.6378	1	2	3	6	10
162	21251	2.2036	1	1	2	3	4
163	13	2.6923	1	1	2	4	5
164	4685	11.4055	5	7	9	13	19
165	1819	6.9940	3	5	7	9	11
166	2982	7.1596	3	4	6	9	13
167	2188	4.1185	2	3	4	5	7
168	1871	5.7691	1	2	3	7	12
169	1391	2.8246	1	1	2	3	6
170	12992	15.9273	3	7	11	20	31
171	1463	6.8578	1	3	5	9	13
172	31475	10.4531	2	4	7	13	22
173	3266	5.2655	1	2	4	7	11
174	168078	6.9517	2	4	5	8	13
175	22521	4.3582	2	3	4	5	7
176	13120	7.7104	2	4	6	9	14
177	15059	6.2747	2	3	5	7	11
178	6479	4.4373	2	3	4	5	8
179	8803	9.5372	3	4	7	11	18
180	70546	7.6470	2	4	6	9	14
181	22180	4.5757	2	3	4	6	8
182	261192	6.2600	2	3	5	7	11
183	77885	4.1977	1	2	3	5	8
184	59	4.0508	1	2	3	4	7
185	3999	6.2591	1	3	5	8	12
186	1	4.0000	4	4	4	4	4
187	1050	3.8629	1	1	2	5	8
188	50649	7.4105	2	3	5	9	15
189	9116	3.8873	1	1	3	5	8
190	99	5.3131	2	3	4	6	10
191	10256	20.0999	7	10	15	24	40
192	965	9.5440	3	6	8	12	16
193	12618	16.6354	7	9	14	20	29
194	1427	9.6797	3	6	9	12	17
195	17622	12.3429	6	7	10	14	20
196	1802	8.0733	4	5	7	10	13
197	78222	8.5152	2	4	7	11	16
198	49186	3.6220	1	1	3	5	7
199	2886	14.4016	4	7	11	18	28
200	1957	13.6811	2	5	10	18	28
201	3042	14.3859	3	6	10	18	30
202	18194	9.7128	2	4	7	12	19
203	29827	9.7680	2	4	7	12	20
204	39939	8.0722	3	4	6	9	15
205	21234	9.1487	2	4	7	11	18
206	2450	5.0184	1	2	4	7	10
207	38205	7.0373	2	3	5	9	13
208	14164	4.0379	1	2	3	5	7
209	271606	10.5789	6	7	9	12	16
210	118940	13.0684	6	8	10	14	21
211	29021	9.4534	5	6	8	11	14

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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
212	18	6.1111	2	2	3	7	9
213	5859	13.0282	3	6	9	16	25
214	42479	10.3023	4	5	8	12	19
215	38652	6.0877	3	4	5	7	10
216	7180	14.5876	3	6	11	18	29
217	17145	21.5360	4	8	14	27	46
218	18844	9.1075	3	4	7	11	17
219	18074	5.1644	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4936	10.7784	2	4	8	13	21
222	5308	5.2472	1	2	4	7	10
223	16064	4.0505	1	2	3	4	7
224	8886	2.9099	1	2	2	3	5
225	10186	5.2852	1	2	3	6	12
226	5572	9.0720	2	3	6	11	20
227	6542	3.8658	1	2	3	4	7
228	4411	3.7150	1	1	2	4	8
229	2541	2.6564	1	1	2	3	5
230	3279	6.4535	1	2	4	7	13
231	10405	6.5790	1	2	4	7	15
232	809	6.6897	1	2	3	7	17
233	5329	11.7467	3	5	9	15	23
234	3072	5.3665	1	2	4	7	11
235	6401	11.4805	2	4	7	12	24
236	39084	8.9773	2	4	7	10	17
237	1693	5.8328	2	3	4	7	10
238	6472	13.9322	4	6	10	17	28
239	60286	10.0598	3	5	7	12	19
240	11175	9.5085	3	4	7	11	18
241	4000	5.6287	2	3	4	7	11
242	2544	10.5491	3	5	8	13	22
243	106101	6.8511	2	3	5	9	13
244	11219	7.2646	2	3	5	9	14
245	5730	5.5091	1	2	4	6	10
246	1753	5.4780	2	3	4	7	10
247	9961	5.1535	1	2	4	6	10
248	6331	6.2402	2	3	5	7	12
249	8552	6.4259	1	2	4	8	13
250	3461	6.8050	2	3	5	8	13
251	3274	3.6130	1	1	2	4	7
253	17409	8.1683	2	3	6	9	16
254	12343	4.7343	1	2	3	6	9
255	2	2.5000	1	1	4	4	4
256	9411	5.4601	1	2	4	6	11
257	28803	5.1188	2	3	4	6	9
258	26586	3.6258	2	2	3	4	6
259	4071	5.9560	1	2	3	6	13
260	4963	2.5350	1	1	2	3	4
261	3080	2.8042	1	1	2	3	5
262	1296	3.5517	1	1	2	3	7
263	29564	20.5709	5	8	14	24	41

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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
264	4234	11.3791	3	5	8	14	23
265	4999	9.8200	2	3	6	11	21
266	4190	4.4174	1	2	3	5	9
267	379	4.8021	1	1	3	5	11
268	1482	5.0628	1	1	2	5	9
269	11065	12.2933	2	4	9	15	25
270	5144	4.0072	1	2	3	5	8
271	20052	11.6591	3	5	8	13	21
272	6944	9.4241	3	5	7	11	18
273	2223	6.8277	2	3	5	8	14
274	3099	10.9935	2	4	7	13	21
275	383	5.6789	1	1	3	5	9
276	877	5.6328	1	2	4	7	11
277	72052	8.4759	3	5	7	10	15
278	26250	6.1446	3	4	5	7	10
279	6	7.0000	2	3	4	11	11
280	13349	6.8287	2	3	5	8	13
281	7419	4.1867	1	2	3	5	8
282	1	2.0000	2	2	2	2	2
283	5928	7.2763	2	3	5	8	14
284	2390	5.0753	1	2	4	6	9
285	4656	21.4021	5	9	15	25	41
286	1753	11.3440	5	6	8	13	22
287	6675	18.9768	5	7	12	21	39
288	533	10.1576	3	4	6	10	21
289	4013	5.6845	2	2	3	5	12
290	9686	3.4577	1	2	2	4	6
291	146	2.1027	1	1	2	2	4
292	5120	17.8982	4	7	13	22	35
293	496	7.4839	1	3	6	10	15
294	90766	7.2914	3	4	6	8	13
295	3379	5.8387	2	3	4	7	11
296	215338	8.3968	2	4	6	10	16
297	44861	5.2013	2	3	4	6	9
298	69	4.4638	1	2	2	5	7
299	888	6.6678	1	3	5	8	14
300	12045	9.3865	3	4	7	11	18
301	2085	5.3050	1	2	4	7	10
302	7144	15.9681	7	9	13	19	28
303	17590	13.3629	6	8	10	15	23
304	14273	13.5524	4	6	10	16	26
305	3538	6.4002	2	3	5	8	12
306	12338	8.8517	3	4	6	11	17
307	4245	4.5246	2	3	4	5	8
308	10437	9.0834	2	3	6	11	19
309	4429	3.9600	1	2	3	5	8
310	35678	5.6214	1	2	4	7	11
311	19461	2.6887	1	1	2	3	5
312	3139	5.5027	1	2	4	7	11
313	1844	2.7533	1	1	2	3	5
314	1	8.0000	8	8	8	8	8

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
315	27894	12.3610	1	3	7	15	27
316	49895	9.1767	2	4	7	12	19
317	745	4.1195	1	2	3	4	8
318	6697	9.0769	2	3	6	11	19
319	839	3.9774	1	1	2	5	8
320	165178	8.4285	3	4	6	10	15
321	29299	5.8938	2	3	5	7	10
322	53	5.6038	2	3	5	7	10
323	20914	4.2820	1	2	3	5	9
324	13699	2.5722	1	1	2	3	5
325	9767	5.7981	2	3	4	7	11
326	3603	3.5795	1	2	3	4	7
327	10	6.5000	1	2	5	8	10
328	1298	4.9561	1	2	4	6	9
329	338	2.8787	1	1	2	4	5
331	30171	7.5097	2	3	6	9	15
332	5910	4.4795	1	2	3	5	9
333	339	7.6254	2	3	5	10	16
334	22733	9.1258	5	6	8	10	14
335	10704	7.2682	5	6	7	8	10
336	107269	5.8199	3	3	4	7	10
337	89282	3.8213	2	3	3	4	6
338	7501	5.3325	1	1	2	6	13
339	3288	4.6946	1	1	2	5	11
340	3	4.6667	3	3	4	7	7
341	13025	4.4253	1	2	3	5	8
342	416	3.8341	1	1	2	4	9
343	2	2.0000	1	1	3	3	3
344	4869	5.3828	1	2	4	6	10
345	2562	4.8989	1	2	3	5	10
346	7815	8.6271	2	3	6	10	17
347	925	4.4108	1	1	3	5	9
348	4360	5.7681	1	2	4	7	11
349	1641	3.0494	1	1	2	4	6
350	8153	5.8803	2	3	5	7	10
352	787	4.8475	1	2	3	6	10
353	2326	11.4596	5	6	9	14	21
354	9569	8.2302	4	5	6	9	14
355	6048	4.9854	3	4	5	6	7
356	31936	4.3107	2	3	4	5	7
357	6917	12.5038	5	7	10	15	23
358	23628	6.5656	3	4	5	7	11
359	27186	4.4800	3	4	4	5	6
360	9695	5.2309	2	3	4	6	9
361	448	5.5670	1	2	3	6	14
363	5796	4.3171	1	2	3	4	8
364	2694	4.1771	1	1	2	5	8
365	3201	10.7688	3	4	7	13	23
366	4975	10.1785	2	3	7	13	22
367	817	3.9584	1	1	3	4	8
368	1515	7.5129	2	4	6	9	14

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2542	4.547	1	2	3	6	9
370	683	7.040	3	4	5	7	11
371	764	4.419	3	3	4	5	6
372	443	3.731	1	2	3	4	6
373	2715	2.594	1	2	2	3	3
374	75	4.027	2	2	2	3	6
375	7	14.714	1	2	2	7	14
376	160	2.906	1	1	2	3	6
377	27	5.111	1	2	4	7	10
378	144	3.632	2	2	3	4	6
379	329	2.960	1	1	2	3	6
380	72	2.792	1	1	1	3	6
381	245	2.482	1	1	1	3	4
382	60	1.433	1	1	1	2	2
383	900	4.437	1	2	3	5	9
384	104	2.654	1	1	2	3	6
385	5	3.000	1	1	3	4	6
386	1	149.000	149	149	149	149	149
387	1	6.000	6	6	6	6	6
389	8	8.375	1	4	7	9	11
390	18	6.056	1	2	3	11	13
392	2500	14.038	5	7	10	18	27
394	1992	10.334	1	2	6	12	22
395	72540	6.472	2	3	5	8	13
396	13	3.154	1	1	2	2	5
397	12766	7.490	2	3	5	9	15
398	14721	8.382	3	4	6	10	15
399	1662	5.261	1	2	4	7	10
400	8125	13.401	3	5	9	17	28
401	6816	15.097	3	6	11	19	31
402	2346	5.159	1	2	3	7	11
403	28354	12.006	2	5	8	15	25
404	5255	5.683	1	2	4	7	12
405	5	2.000	1	1	2	3	3
406	3737	15.477	4	7	11	19	31
407	958	6.558	2	3	5	8	12
408	4841	8.490	1	2	5	10	20
409	7660	9.110	2	4	5	11	21
410	124349	3.621	1	2	3	5	6
411	162	3.272	1	1	2	4	7
412	157	2.892	1	1	2	4	6
413	9700	10.734	2	4	8	14	22
414	1716	6.115	1	2	4	8	13
415	29926	20.640	5	9	15	25	41
416	138291	10.414	2	5	8	13	19
417	47	5.532	2	3	5	7	8
418	14577	8.311	3	4	7	10	15
419	17412	7.497	2	4	6	9	14
420	3780	5.416	2	3	4	7	10
421	12412	5.645	2	3	4	7	10
422	109	6.156	2	3	5	7	12

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
423	7323	11.226	3	5	8	13	22
424	2818	23.715	3	8	16	28	47
425	18133	6.508	2	3	4	8	13
426	6147	7.331	2	3	5	9	15
427	2046	7.858	1	3	5	9	16
428	1150	10.689	2	3	6	13	24
429	31113	12.334	3	4	7	13	23
430	57475	12.437	3	5	9	16	25
431	250	11.300	1	3	5	9	14
432	548	7.708	1	2	4	8	15
433	6008	4.534	1	1	3	5	11
434	18337	7.918	2	3	5	9	15
435	12935	6.364	2	3	5	7	13
436	2504	17.861	5	10	19	25	28
437	10883	16.706	6	10	15	23	28
439	971	9.550	1	3	6	12	22
440	4736	13.224	2	4	8	16	29
441	872	3.688	1	1	2	4	8
442	11761	9.987	1	3	6	12	21
443	6002	3.737	1	1	2	5	8
444	4028	7.426	2	3	5	8	13
445	2264	4.339	1	2	3	5	8
447	3187	3.543	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29594	6.013	1	2	4	7	12
450	7607	3.304	1	1	2	4	7
451	7	147.571	1	3	5	10	11
452	18057	6.266	1	2	4	7	13
453	5986	3.560	1	2	3	4	7
454	4165	7.084	1	2	4	8	14
455	1149	3.269	1	1	2	4	6
456	182	9.242	1	2	5	10	21
457	127	8.835	1	1	3	10	18
458	1650	22.930	5	10	17	30	45
459	585	14.899	3	6	11	18	30
460	2421	9.185	2	4	7	12	19
461	5377	5.533	1	1	2	5	13
462	6756	17.934	5	8	15	23	33
463	9499	6.760	2	3	5	8	13
464	2995	4.124	1	2	3	5	8
465	448	3.364	1	1	1	3	6
466	3722	5.015	1	1	2	4	10
467	3626	6.329	1	1	2	5	10
468	63537	19.076	4	8	14	23	37
471	7812	14.127	7	9	11	16	23
472	184	29.788	1	8	24	43	63
473	8381	17.072	2	4	10	26	41
475	75734	14.078	2	6	11	18	28
476	10885	17.193	6	10	14	20	29
477	37365	10.590	1	3	7	13	22
478	105150	10.267	2	4	7	13	21

TABLE 7A - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V9.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
479	17990	5.4611	1	2	5	7	10
480	117	40.2906	11	16	23	47	90
481	65	45.6615	24	31	39	53	77
482	6901	18.3908	6	9	13	21	35
483	34649	56.5547	17	28	44	69	105
484	316	23.1867	2	9	18	33	49
485	2647	17.1417	6	8	12	19	31
486	1932	17.5088	1	7	13	23	36
487	3112	11.3249	2	4	8	14	22
488	519	22.9518	5	10	16	27	44
489	4816	14.2091	3	5	10	17	29
490	1787	8.9485	2	3	5	10	19
491	6826	6.3898	3	4	5	8	11
492	998	14.3337	3	4	6	24	34
	10357081						

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
001	28876	15.9617	4	7	11	19	32
002	6031	15.1069	4	7	11	19	30
003	3	2.0000	1	1	1	4	4
004	5300	13.0400	3	5	9	16	27
005	53888	6.7762	2	3	5	8	13
006	868	3.2857	1	1	2	3	7
007	5961	22.0765	2	6	11	23	47
008	2772	4.6032	1	1	3	6	10
009	1731	10.3039	2	4	7	12	21
010	20406	10.9344	2	4	7	14	22
011	3565	6.3719	1	2	4	8	13
012	21663	10.6732	2	4	7	12	19
013	5723	8.5598	3	4	7	10	15
014	342315	10.0711	3	4	7	12	19
015	135323	5.4583	2	3	4	6	10
016	11124	9.3788	3	4	7	11	18
017	2966	5.8736	2	3	4	7	10
018	13951	8.0095	2	4	6	9	15
019	6986	5.4705	1	2	4	7	10
020	7578	12.6498	3	5	9	16	25
021	1032	9.6909	3	4	7	12	19
022	9831	5.5487	2	3	4	7	10
023	3143	6.2685	1	2	4	7	12
024	54473	7.3996	2	3	5	9	14
025	22879	4.4291	1	2	3	5	8
026	61	5.9344	1	2	3	8	14
027	2808	8.2942	1	2	4	10	19
028	8249	9.5305	2	3	6	11	19
029	3690	4.8705	1	2	3	6	10
030	2	1.0000	1	1	1	1	1
031	3757	7.0186	2	2	4	8	13
032	2713	3.6922	1	2	3	4	7
034	13703	8.9718	2	3	6	10	17
035	3837	5.2434	1	2	4	6	10
036	20529	2.3437	1	1	2	3	4
037	2746	4.6555	1	1	3	5	10
038	784	2.9426	1	1	2	3	5
039	9719	1.9414	1	1	1	2	3
040	3422	3.4278	1	1	2	4	8
042	20598	2.5786	1	1	2	3	5
043	207	5.5266	1	2	4	6	10
044	1996	6.2856	2	4	5	7	11
045	2641	4.4623	1	2	4	6	8
046	2904	6.3402	1	2	5	8	12
047	1891	4.4093	1	1	3	5	8
048	2	7.0000	5	5	9	9	9
049	2965	7.5400	2	3	5	9	15
050	4906	2.6229	1	1	2	3	4
051	534	2.8614	1	1	2	3	6
052	175	3.1886	1	1	2	3	6
053	6529	3.4422	1	1	2	3	8

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
055	3659	2.7349	1	1	1	2	6
056	1151	2.7958	1	1	2	3	6
057	710	5.3620	1	2	3	6	11
058	1	1.0000	1	1	1	1	1
059	185	2.1568	1	1	1	2	4
060	1	18.0000	18	18	18	18	18
061	385	5.0026	1	1	2	6	12
063	4945	5.6977	1	2	4	7	11
064	4372	8.9318	1	2	6	11	20
065	32587	4.1850	1	2	3	5	8
066	7860	4.3564	1	2	3	5	8
067	437	5.2014	2	3	4	6	9
068	11729	6.0495	2	3	5	7	11
069	3772	4.2858	2	2	4	5	8
070	18	4.3889	1	2	2	5	9
071	136	5.1176	2	3	4	6	10
072	685	5.7460	1	2	3	6	9
073	6685	6.0432	1	2	4	7	12
074	2	11.0000	9	9	13	13	13
075	32193	13.7943	6	8	10	16	26
076	40220	14.8394	4	7	11	18	28
077	3502	6.5580	1	2	5	9	14
078	26963	10.0607	4	7	9	12	16
079	140699	11.8842	4	6	9	14	22
080	9304	7.9451	3	4	7	10	14
081	1	7.0000	7	7	7	7	7
082	70711	9.5833	2	4	7	12	19
083	7420	8.1515	2	4	6	10	15
084	1879	4.4050	1	2	3	6	8
085	17755	9.0945	2	4	7	11	17
086	1757	5.3199	1	2	4	7	10
087	61415	8.1182	2	4	6	10	15
088	166636	7.3926	3	4	6	9	13
089	380530	8.7583	3	5	7	11	15
090	46157	6.2364	3	4	5	8	10
091	48	6.1042	2	3	5	7	11
092	9095	8.7428	3	4	7	11	16
093	1504	6.0632	2	3	5	8	11
094	9730	9.5251	3	4	7	11	18
095	1324	6.1284	2	3	4	7	10
096	181510	7.1153	3	4	6	8	12
097	32577	5.1442	2	3	4	6	9
098	18	6.2778	2	3	5	6	10
099	31096	5.1861	1	2	4	6	10
100	11482	3.1253	1	2	2	4	6
101	19157	6.8025	2	3	5	8	13
102	3754	4.3207	1	2	3	5	8
103	282	33.8262	10	14	21	40	68
104	17814	20.3496	9	12	17	25	35
105	16203	14.4966	7	9	11	16	25
106	76162	15.2542	8	10	13	17	24

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
107	52857	11.7523	7	8	9	13	18
108	8959	15.2274	7	9	12	18	28
110	51947	13.5024	3	8	11	16	25
111	6304	8.4123	3	6	8	10	13
112	131196	6.0898	2	3	5	8	12
113	37297	19.0379	6	8	14	23	37
114	8229	12.4901	3	5	9	15	24
115	8512	13.9016	5	8	11	17	24
116	67194	7.2077	2	3	5	9	14
117	3381	5.5061	1	2	3	7	12
118	8483	3.9088	1	1	2	4	8
119	3237	6.3031	1	2	3	7	15
120	34573	12.4687	2	3	8	16	27
121	146199	9.6359	4	6	8	11	16
122	100359	6.8565	2	4	7	9	11
123	56218	5.3458	1	1	3	7	13
124	125726	5.7739	1	2	5	7	11
125	89536	3.1482	1	1	2	4	7
126	4302	20.4328	5	10	16	29	41
127	612827	7.7476	2	4	6	9	14
128	23541	8.4050	4	5	7	10	13
129	6269	4.7437	1	1	1	6	12
130	71880	8.1132	2	4	7	10	14
131	26526	5.9725	1	3	6	8	10
132	12394	5.5501	1	2	4	7	11
133	4077	3.9146	1	2	3	5	7
134	29162	4.9837	2	2	4	6	9
135	6400	6.5938	2	3	5	8	13
136	1424	4.2507	1	2	3	5	7
138	188352	5.8759	2	3	4	7	11
139	72186	3.6766	1	2	3	5	7
140	346480	4.4712	2	2	4	5	8
141	77799	5.7258	2	3	4	7	10
142	37177	3.9232	1	2	3	5	7
143	117399	3.3738	1	2	3	4	6
144	56530	7.0916	1	3	5	9	14
145	8425	4.1858	1	2	3	5	8
146	7640	13.8241	7	9	11	15	23
147	1590	8.9233	5	7	9	11	13
148	143851	15.9248	7	9	12	19	28
149	18122	9.0774	6	7	8	10	13
150	21960	13.9135	5	8	11	17	25
151	4781	7.7473	3	4	7	10	13
152	4605	10.6725	5	7	9	12	18
153	2059	7.0515	4	5	7	8	10
154	37694	18.0724	7	9	14	22	34
155	4202	8.5626	4	5	7	10	14
157	13356	6.5860	2	3	4	8	13
158	9999	3.0529	1	1	2	4	6
159	16539	6.3772	2	3	5	8	12
160	12946	3.3294	1	2	3	4	6

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
161	24227	4.6376	1	2	3	6	10
162	21251	2.2036	1	1	2	3	4
163	13	2.6923	1	1	2	4	5
164	4685	11.4055	5	7	9	13	19
165	1819	6.9940	3	5	7	9	11
166	2982	7.1596	3	4	6	9	13
167	2188	4.1165	2	3	4	5	7
168	1871	5.7691	1	2	3	7	12
169	1391	2.8246	1	1	2	3	6
170	12992	15.9273	3	7	11	20	31
171	1463	6.8578	1	3	5	9	13
172	31475	10.4531	2	4	7	13	22
173	3266	5.2655	1	2	4	7	11
174	168078	6.9517	2	4	5	8	13
175	22521	4.3582	2	3	4	5	7
176	13120	7.7104	2	4	6	9	14
177	15059	6.2747	2	3	5	7	11
178	6479	4.4373	2	3	4	5	8
179	8803	9.5372	3	4	7	11	18
180	70546	7.6470	2	4	6	9	14
181	22180	4.5757	2	3	4	6	8
182	261192	6.2600	2	3	5	7	11
183	77885	4.1977	1	2	3	5	8
184	59	4.0508	1	2	3	4	7
185	3999	6.2591	1	3	5	8	12
186	1	4.0000	4	4	4	4	4
187	1050	3.8629	1	1	2	5	8
188	50649	7.4105	2	3	5	9	15
189	9116	3.8873	1	1	3	5	8
190	99	5.3131	2	3	4	6	10
191	10256	20.0999	7	10	15	24	40
192	965	9.5440	3	6	8	12	16
193	12618	16.6354	7	9	14	20	29
194	1427	9.6797	3	6	9	12	17
195	17622	12.3429	6	7	10	14	20
196	1802	8.0733	4	5	7	10	13
197	78222	8.5152	2	4	7	11	16
198	49186	3.6220	1	1	3	5	7
199	2886	14.4016	4	7	11	18	28
200	1957	13.6811	2	5	10	18	28
201	3042	14.3859	3	6	10	18	30
202	18194	9.7128	2	4	7	12	19
203	29827	9.7680	2	4	7	12	20
204	39939	8.0722	3	4	6	9	15
205	21234	9.1487	2	4	7	11	18
206	2450	5.0184	1	2	4	7	10
207	38205	7.0373	2	3	5	9	13
208	14164	4.0379	1	2	3	5	7
209	271606	10.5789	6	7	9	12	16
210	118940	13.0684	6	8	10	14	21
211	29021	9.4534	5	6	8	11	14

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
212	18	6.1111	2	2	3	7	9
213	5859	13.0282	3	6	9	16	25
214	42479	10.3023	4	5	8	12	19
215	38652	6.0877	3	4	5	7	10
216	7180	14.5876	3	6	11	18	29
217	17145	21.5360	4	8	14	27	46
218	18844	9.1075	3	4	7	11	17
219	18074	5.1644	2	3	4	6	9
220	4	2.2500	1	1	2	3	3
221	4936	10.7784	2	4	8	13	21
222	5308	5.2472	1	2	4	7	10
223	16039	4.0491	1	2	3	4	7
224	8886	2.9099	1	2	2	3	5
225	10360	5.2777	1	2	3	6	12
226	5572	9.0720	2	3	6	11	20
227	6542	3.8658	1	2	3	4	7
228	4272	3.6987	1	1	2	4	8
229	2541	2.6564	1	1	2	3	5
230	3279	6.4535	1	2	4	7	13
231	10405	6.5790	1	2	4	7	15
232	799	6.6083	1	2	3	7	17
233	5329	11.7467	3	5	9	15	23
234	3072	5.3665	1	2	4	7	11
235	6401	11.4805	2	4	7	12	24
236	39084	8.9773	2	4	7	10	17
237	1693	5.8328	2	3	4	7	10
238	6472	13.9322	4	6	10	17	28
239	60286	10.0598	3	5	7	12	19
240	11175	9.5085	3	4	7	11	18
241	4000	5.6287	2	3	4	7	11
242	2544	10.5491	3	5	8	13	22
243	106101	6.8511	2	3	5	9	13
244	11219	7.2646	2	3	5	9	14
245	5730	5.5091	1	2	4	6	10
246	1753	5.4780	2	3	4	7	10
247	9981	5.1535	1	2	4	6	10
248	6331	6.2402	2	3	5	7	12
249	8552	6.4259	1	2	4	8	13
250	3461	6.8050	2	3	5	8	13
251	3274	3.6130	1	1	2	4	7
253	17409	8.1683	2	3	6	9	16
254	12343	4.7343	1	2	3	6	9
255	2	2.5000	1	1	4	4	4
256	9411	5.4601	1	2	4	6	11
257	28803	5.1188	2	3	4	6	9
258	26586	3.6258	2	2	3	4	6
259	4071	5.9560	1	2	3	6	13
260	4963	2.5350	1	1	2	3	4
261	3080	2.8042	1	1	2	3	5
262	1296	3.5517	1	1	2	3	7
263	29564	20.5709	5	8	14	24	41

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
264	4234	11.3791	3	5	8	14	23
265	4999	9.8200	2	3	6	11	21
266	4190	4.4174	1	2	3	5	9
267	379	4.8021	1	1	3	5	11
268	1482	5.0628	1	1	2	5	9
269	11065	12.2933	2	4	9	15	25
270	5144	4.0072	1	2	3	5	8
271	20052	11.6591	3	5	8	13	21
272	6944	9.4241	3	5	7	11	18
273	2223	6.8277	2	3	5	8	14
274	3099	10.9935	2	4	7	13	21
275	383	5.6789	1	1	3	5	9
276	877	5.6328	1	2	4	7	11
277	72052	8.4759	3	5	7	10	15
278	26250	6.1446	3	4	5	7	10
279	6	7.0000	2	3	4	11	11
280	13349	6.8287	2	3	5	8	13
281	7419	4.1867	1	2	3	5	8
282	1	2.0000	2	2	2	2	2
283	5928	7.2763	2	3	5	8	14
284	2390	5.0753	1	2	4	6	9
285	4656	21.4021	5	9	15	25	41
286	1753	11.3440	5	6	8	13	22
287	6675	18.9768	5	7	12	21	39
288	533	10.1576	3	4	6	10	21
289	4013	5.6845	2	2	3	5	12
290	9686	3.4577	1	2	2	4	6
291	146	2.1027	1	1	2	2	4
292	5120	17.8982	4	7	13	22	35
293	496	7.4839	1	3	6	10	15
294	90766	7.2914	3	4	6	8	13
295	3379	5.8387	2	3	4	7	11
296	215338	8.3968	2	4	6	10	16
297	44861	5.2013	2	3	4	6	9
298	69	4.4638	1	2	2	5	7
299	888	6.6678	1	3	5	8	14
300	12045	9.3865	3	4	7	11	18
301	2085	5.3050	1	2	4	7	10
302	7144	15.9681	7	9	13	19	28
303	17590	13.3629	6	8	10	15	23
304	14273	13.5524	4	6	10	16	26
305	3538	6.4002	2	3	5	8	12
306	12338	8.8517	3	4	6	11	17
307	4245	4.5246	2	3	4	5	8
308	10437	9.0834	2	3	6	11	19
309	4429	3.9600	1	2	3	5	8
310	35678	5.6214	1	2	4	7	11
311	19461	2.6887	1	1	2	3	5
312	3139	5.5027	1	2	4	7	11
313	1844	2.7533	1	1	2	3	5
314	1	8.0000	8	8	8	8	8

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
315	27894	12.3610	1	3	7	15	27
316	49895	9.1767	2	4	7	12	19
317	745	4.1195	1	2	3	4	8
318	6697	9.0769	2	3	6	11	19
319	839	3.9774	1	1	2	5	8
320	165178	8.4285	3	4	6	10	15
321	29299	5.8938	2	3	5	7	10
322	53	5.6038	2	3	5	7	10
323	20914	4.2820	1	2	3	5	9
324	13699	2.5722	1	1	2	3	5
325	9767	5.7981	2	3	4	7	11
326	3603	3.5795	1	2	3	4	7
327	10	6.5000	1	2	5	8	10
328	1298	4.9561	1	2	4	6	9
329	338	2.8787	1	1	2	4	5
331	30171	7.5097	2	3	6	9	15
332	5910	4.4795	1	2	3	5	9
333	339	7.6254	2	3	5	10	16
334	22733	9.1258	5	6	8	10	14
335	10704	7.2682	5	6	7	8	10
336	101256	5.7064	3	3	4	6	10
337	87102	3.8107	2	3	3	4	6
338	14297	6.1942	1	2	4	8	13
339	4685	4.8273	1	2	3	5	10
340	3	4.6667	3	3	4	7	7
341	13025	4.4253	1	2	3	5	8
342	416	3.8341	1	1	2	4	9
343	2	2.0000	1	1	3	3	3
344	4869	5.3828	1	2	4	6	10
345	2562	4.8989	1	2	3	5	10
346	7815	8.6271	2	3	6	10	17
347	925	4.4108	1	1	3	5	9
348	4360	5.7681	1	2	4	7	11
349	1641	3.0494	1	1	2	4	6
350	8153	5.8803	2	3	5	7	10
352	787	4.8475	1	2	3	6	10
353	2326	11.4596	5	6	9	14	21
354	9569	8.2302	4	5	6	9	14
355	6048	4.9854	3	4	5	6	7
356	31936	4.3107	2	3	4	5	7
357	6917	12.5038	5	7	10	15	23
358	23628	6.5656	3	4	5	7	11
359	27186	4.4800	3	4	4	5	6
360	9695	5.2309	2	3	4	6	9
361	448	5.5670	1	2	3	6	14
363	5796	4.3171	1	2	3	4	8
364	2694	4.1771	1	1	2	5	8
365	3201	10.7688	3	4	7	13	23
366	4975	10.1785	2	3	7	13	22
367	817	3.9584	1	1	3	4	8
368	1515	7.5129	2	4	6	9	14

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
369	2542	4.547	1	2	3	6	9
370	683	7.040	3	4	5	7	11
371	764	4.419	3	3	4	5	6
372	443	3.731	1	2	3	4	6
373	2715	2.594	1	2	2	3	3
374	75	4.027	2	2	2	3	6
375	7	14.714	1	2	2	7	14
376	160	2.906	1	1	2	3	6
377	27	5.111	1	2	4	7	10
378	144	3.632	2	2	3	4	6
379	329	2.960	1	1	2	3	6
380	72	2.792	1	1	1	3	6
381	245	2.482	1	1	1	3	4
382	60	1.433	1	1	1	2	2
383	900	4.437	1	2	3	5	9
384	104	2.654	1	1	2	3	6
385	5	3.000	1	1	3	4	6
386	1	149.000	149	149	149	149	149
387	1	6.000	6	6	6	6	6
389	8	8.375	1	4	7	9	11
390	18	6.056	1	2	3	11	13
392	2500	14.038	5	7	10	18	27
394	1992	10.334	1	2	6	12	22
395	72540	6.472	2	3	5	8	13
396	13	3.154	1	1	2	2	5
397	12766	7.490	2	3	5	9	15
398	14721	8.382	3	4	6	10	15
399	1662	5.261	1	2	4	7	10
400	8125	13.401	3	5	9	17	28
401	6816	15.097	3	6	11	19	31
402	2346	5.159	1	2	3	7	11
403	28354	12.006	2	5	8	15	25
404	5255	5.683	1	2	4	7	12
405	5	2.000	1	1	2	3	3
406	3737	15.477	4	7	11	19	31
407	958	6.558	2	3	5	8	12
408	4841	8.490	1	2	5	10	20
409	7660	9.110	2	4	5	11	21
410	124349	3.621	1	2	3	5	6
411	162	3.272	1	1	2	4	7
412	157	2.892	1	1	2	4	6
413	9700	10.734	2	4	8	14	22
414	1716	6.115	1	2	4	8	13
415	29926	20.640	5	9	15	25	41
416	138291	10.414	2	5	8	13	19
417	47	5.532	2	3	5	7	8
418	14577	8.311	3	4	7	10	15
419	17412	7.497	2	4	6	9	14
420	3780	5.416	2	3	4	7	10
421	12412	5.645	2	3	4	7	10
422	109	6.156	2	3	5	7	12

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
423	7323	11.226	3	5	8	13	22
424	2818	23.715	3	8	16	28	47
425	18133	6.508	2	3	4	8	13
426	6147	7.331	2	3	5	9	15
427	2046	7.858	1	3	5	9	16
428	1150	10.689	2	3	6	13	24
429	31113	12.334	3	4	7	13	23
430	57475	12.437	3	5	9	16	25
431	250	11.300	1	3	5	9	14
432	548	7.708	1	2	4	8	15
433	5992	4.500	1	1	3	5	11
434	17930	7.661	2	3	5	9	15
435	12858	6.344	2	3	5	7	13
436	2469	17.753	5	10	18	25	28
437	10763	16.620	6	10	15	23	28
439	971	9.550	1	3	6	12	22
440	4736	13.224	2	4	8	16	29
441	872	3.688	1	1	2	4	8
442	11761	9.987	1	3	6	12	21
443	6002	3.737	1	1	2	5	8
444	4028	7.426	2	3	5	8	13
445	2264	4.339	1	2	3	5	8
447	3187	3.543	1	1	2	4	7
448	1	1.000	1	1	1	1	1
449	29594	6.013	1	2	4	7	12
450	7607	3.304	1	1	2	4	7
451	7	147.571	1	3	5	10	11
452	18057	6.266	1	2	4	7	13
453	5986	3.560	1	2	3	4	7
454	4165	7.084	1	2	4	8	14
455	1149	3.269	1	1	2	4	6
456	182	9.242	1	2	5	10	21
457	127	8.835	1	1	3	10	18
458	1650	22.930	5	10	17	30	45
459	585	14.899	3	6	11	18	30
460	2421	9.185	2	4	7	12	19
461	5377	5.533	1	1	2	5	13
462	6756	17.934	5	8	15	23	33
463	9499	6.760	2	3	5	8	13
464	2995	4.124	1	2	3	5	8
465	448	3.364	1	1	1	3	6
466	3722	5.015	1	1	2	4	10
467	3626	6.329	1	1	2	5	10
468	63800	19.120	4	8	14	23	37
471	7812	14.127	7	9	11	16	23
472	184	29.788	1	8	24	43	63
473	8381	17.072	2	4	10	26	41
475	75734	14.078	2	6	11	18	28
476	10935	17.198	6	10	14	20	29
477	37707	10.597	1	3	7	13	22
478	105147	10.267	2	4	7	13	21

TABLE 7B - MEDICARE PROSPECTIVE PAYMENT SYSTEM
SELECTED PERCENTILE LENGTHS OF STAY
FY91 MEDPAR UPDATE 06/92 GROUPER V10.0

DRG	NUMBER DISCHARGES	ARITHMETIC MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	90TH PERCENTILE
479	17990	5.4611	1	2	5	7	10
480	117	40.2906	11	16	23	47	90
481	64	44.8906	23	31	37	50	72
482	6901	18.3908	6	9	13	21	35
483	34650	56.5558	17	28	44	69	105
484	316	23.1867	2	9	18	33	49
485	2647	17.1417	6	9	12	19	31
486	1932	17.5088	1	7	13	23	36
487	3112	11.3249	2	4	8	14	22
488	519	22.9518	5	10	16	27	44
489	4816	14.2091	3	5	10	17	29
490	1787	8.9485	2	3	5	10	19
491	6826	6.3898	3	4	5	8	11
492	998	14.3337	3	4	6	24	34
	10357081						

BILLING CODE 4120-03-C

TABLE 8a.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)

State	Urban	Rural
Alabama	0.495	0.532
Alaska	0.657	0.883
Arizona	0.576	0.622
Arkansas	0.598	0.570
California	0.502	0.542
Colorado	0.570	0.620
Connecticut	0.645	0.688
Delaware	0.601	0.641
District of Columbia	0.574	
Florida	0.496	0.503
Georgia	0.593	0.581
Hawaii	0.573	0.772
Idaho	0.657	0.673
Illinois	0.553	0.621
Indiana	0.664	0.675
Iowa	0.610	0.729
Kansas	0.562	0.706
Kentucky	0.588	0.579
Louisiana	0.542	0.600
Maine	0.702	0.625
Maryland	0.765	0.806
Massachusetts	0.727	0.800
Michigan	0.560	0.660
Minnesota	0.634	0.721
Mississippi	0.627	0.583
Missouri	0.530	0.561
Montana	0.626	0.698
Nebraska	0.588	0.723
Nevada	0.478	0.681
New Hampshire	0.656	0.688
New Jersey	0.796	
New Mexico	0.524	0.580
New York	0.661	0.734
North Carolina	0.662	0.582
North Dakota	0.660	0.712
Ohio	0.626	0.659
Oklahoma	0.549	0.599
Oregon	0.613	0.680

TABLE 8a.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)—Continued

State	Urban	Rural
Pennsylvania	0.510	0.602
Puerto Rico	0.526	0.620
Rhode Island	0.765	
South Carolina	0.551	0.545
South Dakota	0.627	0.688
Tennessee	0.573	0.572
Texas	0.548	0.653
Utah	0.620	0.641
Vermont	0.674	0.658
Virginia	0.576	0.595
Washington	0.703	0.740
West Virginia	0.598	0.563
Wisconsin	0.720	0.745
Wyoming	0.693	0.776

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED)

State	Ratio
Alabama	0.062
Alaska	0.106
Arizona	0.082
Arkansas	0.065
California	0.051
Colorado	0.058
Connecticut	0.040
Delaware	0.065
District of Columbia	0.045
Florida	0.063
Georgia	0.061
Hawaii	0.057
Idaho	0.052
Illinois	0.053

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED)—Continued

State	Ratio
Indiana	0.071
Iowa	0.064
Kansas	0.065
Kentucky	0.066
Louisiana	0.079
Maine	0.047
Maryland	0.058
Massachusetts	0.056
Michigan	0.058
Minnesota	0.060
Mississippi	0.059
Missouri	0.060
Montana	0.075
Nebraska	0.061
Nevada	0.053
New Hampshire	0.057
New Jersey	0.079
New Mexico	0.058
New York	0.062
North Carolina	0.055
North Dakota	0.073
Ohio	0.064
Oklahoma	0.068
Oregon	0.041
Pennsylvania	0.054
Puerto Rico	0.090
Rhode Island	0.042
South Carolina	0.069
South Dakota	0.076
Tennessee	0.068
Texas	0.071
Utah	0.063
Vermont	0.060
Virginia	0.068
Washington	0.084
West Virginia	0.067
Wisconsin	0.077
Wyoming	0.081

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
010001	10/01/90	09/30/91	1.2806	0.9979
010004	10/01/90	09/30/91	0.9033	0.9616
010005	10/01/90	09/30/91	1.1249	0.9743
010007	10/01/90	09/30/91	1.1007	0.9635
010008	10/01/90	09/30/91	1.0048	0.9708
010009	08/01/90	07/31/91	1.0238	0.9660
010010	10/01/90	09/30/91	1.1145	0.9681
010016	10/01/90	09/30/91	1.0753	0.9774
010019	10/01/90	09/30/91	1.1702	0.9869
010020	07/01/90	11/20/91	1.0085	0.9690
010021	10/01/90	09/30/91	1.2109	0.9802
010029	10/01/90	09/30/91	1.4918	0.9964
010032	01/01/91	12/31/91	0.8937	0.9142
010033	10/01/90	09/30/91	1.9478	0.9962
010035	10/01/90	09/30/91	1.1651	0.9755
010040	01/01/91	12/31/91	1.3049	0.9890
010043	10/01/90	09/30/91	0.9482	0.9536
010044	10/01/90	09/30/91	0.9697	0.9678
010045	10/01/90	09/30/91	1.0115	0.9725
010046	07/01/90	07/31/91	1.3105	0.9906
010047	10/01/90	09/30/91	0.9033	0.9738
010049	09/01/90	08/31/91	1.0894	0.9756
010051	10/01/90	09/30/91	0.8599	0.9590
010052	10/01/90	09/30/91	0.9563	0.9122
010053	07/01/90	09/30/91	1.0054	0.9477
010059	10/01/90	09/30/91	0.9973	0.9683
010061	10/01/90	09/30/91	0.9575	0.9669
010062	10/01/90	09/30/91	0.9481	0.9778

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
010065	01/01/91	12/31/91	1.1990	0.9549
010069	10/01/90	09/30/91	1.1602	0.9505
010073	10/01/90	09/30/91	0.8982	0.9292
010079	10/01/90	09/30/91	1.1474	0.9719
010081	09/01/90	08/31/91	1.8118	0.9952
010083	10/01/90	09/30/91	1.0972	0.9534
010084	01/01/91	12/31/91	1.2941	0.9972
010087	10/01/90	09/30/91	1.5170	0.9965
010092	10/01/90	09/30/91	1.3697	0.9999
010094	09/01/90	08/31/91	1.1874	0.9758
010095	10/01/90	09/30/91	1.0125	0.9462
010096	10/01/90	09/30/91	0.9047	0.9716
010097	10/01/90	09/30/91	1.0062	0.9688
010099	10/01/90	09/30/91	1.0895	0.9614
010100	10/01/90	09/30/91	1.1675	0.9821
010102	10/01/90	09/30/91	0.9123	0.9609
010108	11/01/90	10/31/91	1.1574	0.9745
010109	10/01/90	09/30/91	1.0718	0.9889
010110	10/01/90	09/30/91	0.9068	0.9665
010112	10/01/90	09/30/91	1.1465	0.9662
010115	10/01/90	09/30/91	0.8956	0.9389
010117	10/01/90	09/30/91	1.1192	1.0000
010119	10/01/90	09/30/91	1.1919	0.9942
010120	10/01/90	09/30/91	0.9815	0.9669
010122	01/01/91	12/31/91	0.9541	0.9658
010123	09/01/90	08/31/91	1.2749	0.9815
010124	09/01/90	08/31/91	1.2798	0.9876
010125	10/01/90	09/30/91	1.0998	0.9682
010126	10/01/90	09/30/91	1.0810	0.9709
010127	09/01/90	08/31/91	1.4985	0.9980
010129	10/01/90	09/30/91	1.0510	0.9460
010130	10/01/90	09/30/91	1.1140	0.9612
010137	10/01/90	09/30/91	1.2943	0.9938
010139	01/01/91	12/31/91	1.5773	0.9992
010143	10/01/90	09/30/91	1.1302	0.9731
010144	01/01/91	12/31/91	1.3851	0.9871
010146	10/01/90	09/30/91	1.0477	0.9549
010149	09/01/90	08/31/91	1.3679	0.9915
010152	10/01/90	09/30/91	1.2562	0.9839
010153	10/01/90	09/30/91	0.8914	1.0000
010155	10/01/90	09/30/91	1.1262	0.9360
020001	01/01/91	12/31/91	1.4626	0.9975
020005	10/01/90	09/30/91	0.8931	0.9364
020006	01/01/91	12/31/91	1.0309	0.9708
020012	01/01/91	12/31/91	1.1408	0.9917
020013	01/01/91	12/31/91	0.9180	0.9697
020017	09/01/90	08/31/91	1.3624	0.9902
020025	01/01/91	12/31/91	1.0106	0.9611
030001	01/01/91	12/31/91	1.3279	0.9860
030002	01/01/91	12/31/91	1.7477	0.9970
030004	10/01/90	09/30/91	0.9790	0.9878
030008	09/01/90	08/31/91	1.8840	0.9989
030012	01/01/91	12/31/91	1.2553	0.9815
030013	10/01/90	09/30/91	1.2358	0.9866
030014	01/01/91	12/31/91	1.4202	0.9976
030018	01/01/91	12/31/91	1.6005	0.9985
030023	01/01/91	12/31/91	1.2270	0.9842
030025	01/01/91	12/31/91	1.0695	0.9510
030030	09/01/90	08/31/91	1.6606	0.9994
030035	01/01/91	12/31/91	1.2880	0.9923
030036	01/01/91	12/31/91	1.2311	0.9895
030038	10/01/90	09/30/91	1.4609	0.9990
030041	01/01/91	12/31/91	0.9364	0.9179
030044	10/01/90	09/30/91	1.1153	0.9496
030046	01/01/91	12/31/91	0.9388	0.9615
030047	01/01/91	12/31/91	0.8914	0.9778
030051	07/01/90	09/30/91	1.0618	0.9832
030060	01/01/91	12/31/91	1.0843	0.9703
030061	01/01/91	12/31/91	1.4526	0.9986
030062	01/01/91	12/31/91	1.2974	0.9562
030065	01/01/91	12/31/91	1.4786	0.9980
030067	10/01/90	09/30/91	1.0451	0.9575
030068	01/01/91	12/31/91	0.9909	0.9485
030069	01/01/91	12/31/91	1.3126	0.9724
030083	09/01/90	08/31/91	1.3389	0.9837
030085	09/01/90	08/31/91	1.3875	0.9869
030086	09/01/90	08/31/91	1.1940	0.9428

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
030087	10/01/90	09/30/91	1.6019	0.9988
030088	01/01/91	12/31/91	1.2877	0.9884
030089	01/01/91	12/31/91	1.2560	0.9857
030092	01/01/91	12/31/91	1.4852	0.9848
030093	01/01/91	12/31/91	1.3038	0.9894
030094	09/01/90	08/31/91	1.2987	0.9878
040004	01/01/91	12/31/91	1.2316	0.9958
040005	10/01/90	09/30/91	1.0551	0.9494
040007	10/01/90	09/30/91	1.5315	0.9983
040010	01/01/91	12/31/91	1.1608	0.9869
040013	01/01/90	07/31/91	0.9809	0.9818
040014	09/01/90	08/31/91	1.0982	0.9894
040015	07/01/90	09/30/91	1.0368	0.9148
040018	01/01/91	12/31/91	1.2256	0.9875
040020	10/01/90	09/30/91	1.4571	0.9982
040021	01/01/91	12/31/91	1.2200	0.9941
040024	10/01/90	09/30/91	1.0829	0.9468
040027	01/01/91	12/31/91	1.2885	0.9851
040028	10/01/90	09/30/91	0.9933	0.9736
040029	01/01/91	12/31/91	1.1117	0.9750
040031	01/01/91	12/31/91	0.9701	0.9414
040036	01/01/91	12/31/91	1.2251	0.9921
040041	09/01/90	08/31/91	1.1306	0.9836
040042	01/01/91	12/31/91	1.3007	0.9870
040044	01/01/91	12/31/91	0.9470	0.9568
040045	01/01/91	12/31/91	0.9433	0.9360
040047	01/01/91	12/31/91	1.0528	0.9731
040050	10/01/90	09/30/91	1.1125	0.9720
040064	01/01/91	12/31/91	0.9004	0.9194
040066	01/01/91	12/31/91	1.0686	0.9637
040067	10/01/90	09/30/91	1.0005	0.9688
040072	12/01/90	11/30/91	1.0641	0.9620
040075	01/01/91	12/31/91	1.1147	0.9843
040078	01/01/91	12/31/91	1.2373	0.9900
040081	10/01/90	09/30/91	0.8627	0.9536
040085	01/01/91	12/31/91	1.1474	0.9611
040100	01/01/91	12/31/91	1.1281	0.9864
040105	10/01/90	09/30/91	1.0121	0.9493
040106	10/01/90	09/30/91	1.1808	0.9667
040107	10/01/90	09/30/91	1.0510	0.9564
040114	01/01/91	12/31/91	1.7152	0.9991
040118	01/01/91	12/31/91	1.2038	0.9842
040119	10/01/90	09/30/91	1.1353	0.9883
050002	10/01/90	09/30/91	1.3008	0.9874
050007	01/01/91	12/31/91	1.4866	0.9971
050008	01/01/91	12/31/91	1.4389	0.9899
050013	01/01/91	12/31/91	2.0998	0.9969
050016	01/01/90	12/31/91	1.1762	0.9858
050021	09/01/90	08/31/91	1.2898	0.9777
050022	01/01/91	12/31/91	1.5182	0.9964
050024	01/01/91	12/31/91	1.3870	0.9913
050030	12/01/90	11/30/91	1.2991	0.9888
050032	09/01/90	08/31/91	1.2768	0.9825
050043	09/01/90	08/31/91	1.5657	0.9988
050047	06/17/90	12/31/91	1.6993	0.9980
050053	01/01/91	12/31/91	1.3473	0.9966
050058	10/01/90	09/30/91	1.4050	0.9973
050060	09/01/90	08/31/91	1.4669	0.9974
050061	09/01/90	08/31/91	1.2586	0.9829
050070	01/01/91	12/31/91	1.2068	0.9802
050071	01/01/91	12/31/91	1.3136	0.9851
050072	01/01/91	12/31/91	1.2479	0.9843
050073	01/01/91	12/31/91	1.2152	0.9855
050074	01/01/91	12/31/91	1.0190	0.9606
050075	01/01/91	12/31/91	1.3040	0.9894
050076	01/01/91	12/31/91	1.4446	0.9548
050078	01/01/91	12/31/91	1.3510	0.9923
050080	01/01/91	12/31/91	1.2326	0.9922
050081	09/01/90	08/31/91	1.6385	0.9853
050084	01/01/91	12/31/91	1.5145	0.9969
050091	09/01/90	08/31/91	1.2531	0.9922
050096	01/01/91	12/31/91	1.0380	1.0000
050097	01/01/91	12/31/91	1.4292	0.9938
050099	12/30/90	12/28/91	1.6728	0.9954
050100	10/01/90	09/30/91	1.8267	0.9962
050101	01/01/91	12/31/91	1.3792	0.9882
050102	01/01/91	12/31/91	1.3268	0.9908

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050103	01/01/91	12/31/91	1.4915	0.9969
050107	12/01/90	11/30/91	1.3609	0.9871
050108	01/01/91	12/31/91	1.4254	0.9849
050109	01/01/91	12/31/91	2.1164	0.9973
050111	01/01/91	12/31/91	1.2680	0.9983
050112	10/01/90	09/30/91	1.4461	0.9989
050117	01/01/91	12/31/91	1.2730	0.9948
050121	01/01/91	12/31/91	1.2924	0.9847
050122	01/01/91	12/31/91	1.4411	0.9988
050125	01/01/91	12/31/91	1.2931	0.9862
050126	11/01/90	10/31/91	1.4070	0.9970
050127	10/01/90	09/30/91	1.2631	0.9847
050131	01/01/91	12/31/91	1.2296	0.9802
050132	10/01/90	09/30/91	1.4021	0.9939
050135	10/01/90	09/30/91	1.3064	0.9991
050137	01/01/91	12/31/91	1.2754	0.9839
050138	01/01/91	12/31/91	1.7056	0.9927
050139	01/01/91	12/31/91	1.2103	0.9934
050140	01/01/91	12/31/91	1.3111	0.9832
050144	09/01/90	08/31/91	1.4833	0.9925
050145	01/01/91	12/31/91	1.2967	0.9836
050146	10/01/90	09/30/91	1.3043	1.0000
050149	10/01/90	09/30/91	1.3563	0.9898
050150	01/01/91	12/31/91	1.2240	0.9780
050154	10/01/90	09/30/91	1.2227	0.9811
050155	10/01/90	09/30/91	1.1176	0.9957
050169	10/01/90	09/30/91	1.4898	0.9957
050173	09/01/90	08/31/91	1.2582	0.9854
050180	12/31/90	12/29/91	1.4345	0.9976
050186	09/01/90	09/30/91	1.3260	0.9806
050189	10/01/90	09/30/91	0.9175	0.9862
050196	01/01/91	12/31/91	1.2952	0.9865
050204	10/01/90	09/30/91	1.4014	0.9963
050205	01/01/91	12/31/91	1.2380	0.9963
050208	01/01/91	12/31/91	1.2087	0.9980
050211	01/01/91	12/31/91	1.3405	0.9937
050212	09/01/90	08/31/91	1.1018	0.9934
050214	01/01/91	12/31/91	1.5519	0.9877
050217	01/01/91	12/31/91	1.2153	0.9642
050222	10/01/90	09/30/91	1.5354	0.9979
050224	09/16/90	09/14/91	1.6166	0.9990
050225	01/01/91	12/31/91	1.3236	0.9861
050226	10/01/90	09/30/91	1.4272	0.9988
050231	01/01/91	12/31/91	1.5130	0.9955
050233	10/01/90	09/30/91	1.2236	0.9849
050234	10/01/90	09/30/91	1.2822	0.9911
050235	01/01/91	12/31/91	1.4983	0.9975
050236	01/01/91	12/31/91	1.3921	0.9835
050238	01/01/91	12/31/91	1.4902	0.9930
050239	01/01/91	12/31/91	1.4077	0.9966
050241	01/01/91	12/31/91	1.3074	0.9807
050251	01/01/91	12/31/91	1.1612	0.9684
050254	11/01/90	10/31/91	1.1369	0.9843
050256	11/01/90	10/31/91	1.6747	0.9938
050257	01/01/91	12/31/91	1.1540	0.9872
050264	09/01/90	08/31/91	1.4151	0.9939
050269	10/01/90	09/30/91	1.1091	0.9889
050270	10/01/90	09/30/91	1.3154	0.9850
050272	10/01/90	09/30/91	1.3150	0.9937
050281	10/01/89	08/31/91	1.2894	0.9870
050282	10/01/90	09/30/91	1.2798	0.9879
050286	08/01/90	07/31/91	1.0042	0.9595
050298	01/01/91	12/31/91	1.2365	0.9731
050300	01/01/91	12/31/91	1.2973	0.9920
050301	01/01/91	12/31/91	1.2100	0.9856
050302	01/01/91	12/31/91	1.3079	0.9869
050305	12/30/90	12/28/91	1.4793	0.9970
050309	01/01/91	12/31/91	1.2928	0.9947
050310	09/01/90	08/31/91	1.2163	0.9954
050313	01/01/91	12/31/91	1.1417	0.9807
050317	01/01/91	12/31/91	1.2356	0.9832
050324	10/01/90	09/30/91	1.8415	0.9958
050327	01/01/91	12/31/91	1.6237	0.9984
050328	09/01/90	09/30/91	1.2638	0.9702
050335	01/01/91	12/31/91	1.2144	0.9847
050336	01/01/91	12/31/91	1.2404	0.9715
050345	10/01/90	09/30/91	1.3643	0.9851

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050351	01/01/91	12/31/91	1.5234	0.9970
050352	01/01/91	12/31/91	1.2688	0.9669
050357	10/01/90	09/30/91	1.8316	0.9963
050363	09/01/90	08/31/91	1.3268	0.9689
050367	01/01/91	12/31/91	1.2458	0.9754
050369	01/01/91	12/31/91	1.2762	0.9920
050385	08/01/90	07/31/91	1.2892	0.9777
050391	01/01/91	12/31/91	1.4138	0.9865
050394	01/01/91	12/31/91	1.4959	0.9973
050396	01/01/91	12/31/91	1.5996	0.9994
050404	01/01/91	12/31/91	1.0486	0.9768
050407	01/01/91	12/31/91	1.0963	0.9990
050411	01/01/91	12/31/91	1.3220	0.9875
050417	01/01/91	12/31/91	1.1814	0.9748
050420	01/01/91	12/31/91	1.4096	0.9910
050424	09/01/90	10/31/91	1.7034	0.9985
050425	01/01/91	12/31/91	1.3113	0.9810
050426	09/01/90	08/31/91	1.3808	0.9947
050427	09/01/90	08/31/91	0.9550	0.9405
050431	09/01/90	08/31/91	1.0762	0.9948
050438	10/01/90	09/30/91	1.4842	0.9859
050440	01/01/91	12/31/91	1.1946	0.9895
050441	09/01/90	08/31/91	1.7438	0.9962
050447	09/01/90	08/31/91	1.0444	0.9824
050455	01/01/91	12/31/91	1.8769	0.9975
050456	07/01/90	12/31/91	1.3619	0.9932
050458	01/01/91	12/31/91	0.9534	0.9957
050467	01/01/91	12/31/91	1.2552	0.9870
050469	01/01/91	12/31/91	1.0711	0.9761
050471	09/01/90	08/31/91	1.7495	0.9963
050478	01/01/91	12/31/91	1.0330	0.9500
050481	09/01/90	08/31/91	1.4876	0.9973
050483	10/01/90	09/30/91	1.2361	0.9966
050486	10/01/90	09/30/91	1.4179	0.9916
050489	10/01/90	09/30/91	1.0753	0.9903
050492	09/01/90	08/31/91	1.2800	0.9699
050498	01/01/91	12/31/91	1.1677	0.9855
050503	10/01/90	09/30/91	1.2974	0.9799
050506	08/01/90	07/31/91	1.4945	0.9903
050510	01/01/91	12/31/91	1.3104	0.9843
050512	01/01/91	12/31/91	1.2588	0.9853
050515	01/01/91	12/31/91	1.3251	0.9876
050517	10/01/90	09/30/91	1.3935	0.9885
050523	01/01/91	12/31/91	1.2478	0.9750
050526	09/01/90	08/31/91	1.3600	0.9717
050531	09/01/90	08/31/91	1.2749	0.9969
050537	01/01/91	12/31/91	1.2256	0.9786
050541	01/01/91	12/31/91	1.5068	0.9819
050543	01/01/91	12/31/91	1.3113	0.9857
050549	01/01/91	12/31/91	1.7702	0.9960
050550	09/01/90	08/31/91	1.1381	0.9886
050552	01/01/91	12/31/91	1.0558	0.9931
050557	10/01/90	09/30/91	1.5128	0.9973
050561	01/01/91	12/31/91	1.1930	0.9900
050567	01/01/91	12/31/91	1.6044	0.9963
050570	11/01/90	10/31/91	1.7032	0.9954
050571	10/01/90	09/30/91	1.4060	0.9914
050575	10/01/90	09/30/91	1.2209	0.9956
050580	01/01/91	12/31/91	1.2294	0.9921
050585	01/01/91	12/31/91	1.3795	0.9776
050586	09/01/90	08/31/91	1.3275	0.9910
050587	01/01/91	12/31/91	1.2731	0.9974
050588	09/01/90	08/31/91	1.2534	0.9833
050590	01/01/91	12/31/91	1.3090	0.9881
050591	09/01/90	08/31/91	1.1298	0.9923
050592	09/01/90	08/31/91	1.3014	0.9829
050593	01/01/91	12/31/91	1.2678	0.9674
050597	10/01/90	09/30/91	1.3688	0.9880
050604	01/01/91	12/31/91	1.4412	0.9721
050607	10/01/89	08/31/91	1.2518	0.9873
050609	01/01/91	12/31/91	1.2982	0.9907
050619	01/01/91	12/31/91	1.3745	0.9882
050622	09/01/90	08/31/91	1.0701	0.9718
050624	10/01/90	09/30/91	1.2750	0.9817
050630	01/01/91	12/31/91	1.2385	0.9747
050635	01/01/91	12/31/91	1.2936	0.9913
050644	09/01/90	08/31/91	1.1627	0.9888

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
050655	01/01/91	12/31/91	0.8693	0.9974
050663	10/01/90	09/30/91	1.0987	0.9996
050669	01/01/90	08/31/91	0.9242	1.0000
050670	09/01/90	08/31/91	1.1533	1.0000
050674	01/01/91	12/31/91	1.1965	0.9903
050677	01/01/91	12/31/91	1.3197	0.9860
050680	01/01/91	12/31/91	1.2462	0.9631
050686	01/01/91	12/31/91	1.2746	0.9891
050690	01/01/91	12/31/91	1.1858	0.9870
050695	01/01/91	12/31/91	1.2087	0.9708
060001	01/01/91	12/31/91	1.4559	0.9986
060003	01/01/91	12/31/91	1.2114	0.9903
060004	01/01/91	12/31/91	1.1098	0.9691
060006	01/01/91	12/31/91	1.1637	0.9859
060007	01/01/91	12/31/91	1.1789	0.9553
060009	01/01/91	12/31/91	1.3666	0.9958
060010	01/01/91	12/31/91	1.5334	0.9981
060011	01/01/91	12/31/91	1.2187	0.9845
060014	09/01/90	08/31/91	1.6526	0.9972
060018	01/01/91	12/31/91	1.1693	0.9792
060022	01/01/91	12/31/91	1.5931	0.9982
060027	01/01/91	12/31/91	1.4496	0.9979
060029	01/01/91	12/31/91	0.9594	0.9537
060030	01/01/91	12/31/91	1.3232	0.9933
060033	01/01/91	12/31/91	1.1362	0.9679
060034	01/01/91	12/31/91	1.3456	0.9921
060037	01/01/91	12/31/91	0.9974	0.9319
060038	01/01/91	12/31/91	1.1011	0.9799
060041	01/01/91	12/31/91	1.1076	1.0000
060042	01/01/91	12/31/91	0.9639	0.9708
060043	01/01/91	12/31/91	0.8738	0.9249
060044	01/01/91	12/31/91	1.1889	0.9839
060046	01/01/91	12/31/91	1.0796	0.9578
060047	01/01/91	12/31/91	1.0260	0.9755
060049	01/01/91	12/31/91	1.0374	0.9543
060050	01/01/91	12/31/91	1.2399	0.9705
060052	01/01/91	12/31/91	1.0298	0.9639
060053	01/01/91	12/31/91	1.1423	0.9683
060056	01/01/91	12/31/91	0.8923	0.9838
060057	01/01/91	12/31/91	1.0223	0.9577
060058	01/01/91	12/31/91	0.9001	0.9160
060060	01/01/91	12/31/91	1.0425	0.9648
060062	01/01/91	12/31/91	1.0011	0.9391
060063	01/01/91	12/31/91	1.1814	0.9560
060064	01/01/91	12/31/91	1.3824	0.9963
060065	09/01/90	08/31/91	1.3251	0.9933
060066	01/01/91	12/31/91	0.9405	0.9222
060068	01/01/91	12/31/91	1.1586	0.9807
060070	01/01/91	12/31/91	1.2129	0.9739
060071	01/01/91	12/31/91	1.1363	0.9832
060072	10/01/90	09/30/91	0.9170	0.9707
060073	01/01/91	12/31/91	0.9947	0.9576
060075	01/01/91	12/31/91	1.3080	0.9869
060076	01/01/91	12/31/91	1.4055	0.9798
060085	01/01/91	12/31/91	0.8981	0.9379
060087	09/01/90	08/31/91	1.3945	0.9955
060088	01/01/91	12/31/91	1.1193	0.9236
060090	01/01/91	12/31/91	0.8710	0.9037
060096	11/01/90	10/31/91	0.9925	0.8964
060100	09/01/90	08/31/91	1.3806	0.9847
060101	10/01/90	09/30/91	1.4281	0.9686
060103	01/01/91	12/31/91	1.3073	0.9866
070001	10/01/90	09/30/91	1.7864	0.9995
070002	10/01/90	09/30/91	1.7801	0.9992
070003	10/01/90	09/30/91	1.1602	0.9803
070004	10/01/90	09/30/91	1.1337	0.9843
070005	10/01/90	09/30/91	1.2836	0.9914
070006	10/01/90	09/30/91	1.2742	0.9945
070007	10/01/90	09/30/91	1.3699	0.9919
070008	10/01/90	09/30/91	1.2371	0.9920
070009	10/01/90	09/30/91	1.2983	0.9898
070010	10/01/90	09/30/91	1.4679	0.9987
070011	10/01/90	09/30/91	1.2026	0.9899
070012	10/01/90	09/30/91	1.2419	0.9883
070013	10/01/90	09/30/91	1.3405	0.9914
070014	10/01/90	09/30/91	1.2877	0.9888
070015	10/01/90	09/30/91	1.2395	0.9902

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
070016	10/01/90	09/30/91	1.2969	0.9925
070017	10/01/90	09/30/91	1.2922	0.9860
070018	10/01/90	09/30/91	1.3006	0.9971
070019	10/01/90	09/30/91	1.1696	0.9872
070020	10/01/90	09/30/91	1.3970	0.9892
070021	10/01/90	09/30/91	1.2044	0.9883
070022	10/01/90	09/30/91	1.6748	0.9973
070023	10/01/90	09/30/91	1.2601	0.9997
070024	10/01/90	09/30/91	1.1922	0.9921
070025	10/01/90	09/30/91	1.6628	0.9987
070026	10/01/90	09/30/91	1.2425	0.9873
070027	10/01/90	09/30/91	1.2145	0.9876
070028	10/01/90	09/30/91	1.4915	0.9997
070029	10/01/90	09/30/91	1.2279	0.9916
070030	10/01/90	09/30/91	1.2667	0.9974
070031	10/01/90	09/30/91	1.3122	0.9942
070033	10/01/90	09/30/91	1.3514	0.9924
070034	10/01/90	09/30/91	1.2992	0.9947
070035	10/01/90	09/30/91	1.3613	0.9913
070036	10/01/90	09/30/91	1.3474	0.9812
080005	10/01/90	09/30/91	1.1994	0.9941
090002	01/01/91	12/31/91	1.1861	0.9887
090005	01/01/91	12/31/91	1.2739	0.9979
090006	01/01/91	12/31/91	1.3121	0.9957
090007	10/01/90	09/30/91	1.2718	0.9919
090008	01/01/91	12/31/91	1.4030	0.9948
100001	10/01/90	09/30/91	1.3979	0.9968
100002	10/01/90	09/30/91	1.4242	0.9869
100004	10/01/90	09/30/91	1.0139	0.9353
100005	10/01/90	09/30/91	0.9150	0.9947
100006	10/01/90	09/30/91	1.6152	0.9957
100007	01/01/91	12/31/91	1.8834	0.9971
100008	10/01/90	09/30/91	1.7167	0.9982
100009	10/01/90	09/30/91	1.4240	0.9971
100012	10/01/90	09/30/91	1.5506	0.9993
100014	10/01/90	09/30/91	1.3297	0.9919
100015	08/01/90	07/31/91	1.4013	0.9953
100017	10/01/90	09/30/91	1.6843	0.9957
100018	10/01/90	09/30/91	1.3548	0.9883
100019	10/01/90	09/30/91	1.4874	0.9995
100020	12/01/90	11/30/91	1.3329	0.9942
100021	01/01/91	12/31/91	1.2859	1.0000
100022	10/01/90	09/30/91	1.6075	0.9965
100023	10/01/90	09/30/91	1.3262	0.9831
100024	10/01/90	09/30/91	1.2642	0.9888
100025	01/01/91	12/31/91	1.5216	0.9985
100026	10/01/90	09/30/91	1.4238	0.9998
100028	10/01/90	09/30/91	1.2986	0.9761
100029	10/01/90	09/30/91	1.3179	0.9963
100030	10/01/90	09/30/91	1.2694	0.9963
100034	01/01/91	12/31/91	1.6251	0.9994
100035	09/01/90	08/31/91	1.4645	1.0000
100040	01/01/91	12/31/91	1.6537	0.9979
100042	01/01/91	12/31/91	1.2427	0.9963
100043	10/01/90	09/30/91	1.3729	0.9890
100044	10/01/90	09/30/91	1.4161	0.9906
100045	10/01/90	09/30/91	1.3927	0.9871
100046	01/01/91	12/31/91	1.3332	0.9770
100047	01/01/91	12/31/91	1.5832	0.9952
100048	10/01/90	09/30/91	0.9471	0.9662
100049	10/01/90	09/30/91	1.3533	0.9760
100050	01/01/91	12/31/91	1.2197	0.9961
100051	10/01/90	09/30/91	1.2863	0.9564
100052	10/01/90	09/30/91	1.3213	0.9875
100053	10/01/90	09/30/91	1.2657	0.9959
100054	08/01/90	07/31/91	1.3924	0.9699
100055	10/01/90	09/30/91	1.3559	0.9890
100056	01/01/91	12/31/91	1.5678	0.9851
100057	10/01/90	09/30/91	1.3489	0.9575
100060	01/01/91	12/31/91	1.7888	0.9992
100061	09/01/90	08/31/91	1.4929	0.9976
100062	10/01/90	09/30/91	1.6836	0.9988
100063	01/01/91	12/31/91	1.2967	0.9850
100065	10/01/90	09/30/91	1.2930	0.9986
100069	01/01/91	12/31/91	1.3789	0.9927
100071	10/01/90	09/30/91	1.3921	0.9868
100072	10/01/90	09/30/91	1.1723	0.9835

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
100074	10/01/90	09/30/91	1.2318	0.9903
100077	09/01/90	08/31/91	1.3139	0.9849
100078	10/01/90	09/30/91	1.1488	0.9824
100080	10/01/90	09/30/91	1.5859	0.9990
100081	10/01/90	09/30/91	1.0962	0.9802
100082	10/01/90	09/30/91	1.3658	0.9971
100085	01/01/91	12/31/91	1.3618	0.9905
100087	10/01/90	09/30/91	1.7277	0.9991
100088	10/01/90	09/30/91	1.5083	0.9979
100089	01/01/91	12/31/91	1.2736	0.9863
100090	10/01/90	09/30/91	1.2997	0.9846
100092	10/01/90	09/30/91	1.3270	0.9975
100093	10/01/90	09/30/91	1.5352	0.9938
100098	10/01/90	09/30/91	1.0270	0.9841
100099	10/01/90	09/30/91	1.2802	0.9500
100100	01/01/91	12/31/91	1.2708	0.9970
100102	10/01/90	09/30/91	1.2016	0.9732
100103	10/01/90	09/30/91	1.0130	0.9657
100105	10/01/90	09/30/91	1.3795	0.9860
100107	09/01/90	08/31/91	1.2546	0.9865
100108	10/01/90	09/30/91	1.0990	0.9794
100109	01/01/91	12/31/91	1.2573	0.9724
100110	09/01/90	08/31/91	1.3800	0.9909
100112	10/01/89	07/24/91	0.9678	0.9561
100117	10/01/90	09/30/91	1.2988	0.9701
100118	11/01/90	10/31/91	1.1560	0.9889
100121	10/01/90	09/30/91	1.1162	0.9613
100124	11/01/90	10/31/91	1.2825	0.9760
100127	10/01/90	09/30/91	1.5842	0.9989
100128	10/01/90	09/30/91	2.2783	0.9962
100129	12/01/89	09/10/91	1.4226	0.9884
100130	10/01/90	09/30/91	1.1908	0.9871
100131	09/01/90	08/31/91	1.2109	0.9917
100132	01/01/91	12/31/91	1.3270	0.9730
100134	10/01/90	09/30/91	0.9827	0.9355
100135	10/01/90	09/30/91	1.5133	0.9989
100137	10/01/90	09/30/91	1.1369	0.9656
100138	10/01/90	09/30/91	0.9754	0.9810
100139	10/01/90	09/30/91	1.0576	0.9640
100140	10/01/90	09/30/91	1.1144	0.9697
100142	10/01/90	09/30/91	1.1523	0.9763
100143	01/01/91	12/31/91	1.2722	0.9903
100144	10/01/90	09/30/91	1.2340	0.9905
100146	10/01/90	09/30/91	1.0764	0.9684
100147	10/01/90	09/30/91	1.0828	0.9763
100151	01/01/91	12/31/91	1.7245	0.9996
100154	10/01/90	09/30/91	1.6110	0.9983
100156	11/01/90	10/31/91	1.0674	0.9707
100157	10/01/90	09/30/91	1.4942	0.9993
100159	10/01/90	09/30/91	1.0490	0.9612
100162	10/01/90	09/30/91	1.2998	0.9901
100164	10/01/90	09/30/91	0.9793	1.0000
100165	01/01/91	12/31/91	1.1044	0.9920
100169	11/01/90	10/31/91	1.8109	0.9990
100170	10/01/90	09/30/91	1.4183	0.9949
100173	10/01/90	09/30/91	1.5686	0.9995
100174	10/01/90	09/30/91	1.3610	0.9950
100175	10/01/90	09/30/91	1.0950	0.9713
100176	10/01/90	09/30/91	1.9619	0.9958
100177	10/01/90	09/30/91	1.3381	0.9913
100180	09/01/90	08/31/91	1.4086	0.9956
100181	12/01/90	11/30/91	1.2829	0.9975
100183	01/01/91	12/31/91	1.3537	0.9988
100185	10/01/90	09/30/91	1.2176	0.9024
100186	12/18/90	12/31/91	1.3317	0.9875
100187	01/01/91	12/31/91	1.3433	0.9917
100189	01/01/91	12/31/91	1.3387	0.9844
100194	09/01/90	10/14/91	1.2668	0.9962
100196	09/01/90	08/31/91	1.2388	0.9924
100199	09/01/90	08/31/91	1.1906	0.9963
100203	09/01/90	09/29/91	1.1278	0.9973
100206	12/01/90	11/30/91	1.3591	0.9908
100208	01/01/91	12/31/91	1.4739	0.9929
100209	08/01/90	12/31/91	1.5331	0.9987
100210	01/01/91	12/31/91	1.7034	0.9979
100211	09/01/90	08/31/91	1.2691	0.9863
100212	09/01/90	08/31/91	1.6306	0.9981

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
100217	09/01/90	08/31/91	1.1724	0.9780
100219	09/01/90	10/31/91	1.3843	0.9864
100220	01/01/91	12/31/91	1.7197	0.9995
100221	09/01/90	08/31/91	1.5183	0.9978
100222	01/01/90	11/04/91	1.2342	0.9889
100223	09/01/90	08/31/91	1.4171	0.9857
100224	01/01/91	12/31/91	1.3665	0.9836
100226	09/01/90	08/31/91	1.3133	0.9921
100227	09/01/90	08/31/91	0.9756	0.9881
100228	09/01/90	08/31/91	1.2731	0.9866
100229	09/01/90	08/31/91	1.4623	0.9890
100232	10/01/90	09/30/91	1.3071	0.9853
100234	09/01/90	08/31/91	1.3369	0.9909
100235	09/01/90	09/29/91	1.3401	0.9922
100237	10/01/90	09/30/91	2.0922	0.9990
100238	09/01/90	08/31/91	1.4011	0.9924
100241	10/01/90	09/30/91	0.9984	0.9707
100243	09/01/90	08/31/91	1.3848	0.9876
100246	01/01/91	12/31/91	1.3591	0.9943
100248	08/01/90	07/31/91	1.6899	0.9990
100253	10/01/90	09/30/91	1.3647	0.9817
100255	01/01/91	12/31/91	1.3552	0.9861
100259	09/01/90	08/31/91	1.4203	0.9706
100260	10/01/90	09/30/91	1.4024	0.9889
100262	10/01/90	09/30/91	1.3347	0.9912
100263	09/01/90	08/31/91	1.4559	0.9837
100265	10/01/90	09/30/91	1.2841	0.9858
100266	10/01/90	09/30/91	1.3137	0.9866
100267	01/01/91	12/31/91	1.2673	0.9839
100269	09/01/90	08/31/91	1.4127	0.9808
100273	09/01/90	08/31/91	1.1329	0.9769
100275	01/01/91	12/31/91	1.2911	0.9940
100278	10/01/90	09/30/91	0.6872	0.9294
110001	10/01/90	09/30/91	1.1509	0.9885
110002	01/01/91	12/31/91	1.1993	0.9810
110004	10/01/90	09/30/91	1.2328	0.9927
110005	01/01/91	12/31/91	1.3594	0.9566
110006	10/01/90	09/30/91	1.2862	0.9950
110007	08/01/90	08/31/91	1.3723	0.9975
110009	11/01/90	10/31/91	1.0799	0.9640
110010	09/01/90	08/31/91	1.9547	0.9982
110013	10/01/90	09/30/91	1.0005	0.9558
110014	08/01/90	07/31/91	1.0805	0.9728
110016	09/30/90	09/28/91	1.2461	0.9899
110018	01/01/91	12/31/91	1.1748	0.9568
110020	09/01/90	08/31/91	1.1551	0.9859
110023	01/01/91	12/31/91	1.2044	0.9538
110024	01/01/91	12/31/91	1.3827	0.9912
110025	10/01/90	09/30/91	1.2773	0.9875
110028	12/31/90	12/29/91	1.5625	0.9982
110029	10/01/90	09/30/91	1.3032	0.9906
110032	10/01/90	09/30/91	1.1204	0.9879
110033	08/01/90	07/31/91	1.3284	0.9889
110036	01/01/91	12/31/91	1.6297	0.9975
110037	01/01/91	12/31/91	1.0605	0.9816
110038	10/01/90	09/30/91	1.3245	0.9968
110044	10/01/90	09/30/91	1.1271	0.9706
110045	08/01/90	07/31/91	1.0130	0.9627
110046	11/01/90	10/31/91	1.1848	0.9710
110048	10/01/90	09/30/91	1.1293	0.9692
110049	10/01/90	09/30/91	1.0818	0.9618
110050	01/01/91	12/31/91	1.1083	0.9696
110059	10/01/90	09/30/91	1.3396	0.9660
110061	10/01/90	09/30/91	0.9793	0.9644
110063	12/01/90	11/30/91	1.0270	0.9716
110065	01/01/91	12/31/91	0.9794	0.9875
110070	11/01/90	10/31/91	0.9581	0.9335
110072	01/01/91	12/31/91	0.9904	0.9709
110073	08/01/90	07/31/91	1.2631	0.9611
110074	10/01/90	09/30/91	1.2570	0.9864
110075	10/01/90	09/30/91	1.2160	0.9822
110076	10/01/90	09/30/91	1.3581	0.9880
110078	09/01/90	08/31/91	1.5963	0.9979
110079	01/01/91	12/31/91	1.3224	0.9974
110080	10/01/90	09/30/91	1.0552	0.9945
110082	01/01/91	12/31/91	2.0553	0.9983
110083	01/01/91	12/31/91	1.5286	0.9991

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
110085	01/01/91	12/31/91	1.1694	0.9610
110086	09/01/90	08/31/91	1.0824	0.9691
110087	09/01/90	08/31/91	1.2606	0.9852
110088	01/01/91	12/31/91	0.8980	0.9302
110089	01/01/91	12/31/91	1.1196	0.9629
110091	10/01/90	09/30/91	1.2791	0.9731
110092	10/01/90	09/30/91	1.0652	0.9703
110095	10/01/90	09/30/91	1.3301	0.9757
110096	01/01/91	12/31/91	1.1422	0.9710
110097	01/01/91	12/31/91	1.0895	0.9714
110100	01/01/91	12/31/91	1.1062	0.9777
110105	10/01/90	09/30/91	1.1649	0.9824
110107	10/01/90	09/30/91	1.6085	0.9979
110111	10/01/90	09/30/91	1.1403	0.9872
110112	09/01/90	08/31/91	0.9201	0.9742
110114	10/01/90	09/30/91	1.1536	0.9706
110115	01/01/91	12/31/91	1.6217	0.9983
110118	10/01/90	09/30/91	1.0071	0.9467
110120	10/01/90	09/30/91	1.0366	0.9319
110121	10/01/90	09/30/91	1.1158	0.9747
110122	10/01/90	09/30/91	1.3221	0.9856
110123	10/01/90	09/30/91	0.8699	1.0000
110129	01/01/91	12/31/91	1.5724	0.9975
110130	12/01/90	11/30/91	0.9954	0.9630
110133	07/01/90	09/01/91	0.8836	0.9309
110140	08/01/90	12/31/91	0.8778	0.9621
110142	10/01/90	09/30/91	1.1108	0.9577
110144	10/01/90	09/30/91	1.2363	0.9642
110146	01/01/91	12/31/91	0.9191	0.9587
110149	07/01/90	10/31/91	1.1052	0.9749
110150	10/01/90	09/30/91	1.2278	0.9785
110161	10/01/90	10/31/91	1.2651	0.9897
110165	11/01/89	07/31/91	1.1638	0.9891
110166	10/01/90	09/30/91	1.3456	0.9867
110171	11/01/90	10/31/91	1.3287	0.9919
110172	10/01/90	09/30/91	1.1532	0.9881
110177	09/01/90	08/31/91	1.3965	0.9978
110179	01/01/91	12/31/91	1.2188	0.9766
110187	01/01/91	12/31/91	1.1241	0.9320
110189	01/01/91	12/31/91	1.1022	0.9613
110190	01/01/91	12/31/91	1.1202	0.9606
110192	09/01/90	08/31/91	1.3426	0.9877
110193	01/01/91	12/31/91	1.2226	0.9806
110195	10/01/90	09/30/91	1.0969	0.9744
110198	11/01/90	10/31/91	1.3260	0.9857
110200	10/01/90	09/30/91	1.7387	0.9962
110201	09/01/90	08/31/91	1.2647	0.9946
110203	10/01/90	09/30/91	1.0427	0.9762
120006	01/01/91	12/31/91	1.2132	0.9956
120011	01/01/91	12/31/91	1.2199	0.9946
120022	01/01/91	12/31/91	1.4828	0.9987
130001	12/01/90	11/30/91	1.0871	0.9691
130002	10/01/90	09/30/91	1.3148	0.9868
130005	01/01/91	12/31/91	1.3644	0.9920
130006	10/01/90	09/30/91	1.6766	0.9983
130009	10/01/90	09/30/91	0.9889	0.9438
130010	10/01/90	09/30/91	0.9302	0.9614
130011	01/01/91	12/31/91	1.3006	0.9801
130012	10/01/90	09/30/91	1.0122	0.9455
130014	10/01/90	09/30/91	1.2587	0.9800
130015	10/01/90	09/30/91	0.9981	0.9735
130018	10/01/90	09/30/91	1.5621	0.9993
130019	01/01/91	12/31/91	1.1630	0.9482
130021	12/01/90	11/30/91	0.9053	0.9299
130024	09/01/90	08/31/91	1.1126	0.9586
130025	10/01/90	09/30/91	1.0680	0.9806
130026	01/01/91	12/31/91	1.1236	0.9718
130027	10/01/90	09/30/91	0.8584	0.9564
130028	10/01/90	09/30/91	1.2874	0.9949
130030	10/01/90	09/30/91	0.9618	0.9785
130031	10/01/90	09/30/91	0.9623	0.9558
130034	10/01/90	09/30/91	0.9073	0.9614
130036	01/01/91	12/31/91	1.2010	0.9727
130037	10/01/90	09/30/91	1.4009	0.9633
130039	10/01/90	09/30/91	1.1602	0.9804
130040	10/01/90	09/30/91	1.0492	0.9931
130043	10/01/90	09/30/91	0.9815	0.9717

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
130044	10/01/90	09/30/91	0.9094	0.9480
130045	10/01/90	09/30/91	0.9224	0.9731
130049	12/01/90	11/30/91	1.1969	0.9861
130051	12/01/90	12/31/91	0.9918	0.9837
130054	10/01/90	09/30/91	0.9194	0.9712
130056	10/01/90	09/30/91	0.9862	0.9825
130058	10/01/89	08/31/91	0.9495	1.0000
140002	01/01/91	12/31/91	1.2404	0.9880
140004	10/01/90	09/30/91	0.9856	0.9624
140007	09/01/90	08/31/91	1.2563	0.9920
140008	01/01/91	12/31/91	1.4098	0.9956
140010	10/01/90	09/30/91	1.3500	0.9970
140012	01/01/91	12/31/91	1.2324	0.9868
140013	01/01/91	12/31/91	1.4145	0.9906
140015	10/01/90	09/30/91	1.2324	0.9913
140019	09/01/90	08/31/91	0.9152	0.9706
140029	01/01/91	12/31/91	1.3470	0.9933
140031	01/01/91	12/31/91	1.0586	0.9781
140033	09/01/90	08/31/91	1.2003	0.9921
140034	01/01/91	12/31/91	1.1101	0.9823
140036	10/01/90	09/30/91	1.1245	0.9648
140039	01/01/91	12/31/91	1.0066	0.9561
140046	01/01/91	12/31/91	1.2066	0.9696
140048	01/01/91	12/31/91	1.2186	0.9954
140049	11/01/90	10/31/91	1.3549	0.9974
140051	10/01/90	09/30/91	1.2992	0.9916
140052	01/01/91	12/31/91	1.1951	0.9856
140054	09/30/90	09/28/91	1.3516	0.9892
140058	10/01/90	09/30/91	1.0895	0.9881
140062	01/01/91	12/31/91	1.2520	0.9899
140063	01/01/91	12/31/91	1.3347	0.9948
140064	10/01/90	09/30/91	1.1583	0.9842
140065	01/01/91	12/31/91	1.3743	0.9960
140068	01/01/91	12/31/91	1.1913	0.9889
140067	10/01/90	09/30/91	1.7011	0.9989
140072	07/01/90	08/23/91	1.1304	0.9896
140074	10/01/90	09/30/91	1.1381	0.9369
140075	07/01/90	08/31/91	1.3840	0.9964
140079	01/01/91	12/31/91	1.2521	0.9926
140080	01/01/91	12/31/91	1.8474	0.9959
140084	01/01/91	12/31/91	1.1909	0.9910
140087	01/01/91	12/31/91	1.3704	0.9911
140090	01/01/91	12/31/91	1.3693	0.9978
140093	09/01/90	08/31/91	1.2451	0.9840
140094	01/01/91	12/31/91	1.2807	0.9888
140095	09/01/90	08/31/91	1.2502	0.9853
140097	01/01/91	12/31/91	0.8783	0.9668
140098	01/01/91	12/31/91	1.4170	0.9917
140101	12/01/90	11/30/91	1.0545	0.9762
140103	01/01/91	12/31/91	1.3556	0.9948
140105	01/01/91	12/31/91	1.2889	0.9843
140107	01/01/91	12/31/91	0.9246	0.9633
140108	01/01/91	12/31/91	1.1708	0.9890
140112	10/01/90	09/30/91	1.0460	0.9846
140113	01/01/91	12/31/91	1.4039	0.9979
140118	01/01/91	12/31/91	1.4717	0.9979
140122	01/01/91	12/31/91	1.3930	0.9942
140123	01/01/91	12/31/91	1.1980	0.9957
140124	12/03/90	12/01/91	1.1377	0.9985
140125	01/01/91	12/31/91	1.2510	0.9885
140128	10/01/90	09/30/91	1.1318	0.9591
140129	01/01/91	12/31/91	1.0440	0.9785
140130	01/01/91	12/31/91	1.1376	0.9951
140132	10/01/90	09/30/91	1.5682	0.9987
140135	10/01/90	09/30/91	1.2017	0.9897
140137	01/01/91	12/31/91	1.0057	0.9489
140139	10/01/90	09/30/91	1.0677	0.9590
140141	08/01/90	07/31/91	0.9738	0.9703
140143	10/01/90	09/30/91	1.0546	0.9783
140147	12/01/90	11/30/91	1.1928	0.9837
140148	10/01/90	09/30/91	1.5307	0.9986
140152	01/01/91	12/31/91	1.0219	0.9981
140154	09/01/90	08/31/91	1.2571	0.9877
140155	01/01/91	12/31/91	1.1878	0.9899
140160	08/01/90	07/31/91	1.1532	0.9854
140161	10/01/90	09/30/91	1.1287	0.9818
140162	10/01/90	09/30/91	1.4834	0.9886

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
140167	10/01/90	09/30/91	1.0723	0.9817
140176	10/01/90	09/30/91	1.2124	0.9838
140180	01/01/91	12/31/91	1.4230	0.9972
140181	01/01/91	12/31/91	1.2838	0.9941
140182	11/01/90	10/31/91	1.3137	0.9954
140185	01/01/91	12/31/91	1.3916	0.9889
140186	01/01/91	12/31/91	1.2096	0.9859
140188	09/01/90	08/31/91	0.9522	0.9316
140191	01/01/91	12/31/91	1.4306	0.9959
140192	10/01/90	09/30/91	1.1449	0.9906
140197	10/01/90	09/30/91	1.2887	0.9961
140202	01/01/91	12/31/91	1.2302	0.9905
140203	10/01/90	09/30/91	1.1259	0.9641
140206	10/01/90	09/30/91	1.0900	0.9962
140207	01/01/91	12/31/91	1.2960	0.9959
140208	01/01/91	12/31/91	1.4567	0.9979
140209	01/01/91	12/31/91	1.5995	0.9977
140211	09/01/90	08/31/91	1.1438	0.9893
140212	01/01/91	12/31/91	1.2629	0.9960
140217	09/01/90	08/31/91	1.2150	0.9931
140220	10/01/90	09/30/91	1.1310	0.9689
140226	10/01/90	09/30/91	0.9399	0.9937
140233	10/01/90	09/30/91	1.6558	0.9956
140236	10/01/90	09/30/91	0.9842	0.9918
140240	01/01/91	12/31/91	1.3118	0.9930
140252	11/01/90	10/31/91	1.2851	0.9879
140253	10/01/90	09/30/91	1.2956	0.9990
140258	01/01/91	12/31/91	1.4248	0.9925
140271	01/01/91	12/31/91	1.0489	0.9585
140281	09/01/90	08/31/91	1.5165	0.9984
140285	01/01/91	12/31/91	1.2715	0.9956
140288	01/01/91	12/31/91	1.5491	0.9970
140289	01/01/91	12/31/91	1.2683	0.9848
140290	09/01/90	08/31/91	1.3822	0.9926
140291	01/01/91	12/31/91	1.2727	0.9902
140292	01/01/91	12/31/91	1.1977	0.9719
140294	01/01/91	12/31/91	1.0800	0.9648
150001	01/01/91	12/31/91	1.0653	0.9794
150002	01/01/91	12/31/91	1.3296	0.9958
150003	01/01/91	12/31/91	1.6028	0.9957
150004	01/01/91	12/31/91	1.3222	0.9977
150005	01/01/91	12/31/91	1.2193	0.9802
150006	01/01/91	12/31/91	1.1986	0.9834
150007	01/01/91	12/31/91	1.1959	0.9828
150008	01/01/91	12/31/91	1.3371	0.9979
150009	01/01/91	12/31/91	1.2999	0.9940
150010	01/01/91	12/31/91	1.1878	0.9875
150013	01/01/91	12/31/91	1.2320	0.9744
150014	07/01/90	08/31/91	1.3260	0.9910
150015	01/01/91	12/31/91	1.2376	0.9932
150017	01/01/91	12/31/91	1.6696	0.9996
150018	01/01/91	12/31/91	1.2651	0.9839
150020	10/01/90	09/30/91	1.1241	0.9952
150021	01/01/91	12/31/91	1.6160	0.9984
150022	01/01/91	12/31/91	1.1214	0.9796
150023	09/01/90	08/31/91	1.3740	0.9969
150024	01/01/91	12/31/91	1.1993	0.9927
150026	01/01/91	12/31/91	1.1750	0.9816
150027	01/01/91	12/31/91	1.0046	0.9620
150029	01/01/91	12/31/91	1.2490	0.9868
150030	01/01/91	12/31/91	1.1425	0.9859
150031	10/01/90	09/30/91	1.0721	0.9690
150033	01/01/91	12/31/91	1.5659	0.9983
150034	01/01/91	12/31/91	1.3172	0.9971
150035	01/01/91	12/31/91	1.4009	0.9975
150036	01/01/91	12/31/91	1.0322	0.9822
150037	01/01/91	12/31/91	1.2001	0.9815
150038	01/01/91	12/31/91	1.2252	0.9749
150039	10/01/90	09/30/91	0.9885	0.9598
150042	01/01/91	12/31/91	1.1896	0.9912
150044	01/01/91	12/31/91	1.2335	0.9914
150045	10/01/90	09/30/91	1.1584	0.9788
150046	05/01/90	08/31/91	1.4191	0.9968
150047	01/01/91	12/31/91	1.6844	0.9996
150048	01/01/91	12/31/91	1.1919	0.9864
150049	01/01/91	12/31/91	1.1042	0.9861
150050	01/01/91	12/31/91	1.1569	0.9617

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
150051	10/01/90	09/30/91	1.2461	0.9911
150052	01/01/91	12/31/91	1.0397	0.9607
150053	01/01/91	12/31/91	1.0269	0.9726
150054	01/01/91	12/31/91	1.0263	0.9807
150057	01/01/91	12/31/91	2.1621	0.9875
150058	01/01/91	12/31/91	1.5511	0.9973
150059	01/01/91	12/31/91	1.2267	0.9844
150060	01/01/91	12/31/91	1.1650	0.9672
150061	01/01/91	12/31/91	1.1894	0.9871
150062	01/01/91	12/31/91	1.0766	0.9746
150063	01/01/91	12/31/91	1.1477	0.9765
150064	10/01/90	09/30/91	1.0560	0.9737
150065	01/01/91	12/31/91	1.1029	0.9774
150066	01/01/91	12/31/91	1.1404	0.9719
150067	01/01/91	12/31/91	1.1103	0.9617
150069	01/01/91	12/31/91	1.2483	0.9783
150070	01/01/91	12/31/91	1.0849	0.9342
150071	01/01/91	12/31/91	1.1399	0.9543
150072	01/01/91	12/31/91	1.2786	0.9815
150073	01/01/91	12/31/91	1.0474	0 9649
150074	10/01/90	09/30/91	1.4864	0.9996
150075	10/01/90	09/30/91	1.2383	0.9917
150078	01/01/91	12/31/91	1.0664	0.9879
150079	10/01/90	09/30/91	1.1550	0.9815
150086	01/01/91	12/31/91	1.2567	0.9810
150090	07/01/90	12/31/91	1.2784	0.9864
150091	01/01/91	12/31/91	1.1941	0.9563
150092	01/01/91	12/31/91	1.1163	0.9291
150094	01/01/91	12/31/91	1.0335	0.9701
150095	10/01/90	09/30/91	1.1065	0.9702
150096	01/01/91	12/31/91	1.0522	0.9538
150097	01/01/91	12/31/91	1.0378	0.9702
150098	01/01/91	12/31/91	1.0456	0.9411
150101	01/01/91	12/31/91	1.0838	0.9534
150102	01/01/91	12/31/91	1.0877	0.9638
150104	01/01/91	12/31/91	1.1697	0.9670
150105	01/01/91	12/31/91	1.1936	0.9764
150106	01/01/91	12/31/91	1.0776	0.9536
150109	01/01/91	12/31/91	1.2844	0.9951
150111	01/01/91	12/31/91	1.0875	0.9678
150112	01/01/91	12/31/91	1.1913	0.9871
150113	01/01/91	12/31/91	1.2430	0.9813
150114	01/01/91	12/31/91	1.0742	0.9455
150122	01/01/91	12/31/91	1.0842	0.9371
150123	08/01/90	07/31/91	0.9589	0.9854
150124	10/01/90	09/30/91	1.1830	0.9802
150127	10/01/90	09/30/91	1.1323	0.9363
150128	10/01/90	09/30/91	1.1876	0.9963
150129	09/01/90	08/31/91	1.2691	0.9878
150132	01/01/91	12/31/91	1.3798	0.9980
150133	01/01/91	12/31/91	1.2262	0.9709
150134	09/01/90	08/31/91	1.1485	0.9813
150136	09/01/90	08/31/91	1.0882	1.0000
160001	11/01/90	10/31/91	1.1504	0.9785
160002	10/01/90	09/30/91	1.2315	0.9698
160003	01/01/91	12/31/91	1.0415	0.9751
160008	10/01/90	09/30/91	1.0831	0.9758
160024	01/01/91	12/31/91	1.4475	0.9984
160044	01/01/91	12/31/91	1.2670	0.9649
160045	09/01/90	08/31/91	1.6143	0.9983
160047	10/01/90	09/30/91	1.4141	0.9910
160051	10/01/90	09/30/91	1.3118	0.9486
160071	01/01/91	12/31/91	1.1043	0.9527
160072	01/01/91	12/31/91	1.0534	0.9752
160082	08/01/90	07/31/91	1.6609	0.9980
160092	01/01/91	12/31/91	0.9405	0.9546
160099	10/01/90	09/30/91	1.1015	0.9657
160104	12/01/90	11/30/91	1.1248	0.9881
160110	01/01/91	12/31/91	1.5254	0.9952
160111	09/01/90	08/31/91	1.1404	0.9713
160119	07/01/90	09/30/91	0.8411	0.9534
160122	10/01/90	09/30/91	1.2221	0.9619
160129	01/01/91	12/31/91	1.1463	0.9625
160130	10/01/90	09/30/91	1.2440	0.9905
160131	01/01/91	12/31/91	1.1389	0.9879
160133	01/01/91	12/31/91	1.2545	0.9834
160138	01/01/91	12/31/91	1.2621	0.9668

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
160147	01/01/91	12/31/91	1.1959	0.9747
170001	01/01/91	12/31/91	1.1871	0.9801
170004	01/01/91	12/31/91	1.0666	0.9702
170006	10/01/90	09/30/91	1.2445	0.9904
170008	09/01/90	08/31/91	0.9737	0.9690
170012	10/01/90	09/30/91	1.4313	0.9815
170014	01/01/91	12/31/91	1.0799	0.9543
170017	01/01/91	12/31/91	1.1914	0.9781
170018	01/01/91	12/31/91	1.0790	0.9614
170019	01/01/91	12/31/91	1.1816	0.9778
170021	01/01/90	08/31/91	0.9124	0.9767
170022	10/01/90	09/30/91	1.1870	0.9699
170023	01/01/91	12/31/91	1.3268	0.9880
170024	10/01/90	09/30/91	1.1094	0.9948
170026	10/01/90	09/30/91	0.9880	0.9790
170027	10/01/90	09/30/91	1.1657	0.9621
170030	01/01/91	12/31/91	0.9619	0.9198
170031	01/01/91	12/31/91	0.8845	0.9873
170032	10/01/90	09/30/91	1.0483	0.9672
170033	01/01/91	12/31/91	1.2181	0.9753
170034	01/01/91	12/31/91	0.9467	0.9886
170035	10/01/90	09/30/91	0.8666	0.8963
170036	01/01/91	12/31/91	0.9163	0.9737
170038	01/01/91	12/31/91	1.0021	0.9573
170039	01/01/91	12/31/91	1.0813	0.9645
170041	01/01/91	12/31/91	1.0285	0.9599
170043	01/01/91	12/31/91	1.0836	0.9541
170049	01/01/91	12/31/91	1.2901	0.9865
170050	01/01/91	12/31/91	1.0298	0.9253
170054	01/01/91	12/31/91	1.0964	0.9768
170055	01/01/91	12/31/91	1.0824	0.9788
170060	01/01/91	12/31/91	1.0253	0.9784
170062	10/01/90	09/30/91	0.8355	0.9748
170063	01/01/91	12/31/91	0.9246	0.9233
170064	01/01/91	12/31/91	1.2035	0.9613
170066	01/01/91	12/31/91	0.9297	0.9297
170068	01/01/91	12/31/91	1.2806	0.9775
170070	01/01/91	12/31/91	1.0607	0.9643
170073	01/01/91	12/31/91	1.1376	0.9694
170075	10/01/90	09/30/91	0.8523	0.9754
170076	01/01/91	12/31/91	1.0856	0.9984
170077	01/01/91	12/31/91	0.9483	0.9633
170079	01/01/91	12/31/91	0.9515	0.9101
170080	01/01/91	12/31/91	0.9663	0.9673
170081	01/01/91	12/31/91	1.1453	0.9790
170082	01/01/91	12/31/91	0.9336	0.9815
170086	10/01/90	09/30/91	1.6362	0.9989
170087	10/01/90	09/30/91	1.3417	0.9985
170088	01/01/91	12/31/91	0.9132	0.9387
170090	01/01/91	12/31/91	0.9873	0.9473
170092	01/01/91	12/31/91	0.8454	0.9291
170094	01/01/91	12/31/91	1.0792	0.9475
170097	01/01/91	12/31/91	0.9314	0.9595
170098	01/01/91	12/31/91	1.0584	0.9855
170099	01/01/91	12/31/91	1.3736	1.0000
170101	10/01/90	09/30/91	0.9966	0.9746
170102	01/01/91	12/31/91	0.9843	0.9478
170104	01/01/91	12/31/91	1.4312	0.9972
170106	09/01/90	08/31/91	0.8840	0.9261
170108	01/01/91	12/31/91	0.9255	0.9134
170109	01/01/91	12/31/91	1.0164	0.9400
170110	01/01/91	12/31/91	0.9366	0.9712
170112	01/01/91	12/31/91	0.9089	0.9810
170113	01/01/91	12/31/91	1.0569	0.9695
170114	01/01/91	12/31/91	1.0517	0.9601
170116	01/01/91	12/31/91	1.1438	0.9398
170117	01/01/91	12/31/91	0.9797	0.9836
170119	01/01/91	12/31/91	0.9921	0.9422
170120	01/01/91	12/31/91	1.2404	0.9663
170121	01/01/91	12/31/91	0.7783	0.9407
170122	10/01/90	09/30/91	1.7991	0.9982
170123	01/01/91	12/31/91	1.6703	0.9978
170124	01/01/91	12/31/91	0.9567	0.9512
170126	10/01/90	09/30/91	0.9325	0.9729
170128	01/01/91	12/31/91	0.9678	0.9153
170131	01/01/91	12/31/91	1.1317	0.9660
170134	01/01/91	12/31/91	0.9780	0.9807

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
170137	01/01/91	12/31/91	1.1353	0.9796
170139	01/01/91	12/31/91	1.0304	0.9662
170143	01/01/91	12/31/91	1.1006	0.9487
170144	10/01/90	09/30/91	1.4929	0.9929
170145	01/01/91	12/31/91	1.1522	0.9898
170146	01/01/91	12/31/91	1.2837	0.9986
170147	10/01/90	09/30/91	1.2052	0.9801
170148	10/01/90	09/30/91	1.3403	0.9973
170150	01/01/91	12/31/91	1.1231	0.9535
170151	01/01/91	12/31/91	1.0189	0.9438
170152	01/01/91	12/31/91	0.9367	0.9567
170160	01/01/91	12/31/91	0.9708	0.9535
170164	01/01/91	12/31/91	1.0513	0.9765
170166	01/01/91	12/31/91	0.9869	0.9879
170168	01/01/91	12/31/91	0.9263	0.9585
170170	01/01/90	10/31/91	0.9068	0.9624
170173	01/01/90	10/25/91	0.8782	0.8674
170174	01/01/91	12/31/91	0.9475	0.9086
170175	09/01/90	08/31/91	1.2204	0.9777
170176	09/01/90	08/31/91	1.4214	0.9966
180001	01/01/91	12/31/91	1.1806	0.9956
180004	10/01/90	09/30/91	1.1858	0.9737
180009	10/01/90	09/30/91	1.1718	0.9960
180010	09/01/90	08/31/91	1.7046	0.9995
180011	09/01/90	08/31/91	1.1240	0.9744
180014	09/01/90	08/31/91	1.5630	0.9993
180015	01/01/91	12/31/91	1.1145	0.9921
180016	01/01/91	12/31/91	1.2556	0.9785
180017	10/01/90	09/30/91	1.2195	0.9927
180019	12/01/90	11/30/91	1.1725	0.9766
180023	10/01/90	09/30/91	0.8333	0.9770
180025	09/01/90	08/31/91	1.1348	0.9718
180026	01/01/91	12/31/91	1.1060	0.9641
180030	10/01/90	09/30/91	1.1471	0.9837
180031	10/01/90	09/30/91	1.0060	0.9930
180035	01/01/91	12/31/91	1.4445	0.9990
180036	01/01/91	12/31/91	1.1007	0.9907
180037	09/01/90	08/31/91	1.2798	0.9918
180040	01/01/91	12/31/91	1.9836	0.9993
180041	10/01/90	09/30/91	1.0810	0.9650
180043	10/01/90	09/30/91	1.0062	0.9469
180044	10/01/90	09/30/91	1.0789	0.9811
180045	01/01/91	12/31/91	1.1768	0.9916
180048	10/01/90	09/30/91	1.2056	0.9829
180051	12/01/90	11/30/91	1.2023	0.9864
180058	01/01/91	12/31/91	0.8913	0.9411
180059	01/01/91	12/31/91	0.9118	0.9514
180060	01/01/91	12/31/91	0.8573	1.0000
180062	07/01/90	09/04/91	0.8121	0.9456
180063	10/01/90	09/30/91	1.0327	0.9833
180064	10/01/90	09/30/91	1.0597	0.9753
180066	11/01/90	10/31/91	1.1757	0.9559
180072	10/01/90	09/30/91	1.0925	0.9667
180078	10/01/90	09/30/91	1.0086	0.9846
180079	10/01/90	09/30/91	1.0186	0.9828
180080	09/01/90	08/31/91	1.1375	0.9782
180081	01/01/91	12/31/91	1.4039	0.9980
180085	01/01/91	12/31/91	1.3268	0.9945
180088	01/01/91	12/31/91	1.6584	0.9996
180094	01/01/91	12/31/91	1.0093	0.9713
180095	10/01/90	09/30/91	0.9768	0.9753
180099	10/01/90	09/30/91	0.9662	0.9675
180102	01/01/91	12/31/91	1.4136	0.9967
180103	09/01/90	08/31/91	1.7691	0.9976
180104	09/01/90	08/31/91	1.4002	0.9990
180106	09/01/90	08/31/91	0.8949	0.9598
180115	11/01/90	10/31/91	0.9694	0.9642
180116	09/01/90	08/31/91	1.2810	0.9827
180120	01/01/91	12/31/91	0.8883	0.9658
180121	01/01/91	12/31/91	1.0603	0.9605
180123	09/01/90	08/31/91	1.4452	0.9957
180124	10/01/90	09/30/91	1.3297	0.9958
180126	11/01/90	10/31/91	1.0408	0.9512
180127	08/01/90	07/31/91	1.1495	0.9720
180128	09/01/90	08/31/91	1.1173	0.9816
180130	09/01/90	08/31/91	1.3783	0.9961
180132	09/01/90	08/31/91	1.3109	0.9844

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
180133	09/01/90	08/31/91	1.2193	0.9888
180136	09/01/90	08/31/91	1.2780	0.9906
180137	09/01/90	08/31/91	1.7639	0.9963
180138	01/01/91	12/31/91	1.2505	0.9877
190002	10/01/90	09/30/91	1.5780	0.9983
190003	09/01/90	08/31/91	1.3715	0.9770
190004	10/01/90	09/30/91	1.1510	0.9802
190013	01/01/91	12/31/91	1.1919	0.9812
190018	10/01/90	09/30/91	1.1615	0.9779
190025	10/01/90	09/30/91	1.2542	0.9922
190026	10/01/90	09/30/91	1.3170	0.9978
190034	01/01/91	12/31/91	1.2138	0.9826
190039	01/01/91	12/31/91	1.4427	0.9989
190040	10/01/90	09/30/91	1.3627	0.9963
190043	01/01/91	12/31/91	1.0782	0.9816
190044	10/01/90	09/30/91	1.0913	0.9808
190046	01/01/91	12/31/91	1.3967	0.9984
190049	01/01/91	12/31/91	0.9612	0.9649
190050	11/01/90	10/31/91	1.0344	0.9708
190053	12/01/90	11/30/91	1.0246	0.9590
190054	07/01/90	09/30/91	1.3816	0.9809
190059	11/01/90	10/31/91	0.9408	0.9692
190060	01/01/91	12/31/91	1.2396	0.9934
190064	01/01/91	12/31/91	1.4544	0.9991
190065	10/01/90	09/30/91	1.4556	0.9981
190077	01/01/91	12/31/91	0.9049	0.9641
190078	01/01/91	12/31/91	1.1399	0.9769
190083	10/01/90	09/30/91	0.8837	0.9647
190088	09/01/90	08/31/91	1.3234	0.9780
190089	10/01/90	09/30/91	1.0606	0.9754
190090	09/01/90	08/31/91	1.1983	0.9703
190092	01/01/91	12/31/91	1.1950	0.9922
190095	10/01/90	09/30/91	1.0355	0.9764
190099	09/01/90	08/31/91	1.1890	0.9593
190102	10/01/90	09/30/91	1.4398	0.9986
190106	09/01/90	08/31/91	1.1604	0.9819
190109	10/01/90	09/30/91	1.0960	0.9760
190110	10/01/90	09/30/91	0.9634	0.9731
190111	10/01/90	09/30/91	1.5684	0.9989
190113	01/01/91	12/31/91	1.2906	0.9963
190115	01/01/91	12/31/91	1.2852	0.9943
190116	01/01/91	12/31/91	1.2168	0.9911
190118	10/01/90	09/30/91	0.9912	0.9673
190120	09/01/90	08/31/91	0.8938	0.9106
190125	10/01/90	09/30/91	1.3917	0.9978
190127	10/01/90	09/30/91	1.4583	0.9969
190128	10/01/90	09/30/91	0.8293	0.9961
190130	10/01/90	09/30/91	0.9182	0.9712
190134	10/01/90	09/30/91	1.0004	0.9650
190135	10/01/90	09/30/91	1.3431	0.9979
190136	10/01/90	09/30/91	1.0323	0.9753
190142	11/01/90	10/31/91	0.9442	0.9684
190144	09/01/90	08/31/91	1.1496	0.9736
190145	10/01/90	09/30/91	0.9274	0.9922
190146	01/01/91	12/31/91	1.4728	0.9984
190147	10/01/90	09/30/91	0.9570	0.9589
190149	10/01/90	09/30/91	0.9803	0.9738
190151	10/01/90	09/30/91	1.0824	0.9899
190160	09/01/90	08/31/91	1.1126	0.9965
190162	01/01/91	12/31/91	1.3001	0.9978
190164	01/01/91	12/31/91	1.0557	0.9858
190167	09/01/90	08/31/91	1.2898	0.9844
190175	01/01/91	12/31/91	1.1239	0.8571
190177	01/01/91	12/31/91	1.4642	0.9919
190178	09/01/90	08/31/91	0.9728	0.9639
190184	10/01/90	09/30/91	0.8960	0.9796
190185	01/01/91	12/31/91	1.2192	0.9961
190186	10/01/90	09/30/91	0.9519	0.9799
190189	01/01/91	12/31/91	1.1090	0.9321
190190	04/01/90	12/31/91	0.9948	0.9764
190191	01/01/91	12/31/91	1.2447	0.9805
190193	01/01/91	12/31/91	1.1975	0.9841
190194	10/01/90	09/30/91	1.1301	0.9763
190197	01/01/91	12/31/91	1.2036	0.9918
190198	09/01/90	08/31/91	1.1923	0.9894
190200	09/01/90	08/31/91	1.5966	0.9989
190201	09/01/90	08/31/91	1.2137	0.9837

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
190202	09/01/90	08/31/91	1.4228	0.9969
190203	01/01/91	12/31/91	1.6042	1.0000
190205	09/01/90	08/31/91	1.3354	0.9936
190206	09/01/90	08/31/91	1.4352	0.9978
190207	09/01/90	08/31/91	1.2129	0.9797
190208	01/01/91	12/31/91	0.8820	0.9295
190211	01/01/91	12/31/91	0.5007	1.0000
190212	01/01/91	12/31/91	0.9109	1.0000
200001	01/01/91	12/31/91	1.3139	0.9932
200006	10/01/90	09/30/91	1.0647	0.9657
200007	11/01/90	10/31/91	1.0291	0.9794
200009	10/01/90	09/30/91	1.6652	0.9981
200017	09/01/90	08/31/91	1.3031	0.9916
200018	01/01/91	12/31/91	1.1075	0.9829
200021	10/01/90	09/30/91	1.1342	0.9783
200025	01/01/91	12/31/91	1.1802	0.9929
200026	10/01/90	09/30/91	0.9954	0.9857
200027	01/01/91	12/31/91	1.1128	0.9724
200028	12/01/90	11/30/91	1.0183	0.9850
200031	01/01/91	12/31/91	1.2773	0.9933
200032	01/01/91	12/31/91	1.3002	0.9775
200033	09/30/90	09/28/91	1.6828	0.9968
200034	01/01/91	12/31/91	1.1762	0.9913
200041	01/01/91	12/31/91	1.1606	0.9863
200043	01/01/91	12/31/91	0.6497	0.9527
200044	10/01/90	09/30/91	1.1539	0.9906
200052	10/01/90	09/30/91	1.0225	0.9891
200055	01/01/91	12/31/91	1.0381	0.9703
200062	01/01/91	12/31/91	0.9859	0.9729
200066	10/01/90	09/30/91	1.1383	0.9816
210006	01/01/91	12/31/91	1.0833	0.9921
210011	01/01/91	12/31/91	1.2911	0.9941
210046	07/01/90	11/26/91	1.1206	0.9866
210049	01/01/91	12/31/91	1.1617	0.9880
220001	10/01/90	09/30/91	1.1452	0.9899
220002	10/01/90	09/30/91	1.3390	0.9985
220003	10/01/90	09/30/91	1.1005	0.9781
220004	10/01/90	09/30/91	1.3480	0.9899
220006	10/01/90	09/30/91	1.2643	0.9935
220008	10/01/90	09/30/91	1.1499	0.9878
220010	10/01/90	09/30/91	1.2007	0.9903
220012	10/01/90	09/30/91	1.1816	0.9792
220015	10/01/90	09/30/91	1.2005	0.9920
220016	10/01/90	09/30/91	1.1896	0.9838
220017	10/01/90	09/30/91	1.2507	0.9938
220019	10/01/90	09/30/91	1.0950	0.9867
220020	10/01/90	09/30/91	1.1518	0.9888
220021	10/01/90	09/30/91	1.2296	0.9918
220023	10/01/90	09/30/91	1.2617	0.9937
220024	10/01/90	09/30/91	1.1935	0.9913
220025	10/01/90	09/30/91	1.0234	0.9836
220026	10/01/90	09/30/91	1.2712	0.9944
220028	10/01/90	09/30/91	1.4016	0.9983
220029	10/01/90	09/30/91	1.1155	0.9854
220030	10/01/90	09/30/91	1.0736	0.9802
220031	09/30/90	09/28/91	1.7788	0.9975
220033	10/01/90	09/30/91	1.2330	0.9953
220035	10/01/90	09/30/91	1.1784	0.9948
220036	10/01/90	09/30/91	1.4854	0.9978
220038	10/01/90	09/30/91	1.2641	0.9801
220042	10/01/90	09/30/91	1.1604	0.9880
220045	10/01/90	09/30/91	1.1920	0.9880
220046	10/01/90	09/30/91	1.3652	0.9957
220048	10/01/90	09/30/91	1.1728	0.9928
220049	10/01/90	09/30/91	1.1794	0.9844
220050	10/01/90	09/30/91	0.9903	0.9790
220051	10/01/90	09/30/91	1.2256	0.9880
220052	10/01/90	09/30/91	1.2316	0.9895
220053	10/01/90	09/30/91	1.2756	0.9961
220055	10/01/90	09/30/91	1.1782	0.9920
220057	10/01/90	09/30/91	1.1955	0.9932
220058	10/01/90	09/30/91	1.0048	0.9722
220060	10/01/90	09/30/91	1.1391	0.9944
220062	10/01/90	09/30/91	0.6543	0.9618
220063	10/01/90	09/30/91	1.1276	0.9908
220064	10/01/90	09/30/91	1.1817	0.9852
220065	10/01/90	09/30/91	1.1739	0.9829

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
220066	10/01/90	09/30/91	1.2842	0.9964
220067	10/01/90	09/30/91	1.2425	0.9901
220068	10/01/90	09/30/91	0.6150	0.9916
220070	10/01/90	09/30/91	1.1438	0.9906
220071	10/01/90	09/30/91	1.8445	0.9973
220073	10/01/90	09/30/91	1.2258	0.9930
220074	10/01/90	09/30/91	1.1346	0.9750
220075	10/01/90	09/30/91	0.7565	0.9901
220076	10/01/90	09/30/91	1.1981	0.9872
220077	10/01/90	09/30/91	1.6054	0.9977
220079	10/01/90	09/30/91	1.1169	0.9928
220080	10/01/90	09/30/91	1.1952	0.9926
220081	10/01/90	09/30/91	0.9596	0.9603
220082	10/01/90	09/30/91	1.2244	0.9933
220084	10/01/90	09/30/91	1.1440	0.9686
220086	09/30/90	09/28/91	1.5565	0.9984
220088	10/01/90	09/30/91	1.4871	0.9923
220089	10/01/90	09/30/91	1.2772	0.9902
220090	10/01/90	09/30/91	1.1730	0.9897
220092	10/01/90	09/30/91	1.1913	0.9878
220094	10/01/90	09/30/91	1.2034	0.9901
220095	10/01/90	09/30/91	1.1870	0.9815
220097	10/01/90	09/30/91	1.0106	0.9943
220098	10/01/90	09/30/91	1.2848	0.9779
220099	10/01/90	09/30/91	1.1372	0.9878
220100	10/01/90	09/30/91	1.2696	0.9911
220101	10/01/90	09/30/91	1.3759	0.9920
220102	10/01/90	09/30/91	0.8471	1.0000
220104	10/01/90	09/30/91	1.2536	0.9892
220105	10/01/90	09/30/91	1.1748	0.9877
220106	10/01/90	09/30/91	1.1095	0.9859
220107	10/01/90	09/30/91	1.1494	0.9923
220108	10/01/90	09/30/91	1.1414	0.9902
220110	10/01/90	09/30/91	1.9210	0.9968
220111	10/01/90	09/30/91	1.1783	0.9760
220115	07/01/90	12/05/91	1.2749	0.9913
220116	09/30/90	09/28/91	1.7804	0.9962
220118	10/01/90	09/30/91	1.9208	0.9966
220119	10/01/90	09/30/91	1.3499	0.9883
220120	10/01/90	09/30/91	0.9903	0.9958
220123	10/01/90	09/30/91	0.9499	0.9613
220126	10/01/90	09/30/91	1.2248	0.9767
220128	10/01/90	09/30/91	1.1026	0.9884
220135	10/01/90	09/30/91	1.1185	0.9801
220156	10/01/90	09/30/91	1.2157	0.9871
220162	10/01/90	09/30/91	1.4238	0.7980
220171	10/01/90	09/30/91	1.6225	0.9973
220173	01/01/91	12/31/91	0.5125	1.0000
230003	10/01/90	09/30/91	1.1367	0.9882
230007	01/01/91	12/31/91	1.0879	0.9749
230012	01/01/91	12/31/91	0.8616	0.9919
230013	01/01/91	12/31/91	1.2956	0.9937
230014	04/01/90	12/31/91	0.9522	0.9625
230015	01/01/91	12/31/91	1.4123	0.9841
230017	01/01/91	12/31/91	1.5371	0.9970
230020	01/01/91	12/31/91	1.5989	0.9983
230021	10/01/90	09/30/91	1.5244	0.9973
230022	01/01/91	12/31/91	1.2727	0.9766
230040	10/01/90	09/30/91	1.3122	0.9800
230042	01/01/91	12/31/91	1.1196	0.9908
230053	01/01/91	12/31/91	1.4426	0.9992
230055	01/01/91	12/31/91	1.1107	0.9966
230056	10/01/90	09/30/91	0.9722	0.9609
230063	01/01/91	12/31/91	1.2719	0.9941
230065	01/01/91	12/31/91	1.4319	0.9950
230071	11/01/90	10/31/91	0.6457	1.0000
230076	01/01/91	12/31/91	1.2358	0.9982
230078	10/01/90	09/30/91	1.3192	0.9797
230080	10/01/90	09/30/91	1.2339	0.9835
230087	01/01/91	12/31/91	1.1456	0.9747
230089	09/01/90	08/31/91	1.3523	0.9961
230090	01/01/91	12/31/91	1.1740	0.9757
230096	10/01/90	09/30/91	1.0955	0.9843
230101	10/01/90	09/30/91	1.0478	0.9644
230103	01/01/91	12/31/91	1.0166	0.9687
230105	01/01/91	12/31/91	1.5115	0.9984
230107	01/01/91	12/31/91	0.9771	0.9704

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
230110	10/01/90	09/30/91	1.2243	0.9884
230114	01/01/91	12/31/91	0.7160	1.0000
230115	01/01/91	12/31/91	1.0103	0.9633
230118	10/01/90	09/30/91	1.2660	0.9740
230119	10/01/90	09/30/91	1.2023	0.3900
230121	01/01/91	12/31/91	1.2257	0.9814
230122	10/01/90	09/30/91	1.3557	0.9921
230125	10/01/90	09/30/91	1.3903	0.9822
230128	01/01/91	12/31/91	1.3727	0.9966
230129	01/01/91	12/31/91	1.9116	0.9973
230130	01/01/91	12/31/91	1.5889	0.9992
230134	01/01/91	12/31/91	1.2774	0.9873
230135	01/01/91	12/31/91	1.3010	0.9915
230137	10/01/90	09/30/91	1.0719	0.9841
230138	01/01/91	12/31/91	0.9051	0.9947
230141	10/01/90	09/30/91	1.5223	0.9980
230143	01/01/91	12/31/91	1.2210	0.9764
230144	07/01/90	12/31/91	1.1934	0.9932
230145	10/01/90	09/30/91	1.1114	0.9566
230146	01/01/91	12/31/91	1.2487	0.9875
230149	01/01/91	12/31/91	1.1197	0.9732
230150	10/01/90	09/30/91	1.5916	0.9976
230151	01/01/91	12/31/91	1.3942	0.9825
230155	01/01/91	12/31/91	1.0618	0.9634
230165	06/24/90	07/06/91	1.6982	0.9991
230167	01/01/91	12/31/91	1.1868	0.9945
230169	10/01/90	09/30/91	1.3223	0.9896
230171	01/01/91	12/31/91	1.1133	0.9641
230175	10/01/90	09/30/91	1.0144	0.9491
230184	10/01/90	09/30/91	1.1428	0.9880
230186	01/01/91	12/31/91	1.0063	0.9736
230190	01/01/91	12/31/91	0.9708	0.9554
230191	01/01/91	12/31/91	0.9232	0.9584
230193	01/01/91	12/31/91	1.2926	0.9924
230194	01/01/91	12/31/91	1.1699	0.9762
230195	10/01/90	09/30/91	1.3657	0.9870
230197	10/01/90	09/30/91	1.2315	0.9949
230204	10/01/90	09/30/91	1.2508	0.9944
230205	10/01/90	09/30/91	1.1162	0.9480
230208	01/01/91	12/31/91	1.0606	0.9787
230211	01/01/91	12/31/91	0.9233	0.9441
230213	01/01/91	12/31/91	1.0931	0.9656
230216	01/01/91	12/31/91	1.3052	0.9837
230217	01/01/91	12/31/91	1.1050	0.9767
230223	01/01/91	12/31/91	1.2866	0.9935
230227	01/01/91	12/31/91	1.3578	0.9968
230228	01/01/91	12/31/91	1.2029	0.9931
230230	01/01/91	12/31/91	1.3538	0.9886
230235	01/01/91	12/31/91	0.9915	0.9863
230236	10/01/90	09/30/91	1.3398	0.9972
230237	10/01/90	09/30/91	1.0876	0.9969
230239	10/01/90	09/30/91	1.1530	0.9767
230244	10/01/90	09/30/91	1.3711	0.9871
230253	10/01/90	09/30/91	1.1027	0.9619
230254	01/01/91	12/31/91	1.2664	0.9925
230257	06/24/90	07/06/91	0.8611	0.9601
230259	01/01/91	12/31/91	1.0923	0.9812
230266	10/01/90	09/30/91	1.2935	0.9830
230269	01/01/91	12/31/91	1.2294	0.9945
230273	01/01/91	12/31/91	1.5122	0.9960
230275	01/01/91	12/31/91	0.9074	1.0000
230276	01/01/91	12/31/91	1.0482	0.9893
230277	01/01/91	12/31/91	1.1543	0.9884
240001	01/01/91	12/31/91	1.5241	0.9968
240003	09/01/90	08/31/91	1.2481	0.9794
240004	01/01/91	12/31/91	1.4824	0.9795
240006	01/01/91	12/31/91	1.1396	0.9751
240007	10/01/90	09/30/91	1.1068	0.9705
240008	10/01/90	09/30/91	1.0283	0.9614
240010	01/01/91	12/31/91	1.8606	0.9947
240011	10/01/90	09/30/91	1.0342	0.9877
240013	10/01/90	09/30/91	1.2272	0.9757
240014	01/01/91	12/31/91	1.1829	0.9734
240016	10/01/90	09/30/91	1.3550	0.9870
240018	01/01/90	09/30/91	1.2384	0.9729
240019	01/01/91	12/31/91	1.3374	0.9989
240020	10/01/90	09/30/91	1.2248	0.9624

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
240021	10/01/90	09/30/91	1.0259	0.9499
240022	01/01/91	12/31/91	1.1065	0.9653
240023	01/01/91	12/31/91	1.0495	0.9514
240025	01/01/91	12/31/91	1.2071	0.9746
240027	10/01/90	09/30/91	1.0615	0.9713
240028	10/01/90	09/30/91	1.1175	0.9705
240029	10/01/90	09/30/91	1.1760	0.9798
240030	01/01/91	12/31/91	1.3259	0.9842
240031	01/01/91	12/31/91	0.9270	0.9572
240038	01/01/91	12/31/91	1.4546	0.9985
240041	10/01/90	09/30/91	1.2216	0.9972
240043	01/01/91	12/31/91	1.1400	0.9751
240045	10/01/90	09/30/91	1.1153	0.9494
240047	01/01/91	12/31/91	1.3942	0.9932
240048	09/01/90	08/31/91	1.2606	0.9891
240050	09/01/90	08/31/91	1.1107	0.9767
240051	10/01/90	09/30/91	0.8744	0.9292
240052	10/01/90	09/30/91	1.2223	0.9832
240056	01/01/91	12/31/91	1.3150	0.9824
240057	01/01/91	12/31/91	1.7321	0.9983
240058	10/01/90	09/30/91	0.9987	0.9196
240059	10/01/90	09/30/91	1.1115	0.9747
240061	01/01/91	12/31/91	1.4353	0.9945
240063	09/01/90	08/31/91	1.4998	0.9888
240064	01/01/91	12/31/91	1.2106	0.9746
240065	01/01/90	09/30/91	1.0076	0.9619
240066	10/01/90	09/30/91	1.3516	0.9744
240069	01/01/91	12/31/91	1.1981	0.9719
240071	01/01/91	12/31/91	1.1188	0.9696
240072	01/01/91	12/31/91	0.9585	0.9362
240073	01/01/91	12/31/91	1.0173	0.9442
240076	01/01/91	12/31/91	1.1096	0.9678
240078	01/01/91	12/31/91	1.3928	0.9971
240079	10/01/90	09/30/91	1.0762	0.9690
240080	01/01/91	12/31/91	1.3699	0.9974
240082	01/01/91	12/31/91	1.1664	0.9856
240083	01/01/91	12/31/91	1.2498	0.9438
240084	01/01/91	12/31/91	1.2999	0.9674
240085	01/01/91	12/31/91	0.8611	0.9679
240086	10/01/90	09/30/91	1.0704	0.9846
240087	01/01/91	12/31/91	1.0593	0.9760
240088	01/01/91	12/31/91	1.4549	0.9729
240090	05/01/90	09/30/91	1.0207	0.9747
240091	01/01/91	12/31/91	0.9866	0.9792
240093	10/01/90	09/30/91	1.2947	0.9770
240094	10/01/90	09/30/91	1.0016	0.9046
240096	01/01/91	12/31/91	1.0241	0.9647
240097	01/01/91	12/31/91	1.1094	0.9322
240098	10/01/90	09/30/91	0.9247	0.9523
240100	12/01/90	11/30/91	1.3039	0.9824
240102	01/01/91	12/31/91	1.0884	0.9730
240103	10/01/90	09/30/91	1.1640	0.9721
240105	10/01/90	09/30/91	0.8942	0.9730
240106	01/01/91	12/31/91	1.3227	0.9916
240107	01/01/91	12/31/91	0.9526	0.9685
240108	10/01/90	09/30/91	0.9344	0.9673
240109	01/01/91	12/31/91	0.9792	0.9885
240111	01/01/91	12/31/91	0.9856	0.9450
240112	01/01/91	12/31/91	0.9702	0.9777
240114	01/01/91	12/31/91	1.0439	0.8536
240115	01/01/91	12/31/91	1.5609	0.9950
240116	10/01/90	09/30/91	0.9139	0.9547
240117	11/01/90	10/31/91	1.1304	0.9592
240119	01/01/91	12/31/91	0.9073	0.9444
240121	10/01/90	09/30/91	0.9304	0.9339
240122	10/01/90	09/30/91	1.0907	0.9756
240123	01/01/91	12/31/91	1.1197	0.9250
240124	01/01/91	12/31/91	1.0316	0.9671
240127	01/01/91	12/31/91	0.9813	0.9697
240128	01/01/91	12/31/91	1.1150	0.9765
240130	01/01/91	12/31/91	0.9835	0.9529
240132	01/01/91	12/31/91	1.2614	0.9847
240133	01/01/91	12/31/91	1.1554	0.9509
240135	10/01/90	09/30/91	0.8410	0.9697
240136	01/01/91	12/31/91	0.8833	0.9400
240138	10/01/90	09/30/91	0.8740	0.9631
240139	10/01/90	09/30/91	0.9807	0.9638

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
240140	01/01/91	12/31/91	0.7912	0.9409
240141	01/01/91	12/31/91	1.0218	0.9494
240142	01/01/91	12/31/91	1.0787	0.9875
240143	10/01/90	09/30/91	0.9575	0.9297
240144	01/01/91	12/31/91	0.9736	0.9386
240146	10/01/90	09/30/91	0.9870	0.9487
240148	01/01/91	12/31/91	0.9621	0.9524
240150	10/01/90	09/30/91	0.9483	0.9596
240152	01/01/91	12/31/91	0.9829	0.9522
240153	10/01/90	09/30/91	0.9831	0.9869
240154	01/01/91	12/31/91	0.9714	0.9641
240155	10/01/90	09/30/91	0.9229	0.8731
240157	09/01/90	08/31/91	1.0535	0.9566
240158	05/01/90	07/31/91	0.9470	0.9354
240161	10/01/90	09/30/91	0.9873	0.9617
240162	01/01/91	12/31/91	1.0559	0.9588
240163	01/01/91	12/31/91	0.9190	0.9480
240166	10/01/90	09/30/91	1.1563	0.9623
240169	01/01/91	12/31/91	0.9770	0.9579
240170	01/01/91	12/31/91	1.0848	0.9589
240172	01/01/91	12/31/91	1.1216	0.9530
240173	01/01/91	12/31/91	0.9711	0.9473
240176	10/01/90	09/30/91	0.8986	1.0000
240179	01/01/91	12/31/91	0.9851	0.9640
240180	01/01/91	12/31/91	0.9581	0.9602
240183	01/01/90	11/30/91	1.1558	0.9705
240184	10/01/90	09/30/91	1.0729	0.9831
240187	01/01/91	12/31/91	1.2212	0.9627
240192	01/01/91	12/31/91	0.9275	0.9593
240193	10/01/90	09/30/91	1.0762	0.9748
240196	01/01/91	12/31/91	1.2889	0.9965
240200	01/01/91	12/31/91	0.8728	0.8800
240201	01/01/90	08/14/91	1.0074	0.9734
240207	01/01/91	12/31/91	1.1590	0.9699
240210	09/01/90	08/31/91	1.2412	0.9828
240211	10/01/90	09/30/91	1.3121	1.0000
250002	10/01/90	09/30/91	0.8050	0.9495
250003	10/01/90	09/30/91	0.9659	0.9531
250004	10/01/90	09/30/91	1.4418	0.9980
250005	10/01/90	09/30/91	0.9575	0.9532
250007	10/01/90	09/30/91	1.1603	0.9924
250008	10/01/90	09/30/91	0.8875	0.9388
250009	10/01/90	09/30/91	1.0943	0.9837
250010	10/01/90	09/30/91	1.0839	0.9523
250012	01/01/91	12/31/91	0.9437	0.9543
250015	10/01/90	09/30/91	0.9458	0.9553
250016	05/01/90	12/31/91	0.8609	0.9958
250018	10/01/90	09/30/91	1.0173	0.9475
250019	10/01/90	09/30/91	1.2662	0.9974
250020	10/01/90	09/30/91	1.0173	0.9481
250021	10/01/90	09/30/91	0.8911	0.9606
250023	10/01/90	09/30/91	0.8304	0.9587
250024	10/01/90	09/30/91	0.9341	0.9660
250025	10/01/90	09/30/91	1.0210	0.9675
250027	10/01/90	09/30/91	0.9803	0.9632
250029	01/01/91	12/31/91	0.9321	0.9507
250030	01/01/91	12/31/91	0.9347	0.9669
250035	10/01/90	09/30/91	0.8378	0.9752
250036	10/01/90	09/30/91	0.9633	0.9609
250037	10/01/90	09/30/91	0.8884	0.9344
250038	10/01/90	09/30/91	0.8919	0.9677
250039	10/01/90	09/30/91	1.0096	0.9576
250040	10/01/90	09/30/91	1.2067	0.9923
250042	10/01/90	09/30/91	1.1284	0.9873
250043	10/01/90	09/30/91	0.8837	0.9441
250045	10/01/90	09/30/91	1.1650	0.9640
250047	10/01/90	09/30/91	0.9318	0.9740
250048	01/01/91	12/31/91	1.3615	0.9971
250049	10/01/90	09/30/91	0.9237	0.9751
250050	10/01/90	09/30/91	1.1696	0.9838
250051	10/01/90	09/30/91	0.8801	0.9581
250057	10/01/90	09/30/91	1.0856	0.9829
250058	10/01/90	09/30/91	1.1685	0.9877
250059	10/01/90	09/30/91	1.0076	0.9474
250060	10/01/90	09/30/91	0.7967	0.9510
250061	10/01/90	09/30/91	0.9060	0.9754
250062	01/01/91	12/31/91	0.9781	0.9618

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
250063	10/01/90	09/30/91	0.8544	0.9714
250065	10/01/90	09/30/91	0.9447	0.9680
250066	10/01/90	09/30/91	0.9373	0.9761
250067	10/01/90	09/30/91	1.0111	0.9850
250068	10/01/90	09/30/91	0.8492	0.9446
250069	01/01/91	12/31/91	1.2494	0.9942
250071	10/01/90	09/30/91	1.0477	0.9587
250073	01/01/91	12/31/91	0.9885	0.9520
250076	10/01/90	09/30/91	0.9145	0.9406
250077	10/01/90	09/30/91	0.9283	0.9710
250078	10/01/90	09/30/91	1.3873	0.9978
250079	10/01/90	09/30/91	0.8617	0.9617
250081	10/01/90	09/30/91	1.2182	0.9929
250082	10/01/90	09/30/91	1.2492	0.9907
250083	01/01/91	12/31/91	0.9028	0.9719
250084	10/01/90	09/30/91	1.1969	0.9947
250085	10/01/90	09/30/91	1.0031	0.9714
250086	10/01/90	09/30/91	0.9208	0.9686
250088	10/01/90	09/30/91	1.0110	0.9630
250089	01/01/91	12/31/91	0.9931	0.9799
250091	10/01/90	09/30/91	1.0214	0.9743
250093	10/01/90	09/30/91	1.1520	0.9887
250095	10/01/90	09/30/91	1.0467	0.9701
250096	10/01/90	09/30/91	1.1961	0.9897
250097	10/01/90	09/30/91	1.1841	0.9744
250098	10/01/90	09/30/91	0.8416	0.9454
250099	10/01/90	09/30/91	1.2073	0.9846
250100	10/01/90	09/30/91	1.1521	0.9633
250101	10/01/90	09/30/91	0.8836	0.9784
250104	10/01/90	09/30/91	1.3148	0.9981
250105	10/01/90	09/30/91	0.9041	0.9587
250107	10/01/90	09/30/91	0.9158	0.9696
250109	10/01/90	09/30/91	0.9824	0.9523
250112	10/01/90	09/30/91	0.9499	0.9660
250117	01/01/91	12/31/91	1.1020	0.9834
250119	10/01/90	09/30/91	0.9624	0.9716
250120	10/01/90	09/30/91	1.0683	0.9922
250122	09/01/90	08/31/91	1.2603	0.9946
250124	01/01/91	12/31/91	0.8784	0.9662
250125	01/01/91	12/31/91	1.2835	0.9889
250129	09/01/90	12/31/91	1.1708	0.9882
250136	01/01/91	12/31/91	0.7666	1.0000
250139	10/01/90	09/30/91	0.9012	0.9588
250140	10/01/90	09/30/91	0.8143	0.9870
260003	09/01/90	08/31/91	0.9668	0.9558
260004	01/01/91	12/31/91	1.0707	0.9824
260005	01/01/91	12/31/91	1.3836	0.9949
260011	01/01/91	12/31/91	1.5313	0.9945
260012	10/01/90	09/30/91	1.0062	0.9673
260014	01/01/91	12/31/91	1.6131	0.9989
260015	01/01/91	12/31/91	1.2203	0.9493
260017	01/01/91	12/31/91	1.2136	0.9785
260018	10/01/90	09/30/91	0.9483	0.9429
260019	01/01/91	12/31/91	1.0231	0.9666
260021	10/01/90	09/30/91	1.2800	0.9924
260023	10/01/90	09/30/91	1.2745	0.9934
260024	12/01/90	11/30/91	1.0524	0.9867
260025	10/01/90	09/30/91	1.3079	0.9813
260027	01/01/91	12/31/91	1.5166	0.9984
260029	10/01/90	09/30/91	1.1625	0.9783
260030	10/01/90	09/30/91	1.1174	0.9796
260032	01/01/91	12/31/91	1.6358	0.9981
260034	01/01/91	12/31/91	1.0373	0.9816
260035	12/01/90	11/30/91	1.0507	0.9777
260036	01/01/91	12/31/91	1.0389	0.9531
260039	09/01/90	08/31/91	1.3077	0.9722
260040	10/01/90	09/30/91	1.4982	0.9989
260044	01/01/91	12/31/91	1.0679	0.9801
260050	01/01/91	12/31/91	1.0874	0.9675
260053	10/01/90	09/30/91	1.0735	0.9840
260054	01/01/91	12/31/91	1.3418	0.9941
260057	10/01/90	09/30/91	1.1603	0.9797
260062	10/01/90	09/30/91	1.1677	0.9853
260063	01/01/91	12/31/91	1.1645	0.9647
260064	01/01/91	12/31/91	1.3670	0.9869
260068	01/01/91	12/31/91	1.7744	0.9994
260070	01/01/91	12/31/91	1.1166	0.9389

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
260073	01/01/91	12/31/91	1.0164	0.9714
260074	01/01/91	12/31/91	1.1967	0.9679
260078	01/01/91	12/31/91	1.1004	0.9761
260080	09/01/90	08/31/91	1.1325	0.9173
260091	01/01/91	12/31/91	1.5519	0.9970
260092	01/01/91	12/31/91	1.0959	0.9632
260097	10/01/90	09/30/91	1.1887	0.9691
260100	10/01/90	09/30/91	1.1553	0.9746
260102	01/01/91	12/31/91	0.9515	0.9748
260103	01/01/91	12/31/91	1.3060	0.9918
260107	10/01/90	09/30/91	1.3056	0.9994
260110	01/01/91	12/31/91	1.6245	0.9980
260111	01/01/91	12/31/91	0.9776	0.9668
260113	10/01/90	09/30/91	1.1684	0.9859
260116	01/01/91	12/31/91	1.2021	0.9887
260119	01/01/91	12/31/91	1.1421	0.9700
260120	12/01/90	11/30/91	1.1855	0.9719
260122	11/01/90	10/31/91	1.2564	0.9749
260123	01/01/91	12/31/91	0.9326	0.9846
260134	01/01/91	12/31/91	1.2845	0.9848
260138	01/01/91	12/31/91	1.8406	0.9990
260158	01/01/91	12/31/91	1.0872	0.9730
260159	01/01/91	12/31/91	1.1101	0.9713
260160	01/01/91	12/31/91	1.1429	0.9707
260162	01/01/91	12/31/91	1.0360	0.9749
260165	01/01/91	12/31/91	0.9467	0.9723
260166	01/01/91	12/31/91	1.2226	0.9886
260178	01/01/91	12/31/91	1.4275	0.9959
260179	01/01/91	12/31/91	1.5147	0.9993
260180	01/01/91	12/31/91	1.5581	0.9964
260182	07/01/90	09/30/91	1.0276	0.9673
260188	01/01/91	12/31/91	1.1871	0.9805
260190	01/01/91	12/31/91	1.1618	0.9923
260191	01/01/91	12/31/91	1.2471	0.9840
260193	01/01/91	12/31/91	1.2247	0.9822
260195	09/28/90	09/26/91	1.1173	0.9634
260198	07/01/90	10/31/91	1.2658	0.9809
260200	01/01/91	12/31/91	1.1923	0.9687
260202	10/01/90	09/30/91	1.3740	0.9754
270002	10/01/90	09/30/91	1.2246	0.9838
270006	10/01/90	09/30/91	0.8607	1.0000
270007	10/01/90	09/30/91	0.9594	0.9566
270013	01/01/91	12/31/91	1.3018	0.9888
270014	01/01/91	12/31/91	1.6441	0.9968
270019	01/01/91	12/31/91	0.9794	0.9594
270021	10/01/90	09/30/91	1.0866	0.9896
270030	01/01/91	12/31/91	0.9277	0.9168
270033	01/01/91	12/31/91	0.8019	0.9586
270035	10/01/90	09/30/91	1.0434	0.9849
270039	01/01/91	12/31/91	0.9036	0.9673
270048	11/01/90	10/31/91	1.0827	0.9698
270057	01/01/91	12/31/91	1.1048	0.9834
270059	11/01/90	10/31/91	0.8522	0.9605
270063	10/01/90	09/30/91	0.8775	0.9807
270083	01/01/91	12/31/91	1.0149	0.9535
280001	10/01/90	09/30/91	1.1286	0.9485
280005	09/01/90	08/31/91	1.4427	0.9914
280012	01/01/91	12/31/91	1.1809	0.9853
280015	10/01/90	09/30/91	1.0098	0.9808
280017	08/01/90	07/31/91	1.1658	0.9673
280025	09/01/90	08/31/91	0.9861	0.9612
280030	09/01/90	08/31/91	1.7555	0.9983
280031	10/01/90	09/30/91	1.1035	0.9736
280032	01/01/91	12/31/91	1.2118	0.9915
280034	09/01/90	08/31/91	1.2686	0.9887
280038	10/01/90	09/30/91	1.0332	0.9771
280039	10/01/90	09/30/91	1.0738	0.9458
280040	01/01/91	12/31/91	1.5883	0.9944
280041	01/01/91	12/31/91	0.9268	0.9894
280046	01/01/91	12/31/91	1.0125	0.9727
280047	01/01/91	12/31/91	1.1805	0.9672
280048	10/01/90	09/30/91	1.0651	0.9972
280054	10/01/90	09/30/91	1.1591	0.9721
280057	10/01/90	09/30/91	1.0140	0.9793
280058	10/01/90	09/30/91	1.2385	0.9643
280061	01/01/91	12/31/91	1.3005	0.9937
280065	01/01/91	12/31/91	1.1577	0.9860

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
280074	10/01/90	09/30/91	1.1618	0.9805
280076	08/01/90	07/31/91	0.9625	0.9490
280078	05/01/90	10/18/91	0.9264	0.9093
280079	08/01/90	07/31/91	0.9452	0.9814
280081	10/01/90	09/30/91	1.4439	0.9969
280083	11/01/90	10/31/91	0.9812	0.9637
280085	01/01/91	12/31/91	0.9515	1.0000
280088	09/24/90	09/22/91	1.6348	0.9984
280089	10/01/90	09/30/91	1.0325	0.9939
280101	10/01/90	09/30/91	1.1227	0.9959
280102	01/01/91	12/31/91	0.8383	0.9334
280106	08/01/90	07/31/91	1.0201	0.9756
280107	11/01/90	10/31/91	1.0708	0.9474
280108	01/01/91	12/31/91	1.0423	0.9874
280109	08/01/90	07/31/91	0.9163	0.9805
280114	08/01/90	07/31/91	0.9298	0.9880
280115	01/01/91	12/31/91	0.9729	0.9705
290003	09/01/90	08/31/91	1.6223	0.9983
290005	09/01/90	08/31/91	1.1910	0.9932
290006	01/01/91	12/31/91	1.0680	0.9722
290009	01/01/91	12/31/91	1.5643	0.9964
290010	01/01/91	12/31/91	1.0543	0.9828
290018	10/01/90	09/30/91	0.9938	0.9543
290021	01/01/91	12/31/91	1.5631	0.9982
290022	10/01/90	09/30/91	1.6766	0.9987
290032	01/01/91	12/31/91	1.3852	0.9780
300001	10/01/90	09/30/91	1.2908	0.9955
300005	10/01/90	09/30/91	1.3439	0.9930
300006	10/01/90	09/30/91	1.1131	0.9585
300007	10/01/90	09/30/91	1.1022	0.9757
300008	10/01/90	09/30/91	1.2357	0.9915
300009	10/01/90	09/30/91	1.2334	0.9555
300011	01/01/91	12/31/91	1.2347	0.9936
300012	10/01/90	09/30/91	1.2615	0.9809
300013	10/01/90	09/30/91	1.1566	0.9612
300014	10/01/90	09/30/91	1.3455	0.9915
300016	10/01/90	09/30/91	1.2373	0.9888
300017	08/01/90	07/31/91	1.1791	0.9793
300018	01/01/91	12/31/91	1.1924	0.9926
300020	10/01/90	09/30/91	1.1541	0.9928
300021	10/01/90	09/30/91	1.1561	0.9849
300022	01/01/91	12/31/91	1.1134	0.9653
300023	10/01/90	09/30/91	1.2241	0.9822
300024	10/01/90	09/30/91	1.2564	0.9767
300028	10/01/90	09/30/91	1.1812	0.9707
300033	10/01/90	09/30/91	1.0753	0.9748
310001	01/01/91	12/31/91	1.6577	0.9995
310002	01/01/91	12/31/91	1.8318	0.9986
310003	01/01/91	12/31/91	1.2299	0.9940
310005	01/01/91	12/31/91	1.2373	0.9909
310006	01/01/91	12/31/91	1.1527	0.9942
310008	01/01/91	12/31/91	1.3263	0.9948
310009	01/01/91	12/31/91	1.1823	0.9963
310010	01/01/91	12/31/91	1.2262	0.9938
310011	01/01/91	12/31/91	1.2183	0.9933
310012	01/01/91	12/31/91	1.5608	0.9988
310013	01/01/91	12/31/91	1.2893	0.9969
310014	01/01/91	12/31/91	1.6075	0.9973
310015	01/01/91	12/31/91	1.6005	0.9989
310016	01/01/91	12/31/91	1.2585	0.9984
310017	01/01/91	12/31/91	1.3329	0.9902
310018	01/01/91	12/31/91	1.2422	0.9941
310019	01/01/91	12/31/91	1.6587	0.9982
310020	01/01/91	12/31/91	1.2177	0.9952
310021	01/01/91	12/31/91	1.2315	0.9940
310022	01/01/91	12/31/91	1.2058	0.9936
310024	01/01/91	12/31/91	1.2351	0.9907
310025	01/01/91	12/31/91	1.1611	0.9896
310026	01/01/91	12/31/91	1.2179	0.9952
310027	01/01/91	12/31/91	1.2667	0.9949
310028	01/01/91	12/31/91	1.1674	0.9790
310029	01/01/91	12/31/91	1.8063	0.9956
310031	01/01/91	12/31/91	2.7639	0.9966
310032	01/01/91	12/31/91	1.2687	0.9876
310034	01/01/91	12/31/91	1.1591	0.9933
310036	01/01/91	12/31/91	1.2208	0.9913
310037	01/01/91	12/31/91	1.2156	0.9924

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
310038	01/01/91	12/31/91	1.7265	0.9977
310039	01/01/91	12/31/91	1.2903	0.9970
310040	01/01/91	12/31/91	1.2030	0.9987
310041	01/01/91	12/31/91	1.2659	0.9951
310042	01/01/91	12/31/91	1.1365	0.9967
310043	01/01/91	12/31/91	1.1940	0.9944
310044	01/01/91	12/31/91	1.2474	0.9923
310045	01/01/91	12/31/91	1.2620	0.9968
310047	01/01/91	12/31/91	1.2770	0.9883
310048	01/01/91	12/31/91	1.2203	0.9942
310049	01/01/91	12/31/91	1.2695	0.9971
310050	10/01/90	09/30/91	1.1906	0.9933
310051	01/01/91	12/31/91	1.2875	0.9943
310052	01/01/91	12/31/91	1.1881	0.9936
310054	01/01/91	12/31/91	1.2728	0.9950
310056	01/01/91	12/31/91	1.1524	0.9850
310057	01/01/91	12/31/91	1.2381	0.9921
310058	01/01/91	12/31/91	1.1516	0.9962
310060	01/01/91	12/31/91	1.1951	0.9931
310061	01/01/91	12/31/91	1.1779	0.9874
310062	01/01/91	12/31/91	1.1892	0.9972
310063	01/01/91	12/31/91	1.3007	0.9949
310064	01/01/91	12/31/91	1.2243	0.9919
310067	01/01/91	12/31/91	1.2155	0.9927
310069	01/01/91	12/31/91	1.1418	0.9782
310070	01/01/91	12/31/91	1.2847	0.9963
310071	01/01/91	12/31/91	0.6936	1.0000
310072	01/01/91	12/31/91	1.2939	0.9886
310073	01/01/91	12/31/91	1.3973	0.9981
310074	01/01/91	12/31/91	1.2923	0.9938
310075	01/01/91	12/31/91	1.2579	0.9944
310076	01/01/91	12/31/91	1.3520	0.9964
310077	01/01/91	12/31/91	1.5813	0.9981
310078	01/01/91	12/31/91	1.3174	0.9988
310081	01/01/91	12/31/91	1.2105	0.9903
310083	01/01/91	12/31/91	1.2825	0.9971
310084	01/01/91	12/31/91	1.2199	0.9941
310085	01/01/91	12/31/91	1.2154	0.9963
310086	01/01/91	12/31/91	1.1849	0.9916
310087	01/01/91	12/31/91	1.1833	0.9822
310088	01/01/91	12/31/91	1.2435	0.9881
310090	01/01/91	12/31/91	1.2598	0.9905
310091	01/01/91	12/31/91	1.2488	0.9865
310092	01/01/91	12/31/91	1.3295	0.9951
310093	01/01/91	12/31/91	1.1019	0.9937
310096	01/01/91	12/31/91	1.7318	0.9980
310105	01/01/91	12/31/91	1.1204	0.9906
310108	01/01/91	12/31/91	1.3575	0.9955
310110	01/01/91	12/31/91	1.2319	0.9947
310111	01/01/91	12/31/91	1.2379	0.9924
310112	01/01/91	12/31/91	1.2275	0.9966
310113	01/01/91	12/31/91	1.2209	0.9844
310115	01/01/91	12/31/91	1.1913	0.9933
310116	01/01/91	12/31/91	1.2660	0.9939
310118	10/01/90	09/30/91	1.2049	0.9943
310120	01/01/91	12/31/91	1.0594	0.9923
310121	01/01/91	12/31/91	1.0688	0.9034
320019	09/01/90	08/31/91	1.3408	0.9977
320035	01/01/91	12/31/91	1.0556	0.9691
320038	09/01/90	08/31/91	1.2492	0.9602
320048	07/01/90	12/31/91	1.2824	0.9958
320063	09/01/90	08/31/91	1.2816	0.9786
320067	01/01/91	12/31/91	0.8769	0.9847
330001	01/01/91	12/31/91	1.1577	0.9891
330002	01/01/91	12/31/91	1.4261	0.9966
330003	01/01/91	12/31/91	1.3330	0.9963
330004	01/01/91	12/31/91	1.3560	0.9958
330005	01/01/91	12/31/91	1.6850	0.9995
330006	01/01/91	12/31/91	1.3704	0.9932
330007	01/01/91	12/31/91	1.3633	0.9945
330008	01/01/91	12/31/91	1.1902	0.9903
330009	01/01/91	12/31/91	1.3196	0.9975
330010	01/01/91	12/31/91	1.2416	0.9874
330011	01/01/91	12/31/91	1.1795	0.9954
330012	01/01/91	12/31/91	1.5904	0.9953
330013	01/01/91	12/31/91	2.0580	0.9963
330014	01/01/91	12/31/91	1.4092	0.9928

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
330015	01/01/91	12/31/91	0.8736	1.0000
330016	01/01/91	12/31/91	0.9805	0.9757
330019	01/01/91	12/31/91	1.3070	0.9951
330020	01/01/91	12/31/91	0.9994	0.9808
330022	01/01/91	12/31/91	0.9905	0.9736
330023	01/01/91	12/31/91	1.2098	0.9890
330024	01/01/91	12/31/91	1.7348	0.9996
330025	01/01/91	12/31/91	1.1008	0.9911
330027	01/01/91	12/31/91	1.4005	0.9826
330028	01/01/91	12/31/91	1.3003	0.9943
330029	01/01/91	12/31/91	1.1108	0.9936
330030	01/01/91	12/31/91	1.1574	0.9916
330033	01/01/91	12/31/91	1.1226	0.9820
330034	01/01/91	12/31/91	1.0669	0.9949
330036	01/01/91	12/31/91	1.1939	0.9928
330037	01/01/91	12/31/91	1.0528	0.9882
330038	01/01/91	12/31/91	1.1852	0.9874
330039	01/01/91	12/31/91	0.8981	0.9704
330041	01/01/91	12/31/91	1.3626	0.9975
330043	01/01/91	12/31/91	1.2430	0.9917
330044	01/01/91	12/31/91	1.1996	0.9938
330045	01/01/91	12/31/91	1.3076	0.9949
330046	01/01/91	12/31/91	1.5956	0.9973
330047	01/01/91	12/31/91	1.2635	0.9947
330048	01/01/91	12/31/91	1.2585	0.9915
330049	01/01/91	12/31/91	1.3039	0.9893
330053	01/01/91	12/31/91	1.0465	0.9921
330055	01/01/91	12/31/91	1.3877	0.9955
330056	01/01/91	12/31/91	1.4353	0.9980
330057	01/01/91	12/31/91	1.5729	0.9981
330058	01/01/91	12/31/91	1.3215	0.9904
330059	01/01/91	12/31/91	1.4891	0.9993
330061	01/01/91	12/31/91	1.3168	0.9957
330062	01/01/91	12/31/91	1.0897	0.9747
330064	01/01/91	12/31/91	1.3062	0.9964
330065	01/01/91	12/31/91	1.1855	0.9948
330066	01/01/91	12/31/91	1.2114	0.9961
330067	01/01/91	12/31/91	1.3305	0.9893
330072	01/01/91	12/31/91	1.3365	0.9963
330073	01/01/91	12/31/91	1.1686	0.9859
330074	01/01/91	12/31/91	1.2262	0.9920
330075	01/01/91	12/31/91	1.0491	0.9885
330078	01/01/91	12/31/91	1.3601	0.9965
330079	01/01/91	12/31/91	1.1036	0.9868
330082	01/01/91	12/31/91	1.2040	0.9919
330084	01/01/91	12/31/91	0.9497	0.9793
330085	01/01/91	12/31/91	1.3489	0.9925
330086	01/01/91	12/31/91	1.2678	0.9952
330088	01/01/91	12/31/91	1.0996	0.9793
330090	01/01/91	12/31/91	1.7093	0.9968
330091	01/01/91	12/31/91	1.3826	0.9953
330092	01/01/91	12/31/91	0.9649	0.9776
330094	01/01/91	12/31/91	1.2793	0.9899
330095	01/01/91	12/31/91	1.2530	0.9972
330097	01/01/91	12/31/91	1.1576	0.9919
330100	01/01/91	12/31/91	0.6753	0.9978
330101	01/01/91	12/31/91	1.6301	0.9980
330102	01/01/91	12/31/91	1.2835	0.9979
330103	01/01/91	12/31/91	1.1719	0.9840
330104	01/01/91	12/31/91	1.3352	0.9935
330106	01/01/91	12/31/91	1.5305	0.9993
330107	01/01/91	12/31/91	1.2543	0.9806
330108	01/01/91	12/31/91	1.2213	0.9929
330110	01/01/91	12/31/91	1.0812	0.9801
330111	01/01/91	12/31/91	1.1379	0.9715
330114	01/01/91	12/31/91	0.9716	0.9647
330115	01/01/91	12/31/91	1.2007	0.9777
330116	01/01/91	12/31/91	0.9737	0.9632
330118	01/01/91	12/31/91	1.5710	0.9979
330119	01/01/91	12/31/91	1.6069	0.9992
330121	01/01/91	12/31/91	0.9922	0.9870
330122	01/01/91	12/31/91	1.3014	0.9934
330125	01/01/91	12/31/91	1.7736	0.9982
330126	01/01/91	12/31/91	1.2054	0.9868
330132	01/01/91	12/31/91	1.1018	0.9816
330133	01/01/91	12/31/91	1.2999	0.9964
330135	01/01/91	12/31/91	1.2178	0.9804

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
330136	01/01/91	12/31/91	1.2479	0.9881
330140	01/01/91	12/31/91	1.6427	0.9981
330141	01/01/91	12/31/91	1.2623	0.9958
330144	01/01/91	12/31/91	1.0315	0.9764
330148	01/01/91	12/31/91	1.0184	0.9789
330151	01/01/91	12/31/91	1.1353	0.9826
330152	01/01/91	12/31/91	1.3951	0.9949
330153	01/01/91	12/31/91	1.3152	0.9944
330154	01/01/91	12/31/91	1.4343	0.9995
330155	01/01/91	12/31/91	1.1867	0.9777
330157	01/01/91	12/31/91	1.3015	0.9916
330158	01/01/91	12/31/91	1.2923	0.9946
330159	01/01/91	12/31/91	1.3053	0.9935
330160	01/01/91	12/31/91	1.4509	0.9968
330161	01/01/91	12/31/91	1.0523	0.9929
330162	01/01/91	12/31/91	1.2550	0.9947
330163	01/01/91	12/31/91	1.1614	0.9951
330164	01/01/91	12/31/91	1.3725	0.9963
330166	01/01/91	12/31/91	0.9165	0.9666
330167	01/01/91	12/31/91	1.5388	0.9978
330169	01/01/91	12/31/91	1.3878	0.9965
330171	01/01/91	12/31/91	1.2918	0.9960
330174	01/01/91	12/31/91	0.6686	0.9339
330175	01/01/91	12/31/91	1.0456	0.9932
330179	01/01/91	12/31/91	0.9425	0.9864
330180	01/01/91	12/31/91	1.2191	0.9948
330181	01/01/91	12/31/91	1.2596	0.9972
330182	01/01/91	12/31/91	2.2788	0.9988
330183	01/01/91	12/31/91	1.4314	0.9944
330184	01/01/91	12/31/91	1.2307	0.9917
330185	01/01/91	12/31/91	1.1676	0.9931
330186	01/01/91	12/31/91	0.9769	0.9685
330188	01/01/91	12/31/91	1.2120	0.9956
330189	01/01/91	12/31/91	0.8722	1.0000
330191	01/01/91	12/31/91	1.2472	0.9965
330193	01/01/91	12/31/91	1.3380	0.9962
330194	01/01/91	12/31/91	1.7382	0.9990
330195	01/01/91	12/31/91	1.6286	0.9973
330197	01/01/91	12/31/91	1.0129	0.9826
330198	01/01/91	12/31/91	1.3286	0.9941
330201	01/01/91	12/31/91	1.5001	0.9995
330203	01/01/91	12/31/91	1.3978	0.9974
330205	01/01/91	12/31/91	1.0892	0.9820
330208	01/01/91	12/31/91	1.1677	0.9955
330209	01/01/91	12/31/91	1.2120	0.9854
330211	01/01/91	12/31/91	1.2443	0.9868
330212	01/01/91	12/31/91	1.2332	0.9959
330213	01/01/91	12/31/91	1.1090	0.9704
330214	01/01/91	12/31/91	1.7320	0.9992
330215	01/01/91	12/31/91	1.2038	0.9923
330218	01/01/91	12/31/91	1.2668	0.9906
330219	01/01/91	12/31/91	1.5482	0.9984
330221	01/01/91	12/31/91	1.2762	0.9962
330222	01/01/91	12/31/91	1.2217	0.9886
330223	01/01/91	12/31/91	1.0822	0.9742
330224	01/01/91	12/31/91	1.2347	0.9946
330225	01/01/91	12/31/91	1.1868	0.9958
330226	01/01/91	12/31/91	1.2793	0.9916
330229	01/01/91	12/31/91	1.2083	0.9824
330230	01/01/91	12/31/91	1.4617	0.9948
330232	01/01/91	12/31/91	1.2602	0.9973
330233	01/01/91	12/31/91	1.5136	0.9971
330235	01/01/91	12/31/91	1.2051	0.9955
330236	01/01/91	12/31/91	1.3353	0.9951
330238	01/01/91	12/31/91	1.0762	0.9875
330239	01/01/91	12/31/91	1.1767	0.9945
330241	01/01/91	12/31/91	1.7846	0.9952
330242	01/01/91	12/31/91	1.2800	0.9967
330244	01/01/91	12/31/91	1.0915	0.9987
330245	01/01/91	12/31/91	1.3205	0.9877
330246	01/01/91	12/31/91	1.2066	0.9948
330247	01/01/91	12/31/91	0.6192	1.0000
330249	01/01/91	12/31/91	1.2142	0.9823
330250	01/01/91	12/31/91	1.2671	0.9949
330252	01/01/91	12/31/91	0.9231	0.9485
330254	01/01/91	12/31/91	1.0081	0.9888
330258	01/01/91	12/31/91	1.3424	0.9911

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
330259	01/01/91	12/31/91	1.3447	0.9959
330261	01/01/91	12/31/91	1.2431	0.9940
330263	01/01/91	12/31/91	1.0611	0.9799
330264	01/01/91	12/31/91	1.1762	0.9920
330265	01/01/91	12/31/91	1.2462	0.9943
330267	01/01/91	12/31/91	1.2433	0.9934
330268	01/01/91	12/31/91	1.1202	0.9727
330270	01/01/91	12/31/91	1.8605	0.9971
330273	01/01/91	12/31/91	1.2056	0.9893
330275	01/01/91	12/31/91	1.2347	0.9981
330276	01/01/91	12/31/91	1.2125	0.9847
330277	01/01/91	12/31/91	1.1833	0.9831
330279	01/01/91	12/31/91	1.2308	0.9953
330281	01/01/91	12/31/91	0.5490	1.0000
330285	01/01/91	12/31/91	1.6676	0.9977
330286	01/01/91	12/31/91	1.3184	0.9919
330288	01/01/91	12/31/91	1.0362	0.9839
330290	01/01/91	12/31/91	1.6676	0.9981
330293	01/01/91	12/31/91	1.1914	0.9938
330304	01/01/91	12/31/91	1.1936	0.9915
330306	01/01/91	12/31/91	1.3668	0.9961
330307	01/01/91	12/31/91	1.1312	0.9812
330308	01/01/91	12/31/91	1.2220	0.9968
330309	01/01/91	12/31/91	1.2797	0.9963
330314	01/01/91	12/31/91	1.3124	0.9937
330315	01/01/91	12/31/91	1.1847	0.9917
330316	01/01/91	12/31/91	1.2838	0.9926
330327	01/01/91	12/31/91	0.9646	0.9763
330331	01/01/91	12/31/91	1.1964	0.9942
330332	01/01/91	12/31/91	1.2709	0.9950
330333	01/01/91	12/31/91	1.3218	0.9976
330336	01/01/91	12/31/91	1.2602	0.9863
330338	01/01/91	12/31/91	1.1473	0.9937
330339	01/01/91	12/31/91	0.8252	1.0000
330340	01/01/91	12/31/91	1.1362	0.9791
330350	01/01/91	12/31/91	1.8601	0.9970
330353	01/01/91	12/31/91	1.2202	0.9916
330357	01/01/91	12/31/91	1.3670	0.9875
330359	01/01/91	12/31/91	0.9375	0.9742
330372	01/01/91	12/31/91	1.2491	0.9920
330381	01/01/91	12/31/91	1.2263	0.9986
330386	01/01/91	12/31/91	1.1966	0.9701
330387	01/01/91	12/31/91	0.8518	0.9429
330389	01/01/91	12/31/91	1.8306	0.9943
330390	01/01/91	12/31/91	1.1703	1.0000
330393	01/01/91	12/31/91	1.6281	0.9975
330394	01/01/91	12/31/91	1.3967	0.9985
330395	01/01/91	12/31/91	1.3223	0.9926
330397	01/01/91	12/31/91	1.4223	0.9962
330398	01/01/91	12/31/91	1.2796	0.9909
330399	01/01/91	12/31/91	1.3598	0.9982
340001	10/01/90	09/30/91	1.2428	0.9817
340002	10/01/90	09/30/91	1.7824	0.9964
340003	10/01/90	09/30/91	1.1463	0.9553
340004	10/01/90	09/30/91	1.3921	0.9937
340005	10/01/90	09/30/91	1.2275	0.9861
340006	10/01/90	09/30/91	1.1724	0.9682
340007	10/01/90	09/30/91	1.1175	0.9733
340008	10/01/90	09/30/91	1.2245	0.9822
340009	10/01/90	09/30/91	1.2459	0.9868
340010	09/24/90	09/28/91	1.3121	0.9770
340011	10/01/90	09/30/91	1.0776	0.9767
340012	10/01/90	09/30/91	1.0763	0.9854
340013	10/01/90	09/30/91	1.1930	0.9735
340015	10/01/90	09/30/91	1.2281	0.9777
340016	10/01/90	09/30/91	1.2019	0.9800
340017	10/01/90	09/30/91	1.2022	0.9854
340018	10/01/90	09/30/91	1.2033	0.9711
340021	10/01/90	09/30/91	1.2187	0.9865
340022	10/01/90	09/30/91	1.1383	0.9590
340023	01/01/91	12/31/91	1.3119	0.9881
340024	10/01/90	09/30/91	1.2321	0.9600
340025	10/01/90	09/30/91	1.0963	0.9850
340027	10/01/90	09/30/91	1.1213	0.9936
340028	10/01/90	09/30/91	1.3819	0.9923
340031	10/01/90	09/30/91	1.0763	0.9821
340034	10/01/90	09/30/91	1.2825	0.9615

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
340035	10/01/90	09/30/91	1.0860	0.9740
340036	10/01/90	09/30/91	1.0823	0.9596
340037	10/01/90	09/30/91	1.2533	0.9862
340038	10/01/90	09/30/91	1.2044	0.9839
340039	10/01/90	09/30/91	1.2308	0.9804
340040	10/01/90	09/30/91	1.7185	0.9991
340041	10/01/90	09/30/91	1.2352	0.9717
340042	10/01/90	09/30/91	1.1506	0.9799
340044	10/01/90	09/30/91	1.0088	0.9562
340045	10/01/90	09/30/91	0.9709	0.9405
340049	10/01/90	09/30/91	0.5900	1.0000
340050	10/01/90	09/30/91	1.2031	0.9736
340051	10/01/90	09/30/91	1.2320	0.9774
340052	10/01/90	09/30/91	0.9564	0.9778
340053	10/01/90	09/30/91	1.5728	0.9980
340054	10/01/90	09/30/91	0.9768	0.9722
340055	10/01/90	09/30/91	1.1573	0.9892
340060	10/01/90	09/30/91	1.1815	0.9659
340063	10/01/90	09/30/91	1.0201	0.9685
340064	10/01/90	09/30/91	1.0986	0.9630
340065	10/01/90	09/30/91	1.2349	0.9662
340067	10/01/90	09/30/91	1.1112	0.9704
340068	10/01/90	09/30/91	1.2557	0.9721
340069	10/01/90	09/30/91	1.7419	0.9962
340070	10/01/90	09/30/91	1.2917	0.9733
340071	10/01/90	09/30/91	1.0850	0.9583
340072	10/01/90	09/30/91	1.0490	0.9740
340075	10/01/90	09/30/91	1.1890	0.9832
340080	10/01/90	09/30/91	1.0912	0.9713
340084	10/01/90	09/30/91	1.0187	0.9836
340085	10/01/90	09/30/91	1.2491	0.9873
340087	10/01/90	09/30/91	1.0739	0.9804
340088	10/01/90	09/30/91	1.0851	0.9629
340089	10/01/90	09/30/91	1.0024	0.9645
340090	10/01/90	09/30/91	1.1459	0.9571
340091	10/01/90	09/30/91	1.6608	0.9989
340093	10/01/90	09/30/91	1.0467	0.9813
340094	10/01/90	09/30/91	1.3460	0.9861
340096	10/01/90	09/30/91	1.2126	0.9677
340097	10/01/90	09/30/91	1.0050	0.9631
340098	09/30/90	09/28/91	1.6140	0.9972
340099	10/01/90	09/30/91	1.1447	0.9661
340100	10/01/89	09/30/91	1.2013	0.9880
340101	01/01/91	12/31/91	1.0685	0.9624
340104	10/01/90	09/30/91	1.0045	0.9909
340105	10/01/90	09/30/91	1.3333	0.9963
340106	10/01/90	09/30/91	1.1011	0.9649
340107	01/01/91	12/31/91	1.3185	0.9798
340109	10/01/90	09/30/91	1.2925	0.9815
340111	10/01/90	09/30/91	1.1769	0.9594
340112	10/01/90	09/30/91	1.0080	0.9663
340113	10/01/90	09/30/91	1.9529	0.9990
340114	10/01/90	09/30/91	1.3834	0.9974
340115	10/01/90	09/30/91	1.4477	0.9955
340119	10/01/90	09/30/91	1.2129	0.9782
340120	10/01/90	09/30/91	1.0568	0.9497
340121	10/01/90	09/30/91	0.9505	0.9729
340122	10/01/90	09/30/91	1.0412	0.9621
340123	10/01/90	09/30/91	1.2013	0.9656
340124	10/01/90	09/30/91	1.0945	0.9515
340125	10/01/90	09/30/91	1.4419	0.9901
340126	10/01/90	09/30/91	1.2851	0.9815
340127	10/01/90	09/30/91	1.2221	0.9664
340129	10/01/90	09/30/91	1.1279	0.9783
340130	10/01/90	09/30/91	1.4048	0.9724
340131	10/01/90	09/30/91	1.3438	0.9910
340132	10/01/90	09/30/91	1.3693	0.9628
340133	10/01/90	09/30/91	1.2042	0.9541
340141	10/01/90	09/30/91	1.5276	0.9974
340142	10/01/90	09/30/91	1.1672	0.9757
340145	10/01/90	09/30/91	1.1948	0.9730
340146	10/01/90	09/30/91	1.0162	0.9637
340147	10/07/90	10/05/91	1.2836	0.9928
340151	10/01/90	09/30/91	1.1661	0.9810
340159	10/01/90	09/30/91	1.2011	0.9535
340162	01/01/91	12/31/91	1.2550	0.9866
340166	10/01/90	09/30/91	1.3215	0.9914

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
340168	10/01/90	09/30/91	0.5394	1.0000
350004	10/01/90	09/30/91	1.8750	0.9985
350007	10/01/90	09/30/91	1.0198	0.9563
350015	01/01/91	12/31/91	1.5242	0.9954
350016	01/01/91	12/31/91	0.9758	0.9885
350018	10/01/90	09/30/91	1.0307	0.9727
350019	01/01/91	12/31/91	1.5200	0.9965
350020	10/01/90	09/30/91	1.3390	0.9893
350023	01/01/91	12/31/91	0.9428	0.9948
350024	10/01/90	09/30/91	1.0004	0.9851
350027	10/01/90	09/30/91	0.9808	0.9883
350032	07/01/90	12/29/91	1.1451	1.0000
350033	01/01/91	12/31/91	0.9818	0.9844
350038	01/01/91	12/31/91	0.9640	0.9639
350041	01/01/91	12/31/91	0.9867	0.9742
350042	01/01/91	12/31/91	0.9259	0.9937
350051	01/01/91	12/31/91	0.9237	0.9761
350055	01/01/91	12/31/91	0.9464	0.9433
350066	10/01/90	09/30/91	0.9845	0.9509
360001	01/01/91	12/31/91	1.2267	0.9897
360002	01/01/91	12/31/91	1.1530	0.9758
360007	01/01/91	12/31/91	1.1598	0.9850
360009	01/01/91	12/31/91	1.3244	0.9894
360010	01/01/91	12/31/91	1.1637	0.9729
360012	01/01/91	12/31/91	1.2956	0.9808
360013	01/01/91	12/31/91	1.0928	0.9735
360015	01/01/91	12/31/91	1.4545	0.9982
360016	01/01/91	12/31/91	1.4854	0.9990
360018	01/01/91	12/31/91	1.3809	0.9990
360019	01/01/91	12/31/91	1.1824	0.9866
360020	01/01/91	12/31/91	1.2523	0.9936
360021	01/01/91	12/31/91	1.1998	0.9893
360024	01/01/91	12/31/91	1.2610	0.9914
360025	01/01/91	12/31/91	1.2159	0.9846
360026	01/01/91	12/31/91	1.1348	0.9921
360027	01/01/91	12/31/91	1.5200	0.9977
360030	01/01/91	12/31/91	1.1521	0.9766
360032	01/01/91	12/31/91	1.1268	0.9772
360034	01/01/91	12/31/91	1.0958	0.9472
360036	01/01/91	12/31/91	1.1847	0.9807
360037	01/01/91	12/31/91	1.8629	0.9904
360038	01/01/91	12/31/91	1.4772	0.9975
360039	01/01/91	12/31/91	1.2374	0.9932
360041	01/01/91	12/31/91	1.2398	0.9926
360042	01/01/91	12/31/91	1.0810	0.9566
360044	01/01/91	12/31/91	1.1141	0.9744
360045	01/01/90	08/31/91	1.4509	0.9966
360046	01/01/91	12/31/91	1.1344	0.9790
360047	01/01/91	12/31/91	1.1075	0.9741
360049	01/01/91	12/31/91	1.2513	0.9919
360050	01/01/91	12/31/91	1.2033	0.9660
360051	01/01/91	12/31/91	1.4573	0.9974
360055	01/01/91	12/31/91	1.1903	0.9908
360056	01/01/91	12/31/91	1.3094	0.9888
360057	01/01/91	12/31/91	0.9635	0.9687
360059	01/01/91	12/31/91	1.4728	0.9943
360061	01/01/91	12/31/91	1.1965	1.0000
360063	01/01/91	12/31/91	1.0440	0.9719
360064	01/01/91	12/31/91	1.4653	0.9971
360065	01/01/91	12/31/91	1.1896	0.9816
360066	01/01/91	12/31/91	1.2372	0.9899
360067	01/01/91	12/31/91	1.1249	0.9723
360068	01/01/91	12/31/91	1.4608	0.9977
360069	01/01/91	12/31/91	1.0494	0.9662
360070	01/01/91	12/31/91	1.4329	0.9917
360071	01/01/91	12/31/91	1.2858	0.9795
360072	01/01/91	12/31/91	1.1634	0.9724
360074	10/01/90	09/30/91	1.3164	0.9944
360075	01/01/91	12/31/91	1.4103	0.9940
360076	01/01/91	12/31/91	1.2503	0.9883
360077	01/01/91	12/31/91	1.4076	0.9966
360078	01/01/91	12/31/91	1.3057	0.9865
360079	01/01/91	12/31/91	1.6483	0.9964
360080	01/01/91	12/31/91	1.2267	0.9913
360081	01/01/91	12/31/91	1.3116	0.9970
360082	01/01/91	12/31/91	1.3121	0.9897
360083	01/01/91	12/31/91	1.2053	0.9893

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
360084	01/01/91	12/31/91	1.4184	0.9950
360086	01/01/91	12/31/91	1.3178	0.9916
360087	01/01/91	12/31/91	1.3168	0.9887
360088	01/01/91	12/31/91	1.1471	0.9736
360089	01/01/91	12/31/91	1.1064	0.9826
360091	01/01/91	12/31/91	1.3101	0.9872
360092	01/01/91	12/31/91	1.1503	0.9684
360093	01/01/91	12/31/91	1.2105	0.9720
360094	01/01/91	12/31/91	1.2387	0.9980
360095	01/01/91	12/31/91	1.2884	0.9839
360096	01/01/91	12/31/91	1.1105	0.9861
360098	01/01/91	12/31/91	1.3091	0.9893
360099	10/01/90	09/30/91	1.0405	0.9751
360100	01/01/91	12/31/91	1.2768	0.9889
360101	01/01/91	12/31/91	1.6186	0.9952
360102	01/01/91	12/31/91	1.2469	0.9957
360103	01/01/91	12/31/91	1.3518	0.9974
360104	01/01/91	12/31/91	0.9000	0.9954
360106	01/01/91	12/31/91	1.1242	0.9621
360107	09/01/90	08/31/91	1.2023	0.9680
360108	01/01/91	12/31/91	1.0197	0.9684
360109	01/01/91	12/31/91	1.0426	0.9691
360112	01/01/91	12/31/91	1.6215	0.9981
360113	01/01/91	12/31/91	1.2377	0.9929
360114	01/01/91	12/31/91	1.0423	0.9761
360115	01/01/91	12/31/91	1.2475	0.9901
360116	01/01/91	12/31/91	1.0458	0.9615
360118	01/01/91	12/31/91	1.2714	0.9856
360119	01/01/91	12/31/91	1.2327	0.9918
360120	01/01/91	12/31/91	0.5370	1.0000
360121	10/01/90	09/30/91	1.1904	0.9843
360122	01/01/91	12/31/91	1.2472	0.9905
360123	01/01/91	12/31/91	1.1627	0.9928
360124	01/01/91	12/31/91	1.2223	0.9788
360125	01/01/91	12/31/91	1.0769	0.9777
360126	01/01/91	12/31/91	1.2292	0.9897
360127	01/01/91	12/31/91	1.0349	0.9690
360128	01/01/91	12/31/91	1.0575	0.9788
360129	01/01/91	12/31/91	1.0374	0.9506
360130	01/01/91	12/31/91	1.1056	0.9841
360131	01/01/91	12/31/91	1.2531	0.9889
360132	01/01/91	12/31/91	1.1616	0.9843
360133	01/01/91	12/31/91	1.3247	0.9951
360135	01/01/91	12/31/91	1.0922	0.9830
360136	01/01/91	12/31/91	1.1116	0.9475
360137	01/01/91	12/31/91	1.5101	0.9967
360139	01/01/91	12/31/91	1.0720	0.9677
360140	01/01/91	12/31/91	1.0483	0.9828
360141	01/01/91	12/31/91	1.4184	0.9977
360142	01/01/91	12/31/91	0.9963	0.9552
360143	01/01/91	12/31/91	1.2329	0.9939
360144	01/01/91	12/31/91	1.2822	0.9921
360145	01/01/91	12/31/91	1.5243	0.9971
360147	10/01/90	09/30/91	1.2249	0.9680
360148	01/01/91	12/31/91	1.2000	0.9751
360149	01/01/91	12/31/91	1.1031	0.9899
360150	01/01/91	12/31/91	1.2363	0.9845
360151	01/01/91	12/31/91	1.3006	0.9941
360152	01/01/91	12/31/91	1.5025	0.9976
360153	01/01/91	12/31/91	1.1381	0.9887
360154	01/01/91	12/31/91	1.0700	0.9760
360155	01/01/91	12/31/91	1.2207	0.9966
360156	10/01/90	09/30/91	1.1352	0.9766
360159	01/01/91	12/31/91	1.1406	0.9708
360162	01/01/91	12/31/91	1.2472	0.9928
360163	01/01/91	12/31/91	1.6391	0.9970
360164	01/01/91	12/31/91	0.9701	0.9874
360165	11/01/90	10/31/91	1.0911	0.9822
360166	01/01/91	12/31/91	0.9723	0.9934
360169	01/01/91	12/31/91	1.0188	0.9558
360170	01/01/91	12/31/91	1.1666	0.9808
360172	01/01/91	12/31/91	1.3425	0.9865
360174	01/01/91	12/31/91	1.1711	0.9892
360175	01/01/91	12/31/91	1.1311	0.9756
360176	01/01/91	12/31/91	1.1512	0.9618
360177	01/01/91	12/31/91	1.1965	0.9624
360179	12/30/90	12/28/91	1.2456	0.9968

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
360180	01/01/91	12/31/91	2.1171	0.9987
360184	01/01/91	12/31/91	0.7143	0.9778
360186	01/01/91	12/31/91	1.1444	0.9626
360188	01/01/91	12/31/91	1.0064	0.9612
360189	01/01/91	12/31/91	1.0439	0.9870
360192	01/01/91	12/31/91	1.2811	0.9940
360193	01/01/91	12/31/91	1.2682	0.9923
360194	10/01/90	09/30/91	1.0657	0.9826
360195	01/01/91	12/31/91	1.2155	0.9577
360197	01/01/91	12/31/91	1.1790	0.9537
360200	01/01/91	12/31/91	1.1631	0.9825
360203	01/01/91	12/31/91	1.1251	0.9740
360204	01/01/91	12/31/91	1.1855	0.9888
360210	01/01/91	12/31/91	1.1895	0.9730
360211	01/01/91	12/31/91	1.1698	0.9909
360212	01/01/91	12/31/91	1.4148	0.9965
360213	01/01/91	12/31/91	1.0878	0.9879
360218	01/01/91	12/31/91	1.2981	0.9858
360230	01/01/91	12/31/91	1.3032	0.9915
360231	01/01/91	12/31/91	1.1291	0.9657
360232	01/01/91	12/31/91	1.1424	0.9770
360234	01/01/91	12/31/91	1.2469	0.9937
360236	01/01/91	12/31/91	1.1986	0.9864
360239	01/01/91	12/31/91	1.2010	0.9838
360240	01/01/91	12/31/91	0.5534	1.0000
360241	01/01/91	12/31/91	0.6349	1.0000
370001	01/01/91	12/31/91	1.6645	0.9981
370002	01/01/91	12/31/91	1.2051	0.9815
370006	10/01/90	09/30/91	1.2104	0.9897
370007	01/01/91	12/31/91	1.1412	0.9660
370014	10/01/90	09/30/91	1.1519	0.9821
370017	01/01/91	12/31/91	0.9980	0.9560
370018	11/01/90	10/31/91	1.1852	0.9883
370020	10/01/90	09/30/91	1.2597	0.9830
370021	09/01/90	08/31/91	0.9662	0.9617
370025	10/01/90	09/30/91	1.3097	0.9902
370032	11/01/90	10/31/91	1.3385	0.9973
370033	10/01/90	09/30/91	1.2096	0.9894
370037	01/01/91	12/31/91	1.5410	0.9981
370039	11/01/90	10/31/91	1.2375	0.9781
370040	10/01/90	09/30/91	1.0307	0.9695
370049	01/01/91	12/31/91	1.2992	0.9751
370051	10/01/90	09/30/91	0.9755	0.9678
370054	01/01/91	12/31/91	1.2703	0.9823
370057	01/01/91	12/31/91	1.0796	0.9662
370071	07/01/90	12/31/91	1.0037	0.9662
370077	01/01/91	12/31/91	1.1983	0.9912
370078	01/01/91	12/31/91	1.5209	0.9993
370092	10/01/90	09/30/91	1.0339	0.9472
370093	09/01/90	08/31/91	1.6126	0.9983
370094	01/01/91	12/31/91	1.2836	0.9975
370095	01/01/91	12/31/91	0.8996	0.9650
370105	10/01/90	09/30/91	1.8890	0.9941
370106	11/01/90	10/31/91	1.3356	0.9995
370108	10/01/90	09/30/91	1.0337	0.9744
370114	10/01/90	09/30/91	1.5430	0.9994
370117	10/01/90	10/20/91	1.3104	0.9895
370121	09/01/90	08/31/91	1.1812	0.9723
370141	09/01/90	08/31/91	1.4333	0.9961
370148	01/01/91	12/31/91	1.0293	0.9819
370148	09/01/90	08/31/91	1.2728	0.9887
370149	10/01/90	09/30/91	1.2142	0.9781
370157	10/01/90	09/30/91	0.9177	0.9555
370161	11/01/90	10/31/91	1.1359	0.9656
370165	10/01/90	09/30/91	1.1678	0.9866
370169	01/01/91	12/31/91	1.0252	0.9602
370176	01/01/91	12/31/91	1.2606	0.9815
370177	01/01/91	12/31/91	0.9454	0.9689
370179	10/01/90	09/30/91	1.0758	0.9290
370189	01/01/91	12/31/91	0.9631	0.9823
380004	01/01/91	12/31/91	1.8075	0.9804
380006	01/01/91	12/31/91	1.2208	0.9778
380010	01/01/91	12/31/91	1.1584	0.9795
380014	01/01/91	12/31/91	1.3162	0.9788
380018	10/01/90	09/30/91	1.8719	0.9977
380019	01/01/91	12/31/91	1.2112	0.9922
380020	10/01/90	09/30/91	1.3492	0.9836

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
380021	10/01/90	09/30/91	1.2308	0.9906
380022	10/01/90	09/30/91	1.2365	0.9823
380026	01/01/91	12/31/91	1.4080	0.9554
380029	10/01/90	09/30/91	1.1623	0.9595
380036	01/01/91	12/31/91	1.0743	0.9431
380038	08/01/90	07/31/91	1.2550	0.9751
380039	01/01/91	12/31/91	1.3001	0.9893
380042	01/01/91	12/31/91	1.0988	0.9678
380047	01/01/91	12/31/91	1.5499	0.9994
380050	10/01/90	09/30/91	1.3313	0.9841
380051	10/01/90	09/30/91	1.4276	0.9930
380052	01/01/91	12/31/91	1.1835	0.9786
380055	01/01/91	12/31/91	1.1800	0.9903
380056	01/01/91	12/31/91	1.0506	0.9654
380059	07/01/90	07/31/91	0.9216	0.9662
380060	01/01/91	12/31/91	1.3427	0.9912
380061	01/01/91	12/31/91	1.6171	0.9980
380064	08/01/90	07/31/91	1.3093	0.9890
380068	10/01/90	09/30/91	1.0739	0.9600
380070	01/01/91	12/31/91	1.0567	0.9585
380075	01/01/91	12/31/91	1.3789	0.9916
380082	01/01/91	12/31/91	1.2801	0.9895
380091	01/01/91	12/31/91	1.1475	0.9866
390028	01/01/91	12/31/91	1.7001	0.9976
390054	01/01/91	12/31/91	1.1090	0.9820
390060	01/01/91	12/31/91	1.1547	0.9892
390128	01/01/91	12/31/91	1.1854	0.9916
390169	01/01/91	12/31/91	1.2253	0.9975
390186	01/01/91	12/31/91	1.1687	0.9810
390224	10/01/90	09/30/91	0.9582	0.9775
390237	01/01/91	12/31/91	1.4831	0.9977
400002	01/01/91	12/31/91	1.2248	0.9990
400005	01/01/91	12/31/91	1.0805	0.9997
400007	01/01/91	12/31/91	1.1059	0.9989
400008	01/01/91	12/31/91	1.1672	0.9980
400010	10/01/90	09/30/91	0.9643	0.9905
400011	01/01/91	12/31/91	1.0816	0.9961
400014	01/01/91	12/31/91	1.3134	0.9986
400016	10/01/90	09/30/91	1.2611	0.9994
400017	01/01/91	12/31/91	1.1175	0.9976
400019	01/01/91	12/31/91	1.4370	0.9988
400022	01/01/91	12/31/91	1.2916	0.9998
400024	01/01/91	12/31/91	1.0561	0.9987
400029	07/01/90	08/31/91	1.0231	0.9967
400032	01/01/91	12/31/91	1.1341	0.9981
400089	01/01/91	12/31/91	1.0793	0.9968
400094	01/01/91	12/31/91	0.9243	0.9934
400098	01/01/91	12/31/91	1.2146	0.9987
400106	10/01/90	09/30/91	1.1439	0.9978
400109	10/01/90	09/30/91	1.4983	0.9997
400111	01/01/91	12/31/91	1.2501	0.9976
400112	09/01/90	08/31/91	1.2031	0.9959
400113	10/01/90	09/30/91	1.1983	0.9987
400115	01/01/91	12/31/91	1.0223	0.9944
400117	01/01/91	12/31/91	1.1765	0.9976
400118	1/01/91	12/31/91	1.1673	0.9979
400120	01/01/91	12/31/91	1.2988	0.9994
410001	10/01/90	09/30/91	1.2662	0.9921
410002	10/01/90	09/30/91	1.2509	0.9904
410004	10/01/90	09/30/91	1.4269	0.9940
410005	10/01/90	09/30/91	1.2986	0.9964
410006	10/01/90	09/30/91	1.1891	0.9903
410007	10/01/90	09/30/91	1.5203	0.9980
410008	10/01/90	09/30/91	1.1992	0.9802
410009	10/01/90	09/30/91	1.3381	0.9947
410010	10/01/90	09/30/91	1.0294	0.9872
410011	10/01/90	09/30/91	1.1919	0.9932
410012	10/01/90	09/30/91	1.5865	0.9979
410013	10/01/90	09/30/91	1.1509	0.9835
420005	01/01/91	12/31/91	1.0876	0.9793
420007	09/23/90	10/05/91	1.4065	0.9989
420009	10/01/90	09/30/91	1.2309	0.9622
420010	10/01/90	09/30/91	1.0721	0.9530
420011	10/01/90	09/30/91	1.0839	0.9713
420014	10/01/90	09/30/91	1.1135	0.9763
420015	10/01/90	09/30/91	1.2546	0.9842
420016	10/01/90	09/30/91	1.2158	0.9845

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
420018	09/30/90	09/28/91	1.6263	0.9957
420019	10/01/90	09/30/91	1.1680	0.9761
420020	10/01/90	09/30/91	1.1754	0.9761
420022	09/23/90	10/05/91	0.9958	0.9743
420023	01/01/91	12/31/91	1.2720	0.9952
420026	09/09/90	09/07/91	1.7991	0.9975
420027	09/30/90	09/28/91	1.3436	0.9891
420028	10/01/90	09/30/91	1.0488	0.9657
420029	10/01/90	09/30/91	1.8435	1.0000
420030	01/01/91	12/31/91	1.1872	0.9583
420031	10/01/90	09/30/91	0.9742	0.9319
420033	10/01/90	09/30/91	1.1675	0.9811
420036	10/01/90	09/30/91	1.2538	0.9828
420037	10/01/90	09/30/91	1.2815	0.9708
420038	10/01/90	09/30/91	1.2053	0.9692
420039	10/01/90	09/30/91	1.1185	0.9800
420040	10/01/90	09/30/91	1.3052	0.9952
420042	10/01/90	09/30/91	1.0814	0.9814
420043	10/01/90	09/30/91	1.1441	0.9748
420044	10/01/90	09/30/91	1.1474	0.9901
420048	10/01/90	09/30/91	1.1336	0.9657
420049	10/01/90	09/30/91	1.0915	0.9787
420051	10/01/90	09/30/91	1.5379	0.9979
420054	09/01/90	08/31/91	1.1393	0.9583
420055	10/01/90	09/30/91	1.0306	0.9841
420056	10/01/90	09/30/91	1.0070	0.9070
420057	10/01/90	09/30/91	1.0886	0.9748
420059	10/01/90	09/30/91	1.0510	0.9601
420061	10/01/90	09/30/91	1.2715	0.9562
420064	10/01/90	09/30/91	1.0773	0.9636
420066	10/01/90	09/30/91	0.9927	0.9472
420067	10/01/90	09/30/91	1.1022	0.9549
420068	10/01/90	09/30/91	1.1764	0.9908
420069	10/01/90	09/30/91	1.0010	0.9458
420070	10/01/90	09/30/91	1.2662	0.9781
420071	10/01/90	09/30/91	1.3715	0.9914
420072	10/01/90	09/30/91	1.0016	0.9724
420073	10/01/90	09/30/91	1.2818	0.9874
420074	10/01/90	09/30/91	0.9675	0.9484
420075	10/01/90	09/30/91	1.0723	0.9638
420076	01/01/91	12/31/91	1.2336	0.9956
420078	10/01/90	09/30/91	1.5706	0.9981
420081	10/01/90	09/30/91	0.7937	0.9714
420086	10/01/90	09/30/91	1.3756	0.9930
420087	10/01/90	09/30/91	1.5223	0.9985
420088	10/01/90	09/30/91	1.1815	0.9887
420089	09/01/90	08/31/91	1.2692	0.9879
430008	01/01/91	12/31/91	1.2104	0.9812
430009	01/01/91	12/31/91	0.9819	0.9494
430013	10/01/90	09/30/91	1.2429	0.9828
430014	10/01/90	09/30/91	1.1908	0.9831
430015	08/01/90	07/31/91	1.0321	0.9783
430016	10/01/90	09/30/91	1.7031	0.9977
430017	01/01/90	12/18/91	1.0902	0.9814
430023	09/01/90	08/31/91	0.9512	0.9729
430024	01/01/91	12/31/91	1.0153	0.9517
430026	01/01/91	12/31/91	0.8874	0.9570
430028	01/01/91	12/31/91	1.0921	0.9863
430029	09/01/90	08/31/91	0.9991	0.9692
430031	01/01/91	12/31/91	0.9924	0.9631
430034	01/01/91	12/31/91	1.0600	1.0000
430036	01/01/91	12/31/91	1.0445	0.9820
430038	01/01/91	12/31/91	1.0571	0.9916
430040	10/01/90	09/30/91	0.9194	0.9812
430041	01/01/91	12/31/91	0.9497	0.9491
430043	01/01/91	12/31/91	1.1726	0.9900
430044	01/01/91	12/31/91	0.9371	0.9726
430047	01/01/91	12/31/91	1.1379	0.9663
430048	01/01/91	12/31/91	1.1525	0.9850
430049	01/01/91	12/31/91	0.9244	0.9562
430051	01/01/91	12/31/91	0.9945	0.9335
430056	01/01/91	12/31/91	0.8854	0.9406
430057	01/01/91	12/31/91	0.9508	0.9778
430060	01/01/91	12/31/91	1.0189	0.9053
430064	12/01/90	11/30/91	1.0512	0.9711
430065	10/01/90	09/30/91	0.9439	0.9233
430073	10/01/90	09/30/91	1.1114	0.9949

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
430076	01/01/91	12/31/91	0.9984	0.9794
430079	01/01/91	12/31/91	1.0127	0.9897
430080	10/01/90	09/30/91	0.8204	1.0000
430087	01/01/91	12/31/91	1.0659	0.9661
430088	01/01/91	12/31/91	0.9353	0.9770
440008	01/01/91	12/31/91	0.9674	0.9628
440018	11/01/90	10/31/91	1.3078	0.9707
440020	09/01/90	09/29/91	1.2123	0.9702
440026	09/01/90	09/30/91	1.2592	0.9827
440034	01/01/91	12/31/91	1.3929	0.9967
440046	01/01/91	12/31/91	1.0276	0.9957
440047	09/01/90	08/31/91	0.9033	0.9687
440048	10/01/90	09/30/91	1.5925	0.9975
440049	01/01/91	12/31/91	1.6117	0.9990
440050	01/01/91	12/31/91	1.1605	0.9870
440058	01/01/91	12/31/91	1.1619	0.9729
440061	10/01/90	09/30/91	1.1047	0.9703
440064	01/01/91	12/31/91	1.1236	0.9680
440067	09/01/90	08/31/91	1.1662	0.9680
440068	10/01/90	09/30/91	1.1649	0.9750
440071	01/01/91	12/31/91	1.3317	0.9984
440072	01/01/91	12/31/91	1.3975	0.9652
440078	10/01/90	09/30/91	1.0118	0.9811
440079	01/01/91	12/31/91	0.8359	0.9666
440081	01/01/91	12/31/91	1.1793	0.9756
440083	01/01/91	12/31/91	1.2345	0.9794
440087	01/01/91	12/31/91	0.9950	0.9478
440091	09/01/90	08/31/91	1.3908	0.9988
440095	01/01/91	12/31/91	1.0625	0.9706
440100	01/01/91	12/31/91	1.0898	0.9626
440110	01/01/91	12/31/91	1.0966	0.9636
440120	01/01/91	12/31/91	1.4435	0.9990
440125	01/01/91	12/31/91	1.4546	0.9990
440136	09/01/90	08/31/91	1.2368	0.9825
440145	11/01/89	09/30/91	0.9976	0.9586
440146	01/01/91	12/31/91	1.2639	0.9750
440148	01/01/91	12/31/91	1.1627	0.9693
440149	11/01/90	10/31/91	1.1682	0.9742
440150	01/01/91	12/31/91	1.3003	0.9909
440157	01/01/91	12/31/91	0.9953	0.9833
440161	01/01/91	12/31/91	1.5728	0.9979
440168	01/01/91	12/31/91	1.0236	0.9545
440174	01/01/91	12/31/91	0.9155	0.9458
440178	09/01/90	08/31/91	1.1862	0.9873
440181	01/01/91	12/31/91	1.0171	0.9593
440182	01/01/91	12/31/91	0.9260	0.9503
440184	01/01/91	12/31/91	1.2642	0.9883
440185	09/01/90	08/31/91	1.0551	0.9876
440186	11/01/90	10/31/91	1.1406	0.9551
440189	08/01/90	07/31/91	1.4639	0.9927
440194	09/01/90	08/31/91	1.2402	0.9823
440196	01/01/91	12/31/91	0.9593	0.9708
440200	12/01/90	11/30/91	1.0918	0.9560
440203	01/01/91	12/31/91	0.9910	0.9800
440205	01/01/91	12/31/91	0.9641	0.9783
450002	01/01/91	12/31/91	1.4287	0.9987
450005	09/01/90	08/31/91	1.0257	0.9776
450010	10/01/90	09/30/91	1.2778	0.9942
450011	01/01/91	12/31/91	1.5650	0.9980
450014	01/01/91	12/31/91	1.1148	0.9658
450015	10/01/90	09/30/91	1.5148	0.9990
450016	01/01/91	12/31/91	1.6676	0.9975
450018	09/01/90	08/31/91	1.6354	0.9989
450020	01/01/91	12/31/91	1.0695	0.9606
450024	10/01/90	09/30/91	1.2745	0.9932
450025	01/01/91	12/31/91	1.4745	0.9953
450026	01/01/91	12/31/91	1.4051	0.9935
450032	10/01/90	09/30/91	1.2141	0.9746
450033	09/01/90	08/31/91	1.6021	0.9993
450037	10/01/90	09/30/91	1.4613	0.9978
450039	10/01/90	09/30/91	1.1669	0.9987
450041	01/01/91	12/31/91	0.9680	0.9505
450043	01/01/90	10/04/91	1.4065	0.9983
450046	01/01/90	09/30/91	1.4016	0.9972
450047	10/01/90	09/30/91	1.0057	0.9721
450050	01/01/91	12/31/91	1.2977	0.9671
450053	01/01/91	12/31/91	1.1278	0.9389

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450054	09/01/90	08/31/91	1.6250	0.9982
450055	10/01/90	09/30/91	1.0724	0.9639
450057	07/04/90	11/26/91	1.2081	0.9917
450058	09/01/90	08/31/91	1.5007	0.9987
450059	01/01/91	12/31/91	1.3316	0.9749
450063	10/01/90	09/30/91	0.9350	0.9435
450065	10/01/90	09/30/91	1.1409	0.9734
450068	10/01/90	09/30/91	1.6478	0.9976
450072	01/01/91	12/31/91	1.1702	0.9610
450073	01/01/91	12/31/91	1.1079	0.9608
450076	09/01/90	08/31/91	1.2329	0.9999
450077	10/01/90	09/30/91	0.9717	0.9851
450080	10/01/90	09/30/91	1.1683	0.9744
450081	01/01/91	12/31/91	1.2080	0.9780
450082	10/01/90	09/30/91	0.9919	0.9456
450083	11/01/90	10/31/91	1.5629	0.9917
450085	10/01/90	09/30/91	0.9964	0.9787
450087	09/01/90	08/31/91	1.3355	0.9864
450094	01/01/91	12/31/91	1.3867	0.9948
450097	01/01/91	12/31/91	1.4069	0.9919
450098	11/01/90	10/31/91	1.1282	0.9799
450101	09/01/90	08/31/91	1.3795	0.9983
450104	01/01/91	12/31/91	1.2224	0.9712
450107	01/01/91	12/31/91	1.4521	0.9986
450108	10/01/90	09/30/91	0.9627	0.9495
450110	10/01/90	09/30/91	1.2206	0.9950
450112	01/01/91	12/31/91	1.2484	0.9849
450118	09/01/90	08/31/91	1.4270	0.9988
450119	10/01/90	09/30/91	1.2430	0.9817
450121	10/01/90	09/30/91	1.3732	0.9920
450123	05/01/90	12/31/91	1.0563	0.9819
450124	10/01/90	09/30/91	1.4619	0.9992
450127	10/01/90	09/30/91	0.9736	0.9496
450130	01/01/91	12/31/91	1.4751	0.9990
450131	08/01/90	07/31/91	1.2383	0.9888
450132	10/01/90	09/30/91	1.4472	0.9962
450133	10/01/90	09/30/91	1.4367	0.9967
450135	10/01/90	09/30/91	1.5550	0.9974
450137	10/01/90	09/30/91	1.3443	0.9949
450140	10/01/90	09/30/91	0.9001	0.9352
450142	09/01/90	08/31/91	1.2780	0.9875
450144	10/01/90	09/30/91	1.1362	0.9725
450145	01/01/91	12/31/91	0.9849	0.9678
450146	10/01/90	09/30/91	1.0151	0.9484
450148	10/01/90	09/30/91	1.3142	0.9798
450149	11/01/90	10/31/91	1.3871	0.9950
450150	10/01/90	09/30/91	1.0018	0.9409
450151	10/01/90	09/30/91	1.0753	0.9773
450152	10/01/90	09/30/91	1.4101	0.9954
450153	01/01/91	12/31/91	1.5958	0.9989
450154	10/01/90	09/30/91	1.1204	0.9645
450155	10/01/90	09/30/91	1.0537	0.9759
450160	10/01/90	09/30/91	1.0303	0.9536
450162	09/01/90	09/29/91	1.3480	0.9853
450163	01/01/91	12/31/91	1.1154	0.9678
450164	10/01/90	09/30/91	0.9316	0.9597
450165	01/01/91	12/31/91	0.9464	0.9888
450166	01/01/91	12/31/91	0.8739	0.9885
450169	01/01/91	12/31/91	0.8471	0.9495
450175	01/01/90	09/30/91	1.2209	0.9791
450176	10/01/90	09/30/91	1.2811	0.9733
450178	01/01/91	12/31/91	1.0877	0.9553
450181	01/01/91	12/31/91	1.0169	0.9702
450185	10/01/90	09/30/91	1.0490	0.8945
450187	01/01/91	12/31/91	1.2248	0.9819
450191	01/01/91	12/31/91	1.1094	0.9761
450192	09/01/90	08/31/91	1.1054	0.9823
450193	10/01/90	09/30/91	2.1579	0.9989
450194	01/01/91	12/31/91	1.1427	0.9873
450195	01/01/91	12/31/91	1.3861	0.9790
450196	01/01/91	12/31/91	1.2515	0.9873
450197	09/01/90	08/31/91	1.2111	0.9914
450200	10/01/90	09/30/91	1.2927	0.9960
450201	01/01/91	12/31/91	0.9547	0.9516
450203	10/01/90	09/30/91	1.1623	0.9910
450209	10/01/90	09/30/91	1.3431	0.9924
450210	01/01/91	12/31/91	1.1553	0.9588

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450211	01/01/91	12/31/91	1.2503	0.9928
450213	01/01/91	12/31/91	1.4458	0.9932
450214	09/01/90	08/31/91	1.3040	0.9729
450218	10/01/89	07/08/91	0.9753	0.9627
450224	10/01/90	09/30/91	1.1294	0.9688
450229	09/01/90	08/31/91	1.3647	0.9893
450231	01/01/91	12/31/91	1.5913	0.9981
450234	10/01/90	09/30/91	0.9360	0.9254
450236	10/01/90	09/30/91	1.1319	0.9844
450237	01/01/91	12/31/91	1.5122	0.9975
450239	08/01/90	07/31/91	1.1595	0.9645
450243	09/01/90	08/31/91	0.9226	0.9676
450246	10/01/90	09/30/91	0.9865	0.9453
450253	01/01/91	12/31/91	1.0854	0.9828
450259	01/01/91	12/31/91	1.2132	0.9888
450264	10/01/90	09/30/91	0.8622	0.9733
450271	01/01/91	12/31/91	1.2010	0.9700
450272	01/01/91	12/31/91	1.3414	0.9712
450276	10/01/90	09/30/91	0.9944	0.9644
450280	01/01/91	12/31/91	1.3219	0.9951
450283	11/01/90	10/31/91	1.1408	0.9429
450286	01/01/91	12/31/91	1.0929	0.9818
450292	10/01/90	09/30/91	1.2528	0.9766
450293	01/01/91	12/31/91	1.0120	0.9524
450296	01/01/91	12/31/91	1.1909	0.9711
450297	01/01/91	12/31/91	1.0831	0.9934
450299	09/01/90	08/31/91	1.3598	0.9832
450303	01/01/91	12/31/91	0.9492	0.9543
450306	01/01/91	12/31/91	1.0313	0.9368
450315	09/01/90	08/31/91	1.2251	0.9959
450321	01/01/91	12/31/91	0.8468	0.9630
450322	01/01/91	12/31/91	0.9284	0.9381
450327	10/01/90	09/30/91	0.9950	0.9573
450334	10/01/90	09/30/91	1.0743	0.9830
450337	11/01/90	10/31/91	1.1766	0.9809
450340	01/01/91	12/31/91	1.3383	0.9873
450346	09/01/90	08/31/91	1.3163	0.9968
450347	01/01/91	12/31/91	1.2101	0.9790
450348	09/01/90	08/31/91	0.9825	0.9594
450352	10/01/90	09/30/91	1.2137	0.9610
450353	09/01/90	08/31/91	1.1378	0.9606
450355	08/01/90	07/31/91	1.0480	0.9195
450358	01/01/91	12/31/91	1.9932	0.9988
450365	01/01/91	12/31/91	0.9500	0.9944
450369	10/01/90	09/30/91	1.2014	0.9508
450371	01/01/91	12/31/91	1.1331	0.9840
450373	11/01/90	10/31/91	1.1519	0.9702
450374	10/01/90	09/30/91	0.8627	0.9181
450376	01/01/90	09/30/91	1.4706	0.9953
450378	09/01/90	08/31/91	1.3133	0.9826
450388	10/01/90	09/30/91	1.6332	0.9991
450389	11/01/90	10/31/91	1.2225	0.9857
450399	10/01/90	09/30/91	1.0342	0.9692
450403	10/01/90	09/30/91	1.2076	0.9891
450410	01/01/90	11/10/91	1.0733	0.9891
450417	01/01/91	12/31/91	1.0491	0.9237
450419	10/01/90	09/30/91	1.2507	0.9694
450422	10/01/90	09/30/91	0.7583	1.0000
450423	09/01/90	08/31/91	1.3829	0.9960
450424	01/01/91	12/31/91	1.2943	0.9780
450429	12/01/90	11/30/91	0.9101	0.9603
450431	01/01/91	12/31/91	1.5383	0.9975
450438	01/01/91	12/31/91	1.0401	0.9578
450446	01/01/91	12/31/91	0.8818	0.9682
450450	10/01/90	09/30/91	1.0881	0.9777
450462	10/01/90	09/30/91	1.5907	0.9986
450464	10/01/90	09/30/91	0.9141	0.9752
450465	10/01/90	09/30/91	1.1021	0.9778
450475	10/01/90	09/30/91	1.1378	0.9837
450488	10/01/90	09/30/91	1.2064	0.9643
450514	01/01/91	12/31/91	1.1361	0.9827
450518	01/01/91	12/31/91	1.3095	0.9959
450523	01/01/91	12/31/91	1.5068	0.9919
450530	12/01/90	11/30/91	1.2867	0.9954
450534	10/01/90	09/30/91	0.9602	0.9588
450535	01/01/91	12/31/91	1.2130	0.9880
450538	01/01/91	12/31/91	1.2380	0.9809

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450539	09/01/90	09/29/91	1.2853	0.9570
450544	08/01/90	07/31/91	1.2416	0.9934
450547	10/01/90	09/30/91	0.9701	0.9705
450550	01/01/91	12/31/91	1.0519	0.9939
450558	09/01/90	08/31/91	1.7904	0.9966
450559	10/01/90	09/30/91	0.8843	0.9789
450561	10/01/90	09/30/91	1.5108	0.9979
450565	10/01/90	09/30/91	1.2898	0.9839
450571	10/01/90	09/30/91	1.4391	0.9986
450574	10/01/90	09/30/91	1.0266	0.9367
450575	10/01/90	09/30/91	0.9916	0.9894
450578	10/01/90	09/30/91	0.9534	0.9568
450580	10/01/90	09/30/91	1.1794	0.9815
450583	10/01/90	09/30/91	1.0084	0.9895
450584	10/01/90	09/30/91	1.1806	0.9695
450587	09/01/90	08/31/91	1.2459	0.9828
450591	10/01/90	09/30/91	1.2403	0.9759
450596	10/01/90	09/30/91	1.2377	0.9776
450597	10/01/90	09/30/91	1.0338	0.9710
450604	01/01/91	12/31/91	1.2403	0.9776
450605	01/01/91	12/31/91	1.2221	0.9854
450607	10/01/90	09/30/91	0.9056	0.9370
450609	10/01/90	09/30/91	0.8575	0.9792
450614	10/01/90	09/30/91	1.0172	0.9355
450615	01/01/91	12/31/91	0.9560	0.9603
450617	09/01/90	08/31/91	1.3755	0.9956
450620	07/01/90	09/30/91	1.0837	0.9294
450623	10/01/90	09/30/91	1.1524	0.9746
450626	10/01/90	09/30/91	0.9541	0.9173
450628	10/01/90	09/30/91	0.9605	0.9701
450631	09/01/90	08/31/91	1.6431	0.9975
450632	10/01/90	09/30/91	0.9911	0.9683
450633	09/01/90	08/31/91	1.5670	0.9972
450634	01/01/91	12/31/91	1.3617	0.9933
450637	09/01/90	08/31/91	1.3126	0.9793
450639	10/01/90	09/30/91	1.5123	0.9978
450644	09/01/90	08/31/91	1.5941	0.9957
450646	01/01/91	12/31/91	1.4885	0.9960
450647	09/01/90	08/31/91	1.9489	0.9990
450648	10/01/90	09/30/91	1.1052	0.9818
450652	10/01/90	09/30/91	0.9360	0.9419
450653	08/01/90	07/31/91	1.2340	0.9844
450654	10/01/90	09/30/91	0.9855	0.9915
450656	01/01/91	12/31/91	1.2559	0.9920
450659	01/01/91	12/31/91	1.4484	0.9982
450661	01/01/91	12/31/91	1.2415	0.9922
450662	09/01/90	08/31/91	1.4170	0.9900
450666	09/01/90	08/31/91	1.2138	0.9898
450669	07/01/90	07/01/91	1.2844	0.9814
450672	08/01/90	07/31/91	1.5957	0.9984
450673	10/01/90	09/30/91	1.0201	0.9685
450677	01/01/91	12/31/91	1.3292	0.9952
450683	10/01/90	09/30/91	1.2997	0.9713
450685	07/01/90	09/23/91	1.2335	0.9918
450686	12/31/90	12/31/91	1.3484	0.9936
450690	09/01/90	08/31/91	1.3215	0.9957
450696	11/01/90	10/31/91	1.1030	1.0000
450697	01/01/91	12/31/91	1.4486	0.9935
450698	10/01/89	09/30/91	0.8955	0.9375
450700	01/01/91	12/31/91	0.9278	0.9510
450702	09/01/90	08/31/91	1.2830	0.9925
450703	01/01/91	12/31/91	1.3000	0.9860
450705	10/01/90	09/30/91	0.8045	0.9776
450706	01/01/91	12/31/91	1.2497	0.9750
450711	10/01/90	09/30/91	1.6238	0.9982
450712	11/01/90	10/31/91	0.7660	1.0000
450713	01/01/91	12/31/91	1.2557	0.9824
450715	09/01/90	08/31/91	1.3498	0.9939
450716	01/01/91	12/31/91	1.2058	0.9822
450717	01/01/91	12/31/91	1.1978	0.9662
450718	01/01/91	12/31/91	1.1202	0.9826
450724	01/01/91	12/31/91	1.1409	0.9954
450725	09/01/90	08/31/91	0.9157	0.9873
450726	10/01/90	09/30/91	0.8589	0.9368
450727	10/01/90	09/30/91	0.9540	0.9696
450728	10/01/90	09/30/91	0.8538	0.9113
450729	01/01/91	12/31/91	1.0063	0.9791

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
450732	08/01/90	07/31/91	1.1639	0.9493
450734	09/01/90	08/31/91	1.2400	0.9915
450735	01/01/91	12/31/91	0.8527	0.9792
450742	09/01/90	12/18/91	1.3082	0.9777
450745	01/01/91	12/31/91	0.8729	0.9968
450746	10/01/90	09/30/91	0.9038	0.9070
450747	01/01/91	12/31/91	1.3262	0.9772
450751	01/01/91	12/31/91	1.3289	0.9772
450754	10/01/90	09/30/91	0.8799	0.9580
450757	01/01/91	12/31/91	0.9338	0.9108
450759	01/01/90	12/31/91	1.0712	0.9928
450760	01/01/90	12/31/91	1.2785	0.9837
450761	10/01/90	09/30/91	0.9393	0.9630
450763	10/01/90	09/30/91	1.0462	0.9475
450768	01/01/91	12/31/91	1.6546	0.9973
460001	01/01/91	12/31/91	1.6042	0.9980
460004	01/01/91	12/31/91	1.7099	0.9980
460006	01/01/91	12/31/91	1.3234	0.9860
460007	01/01/91	12/31/91	1.3637	0.9839
460010	01/01/91	12/31/91	1.9961	0.9989
460011	01/01/91	12/31/91	1.3182	0.9682
460013	09/01/90	08/31/91	1.4279	0.9937
460014	01/01/91	12/31/91	1.0365	0.8998
460015	01/01/91	12/31/91	1.2228	0.9707
460016	01/01/91	12/31/91	0.9737	0.9539
460017	09/01/90	08/31/91	1.2304	0.9794
460018	01/01/91	12/31/91	0.9520	0.9820
460019	01/01/91	12/31/91	0.9794	0.9588
460020	01/01/91	12/31/91	0.9409	0.9691
460021	01/01/91	12/31/91	1.3083	0.9905
460022	01/01/91	12/31/91	0.9658	0.9922
460023	01/01/91	12/31/91	1.0875	0.9760
460024	10/01/90	09/30/91	1.0085	0.9963
460025	01/01/91	12/31/91	0.8296	0.9868
460026	01/01/91	12/31/91	0.9268	0.9453
460027	01/01/91	12/31/91	0.9402	0.9841
460029	01/01/91	12/31/91	0.9919	0.9579
460033	01/01/91	12/31/91	0.9783	0.9021
460036	01/01/91	12/31/91	0.9487	0.9468
460039	01/01/91	12/31/91	0.9283	0.9276
460041	09/01/90	08/31/91	1.2405	0.9751
460042	10/01/90	09/30/91	1.3798	0.9854
460043	01/01/91	12/31/91	1.4477	0.8859
460044	01/01/91	12/31/91	1.1163	0.9696
460046	01/01/91	12/31/91	1.1878	0.5694
460047	11/01/90	10/31/91	1.6065	0.9986
470001	10/01/90	09/30/91	1.1566	0.9793
470003	10/01/90	09/30/91	1.9195	0.9972
470004	10/01/90	09/30/91	1.1700	0.9793
470005	10/01/90	09/30/91	1.1992	0.9909
470006	10/01/90	09/30/91	1.2789	0.9778
470008	10/01/90	09/30/91	1.2181	0.9765
470010	10/01/90	09/30/91	1.0242	0.9684
470011	10/01/90	09/30/91	1.1590	0.9848
470012	10/01/90	09/30/91	1.2581	0.9853
470013	10/01/90	09/30/91	1.1233	0.9882
470015	10/01/90	09/30/91	1.2187	0.9952
470018	10/01/90	09/30/91	1.1700	0.9701
470020	10/01/90	09/30/91	0.9983	0.9727
470023	10/01/90	09/30/91	1.2301	0.9519
470024	10/01/90	09/30/91	1.1111	0.9700
490001	10/01/90	09/30/91	1.1390	0.9847
490002	09/01/90	09/29/91	1.0256	0.9769
490003	10/01/90	09/30/91	0.6383	0.9998
490004	01/01/91	12/31/91	1.2313	0.9879
490005	01/01/91	12/31/91	1.3969	0.9956
490006	10/01/90	09/30/91	1.1331	0.9706
490008	01/01/91	12/31/91	1.1698	0.9837
490011	01/01/91	12/31/91	1.3148	0.9926
490012	08/01/90	07/31/91	1.0070	0.9636
490013	09/01/90	08/31/91	1.1266	0.9861
490014	01/01/91	12/31/91	1.5962	0.9888
490015	09/01/90	12/10/91	1.4713	0.9932
490017	09/01/90	08/31/91	1.2811	0.9862
490018	01/01/91	12/31/91	1.0967	0.9737
490019	10/01/90	09/30/91	1.1416	0.9737
490020	01/01/91	12/31/91	1.0847	0.9781

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
490021	01/01/91	12/31/91	1.3966	0.9960
490023	10/01/90	09/30/91	1.1882	0.9941
490024	10/01/90	09/30/91	1.6479	0.9982
490027	10/01/90	09/30/91	1.0299	0.9774
490030	10/01/90	09/30/91	1.3039	0.9976
490031	01/01/91	12/31/91	1.0589	0.9672
490033	01/01/91	12/31/91	1.2290	0.9809
490037	01/01/91	12/31/91	1.1280	0.9833
490038	10/01/90	09/30/91	1.2388	0.9869
490040	10/01/90	09/29/91	1.3896	0.9988
490041	01/01/91	12/31/91	1.1601	0.9881
490042	10/01/90	09/30/91	1.2789	0.9852
490044	10/01/90	09/30/91	1.2705	0.9925
490045	10/01/90	09/30/91	1.1531	0.9928
490047	10/01/90	09/30/91	1.1620	0.9840
490048	01/01/91	12/31/91	1.3586	0.9963
490050	01/01/91	12/31/91	1.3227	0.9970
490052	01/01/91	12/31/91	1.4139	0.9986
490054	10/01/90	09/30/91	1.0617	0.9695
490057	01/01/91	12/31/91	1.3604	0.9995
490059	09/01/90	08/31/91	1.4025	0.9990
490060	09/01/90	08/31/91	1.0792	0.9888
490063	01/01/91	12/31/91	1.5865	0.9983
490066	01/01/91	12/31/91	1.1257	0.9689
490067	01/01/91	12/31/91	1.2768	0.9913
490069	10/01/90	09/30/91	1.3551	0.9989
490071	01/01/91	12/31/91	1.3146	0.9943
490073	09/01/90	08/31/91	1.1743	0.9930
490074	01/01/91	12/31/91	1.2773	0.9921
490075	01/01/91	12/31/91	1.2630	0.9864
490077	10/01/90	09/30/91	1.1730	0.9942
490079	01/01/91	12/31/91	1.2537	0.9775
490083	10/01/90	09/30/91	0.7790	0.9914
490084	01/01/91	12/31/91	1.1339	0.9271
490085	10/01/90	09/30/91	1.2241	0.9701
490088	10/01/90	09/30/91	1.1262	0.9799
490089	10/01/90	09/30/91	1.0387	0.9723
490091	10/01/90	09/30/91	1.1636	0.9934
490092	01/01/91	12/31/91	1.1466	0.9766
490095	01/01/91	12/31/91	1.2779	0.9858
490097	09/01/90	08/31/91	1.1294	0.9914
490099	09/01/90	08/31/91	0.9518	0.9537
490100	10/01/90	09/30/91	1.2980	0.9969
490101	01/01/91	12/31/91	1.1204	0.9824
490107	01/01/91	12/31/91	1.2668	0.9895
490110	10/01/90	09/30/91	1.2088	0.9959
490112	09/01/90	08/31/91	1.5131	0.9981
490113	11/01/90	10/31/91	1.2327	0.9745
490115	10/01/90	09/30/91	1.1523	0.9827
490116	09/01/90	08/31/91	1.1746	0.9826
490117	12/01/90	11/30/91	1.0755	0.9840
490122	01/01/91	12/31/91	1.2187	0.9939
490126	10/01/90	09/30/91	1.1978	0.9856
490129	01/01/91	12/31/91	1.1320	1.0000
490130	01/01/91	12/31/91	1.2380	0.9794
500001	01/01/91	12/31/91	1.2970	0.9836
500002	01/01/91	12/31/91	1.4504	0.9878
500003	01/01/91	12/31/91	1.2646	0.9844
500005	01/01/91	12/31/91	1.7013	0.9979
500007	01/01/91	12/31/91	1.3185	0.9801
500009	01/01/91	12/31/91	1.3636	0.9908
500011	01/01/91	12/31/91	1.2267	0.9869
500012	01/01/91	12/31/91	1.4868	0.9974
500014	01/01/91	12/31/91	1.6738	0.9983
500015	01/01/91	12/31/91	1.2899	0.9881
500016	01/01/91	12/31/91	1.3464	0.9918
500019	01/01/91	12/31/91	1.2249	0.9717
500024	01/01/91	12/31/91	1.3638	0.9893
500025	01/01/91	12/31/91	1.9064	0.9986
500026	01/01/91	12/31/91	1.2769	0.9853
500027	01/01/91	12/31/91	1.5768	0.9985
500028	01/01/91	12/31/91	0.9556	0.9759
500029	01/01/91	12/31/91	0.9233	0.9317
500031	01/01/91	12/31/91	1.2594	0.9678
500033	01/01/91	12/31/91	1.1896	0.9410
500035	01/01/91	12/31/91	1.3940	0.9937
500036	11/01/90	10/31/91	1.2793	0.9932

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
500037	01/01/91	12/31/91	1.1866	0.9863
500042	01/01/91	12/31/91	1.3228	0.9787
500043	01/01/91	12/31/91	1.2249	0.9400
500044	01/01/91	12/31/91	1.8839	0.9997
500045	01/01/91	12/31/91	1.2083	0.9879
500048	08/01/90	07/31/91	0.9433	0.9687
500049	01/01/91	12/31/91	1.2372	0.9888
500050	10/01/90	09/30/91	1.2736	0.9903
500051	10/01/90	09/30/91	1.6321	0.9983
500052	01/01/91	12/31/91	1.2104	0.9953
500053	01/01/91	12/31/91	1.2501	0.9828
500054	01/01/91	12/31/91	1.8535	0.9987
500055	08/01/90	07/31/91	0.9833	0.9633
500057	10/01/90	09/30/91	1.2811	0.9876
500058	01/01/91	12/31/91	1.3570	0.9821
500059	01/01/91	12/31/91	1.1252	0.9543
500060	01/01/91	12/31/91	1.2055	0.9735
500061	01/01/91	12/31/91	1.1906	0.9042
500062	01/01/91	12/31/91	0.9371	0.9237
500065	01/01/91	12/31/91	1.3252	0.9609
500068	01/01/91	12/31/91	1.1557	0.9956
500069	01/01/91	12/31/91	1.0029	0.9055
500071	01/01/91	12/31/91	1.3758	0.9506
500072	01/01/91	12/31/91	1.1995	0.9816
500073	01/01/91	12/31/91	0.9586	0.9693
500074	01/01/91	12/31/91	1.0982	0.9839
500077	08/01/90	07/31/91	1.2387	0.9871
500078	11/01/90	10/31/91	1.2867	0.9929
500079	10/01/90	09/30/91	1.2507	0.9820
500080	01/01/91	12/31/91	0.8805	0.9175
500084	01/01/91	12/31/91	1.0142	0.9832
500085	01/01/91	12/31/91	1.0608	0.9527
500088	01/01/91	12/31/91	1.3045	0.9908
500089	01/01/91	12/31/91	0.9888	0.9783
500090	01/01/91	12/31/91	0.8569	0.9231
500092	01/01/91	12/31/91	1.1096	0.9779
500094	01/01/91	12/31/91	0.8671	0.8975
500096	01/01/91	12/31/91	1.0038	0.9390
500097	01/01/91	12/31/91	1.1901	0.9742
500098	01/01/91	12/31/91	0.9062	0.9932
500101	01/01/91	12/31/91	0.8961	0.9377
500102	01/01/91	12/31/91	0.9386	0.9654
500106	01/01/91	12/31/91	0.9803	0.9633
500107	01/01/91	12/31/91	1.1532	0.9787
500110	01/01/91	12/31/91	1.2111	0.9813
500118	01/01/91	12/31/91	1.2002	0.9498
500119	01/01/91	12/31/91	1.2372	0.9838
500122	01/01/91	12/31/91	1.2396	0.9672
500123	01/01/91	12/31/91	0.9900	0.9627
500124	01/01/91	12/31/91	1.3030	0.9846
500125	01/01/91	12/31/91	0.9645	0.9397
500129	01/01/91	12/31/91	1.6686	0.9974
500132	01/01/91	12/31/91	0.8387	0.9585
500134	01/01/91	12/31/91	0.7658	0.9936
500140	10/01/90	09/30/91	0.9810	1.0000
510001	01/01/91	12/31/91	1.6762	0.9936
510002	09/01/90	08/31/91	1.2913	0.9771
510004	11/01/90	10/31/91	0.9587	0.9273
510005	01/01/91	12/31/91	0.9445	0.9613
510006	10/01/90	09/30/91	1.2050	0.9868
510007	10/01/90	09/30/91	1.3756	0.9997
510008	01/01/91	12/31/91	1.1462	0.9927
510009	01/01/91	12/31/91	1.0408	0.9810
510012	10/01/90	09/30/91	1.0412	0.9833
510013	10/01/90	09/30/91	1.1464	0.9939
510016	01/01/91	12/31/91	0.9640	0.9660
510018	10/01/90	09/30/91	1.1305	0.9814
510022	01/01/91	12/31/91	1.6335	0.9985
510028	01/01/91	12/31/91	1.0591	0.9894
510029	10/01/90	09/30/91	1.2375	0.9890
510030	10/01/90	09/30/91	1.1187	0.9924
510031	01/01/91	12/31/91	1.2671	0.9930
510033	01/01/91	12/31/91	1.2335	0.9932
510038	10/01/90	09/30/91	1.0024	0.9676
510039	01/01/91	12/31/91	1.2758	0.9928
510040	01/01/91	12/31/91	0.9602	0.9911
510047	01/01/91	12/31/91	1.1351	0.9831

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
510048	01/01/91	12/31/91	1.1573	0.9860
510050	10/01/90	09/30/91	1.2335	0.9931
510053	10/01/90	09/30/91	1.0016	0.9626
510055	10/01/90	09/30/91	1.1704	0.9937
510059	01/01/91	12/31/91	1.3021	0.9908
510060	09/01/90	08/31/91	1.1601	0.9844
510063	01/01/91	12/31/91	1.0489	0.9627
510065	01/01/91	12/31/91	0.9841	0.9622
510066	01/01/91	12/31/91	1.1224	0.9905
510067	09/01/90	08/31/91	1.2654	0.9912
510068	10/01/90	09/30/91	1.1022	0.9784
510076	01/01/91	12/31/91	1.0242	0.9863
510077	10/01/90	09/30/91	1.1352	0.9899
510081	10/01/90	09/30/91	1.0050	0.9749
510082	01/01/91	12/31/91	1.0014	0.9690
510084	01/01/91	12/31/91	0.9518	0.9603
510085	10/01/90	09/30/91	1.1973	0.9861
520002	10/01/90	09/30/91	1.2780	0.9778
520003	01/01/91	12/31/91	1.1432	0.9629
520008	10/01/90	09/30/91	1.2056	0.9883
520010	01/01/91	12/31/91	1.0845	0.9551
520012	10/01/90	09/30/91	0.9411	0.9521
520014	10/01/90	09/30/91	1.1710	0.9849
520018	10/01/90	09/30/91	0.9627	0.9612
520019	10/01/90	09/30/91	1.2388	0.9826
520021	10/01/90	09/30/91	1.1852	0.9899
520024	10/01/90	09/30/91	0.9845	0.9657
520026	01/01/91	12/31/91	1.0865	0.9827
520029	10/01/90	09/30/91	0.9270	0.9722
520031	10/01/90	09/30/91	1.1637	0.9811
520032	10/01/90	09/30/91	1.1472	0.9642
520033	09/01/90	08/31/91	1.2481	0.9628
520034	10/01/90	09/30/91	1.1804	0.9768
520035	01/01/91	12/31/91	1.2333	0.9877
520037	10/01/90	09/30/91	1.6024	0.9989
520038	01/01/91	12/31/91	1.2627	0.9821
520039	01/01/91	12/31/91	1.0191	0.9460
520042	10/01/90	09/30/91	1.0163	0.9527
520045	01/01/91	12/31/91	1.6931	0.9986
520048	10/01/90	09/30/91	1.3200	0.9888
520049	10/01/90	09/30/91	1.8080	0.9955
520053	01/01/91	12/31/91	1.0808	0.9380
520054	01/01/91	12/31/91	1.1890	0.9766
520056	10/01/90	09/30/91	1.3019	0.9903
520057	01/01/91	12/31/91	1.1617	0.9809
520058	10/01/90	09/30/91	1.1012	0.9714
520059	10/01/90	09/30/91	1.2678	0.9718
520060	10/01/90	09/30/91	1.2476	0.9593
520062	10/01/90	09/30/91	1.1787	0.9764
520064	12/30/90	12/28/91	1.5396	0.9890
520069	01/01/91	12/31/91	1.1928	0.9904
520070	01/01/91	12/31/91	1.3637	0.9855
520071	10/01/90	09/30/91	1.1819	0.9715
520077	10/01/90	09/30/91	1.0274	0.9813
520078	01/01/91	12/31/91	1.3239	0.9922
520082	08/01/90	07/31/91	1.2997	0.9803
520083	01/01/91	12/31/91	1.5158	0.9984
520084	10/01/90	09/30/91	1.0874	0.9651
520089	01/01/91	12/31/91	1.4474	0.9959
520090	10/01/90	09/30/91	1.1410	0.9620
520095	01/01/91	12/31/91	1.3340	0.9685
520100	01/01/91	12/31/91	1.2255	0.9815
520101	10/01/90	09/30/91	1.1709	0.9682
520102	01/01/91	12/31/91	1.2104	0.9721
520103	10/01/90	09/30/91	1.3486	0.9802
520107	01/01/91	12/31/91	1.2459	0.9861
520109	10/01/90	09/30/91	1.0769	0.9788
520110	01/01/91	12/31/91	0.9853	0.9917
520113	10/01/90	09/30/91	1.2143	0.9803
520115	10/01/90	09/30/91	1.2829	0.9658
520116	10/01/90	09/30/91	1.2023	0.9736
520117	09/01/90	08/31/91	1.0600	0.9693
520118	01/01/91	12/31/91	0.9669	0.9541
520123	10/01/90	09/30/91	1.0428	0.9540
520130	10/01/90	09/30/91	1.0552	0.9091
520131	01/01/91	12/31/91	1.0519	0.9348
520135	01/01/91	12/31/91	1.0352	0.9618

TABLE 9.—1991 TRANSFER ADJUSTED CASE MIX INDEX AND TRANSFER ADJUSTMENT TO DISCHARGES FOR CAPITAL HOSPITAL-SPECIFIC RATE REDETERMINATIONS—Continued

Provider number	Cost reporting period		Transfer adjusted case mix index	Transfer adjustment to discharges
	Begin	End		
520138	12/30/90	12/28/91	1.8574	0.9979
520139	09/03/90	09/01/91	1.1996	0.9834
520140	01/01/91	12/31/91	1.4267	0.9974
520144	10/01/90	09/30/91	1.0104	0.9588
520145	01/01/91	12/31/91	1.0190	0.9970
520146	01/01/91	12/31/91	1.1808	0.9655
520148	01/01/91	12/31/91	1.1001	0.9651
520149	01/01/91	12/31/91	1.0452	0.9498
520152	10/01/90	09/30/91	1.1381	0.9665
520153	10/01/90	09/30/91	1.0132	0.9362
520154	10/01/90	09/30/91	1.1116	0.9678
520156	01/01/91	12/31/91	1.0869	0.9421
520157	01/01/91	12/31/91	1.0253	0.9825
520160	01/01/91	12/31/91	1.7842	0.9954
520171	01/01/91	12/31/91	0.9747	0.9766
520173	10/01/90	09/30/91	1.0623	0.9807
520174	01/01/91	12/31/91	1.4356	0.9874
520177	01/01/91	12/31/91	1.5539	0.9929
530008	01/01/91	12/31/91	1.1720	0.9834
530010	01/01/91	12/31/91	1.2714	0.9902
530023	01/01/91	12/31/91	0.8741	0.9478
530024	01/01/91	12/31/91	0.9679	0.9300
530032	01/01/91	12/31/91	1.2207	0.9549

Appendix A—Regulatory Impact Analysis

I. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. 12291 criteria for a "major rule;" that is, a rule that 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 final 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 final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area or a New England County Metropolitan Area.

Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent New England Metropolitan County. Thus, for purposes of the prospective payment system, we classified these hospitals as urban hospitals.

It is clear that the changes being implemented in this document 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 final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in accordance with E.O. 12291 and the RFA.

II. Changes in the Final Rule

There are no major policy changes in this final rule compared to those in the proposed rule. Consequently, in general, the differences in this final rule impact analysis compared to that in the proposed rule are the result of using later or more complete hospital data. For example, a more complete FY 1991 MEDPAR file is now available compared to the one available at the time of the proposed rule. In addition, more recent hospital-specific data, including cost reports, are used in this analysis.

Since publication of the June 4, 1992 proposed rule, the latest hospital market basket forecast provides an increase of 4.1 percent in the operating costs of hospitals paid under the prospective payment system, compared to the 4.3 percent increase projected in the proposed rule. This results in a 2.55 percent increase in the standardized payment amounts for hospitals paid the urban rate rather than the 2.75 percent increase projected at the time of the proposed rule. The rural standardized amounts will increase by 3.55 percent rather than 3.75 percent. The hospital-specific rates for sole community hospitals and Medicare-dependent, small rural hospitals will increase by 4.1 percent. For hospitals excluded from the prospective payment system, the increase in the market basket is now projected to be 4.2 percent, down from a projected 4.5 percent at the time of the proposed rule.

With regard to the capital prospective payment system, we have revised our estimate of the rate of increase in capital costs per case and our budget neutrality target. The FY 1993 Federal rate and the hospital-specific rate will increase 0.4 percent and 0.62 percent, respectively, from their FY 1992 levels. However, our estimate of FY 1993 capital costs per case, which is used to establish the budget neutrality target, is lower than in the proposed rule. We

now estimate that FY 1993 payments per case will increase 6.2 percent over FY 1992 levels. The impacts of these revised increases are illustrated in the analyses below.

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 final policy and rate changes on current and projected payment rates. In this analysis, we examine the effects on hospital operating and capital payments of both statutory and regulatory policy. The analysis projects estimated payments under each major statutory or policy change while holding all other payment variables constant and compares these with current estimated payments to calculate the percentage differences. We cannot, however, 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 would expect hospitals to adapt to many of these changes, however. To the extent they are able to do so, the actual impacts of these changes will vary from the estimates discussed below.

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 57 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 August 1992, just under 5,400 hospitals were receiving prospectively based payments for their Medicare inpatient services. This represents about 83 percent of all Medicare-participating hospitals.

Among the 5,386 prospective payment hospitals included in our analysis, there are over 850 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. As discussed above in section IV.B.3 of the preamble to this final rule, we are implementing triennial reviews of hospitals' eligibility for rural referral center status during FY 1993, and we expect some hospitals currently designated as rural referral centers will lose their status. We have included all current rural referral centers in the tables in this impact analysis, however, without projecting which hospitals may no longer meet the criteria. In addition, there are approximately 1,600 hospitals that receive additional payments on the basis of qualifying as disproportionate share hospitals. Of these hospitals, 46 also receive special payments as rural referral centers, and 101 as sole community hospitals. Our analysis identified 1,041 hospitals that are receiving additional payments for the indirect cost of medical education, reduced from 1,207 in the proposed rule. This reduction is the result of our identification of a number of hospitals, most of which were previously reported as small teaching programs, that are in fact no longer teaching hospitals. There are approximately 560 urban 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. According to the latest hospital-specific data, some of these hospitals have already begun to lose their special status (cost reporting periods beginning on May 1, 1992, for example). For purposes of the operating impact analysis, we have shown all hospitals that qualified for this special provision as of the beginning of FY 1992 in the tables. There are 501 such hospitals in our analysis. Since this special provision is not applicable for capital payments, we have grouped these hospitals according to the most recent data, which results in a decline to 443 in the number of Medicare-dependent, small rural hospitals shown in the capital impact tables.

Under the capital prospective payment system, approximately 2,250 urban hospitals with more than 100 beds receive an additional payment for serving low-income patients. (A capital disproportionate share adjustment is made to all urban hospitals with more than 100 beds that serve low-income patients.) Additional capital payments are also made to the 1,041 hospitals that we have identified as teaching hospitals.

In addition, there are special payment protections for sole community hospitals and for urban hospitals with 100 or more beds that either have a disproportionate share percentage of at least 20.2 percent or derive at least 30 percent of their total inpatient revenues from State or local government sources for the care of indigent patients. We have identified 561 sole community hospitals and about 760 urban hospitals that qualify for these special provisions.

As of August 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 hospitals and 1,893 excluded units in hospitals included in the prospective payment 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 will 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 4.2 percent.

The impact of this update in the rate-of-increase limit on excluded hospitals and units 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 cost increases per case above the cumulative update in their rate-of-increase limit, the major

effect will be the amount of excess costs that the hospitals will have to absorb.

In this context, we note that for cost reporting periods beginning in FY 1992, section 1886(b)(1)(B) of the Act allows an excluded hospital or unit whose costs 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 and 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 Final Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are implementing policy changes and payment rate updates for the prospective payment systems for operating costs and for capital-related costs. We have prepared a separate analysis of the changes to each system.

The data used in developing the quantitative analysis of changes in operating payments that are presented below are taken from FY 1991 MEDPAR 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, as noted above, it does not take into account behavioral changes that hospitals may adopt in response to the policy changes. Second, we are unable to precisely quantify every effect of the changes contained in this rule. Given the data we have available, however, we have attempted to estimate payments under each scenario as precisely as possible. Third, we could not categorize every hospital in accordance with the groupings we examined because in some cases the hospital-specific data necessary to do so were missing. For example, parts of the data needed to determine Medicare's utilization percentage were missing for 245 hospitals.

To illustrate the effects of hospital geographic reclassifications for FY 1993, hospitals are grouped in Table I based on both their actual geographic location and their actual payment classification after any reclassifications under sections 1886(d) (8) or (10) of the Act. For example, Table I shows that the numbers of prospective payment hospitals actually located in large urban, other urban, and rural areas are 1,474, 1,422, and 2,490, respectively. The corresponding numbers of hospitals in these three groups after geographic reclassification shows the numbers of large urban, other urban, and rural hospitals to be 1,628, 1,487, and 2,271, respectively. The effects of geographic reclassification are further evident in column 2 and in the row groupings of reclassified and nonreclassified hospitals.

To simulate the impact of the expiration of the provisions 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 MDH'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 FY 1993 standardized amount payments for operating costs. We then computed payments for the remainder of the Federal fiscal year based on the 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 standardized amount payments, we computed hospital-specific payments for 3 months and payments under the standardized amounts for 9 months. Hospitals with cost reporting periods ending after March 31 and on or before September 30 were paid on the basis of the Federal payment rates for the entire period. Since some MDHs lost their special protection during FY 1992 (for example, MDHs with cost reporting periods beginning July 1), a similar reduction was made in estimated FY 1992 payments. The annual impact on MDHs of the expiration of this special provision is illustrated below. We simulated a full 12 months of FY 1993 payments to MDH's under the special provision compared with 12 months of payment without the provision.

Average payment/ case 12 months payment as an MDH	Average payment/ case 12 months payment without the MDH payment protection	Percent change
$3,446	$3,114	−9.6

The analysis in Table I examines the following major changes set forth in this final rule—

- The effects of the annual reclassification of DRGs 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 effects of the additional outlier payments that we estimate will be made during FY 1993 compared to our estimate of FY 1992 outlier payments (column 3A).
- The effect of the 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 3B).
- The net effect of the outlier changes shown in columns 3A and 3B (column 3C).
- The combined effect of all changes being presented in this final rule (column 4).

In order to present the effects of the separate policy changes displayed in columns 1, 2, 3A, 3B, and 3C of Table I, we added each change incrementally, so that the percentages in the columns represent the differences in payments relative to the previous column. The baseline for comparison is an FY 1993 system absent any of the changes described above. It does reflect the statutory MDH phase-out during FY 1993. For example, column 1 displays the impacts of the DRG reclassifications and recalibration relative to estimated FY 1993 payments absent these changes. Similarly, column 2 examines the impacts of the standardized amount and wage index changes resulting from geographic reclassifications exclusive of the effects of the DRG reclassifications and recalibration. Columns 3A, 3B, and 3C show the impacts of the outlier changes in a similar manner. The last column in Table I displays the combined changes from 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. This column compares estimated final FY 1993 payments to estimated FY 1992 payments. Thus, the last column is the only one that reflects the effects of all

the quantifiable policy changes on simulated FY 1993 payments.

TABLE I.—IMPACT OF CHANGES IN THE PROSPECTIVE PAYMENT SYSTEM FOR OPERATING COSTS FOR FY 1993

[Percent Change in Payments]

	Number of hospitals [1]	DRG reclassification and recalibration [2] (1)	Geographic reclassification [3] (2)	Outlier Payment Changes			All changes [6] (4)
				Payment level adjust.[4] (3A)	Proposed policy [5] (3B)	Sum of (A) & (B) (3C)	
By geographic location:							
All hospitals	5,386	0.0	0.0	1.4	0.0	1.4	4.0
Large urban areas (populations over 1 million)	1,474	0.1	−0.1	1.6	−0.1	1.5	4.1
Other urban areas (populations of 1 million or fewer)	1,422	0.0	0.1	1.5	0.1	1.6	4.2
Rural areas	2,490	−0.1	0.1	0.6	0.0	0.6	3.0
Urban hospitals	2,896	0.0	0.0	1.6	0.0	1.6	4.1
0–99 beds	682	−0.1	0.0	0.9	0.2	1.1	3.7
100–199 beds	872	0.1	0.1	1.2	0.2	1.4	4.1
200–299 beds	612	0.1	0.0	1.4	0.1	1.5	4.2
300–499 beds	537	0.0	−0.1	1.7	−0.1	1.6	4.1
500 or more beds	193	0.0	0.0	1.9	−0.3	1.6	4.2
Rural hospitals	2,490	−0.1	0.1	0.6	0.0	0.6	3.0
0–49 beds	1,232	−0.2	0.2	0.1	0.0	0.1	2.0
50–99 beds	761	−0.1	0.2	0.3	0.0	0.3	2.6
100–149 beds	259	0.0	0.0	0.6	0.1	0.7	3.1
150–199 beds	123	0.0	−0.1	0.7	0.0	0.7	3.6
200–499 beds	112	0.0	−0.2	1.1	0.0	1.1	3.6
500 or more beds	3	−0.1	−0.4	0.9	0.1	1.0	3.5
Urban by region:							
New England	172	−0.2	0.3	1.6	−0.3	1.3	4.0
Middle Atlantic	456	0.4	0.0	2.1	−1.2	0.9	3.8
South Atlantic	421	−0.1	0.0	1.7	0.2	1.9	4.4
East North Central	476	0.0	−0.2	1.3	0.3	1.6	4.0
East South Central	168	0.1	−0.1	1.7	0.4	2.1	4.7
West North Central	183	−0.1	−0.2	1.3	0.4	1.7	3.9
West South Central	357	0.1	0.3	1.5	0.5	2.0	5.0
Mountain	113	−0.1	−0.2	1.4	0.5	1.9	4.3
Pacific	501	−0.2	0.0	1.3	0.4	1.7	3.9
Puerto Rico	49	0.2	−0.2	0.8	0.1	0.9	3.5
Rural by region:							
New England	56	−0.1	−0.2	0.8	0.0	0.8	3.9
Middle Atlantic	93	0.0	−0.4	1.1	−0.8	0.3	1.5
South Atlantic	340	0.0	−0.7	1.0	0.0	1.0	3.1
East North Central	344	−0.1	0.5	0.4	0.1	0.5	2.9
East South Central	298	0.0	−0.2	0.6	0.1	0.7	3.4
West North Central	564	−0.2	0.7	0.2	0.1	0.3	2.3
West South Central	396	−0.1	0.5	0.5	0.2	0.7	3.2
Mountain	237	−0.2	0.0	0.3	0.1	0.4	3.5
Pacific	156	−0.1	0.8	0.3	0.1	0.4	4.1
Puerto Rico	6	−0.1	−0.4	0.2	0.1	0.3	3.3
By payment classification:							
All Hospitals	5,386	0.0	0.0	1.4	0.0	1.4	4.0
Large Urban areas (populations over 1 million)	1,628	0.1	0.0	1.6	−0.1	1.5	4.2
Other Urban areas (populations of 1 million or fewer)	1,487	0.0	0.0	1.4	0.1	1.5	4.1
Rural areas	2,271	−0.1	−0.1	0.5	0.0	0.5	2.8
Teaching status:							
Non-teaching	4,345	0.0	0.0	1.2	0.2	1.4	3.9
Resident/bed ratio less than 0.25	811	0.0	−0.1	1.5	−0.1	1.4	3.9
Resident/bed ratio 0.25 or greater	230	0.1	0.1	2.0	−0.5	1.5	4.2
Disproportionate share hospitals (DSH):							
Non-DSH	3,734	−0.1	0.0	1.3	0.1	1.4	3.9
Urban DSH:							
100 beds or more	1,161	0.1	0.0	1.6	−0.2	1.4	4.1
Fewer than 100 beds	99	−0.1	0.0	0.6	0.2	0.8	3.3
Rural DSH:							
Sole Community (SCH)	101	0.0	−0.5	0.3	0.0	0.3	3.3
Referral Centers (RRC)	46	0.0	0.4	1.0	−0.1	0.9	3.9
Other rural DSH hospitals:							
100 beds or more	66	0.0	−2.4	0.8	−0.1	0.7	1.7
Fewer than 100 beds	179	−0.2	−0.4	0.3	0.0	0.3	2.8
Urban teaching and DSH:							
Both teaching and DSH	561	0.1	0.0	1.8	−0.4	1.4	4.1
Teaching and no DSH	429	−0.1	−0.1	1.6	0.1	1.7	4.0
No teaching and DSH	699	0.1	0.0	1.3	0.1	1.4	4.1
No teaching and no DSH	1,426	0.0	0.1	1.4	0.2	1.6	4.3
Rural hospital types:							
Non special status	983	−0.1	−0.9	0.5	0.0	0.5	3.1
RRC	180	0.0	0.4	0.9	0.1	1.0	3.9
SCH	561	−0.1	0.0	0.1	0.0	0.1	3.8
Medicare-dependent (MDH)	501	−0.2	0.3	0.2	0.0	0.2	−4.0

TABLE I.—IMPACT OF CHANGES IN THE PROSPECTIVE PAYMENT SYSTEM FOR OPERATING COSTS FOR FY 1993 —Continued

[Percent Change in Payments]

	Number of hospitals [1]	DRG reclassification and recalibration [2] (1)	Geographic reclassification [3] (2)	Outlier Payment Changes			All changes [6] (4)
				Payment level adjust.[4] (3A)	Proposed policy [5] (3B)	Sum of (A) & (B) (3C)	
SCH and RRC	46	0.1	0.2	0.5	−0.3	0.2	3.7
SCH or MDH	1,108	−0.1	0.1	0.2	−0.1	0.1	1.6
Type of ownership:							
Voluntary	3,212	0.0	−0.1	1.5	−0.1	1.4	3.9
Proprietary	729	0.0	0.0	1.5	0.4	1.9	4.6
Government	1,445	0.0	0.2	1.2	0.0	1.2	3.8
Medicare utilization Percent of days:							
0–25%	293	0.2	0.0	1.4	−0.1	1.3	4.1
25–50%	1,782	0.0	0.0	1.6	0.0	1.6	4.1
50–65%	2,201	0.0	0.0	1.3	0.0	1.3	4.0
Over 65%	865	0.1	−0.1	1.1	0.0	1.1	2.9
N/A	245	0.4	0.6	1.6	−0.5	1.1	4.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board							
Reclassification Status during FY 1992 and FY 1993:							
Reclass. FY92 and FY93	849	0.0	−0.7	1.0	0.0	1.0	3.1
Reclass. FY93 only	344	0.2	4.4	1.4	−0.3	1.1	8.2
Reclass. FY92 only	80	0.0	−3.1	1.0	0.2	1.2	0.8
FY93 reclassifications—All hospitals:							
Reclassified	1,193	0.0	1.0	1.2	−1.0	1.1	4.7
Nonreclassified	4,143	0.0	−0.3	1.5	0.0	1.5	3.8
Urban hospitals:							
Reclassified	370	0.1	1.4	1.5	−0.2	1.3	5.5
Nonreclassified	2,526	0.0	−0.3	1.6	0.0	1.6	3.9
Rural Hospitals:							
Reclassified	823	−0.1	0.3	0.7	0.0	0.7	3.6
Nonreclassified	1,617	−0.1	−0.4	0.4	0.0	0.4	2.1
Other Reclassified Hospitals: (Section 1886(D)(8)(B))	50	0.0	0.2	0.9	0.1	1.0	3.8

[1] Because data necessary to classify some hospitals by category were missing, these hospitals were not categorized, or are shown as N/A. Therefore, the total number of hospitals in each category may not equal the national total. Hospital-specific data and number of discharges data are from FY 1991, and hospital cost report data are from cost 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 are now estimated to equal 3.84 percent of total prospective payments. FY 1993 outlier payments are estimated at 5.1 percent.

[5] This column displays the impact of the change for computing day outlier cases as follows: 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 standardized amounts in accordance with 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 any interactive effects that we are not able to quantify.

B. The Impact of the Changes to the DRG Weights (Column 1)

In column 1 of Table I, we present the combined effects of the revised DRG classification system and the subsequent recalibration of the DRG weights incorporating these redefined DRGs. Section 1886(d)(4)(C)(i) of the Act requires us to make appropriate classification changes and recalibrate the DRG weights each year 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 classification and recalibration changes across hospital groupings is small. Column 1 shows that, for most hospital groups, the impact of this change would be between plus or minus 0.2 percent difference relative to payments without these changes. The reductions occur primarily among small urban and rural hospitals. The impact on rural hospitals overall is 0.1 percent lower payments. 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. An exception to the generally minimal impact are urban hospitals in the Middle Atlantic region. Their payments increase by 0.4 percent due to the DRG changes, up from 0.3 percent in the proposed rule.

C. The Impact of MGCRB Reclassifications on Hospitals (Column 2)

1. Impact of Current Policies

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review Board (MGCRB). The first hospital reclassifications based on decisions of the MGCRB were effective October 1, 1991. The MGCRB

considers hospitals' applications for geographic reclassification for purposes of receiving a different wage index value or a higher standardized amount or both under the prospective payment system. 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.)

Both the 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 1,243 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, which deems certain rural counties adjacent to one or more urban areas as belonging to an urban area.

The wage index values and the standardized payment amounts also reflect any decisions that result from the Administrator's review of MGCRB decisions for FY 1993 as of August 1992 and any reclassification withdrawal requests that were received by the MGCRB. These Administrator's decisions and withdrawals may affect the wage index value for specific geographic areas relative to those used in the impact analysis in the June 4, 1992 proposed rule. They 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.

Approximately 69 percent of all hospitals reclassified for FY 1993 are located in rural areas (823 hospitals). This represents 33 percent of all rural hospitals in our data base. Of the total number of rural hospitals that were reclassified, 79 percent (652 hospitals) were reclassified for purposes of their wage index. Just under 10 percent of rural reclassified hospitals were reclassified for purposes of their standardized amounts and 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 (139 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

Geographic location	Total number of hospitals reclassified	Reclassified for both wage index value and standardized amount		Reclassified for standardized amount		Reclassified for wage index	
		Number	Percent	Number	Percent	Number	Percent
Large Urban	125	36	28	0	0	89	71
Other Urban	245	89	36	17	7	139	57
Rural	823	91	11	80	10	652	55
Total	1193	216	18	97	8	880	74

Overall, 74 percent of the reclassified hospitals were reclassified for purposes of their wage index value, 8 percent were reclassified for purposes of their standardized amounts, and 18 percent were reclassified for purposes of both their wage index value and standardized payment amount.

In the proposed rule, only 6 hospitals in large urban areas were reclassified for both the standardized amount and the wage index, and 125 hospitals in large urban areas were reclassified for purposes of the wage index only. As shown above, a sizable shift occurred among these hospitals in the interim, so that now 36 are reclassified for both the standardized amount and the wage index, and only 89 are reclassified for the wage index only. This shift resulted from a group application from hospitals in a large urban area that was originally granted reclassification by the MGCRB for the wage index only, but upon review was subsequently granted reclassification for the standardized amount as well. (If a group of hospitals is reclassified, the group is reclassified for both its standardized amount and its wage index. Although these hospitals are reported reclassified for both, the payment effect is only on the wage index value.)

Table I shows the impact of changes in reclassification status between FY 1992 and FY 1993. The percentage change shown in Column 2 compares payments incorporating the DRG changes and FY 1992 reclassifications with payments based on the FY 1993 MGCRB decisions. For example, for hospitals that were reclassified in FY 1992, only the differences between their FY 1992 and FY 1993 payments attributable to the MGCRB decisions for FY 1993 are shown. For hospitals reclassified in both FY 1992 and FY 1993, the effect of the increased number of MGCRB reclassifications is to reduce their payments by 0.7 percent. The increased number of reclassifications results in a larger budget neutrality reduction applicable to the urban standardized amount and a decrease in the wage index values assigned to reclassified hospitals. Hospitals that were reclassified for the first time in FY 1993 experience a 4.4 percent increase in payments. Hospitals that were reclassified in FY 1992 but not in FY 1993 will experience a 3.1 percent reduction in payments as a result. This impact is also shown among nonreclassified rural hospitals, where payments are 0.4 percent lower. Fifty-nine rural hospitals that lost their reclassification from FY 1992 to FY 1993 are in this group, and their average decrease in payments per case is 5.8 percent. Overall, geographic reclassification is expected to increase payments per case to rural and other urban hospitals by an average of 0.1 percent, matched by a reduction of 0.1 percent in payments to large urban hospitals. Payments to rural hospitals with fewer than 100 beds are projected to increase by 0.2 percent, while payments to rural hospitals with between 200 and 499 beds will decrease 0.2 percent, and those to hospitals with 500 or more beds are expected to decrease 0.4 percent. Among urban hospitals, we expect hospitals with between 300 and 499 beds to receive an average decrease of 0.1 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. This net increase, however, is primarily the impact of rural referral centers reclassified during FY 1993 that were not reclassified during FY 1992. The impact of reclassification on this group of hospitals is a 9.2 percent increase. Other rural referral centers experience a negative impact from reclassification, especially those which lost their reclassification from FY 1992 to FY 1993, which experience a 2.7 percent decrease in payments. Nonreclassified rural referral centers' payments are reduced on average 0.1 percent due to the budget neutrality adjustment to the urban standardized amounts. Rural disproportionate share hospitals with 100 or more beds may expect an average decrease in payments of 2.4 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 several census divisions are projected to receive decreased payments of 0.2 percent, hospitals in the New England and the West South Central census divisions are expected to receive an average increase of 0.3 percent. Also, rural hospitals in the Pacific, West North Central and the West South Central census divisions can expect an increase of 0.8, 0.7, and 0.5 percent, respectively. 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, urban or rural. These changes result from concentrations of hospitals within these census divisions that are dramatically affected by the FY 1993 geographic reclassifications. For example, in the Pacific division, 12 hospitals reclassified for the first time during FY 1993 have an 11.0 percent average increase in their payments per case due to reclassification. Conversely, in the South Atlantic census division, 9 hospitals that were reclassified during FY 1992 but are not reclassified for FY 1993 will have payments 8.5 percent less than they would have been if they maintained their geographic reclassification.

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. It compares simulated payment levels after the FY 1993 reclassifications with those based on the actual geographic location of reclassified hospitals. 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.—EFFECTS ON PAYMENTS PER CASE OF FY 1993 GEOGRAPHIC RECLASSIFICATION 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	1,193	4,961	5,187	4.6
Standardized amount only	97	4,892	5,016	2.5
Wage index only	880	4,859	5,081	4.6
Both	216	5,292	5,554	4.9
All urban reclassified hospitals:	370	5,922	6,079	2.6
Standardized amount only	17	6,709	6,687	−0.3
Wage index only	228	5,997	6,165	2.8
Both	125	5,707	5,862	2.7
All reclassified rural hospitals:	823	3,991	4,287	7.4
Standardized amount only	80	3,658	3,881	6.1
Wage index only	652	4,013	4,274	6.5
Both	91	3,987	4,584	15.0
All nonreclassified hospitals:	4,143	6,003	5,932	−1.2
Urban non-reclassified hospitals	2,526	6,357	6,278	−1.3
Rural non-reclassified hospitals	1,617	3,526	3,531	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 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 (standardized amount only, wage index only, and both).

As evidenced by the increase in payment for reclassified hospitals and the decrease in payments for nonreclassified hospitals, the effects of the MGCRB reclassification decisions are significant. The net impact of reclassification relative to no reclassification is to increase payments per case to reclassified hospitals by 4.6 percent and to decrease payments per cast to nonreclassified hospitals by 1.2 percent. Because reclassified hospitals have only 28 percent as many cases as nonreclassified hospitals, the per case payment reduction to nonreclassified hospitals is smaller than the per case increase to reclassified hospitals. Hospitals located in rural areas that were reclassified for purposes of both their wage index value and their standardized amount will receive the largest percentage increase in payments per case. They experience an average increase of nearly 15.0 percent above what they would experience without reclassification.

The impact on the 17 hospitals located in urban areas that were reclassified for purposes of their standardized amounts is an average decrease in payments per case of 0.3 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 is greater than the increase in their standardized amount after reclassification to a large urban area. Of course, if they were not reclassified, their payments would have decreased even more.

The reclassification of hospitals primarily affects payment to nonreclassified 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. Nonreclassified urban hospitals (comprising about 61 percent of nonreclassified hospitals) will experience a 1.3 percent decrease in payments per case compared to the level of payments they would receive if there were no reclassifications. The 0.2 percent increase for nonreclassified rural hospitals is largely attributable to a smaller offset to the rural standardized amount for outliers after reclassification. This occurs because the hospitals reclassified for the urban standardized amounts, which have the largest proportion of outlier cases among rural hospitals, are considered as urban hospitals for the purpose of determining the outlier offset percentages after reclassification. The larger rural standardized amount due to the smaller outlier offset results in a net gain for hospitals with the fewest outlier cases (nonreclassified rural hospitals). In the aggregate, payments to hospitals that are receiving the rural standardized payment amounts (which includes rural hospitals reclassified for the wage index only) are budget neutral.

2. Impact of Guideline Changes

Section 412.230(e) of the regulations 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 final rule, we are adding an additional criterion that requires a hospital to demonstrate that its average hourly wage is at least 108 percent of the average hourly wage in its current labor market area. The revised guideline is effective for applications filed by October 1, 1992, which will be reviewed by the MGCRB in FY 1993. They do not affect payment until FY 1994.

Based on the FY 1993 reclassifications, we estimate that under the new wage guideline, 75 percent of the hospitals that qualified for reclassification based on their wage index values would no longer qualify. This includes 89 percent of the urban hospitals and 67 percent of the rural hospitals that qualified in FY 1993. The following table shows the effect of the new wage guideline 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	5386	5386
All reclassified hospitals	1193	553
Standardized amount only	97	274
Wage index only	880	240
Both	216	39
All nonreclassified hospitals	4143	4833
Hospitals affected by revised guideline		817
Changed from wage index only to no reclassification		640
Changed from both to standardized amount only		177
All reclassified urban hospitals	370	170
Standardized amount only	17	133
Wage index only	228	28
Both	125	9
All nonreclassified urban hospitals	2526	2726
Urban hospitals affected by revised guideline		316
Changed from wage index only to no reclassification		200
Changed from both to standardized amount only		116
All reclassified rural hospitals	823	383
Standardized amount only	80	141
Wage index only	652	212
Both	91	30
All nonreclassified rural hospitals	1617	2057
Rural hospitals affected by revised guideline		501
Changed from wage index only to no reclassification		440
Changed from both to standardized amount only		61

For several reasons, it is difficult to estimate the impact the revised guideline will have on FY 1994 reclassifications (the year in which reclassifications based on the revised guidelines 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 final 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. The new wage data, 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.

D. Effect of Changes in Outlier Payments (Columns 3A, B, and C)

1. Outlier Policy Changes

Table I, column 3A, displays the impact of increased FY 1993 outlier payments compared with estimated FY 1992 outlier payments. 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.

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 rather than in column 4. However, because of its significance, we discuss first the impact of the outlier policy changes shown in column 3B, and then the impact of 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 that the patient remains in the hospital. As explained in section V.A.1. of the preamble to this final rule, 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 using a marginal cost factor of 55 percent instead of 60 percent, results in more appropriate payments for day outlier cases. These changes also produce a more equitable distribution of payments across all outlier cases and better protect hospitals from losses resulting from cost outlier 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. When examined by census division, however, the effects of these changes are quite pronounced. Except for hospitals in the New England, Puerto Rico and Middle Atlantic divisions, we project increases in payments to urban hospitals of between 0.2 and 0.5 percent. Urban hospitals in the Middle Atlantic and New England census divisions would experience decreases in their payments of 1.2 and 0.3 percent, respectively. This is because hospitals in these regions have a higher percentage of cases meeting the criteria to qualify as day outliers under the current policy. For rural hospitals, we find similar though less dramatic redistributive effects. The impact on rural hospitals in the Middle Atlantic census division is projected to be a reduction of 0.8 percent.

Our analysis indicates that the effect of this change is that payments per case to large hospitals (over 500 beds) located in urban areas will be about 0.3 percent less. The effect on hospitals located in large urban areas will be 0.1 percent lower payments per case. On the other hand, payments per case to urban hospitals with fewer than 100 beds increase about 0.2 percent.

Among hospitals receiving special payments, payments to hospitals with large teaching programs (resident-to-bed ratios of 0.25 or greater) are reduced 0.6 percent. Estimated payments to disproportionate share hospitals will be 0.3 percent lower. These average payment reductions reflect the reduced payments to hospitals in the Middle Atlantic census division. This is the only census division where payments per case to teaching and disproportionate share hospitals would be decreased.

The principal impact, however, of these changes in day outlier payment policy 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 final rule describes, we now estimate that FY 1992 outlier payments will equal 3.84 percent of total DRG payments (exclusive of indirect teaching and disproportionate share payments) and 4.0 percent of total payments under the prospective payment system for operating costs. The outlier payment percentage in FY 1993 is estimated to be 5.1 percent. The percentage changes shown in column 3A reflect the additional outlier payments that we estimate would be made during FY 1993 under our outlier policy before making the changes to the day outlier calculations as described above compared to our estimate of FY 1992 outlier payments.

The effect is to increase average payments per case, overall, by 1.4 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 is larger for hospitals located in large urban areas—raising payments an average of 1.6 percent. The effect is smallest for rural hospitals—raising their payments by 0.6 percent. Among hospitals that receive additional payments or are grouped according to certain characteristics, hospitals with large teaching programs receive the largest payment increases. The increase averages about 2.0 percent.

The analysis by census division shows urban hospitals in the Middle Atlantic census division receiving the greatest increase in payments. Among hospitals within this census division, urban hospitals receive an average increase of 2.1 percent, the largest increase of all hospital groups, and rural hospitals would receive an average increase of 1.1 percent, the largest increase among rural groups. Thus, in column 3C, we see that the net effect of the difference between FY 1992 outlier payments and FY 1993 estimated payments including the outlier policy changes, is an increase in payments to hospitals in the Middle Atlantic census division of 0.9 percent for urban hospitals and 0.3 percent for rural hospitals.

E. Combined Effects of All Changes (Column 4)

In column 4 of Table I, we present the effects of all final changes for FY 1993 compared to estimated payments under policies in effect for FY 1992. In addition to the changes being implemented 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 for hospitals located in urban and rural areas (2.55 percent for urban hospitals and 3.55 percent for rural hospitals), the phase-out of the MDH 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 final rule and in the preamble. As explained in our introductory remarks to the quantitative analysis section, some changes cannot be captured because we lack 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 final FY 1993 prospective payment rates shows that the average payment to hospitals would increase 4.0 percent. Urban hospitals can expect an increase of 4.1 percent, with hospitals in the large urban areas receiving an increase of 4.1 percent and hospitals in the other urban areas receiving an increase of 4.2 percent. Hospitals in rural areas can expect an average increase in payments of 3.0 percent. The lower increase in rural hospital payments is attributable to the phase-out of the MDH provision and a smaller impact from the underpayment of outliers during FY 1992.

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 5.0 percent, the largest increase of any census division. With the exception of hospitals in Puerto Rico, other projected increases range from 3.8 percent for hospitals in the Middle Atlantic division to 4.7 for the East South Central census division. Hospitals in Puerto Rico are projected to receive average increases of 3.5 percent.

Among the rural areas, the Pacific census division will receive the largest increase in payments per case of 4.1 percent. The smallest increase is projected for the Middle Atlantic census division, where rural payments per case are projected to be 1.5 percent above FY 1992 levels.

Consistent with our expectations, reclassified hospitals will gain the most under the policies being implemented in this document. Hospitals that are being reclassified for the first time in FY 1993 will receive the largest payment gains, 8.2 percent, which is largely as a result of an increase of 4.4 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 an average payment increase of 3.1 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 0.8 percent. Again, the small increase is due largely to the drop in payments of 3.1 percent as a result of these hospitals not being reclassified in FY 1993. Nonreclassified hospitals may expect increased payments amounting to about 3.8 percent.

Rural hospitals with fewer than 50 beds are projected to receive a payment increase of 2.0 percent, and rural hospitals with from 50 to 99 beds are projected to receive an average increase of 2.6 percent. The expiration of the MDH provision has an adverse impact on hospitals in both of these groups. Among MDHs, average payments per case during FY 1993 will be 4.0 percent lower than during FY 1992, because of the elimination of the hospital-specific rate option effective with cost reporting periods ending after March 31, 1993.

Table III presents the projected average payments per case for FY 1992 and 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 under policies 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. Consequently, the last column in Table III is identical to the column 4 in Table I.

TABLE III.—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE

[FY 1992 Payments Compared To FY 1993 Payments]

	Number of hospitals	FY 1992 payments/ case	FY 1993 payments/ case	All changes[1]
By geographic location all hospitals	5,386	5,537	5,756	4.0
Large urban areas (populations over 1 million)	1,474	6,510	6,775	4.1
Other urban areas (populations of 1 million or fewer)	1,422	5,452	5,682	4.2
Rural areas	2,490	3,837	3,952	3.0
Urban hospitals	2,896	6,000	6,248	4.1
0–99 beds	682	4,230	4,385	3.7
100–199 beds	872	5,092	5,303	4.1
200–299 beds	612	5,556	5,788	4.2
300–499 beds	537	6,264	6,521	4.1
500 or more beds	193	7,723	8,047	4.2
Rural hospitals	2,490	3,837	3,952	3.0
0–49 beds	1,232	3,189	3,253	2.0
50–99 beds	761	3,529	3,621	2.6
100–149 beds	259	3,974	4,098	3.1
150–199 beds	123	4,031	4,176	3.6
200–499 beds	112	4,566	4,732	3.6
500 or more beds	3	6,026	6,236	3.5
Urban by region:				
New England	172	6,358	6,615	4.0
Middle Atlantic	456	6,572	6,823	3.8
South Atlantic	421	5,729	5,979	4.4
East north central	476	5,853	6,084	4.0
East south central	168	5,184	5,426	4.7
West north central	183	5,835	6,061	3.9
West south central	357	5,451	5,725	5.0
Mountain	113	5,865	6,116	4.3
Pacific	501	6,772	7,038	3.9
Puerto Rico	49	2,320	2,401	3.5
Rural by region:				
New England	56	4,538	4,713	3.9
Middle Atlantic	93	4,311	4,377	1.5
South Atlantic	340	4,038	4,163	3.1
East north central	344	3,846	3,957	2.9
East south central	298	3,424	3,540	3.4
West north central	564	3,553	3,634	2.3

TABLE III.—COMPARISON OF OPERATING PROSPECTIVE PAYMENTS PER CASE—Continued

[FY 1992 Payments Compared To FY 1993 Payments]

	Number of hospitals	FY 1992 payments/ case	FY 1993 payments/ case	All changes[1]
West south central	396	3,481	3,594	3.2
Mountain	237	4,110	4,255	3.5
Pacific	156	4,654	4,843	4.1
Puerto Rico	6	1,549	1,600	3.3
All hospitals	5,386	5,537	5,756	4.0
Large urban areas (populations over 1 million)	1,628	6,390	6,656	4.2
Other urban areas (populations of 1 million or fewer)	1,487	5,392	5,613	4.1
Rural areas	2,271	3,788	3,893	2.8
Teaching status:				
Non-teaching	4,345	4,632	4,812	3.9
Resident/bed ratio less than 0.25	811	6,068	6,306	3.9
Resident/bed ratio 0.25 or greater	230	9,357	9,755	4.2
Disproportionate share:				
Hospitals (DSH)	3,734	5,013	5,208	3.9
Non-DSH				
Urban DSH:				
100 beds or more	1,161	6,629	6,901	4.1
Fewer than 100 beds	99	4,040	4,175	3.3
Rural DSH:				
Sole community (SCH)	101	3,645	3,766	3.3
Referral centers (RRC)	46	4,614	4,795	3.9
Other rural DSH hospitals:				
100 beds or more	66	3,500	3,561	1.7
Fewer than 100 beds	179	3,029	3,113	2.8
Urban teaching and DSH:				
Both teaching and DSH	561	7,517	7,825	4.1
Teaching and no DSH	429	6,205	6,453	4.0
No teaching and DSH	699	5,315	5,533	4.1
No teaching and no DSH	1,426	4,873	5,083	4.3
Rural hospital types:				
Non special status	983	3,348	3,452	3.1
RRC	180	4,396	4,569	3.9
SCH	561	3,849	3,995	3.8
Medicare-dependent (MDH)	501	3,290	3,157	−4.0
SCH and RRC	46	4,664	4,838	3.7
SCH or MDH	1,108	3,815	3,875	1.6
Type of ownership:				
Voluntary	3,212	5,691	5,913	3.9
Proprietary	729	5,055	5,288	4.6
Government	1,445	5,114	5,310	3.8
Medicare util: percent of days				
0–25	293	7,213	7,507	4.1
25–50	1,782	6,241	6,499	4.1
50–65	2,201	5,020	5,218	4.0
Over 65	865	4,526	4,658	2.9
Unknown	245	5,822	6,094	4.7
Hospitals reclassified by the Medicare Georgraphic Classification Review Board				
Reclassification status during FY 1992 and FY 1993:				
Reclass. FY92 and FY93	849	4,845	4,993	3.1
Reclass. FY93 only	344	5,201	5,626	8.2
Reclass. FY92 only	80	4,973	5,011	0.8
FY93 reclassifications:				
All hospitals				
Reclassified	1,193	4,955	5,187	4.7
Nonreclassified	4,143	5,716	5,932	3.8
All urban hospitals:				
Reclassified	370	5,764	6,079	5.5
Nonreclassified	2,526	6,039	6,276	3.9
All rural hospitals:				
Reclassified	823	4,137	4,287	3.6
Nonreclassified	1,617	3,460	3,531	2.1
Other reclassified:				
(Section 1886(D)(8)(B))	50	4,284	4,446	3.8

[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

An impact analysis of the capital prospective payment system must control for the two transitional payment methods (the hold-harmless method and the fully prospective payment method) and accurately forecast FY 1993 asset acquisitions and disposals. Our analysis is limited by 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 actual hospital capital growth rate for an individual hospital.
- 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 changes we are making to § 412.302(c) in this final rule, 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 make its determination as to whether the obligated capital will qualify as old capital by the later of the end of the hospital's first cost reporting period under the capital prospective payment system or 9 months from the notification date. Since we do not have information on what proportion of an individual hospital's future capital spending will qualify as old capital, we cannot accurately project how an individual hospital will be affected by the transition payment policies.

Prior to this final rule, we had only limited information on which transition payment method would be applicable to an individual hospital. Limited information on initial payments under the capital prospective payment system coupled with an inability to accurately forecast FY 1993 asset acquisition meant that any projection of capital-related costs could be very inaccurate for individual hospitals. We concluded that a cross-sectional impact analysis using the usual prospective payment system hospital groupings (for example, urban or rural, teaching or nonteaching, etc.) that would rely on individual hospital projections from prior cost reports would not be representative. Instead, in the August 30, 1991 final rule we presented the estimated impact of the capital prospective payment system using the results of the FY 1992 actuarial model that distinguished between high capital cost and low capital cost hospitals only.

Although we integrated hospital-specific data into the proposed FY 1993 actuarial model, the data were still sufficiently limited that we continued to present only the effects of the FY 1993 capital payment policies by payment methodology category in the impact analysis for the June 4, 1992 proposed rule. In Table IV of this final rule, we continue to present the redistributive effects that are expected to occur between "hold-harmless" hospitals and "fully prospective" hospitals in FY 1993. In addition, we believe that we have now integrated sufficient hospital-specific information into our actuarial model to project with more confidence the impact of the FY 1993 capital payment policies by the usual prospective payment system hospital groupings. We caution that while we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system for some hospitals and base year cost report data for most of the remaining hospitals, we need to randomly generate the change in old capital costs, the new capital ratio, and obligated costs for individual hospitals. This means that we continue to be unable to accurately predict an individual hospital's FY 1993 capital costs; however, with the more recent data on the experience to date under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings. If a grouping has a limited number of hospitals, the results may not be representative of the actual hospitals in the grouping. We combined these small groupings with other hospital groupings where appropriate. We present the transition payment methodology by hospital grouping in Table V. In Table VI we present the results of the cross-sectional analysis using the results of our actuarial model. This table presents aggregate impact of the FY 1993 payment policies. In Table VII, we present a simulation of payments based on 100 percent of the Federal rate. This simulation shows the average percentage change in the Federal rate attributable to the updated rate and changes in payment adjustments.

B. Projected Impact By Transition Payment Methodology

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1992 through FY 1993 using an actuarial model. The 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, 1991 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	8.56
1993	9.58

- The Medicare case mix index will increase by 2 percent annually.
- The Federal capital rate as well as the hospital-specific rate is updated by the two-year moving average increase in Medicare capital costs per case, net of case-mix change, between FY 1988 and FY 1990. The FY 1993 update is 6.07 percent (see Addendum, part III).
- Consistent with the budget neutrality constraints provided in section 4001(b) of Pub. L. 101-508, estimated aggregate Medicare payments for capital costs in FY 1993 equal 90 percent of total Medicare inpatient

capital costs. The budget neutrality adjustment factor is 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 by payment category. 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 is paid under the fully prospective payment methodology in FY 1992. A high cost hospital is a hospital that, based on its initial hospital-specific rate, is 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	65	60	44	47
High Cost Hospital	35	40	56	53

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	9	91
1993	0.7	5	95

Assuming no behavorial changes in capital expenditures, Table IV displays the percentage change in payments from FY 1992 to FY 1993 using the above described actuarial model.

TABLE IV.—IMPACT OF FY 1993 CHANGES ON PAYMENTS PER DISCHARGE

	No. of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
FY 1992									
Low Cost Hospitals	3,474	5,814,013	$64.55	10.03	$393.49	$3.38	$3.12	$464.54	
Fully Prospective	3,090	5,334,882	64.77	10.00	397.93		2.57	465.26	
Rebase—Fully Prospective	362	446,832	59.42	10.00	368.97		9.38	437.77	
Rebase—100% Federal Rate	2	2,949	523.34	100.00				523.34	
Rebase—Hold Harmless	20	29,350	57.32	9.31		670.16	8.34	735.82	
High Cost Hospitals	1,886	3,849,477	323.54	48.50		481.71	6.62	811.86	
100% Federal Rate	556	1,406,141	696.94	100.00				696.94	
Hold Harmless	1,330	2,443,336	108.64	16.72		758.94	10.42	878.00	
Total Hospitals	5,360	9,663,490	167.72	25.69	236.74	193.93	4.51	602.90	
FY 1993									
Low Cost Hospitals	3,474	5,814,013	$132.77	20.12	$358.92	$3.57	$9.11	$504.37	8.57
Fully Prospective	3,090	5,334,882	132.89	20.00	362.96		6.10	501.95	7.89
Rebase—Fully Prospective	362	446,832	121.89	20.00	336.73		42.28	500.90	14.42
Rebase—100% Federal Rate	1	1,040	528.00	100.00				528.00	0.89
Rebase—Hold Harmless	21	31,259	253.89	40.23		663.64	48.80	966.33	31.33
High Cost Hospitals	1,886	3,849,477	355.36	51.97		476.68	13.68	845.72	4.17
100% Federal Rate	541	1,353,931	696.80	100.00				696.80	−0.02
Hold Harmless	1,345	2,495,546	170.11	25.14		735.30	21.10	926.51	5.52

TABLE IV.—IMPACT OF FY 1993 CHANGES ON PAYMENTS PER DISCHARGE—Continued

	No. of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold-harmless payment	Exceptions payment	Total payment	Percent change
Total Hospitals	5,360	9,663,490	221.44	33.07	215.95	192.03	10.93	640.35	6.21

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 higher than 92.85 percent of reasonable costs. Taking the phase-in of the capital prospective payment system into account, this represents excessive capital payments of approximately $90 million. To achieve budget neutrality in FY 1993, we estimate there should be an aggregate 6.2 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 8.6 percent, and high capital cost hospitals will experience an average increase of 4.2 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 of total capital costs. We estimate average Federal rate payment percentage for those hospitals receiving a hold-harmless payment for old capital will increase from 16.7 percent to 25.1 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will change only marginally.

We are making no changes in our exceptions policies in FY 1993. As a result, the minimum payment levels will be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more 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. As a result, exceptions will increase from 0.7 percent to 1.7 percent total capital payments. 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	294	50.1
High Capital Cost	235	49.9
Total	529	100.0

C. Distribution of Hospitals By Payment Methodologies

Table V presents a cross-sectional summary of hospitals by capital prospective payment methodology. This distribution is not generated by our actuarial model. Rather, it is based on the June 30, 1992 update of the Provider-Specific File used by intermediaries to make interim capital payments using the PRICER program, audit information reported by intermediaries, and cost report data from fiscal years 1988, 1989, and 1990.

As we explain in appendix B, we were not able to determine a hospital specific rate for 26 of the 5,386 hospitals in our data base. Consequently, the payment methodology distribution is based on 5,360 hospitals. In the June 4, 1992 proposed rule, we were able to present interim capital payment data from our Provider Specific File for only 44 percent of the hospitals. Therefore, the data in Table V of the proposed rule was not fully representative of the payment methodologies that will be applicable to the full set of hospitals. In the impact analysis for this final rule, the data from 5,360 should be fully representative of the payment methodologies that will be applicable to hospitals.

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 analysis 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.

The distribution of hospitals 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 grouping is under the fully prospective payment methodology and under the hold-harmless methodology. The information is based on the 5,360 hospitals with interim capital payment data on our data base.

TABLE V.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	5,360	25.5	10.1	64.4
Large urban areas (populations over 1 million)	1,464	33.4	13.3	53.3
Other urban areas (populations of 1 million or fewer)	1,410	30.4	13.4	56.2
Rural areas	2,486	18.1	6.4	75.5
Urban hospitals	2,874	31.9	13.3	54.8
0–99 beds	665	32.3	8.3	59.4
100–199 beds	868	39.3	12.2	48.5
200–299 beds	611	30.8	16.9	52.4
300–499 beds	537	24.6	15.8	59.6
500 or more beds	193	21.2	17.6	61.1
Rural hospitals	2,486	18.1	6.4	75.5
0–49 beds	1,228	13.2	3.5	83.3
50–99 beds	761	21.3	7.6	71.1
100–149 beds	259	24.7	13.9	61.4
150–199 beds	123	26.8	7.3	65.9
200 or more beds	115	24.3	11.3	64.3
By Region:				
Urban by Region	2,874	31.9	13.3	54.8
New England	172	15.7	8.7	75.6
Middle Atlantic	450	19.8	16.2	64.0
South Atlantic	419	40.8	13.8	45.3
East North Central	476	21.2	13.4	65.3
East South Central	168	46.4	11.9	41.7
West North Central	183	27.3	13.7	59.0
West South Central	353	56.7	16.7	26.6
Mountain	112	38.4	12.5	49.1
Pacific	494	28.9	10.7	60.3
Puerto Rico	47	31.9	4.3	63.8
Rural by Region	2,486	18.1	6.4	75.5
New England	56	7.1	8.9	83.9
Middle Atlantic	91	12.1	7.7	80.2
South Atlantic	340	24.7	6.8	68.5
East North Central	344	11.6	6.4	82.0
East South Central	298	25.2	8.7	66.1
West North Central	564	10.6	5.0	84.4
West South Central	394	26.6	8.1	65.2
Mountain	237	16.0	3.0	81.0
Pacific	156	19.9	5.1	75.0
By Payment Classification:				
All hospitals	5,360	25.5	10.1	64.4
Large urban areas (populations over 1 million)	1,618	32.9	13.4	53.6
Other urban areas (populations of 1 million or fewer)	1,475	29.5	12.7	57.8
Rural areas	2,267	17.6	6.0	76.4
Teaching Status:				
Non-teaching	4,321	26.2	9.3	64.5
Resident/bed ratio less than 0.25	809	23.7	13.7	62.5
Resident/bed ratio 0.25 or greater	230	18.7	12.2	69.1
Disproportionate share hospitals (DSH):				
Non-DSH, rural	2,267	17.6	6.0	76.4
Non-DSH, urban, fewer than 100 beds	842	31.1	8.3	60.6
Urban DSH, 100 beds or more	2,251	31.4	14.9	53.8
Urban teaching and DSH:				
Both teaching and DSH	933	22.2	14.1	63.7
Teaching and no DSH	55	29.1	5.5	65.5
No teaching and DSH	1,318	37.9	15.4	46.7
No teaching and no DSH	787	31.3	8.5	60.2
Rural Hospital Types:				
Non-special status hospitals	1,034	16.0	6.8	77.3
RRC	180	23.9	13.3	62.8
SCH	561	22.8	2.9	74.3
Medicare-dependent hospitals (MDH)	443	11.5	5.2	83.3
SCH or MDH	1,050	18.1	4.0	77.9
Type of Ownership:				
Voluntary	3,186	24.0	11.7	64.2
Proprietary	729	52.8	13.0	34.2
Government	1,445	14.9	5.1	80.1
Medicare Utilization as a Percent of Inpatient Days:				
0–25	293	27.3	8.2	64.5
25–50	1,782	28.3	11.3	60.3
50–65	2,201	23.3	9.9	66.8
Over 65	865	20.7	8.7	70.6

The distribution of hospitals by capital payment methodology is somewhat different than the distribution of low and high capital cost hospitals in the August 30, 1991 final rule. In the August 1991 final rule, we anticipated that 71 percent of hospitals would receive payment on a fully prospective basis. Table V indicates that 64.4 percent of hospitals are fully prospective. 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 75 percent of rural hospitals and 80 percent of governmental hospitals are paid under the fully prospective payment methodology compared to an average of 64.4 percent of all hospitals. In contrast, only 34.2 percent of the proprietary hospitals are being paid under the fully prospective payment methodology. This is the only group of hospitals that has a majority of hospitals paid under the hold harmless methodology. As we noted in the August 30, 1991 final rule (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.

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 1993 actuarial model to estimate the potential impact of the FY 1993 operating and capital payment policy changes on total capital payments per case using a universe of 5,360 hospitals. The individual hospital payment parameters are taken from the best available data, including: FY 1991 MEDPAR bills, the June 30, 1992 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. It also presents the portion of the total percentage change in payments that can be attributed to Federal rate changes. Federal rate changes include the 0.41 percent increase in the Federal rate, a 2.0 percent increase in case mix, changes in the adjustments to the Federal rate (e.g., wage index corrections), and reclassifications by the Medicare Geographic Classification Review Board. The residual increase over the portion attributable to Federal rate changes can be attributed to the effects of transition changes, which include: the change from 10% to 20% in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold harmless hospitals, changes in old capital (e.g., obligated capital coming on line), redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) payment classification, and (3) payment region.

The simulation results show that, on average, payments per case can be expected to increase by 6.2 percent in FY 1993. The results also show that a 0.7 percent increase is attributable to Federal rate changes, leaving 5.5 percent attributable to the effects of transition changes and budget neutrality.

By geographic location, rural hospitals can be expected to experience a higher rate of increase than urban hospitals (6.7 percent compared to 6.1 percent). Urban hospitals will gain slightly more than rural hospitals (0.7 percent compared to 0.6 percent) from the Federal rate changes. However, rural hospitals will gain more than urban hospitals (6.1 percent to 5.4 percent) from the effects of transition changes. Since more rural hospitals than urban hospitals (75.5 percent to 54.8 percent) are paid on a fully prospective basis, the greater gain of rural hospitals from the Federal rate changes must result to some degree from the increase in the percentage of the Federal rate portion.

By region, rural hospitals of the Pacific region have the highest rate of increase (8.5 percent, of which 0.5 percent is due to Federal rate changes and 8.0 percent to the effects of transition changes). Urban hospitals of the West South Central region will have the lowest rate of increase (4.0 percent, of which 0.8 percent is due to Federal rate changes and 3.2 percent is due to effects of transition changes).

By type of ownership, government hospitals are projected to have the highest rate of increase (8.5 percent, of which 0.8 percent is due to Federal rate changes and 7.7 percent to the effects of transition changes). Significantly, government hospitals, which have the highest percentage of hospitals paid under the fully prospective methodology (80.1 percent) by type of ownership, can be expected to do much better than proprietary hospitals, which have the highest percentage of hospitals paid hold-harmless (52.8 percent). Payments to proprietary hospitals will increase 4.8 percent and payments to voluntary hospitals will increase 6.1 percent.

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 a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. 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 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.

Reclassified hospitals as a whole can be expected to realize a 6.8 percent increase, of which 0.9 percent is attributable to the Federal rate changes and 5.9 percent is attributable to the effects of transition changes. Nonreclassified hospitals will gain less than reclassified hospitals overall (6.1 percent). While nonreclassified hospitals will gain slightly less (0.7 percent to 0.9 percent) than reclassified hospitals from the Federal rate changes, they will gain significantly less (5.4 percent to 5.9 percent) than the reclassified hospitals from the effects of transition changes. In other words, more (0.5 percent to 0.2 percent) of the greater gain for reclassified hospitals derives from the effects of transition changes than from the Federal rate changes (including the effects of their reclassifications). This result is not unexpected because (1) the comparison is to FY 1992 payments, which already reflect the results of reclassification for most hospitals and (2) a higher percentage of reclassified hospitals are paid under the fully prospective payment methodology. Hospitals reclassified by the Medicare Geographic Classification Review Board only during FY 1993 can be expected to realize a much larger increase (7.8 percent total) than other reclassified hospitals. Of that 7.8 percent aggregate increase for these hospitals, 1.8 percent can be attributed to Federal rate changes, and 6.0 percent is attributable to transition effects. Hospitals reclassified during both FY

1992 and FY 1993 can be expected to experience a 6.4 percent increase, of which 0.5 percent is attributable to Federal rate changes and 5.9 percent is attributable to the effects of transition changes. Hospitals reclassified during FY 1992 only are expected to realize a much smaller increase (3.4 percent, net of a 0.1 percent decrease from Federal rate changes) than other reclassified hospitals in FY 1993 as they lose the higher payments from their geographic reclassification during FY 1992.

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1992 Payments Compared to FY 1993 Payments]

	No. of hospitals	Average FY 1992 payments/ case	Average FY 1993 payments/ case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	5,360	603	640	6.2	0.7
Large urban areas (populations over 1 million)	1,464	711	757	6.4	0.7
Other urban areas (populations of 1 million or fewer)	1,410	605	640	5.7	0.8
Rural areas	2,486	402	429	6.7	0.6
Urban hospitals	2,874	660	700	6.1	0.7
0–99 beds	665	557	587	5.4	0.5
100–199 beds	868	618	656	6.1	0.6
200–299 beds	611	639	678	6.1	0.7
300–499 beds	537	653	692	5.9	0.7
500 or more beds	193	781	833	6.7	0.8
Rural hospitals	2,486	402	429	6.7	0.6
0–49 beds	1,228	282	308	9.0	0.5
50–99 beds	761	373	401	7.4	0.6
100–149 beds	259	449	474	5.6	0.7
150–199 beds	123	432	465	7.6	0.5
200 or more beds	115	498	522	4.9	0.7
By Region:					
Urban by Region	2,874	660	700	6.1	0.7
New England	172	593	638	7.5	0.9
Middle Atlantic	450	654	694	6.1	0.9
South Atlantic	419	674	714	5.9	0.7
East North Central	476	608	652	7.2	0.6
East South Central	168	606	639	5.5	0.9
West North Central	183	651	684	5.0	0.5
West South Central	353	789	821	4.0	0.8
Mountain	112	697	729	4.6	0.6
Pacific	494	715	769	7.6	0.6
Puerto Rico	47	257	274	6.5	0.4
Rural by Region	2,486	402	429	6.7	0.6
New England	56	395	423	7.1	0.6
Middle Atlantic	91	397	428	7.9	0.7
South Atlantic	340	447	468	4.7	0.6
East North Central	344	380	411	8.2	0.7
East South Central	298	384	405	5.4	0.6
West North Central	564	348	373	7.4	0.7
West South Central	394	402	431	7.3	0.9
Mountain	237	449	480	7.0	0.2
Pacific	156	487	528	8.5	0.5
By Payment Classification:					
All hospitals	5,360	603	640	6.2	0.7
Large urban areas (populations over 1 million)	1,618	701	746	6.4	0.7
Other urban areas (populations of 1 million or fewer)	1,475	595	629	5.7	0.7
Rural areas	2,267	394	421	6.9	0.6
Teaching Status:					
Non-teaching	4,321	546	577	5.7	0.7
Resident/bed ratio less than 0.25	809	632	672	6.4	0.8
Resident/bed ratio 0.25 or greater	230	859	925	7.7	0.8
Disproportionate share hospitals (DSH):					
Non-DSH, rural	2,267	394	421	6.9	0.6
Non-DSH, urban, fewer than 100 beds	842	533	563	5.6	0.5
Urban DSH, 100 beds or more	2,251	662	703	6.1	0.7
Urban teaching and DSH:					
Both teaching and DSH	933	693	740	6.8	0.8
Teaching and no DSH	55	614	653	6.3	0.4
No teaching and DSH	1,318	630	663	5.4	0.7
No teaching and no DSH	787	529	558	5.6	0.5
Rural Hospital Types:					
Non special status hospitals	1,034	345	371	7.5	0.6
RRC	180	476	504	5.9	0.8
SCH	561	409	439	7.4	0.3
Medicare-dependent hospitals (MDH)	443	304	327	7.8	0.7
SCH or MDH	1,050	390	418	7.1	0.4

TABLE VI.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1992 Payments Compared to FY 1993 Payments]

	No. of hospitals	Average FY 1992 payments/ case	Average FY 1993 payments/ case	All changes	Portion attributable to Federal rate change
Hospitals Reclassified by the Medicare Geographic Classification Review Board					
Reclassification Status During FY92 and FY93:					
Reclassified During Both FY92 and FY93	849	504	536	6.4	0.5
Reclassified During FY93 Only	344	560	604	7.8	1.8
Reclassified During FY92 Only	80	519	536	3.4	−0.1
FY93 Reclassifications:					
All Reclassified Hospitals	1,193	521	557	6.8	0.9
All Nonreclassified Hospitals	4,117	628	666	6.1	0.7
All Urban Reclassified Hospitals	370	603	647	7.2	1.1
Urban Nonreclassified Hospitals	2,504	669	709	6.0	0.7
All Reclassified Rural Hospitals	823	442	470	6.4	0.8
Rural Reclassified Hospitals	1,613	354	379	7.1	0.4
Other Reclassified Hospitals:					
(Section 1886(D)(8)(B))	50	447	477	6.6	0.6
Type of Ownership:					
Voluntary	3,186	612	649	6.1	0.7
Proprietary	729	712	746	4.8	0.8
Government	1,445	476	517	8.5	0.8
Medicare Utilization as a Percent of Inpatient Days:					
0–25	293	648	698	7.7	0.6
25–50	1,782	665	707	6.3	0.8
50–65	2,201	553	587	6.2	0.7
Over 65	865	549	578	5.2	0.7

E. Cross-Sectional Analysis of Changes in the Federal Rate

The analysis in Table VII examines the impact of following changes in the Federal Rate set forth in this final rule—

- The effects of the annual reclassification of DRGs and the recalibration of the DRG weights required by section 1886(d)(4)(c) of the Act (column 4).
- The effects of hospital reclassifications by the MGCRB for FY 1993 (column 5).
- The net effect of outlier changes (column 6), that is, the additional outlier payments that we estimate will be made during FY 1993 compared to our estimate of FY 1992 outlier payments, the increase in outlier payment levels, and the effect of the outlier payment changes (using a marginal cost factor of .55 and the arithmetic mean to calculate day outlier payments).
- The effects of all changes, including those separately displayed in columns 4, 5, and 6; reflects update and budget neutrality factors.

To estimate the impact of DRG changes, changes due to geographic reclassification, and outlier changes, we simulated payments based on 100% of the Federal rate. Thus, the simulation in Table VII is not representative of changes in capital prospective payment system payments from FY 1992 to FY 1993. Rather, it reflects the percentage change in payments for hospitals receiving 100% of the Federal rate. For other hospitals, it reflects the percentage change in the Federal rate portion of the payments, holding the proportion of the Federal rate payment constant. Unlike the Federal rate payment change in Table VI, the analysis in Table VI does not include any increase in Federal rate payments attributable to anticipated increases in the case-mix index.

In order to present the effects of the separate policy changes displayed in columns 4, 5, and 6, we added each change incrementally, so that the percentages in each column represent the differences in payment relative to the previous column. The baseline for comparison is an FY 1993 system absent any of the changes above. For example, column 4 displays the impact of DRG recalibration and reclassification relative to estimated FY 1993 payments absent these changes. Similarly, column 5 examines the impact of the changes resulting from geographic reclassifications over and above the changes resulting from the DRG reclassifications and recalibration. Column 6 displays the impact of the outlier changes after accounting for the DRG recalibration and geographic reclassification changes. Column 7 displays the combined changes from the previous columns, as well as the effects of the update and budget neutrality factors. This column compares estimated FY 1993 Federal rate payments to estimated FY 1992 Federal rate payments. Thus, the last column is the only one which reflects the effects of all quantifiable policy changes on simulated FY 1993 Federal rate payments.

The table shows that Federal rate payments can be expected to increase 2.0 percent overall prior to consideration of any increase in the case-mix index. Of this total increase, 1.4 percent is due to the outlier changes. DRG recalibration and geographic reclassifications produce no overall effect. The residual over and above the 1.4 percent increase due outlier changes is mostly due to the 0.41 percent increase in the Federal rate.

The table also shows the distributional effects of the changes in Federal rate payments from DRG recalibration, changes due to the geographic adjustment factor and reclassifications, and changes in the outlier payment policy. The DRG changes are expected to produce only minimal effects on the distribution of Federal rate payments. The highest gain from recalibration is projected at 0.4 percent (for urban Middle Atlantic hospitals). The largest loss from recalibration is projected at −0.3 percent (for four categories of hospitals).

The geographic adjustment factor and reclassification changes are in relation to the FY 1992 reclassifications. They are expected to produce only minor effects (from −0.6 percent to 0.5 percent) outside the categories of reclassified hospitals. Among reclassified hospitals, those reclassified during FY 1993 only are expected to experience the largest increase (4.4 percent) from the effects of reclassification of any category.

Hospitals reclassified only during FY 1992 will experience the largest decline (−3.5 percent) from the effects of reclassification. That decline is attributable to the loss of the higher payments from the reclassification in FY 1992. The small (−0.6 percent) decline in payments for hospitals reclassified both during FY 1992 and FY 1993 is due to the effects of the budget neutrality adjustment for changes in the geographic adjustment factor and a decrease in their geographic adjustment factor values. These changes are largely attributable to the additional geographic reclassifications in FY 1993. Reclassified hospitals as a group are expected to experience a 1.0 percent increase from the effects of reclassifications. Nonreclassified hospitals as a group will experience a decline of −0.3 percent from the effects of reclassifications. Relatively more urban hospitals were reclassified for the first time for FY 1993. As a result, urban reclassified hospitals will experience a larger increase in payments (1.4 percent) than rural reclassified hospitals (0.5 percent).

Reclassified hospitals will also experience higher than average overall Federal rate increases. In fact, hospitals reclassified during FY 1993 only will experience the highest overall Federal rate increase (6.4 percent) of any category. All reclassified hospitals will receive on average a higher overall increase (2.7 percent) than all nonreclassified hospitals (1.8 percent). As a group, therefore, reclassified hospitals are projected to do better than nonreclassified hospitals not only from the effects of reclassifications, but also from the effects of other changes to the Federal rate.

Urban hospitals will experience larger increases in payments than rural hospitals from the outlier changes (1.5 percent to 0.7 percent). This is because rural hospitals have fewer outliers than urban hospitals; therefore, rural hospitals will not receive as much benefit from the increase in outlier payments. The lower projected rate of increase for urban hospitals in Region II (Middle Atlantic) compared to other urban hospitals is also explained by the fact that urban hospitals in Region II have proportionately more day outliers than other hospitals. The shift in payments from day outliers to cost outliers therefore has a greater impact on them.

TABLE VII.—HEALTH CARE FINANCING ADMINISTRATION 1993 FINAL CAPITAL PAYMENT SIMULATION BY GEOGRAPHIC LOCATION

	(1) Number of hospitals	(2) Payment per case FY92	(3) Payment per case FY93	(4) Recalibration change	(5) reclassification change	(6) Sum of outlier changes	(7) All changes
All hospitals	5,386	632	644	0.0	0.0	1.4	2.0
Large urban areas (populations over 1 million)	1,474	735	749	0.0	−0.1	1.4	2.0
Other urban areas (populations of 1 million or fewer)	1,422	626	639	0.0	0.1	1.5	2.2
Rural areas	2,490	447	453	−0.1	0.1	0.7	1.3
Urban hospitals	2,896	682	696	0.0	0.0	1.5	2.1
0- 99 beds	682	501	510	−0.1	0.0	1.3	1.8
100-199 beds	872	593	607	0.1	0.1	1.5	2.3
200-299 beds	612	645	660	0.0	0.1	1.5	2.2
300-499 beds	537	710	724	0.0	−0.1	1.5	2.0
500 or more beds	193	838	855	−0.1	0.0	1.5	2.0
Rural hospitals	2,490	447	453	−0.1	0.1	0.7	1.3
0- 49 beds	1,232	374	376	−0.2	0.1	0.2	0.7
50- 99 beds	761	415	420	−0.2	0.1	0.5	1.1
100-149 beds	259	465	471	−0.1	0.0	0.9	1.4
150-199 beds	123	471	478	−0.1	0.1	0.7	1.4
200 or more beds	115	531	540	0.0	0.1	1.1	1.8
Urban by region:							
New England	172	714	724	−0.2	0.3	0.8	1.5
Middle Atlantic	456	730	743	0.4	0.0	0.7	1.7
South Atlantic	421	657	674	−0.1	0.0	2.0	2.6
East North Central	476	666	678	−0.1	−0.1	1.4	1.8
East South Central	168	593	609	0.1	−0.1	2.2	2.8
West North Central	183	675	688	−0.1	−0.2	1.5	1.8
West South Central	357	629	651	0.1	0.3	2.4	3.4
Mountain	113	687	704	−0.2	−0.1	2.1	2.5
Pacific	501	769	782	−0.3	0.0	1.5	1.8
Puerto Rico	49	277	282	0.2	−0.2	1.1	1.7
Rural by region:							
New England	56	519	522	−0.2	−0.4	0.6	0.7
Middle Atlantic	93	496	499	0.0	−0.3	0.3	0.6
South Atlantic	340	471	478	0.0	−0.3	1.1	1.4
East North Central	344	450	456	−0.1	0.3	0.6	1.4
East South Central	298	403	407	0.0	−0.2	0.7	1.1
West North Central	564	416	421	−0.2	0.5	0.4	1.4
West South Central	396	410	417	−0.1	0.5	0.8	1.7
Mountain	237	466	470	−0.2	−0.4	0.8	0.9
Pacific	156	537	545	−0.2	0.5	0.7	1.6
Puerto Rico	6	219	220	−0.1	−0.3	0.4	0.6
All hospitals	5,386	632	644	0.0	0.0	1.4	2.0
Large urban areas (populations over 1 million)	1,628	723	739	0.0	0.0	1.4	2.1
Other urban areas (populations of 1 million or fewer)	1,487	618	631	−0.1	0.0	1.5	2.1
Rural areas	2,271	441	446	−0.1	0.0	0.7	1.2
Teaching status:							
Non-teaching	4,345	546	557	0.0	0.1	1.4	2.1
Resident/bed ratio less than 0.25	811	692	704	0.0	−0.1	1.3	1.8
Resident/bed ratio 0.25 or greater	230	963	983	0.0	0.1	1.4	2.1
Disproportionate share hospitals (DSH):							
Non-DSH, rural	2,271	441	446	−0.1	0.0	0.7	1.2
Non-DSH, urban fewer than 100 beds	859	493	502	−0.1	0.1	1.2	1.8
Urban DSH 100 beds or more	2,256	689	704	0.0	0.0	1.5	2.1

TABLE VII.—HEALTH CARE FINANCING ADMINISTRATION 1993 FINAL CAPITAL PAYMENT SIMULATION BY GEOGRAPHIC LOCATION—Continued

	(1) Number of hospitals	(2) Payment per case FY92	(3) Payment per case FY93	(4) Recalibration change	(5) reclassification change	(6) Sum of outlier changes	(7) All changes
Urban teaching and DSH:							
Both teaching and DSH	934	763	778	0.0	−0.1	1.4	1.9
Teaching and no DSH	56	568	578	−0.3	−0.2	1.7	1.8
No teaching and DSH	1,322	610	624	0.0	0.1	1.7	2.4
No teaching and no DSH	803	489	498	−0.1	0.1	1.2	1.8
Rural hospital types:							
Non special status hospitals	1,038	407	410	−0.1	−0.3	0.6	0.8
RRC	180	508	517	−0.1	0.4	0.9	1.9
SCH	561	424	427	−0.1	−0.3	0.6	0.8
Medicare-dependent hospitals (MDH)	443	376	380	−0.2	0.3	0.4	1.1
SCH and RRC	46	513	520	0.0	−0.1	0.8	1.4
SCH or MDH	1,050	426	431	−0.1	−0.1	0.6	1.0
Type of ownership:							
Voluntary	3,212	650	662	0.0	0.0	1.3	1.8
Proprietary	729	596	614	0.0	0.0	2.4	3.0
Government	1,445	568	578	−0.1	0.2	1.1	1.9
Medicare utilization as a percent of inpatient days:							
0–25	293	752	765	0.2	0.0	1.1	1.8
25–50	1,782	698	712	−0.1	0.0	1.5	2.1
50–65	2,201	587	598	0.0	0.0	1.3	1.9
Over 65	865	536	546	0.0	0.0	1.3	1.8
Unknown	245	651	667	0.3	0.5	1.0	2.5
By Payment Classification							
Hospitals reclassified by the Medicare Geographic Classification Review Board reclassification status during FY92 and FY93							
Reclassified during both FY92 and FY93	849	564	569	0.0	−0.6	1.0	1.0
Reclassified during FY93 only	344	596	634	0.1	4.4	1.1	6.4
Reclassified during FY92 only	80	568	559	−0.1	−3.5	1.3	−1.6
FY93 reclassifications:							
All reclassified hospitals	1,193	574	589	0.0	1.0	1.0	2.7
All nonreclassified hospitals	4,143	650	661	0.0	−0.3	1.5	1.8
Urban reclassified hospitals	370	663	685	0.1	1.4	1.2	3.4
Urban nonreclassified hospitals	2,526	685	698	0.0	−0.2	1.5	1.9
Rural reclassified hospitals	823	484	493	−0.1	0.5	0.8	1.8
Rural nonreclassified hospitals	1,617	400	403	−0.1	−0.5	0.6	0.6
Other reclassified hospitals (section 1886(D)(8)(B))	50	510	519	−0.1	0.1	1.1	1.7

Appendix B: Technical Appendix on the Capital Acquisition Model and Budget Neutrality Adjustment

Section 1886(g)(1) of the Act 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 more recent data include the June 30, 1992 update of the Hospital-Specific File that provides the data items needed by the PRICER program used by the intermediaries to determine interim capital 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 FY 1990 (PPS–7), and data reported by the intermediaries that includes the hospital-specific rate determinations that have been made through June 1992. The June 30, 1992 update to the Provider-Specific File contains data on interim payments under the capital prospective payment system for approximately 60 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 June 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 that will be put in use for patient care services and recognized as old capital each year.

For FY 1993, we are using 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 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 these purposes, 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 life time 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 model first develops the hospital-specific rate. Where available, this rate is taken from the June 1992 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 1989 (PPS–6) as reported on the HCRIS as of June 1992 update. If the hospital-specific rate cannot be determined from the PPS–6 cost reports, the model computes the hospital-specific rate from cost reports beginning in FY 1988 (PPS–5). If still unsuccessful, the model computes the hospital-specific rate from cost reports beginning in FY 1990 (PPS–7). The June 1992 update of HCRIS is used in all cases.

The following table summarizes the data sources for the hospital specific rate.

HOSPITAL SPECIFIC RATE SOURCES BY NUMBER OF HOSPITALS

[In order of selection priority]

Data source	Number of hospitals
Hospital specific file	3,462
Intermediary activity file	1,660
PPS–6 cost reports	216
PPS–5 cost reports	10
PPS–7 cost reports	12
Total	5,360

We were not able to determine a hospital specific rate for 26 of the 5,386 hospitals in the analysis data base. Consequently, we modeled capital budget neutrality using 5,360 hospitals.

The 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 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 capital 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 model. We adjusted the component amounts of total capital costs (old capital, obligated capital, and new capital) proportionately so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

As a refinement, we have independently projected total capital costs per discharge for short term care acute care hospitals that do not have Medicare waivers. (The waiver hospitals are in Maryland, and the Finger Lakes area of New York.) We compared the Medicare inpatient capital per case for short-term acute care hospitals subject to the capital prospective payment system to all short term acute care hospitals (including the waiver hospitals for FY 1990. Excluding the waiver hospitals increased the capital cost per case by 0.7 percent. The rate of increase in capital cost per case with, or without the waiver hospitals is practically identical for FY 1988, FY 1989, and FY 1990. Consequently, we can safely assume that waiver status has negligible impact on average rates of change in capital costs.

To summarize, the model integrates actual data with randomly generated amounts developed from the results of the capital acquisition model. For purposes of aggregate capital, 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 payments parameters (for example, the case-mix index and the geographic adjustment factor). In the model, we now use the actual payment parameters that are applicable to the specific hospital.

To project capital payments, the 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 FY 1992 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 FY 1993 DRGs and relative weights published in this final rule. 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. 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 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 FY 1992 geographic adjustment factor to aggregate Federal rate payments based on the FY 1993 relative weights and the FY 1993 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 .9980 should be applied to the FY 1993 Federal rate.

The methodology used to determine the recalibration and geographic (DRG/GAF) 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 DRG/GAF budget neutrality adjustment factor for changes in the geographic adjustment factor (including geographic reclassification) 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 DRG/GAF budget neutrality adjustment factor, we used the 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 to 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 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 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 estimated 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 and 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. In this regard, we note that in making these projections we have assumed that the DRG/GAF adjustment factor will remain at .9980 because we do not have sufficient information to estimate the change that will occur in the factor in FY 1994. In this final rule, we are adding a new requirement for individual hospital wage index reclassification that we estimate will result in 75 percent of the individual hospitals that qualified for reclassification in FY 1993 no longer qualifying in FY 1994. Although we expect that the fewer reclassification will result in a positive budget neutrality adjustment, we cannot estimate the magnitude of the adjustment at this time for two reasons. First, we do not know how many of the hospitals that no longer qualify for individual wage reclassification will qualify for a group reclassification for purposes of both the wage index and the standardized amount. Second, we do not know the effect that fewer reclassifications, coupled with the new wage data and revised labor market areas, will have on the hospital wage index and geographic adjustment factor.

The projections are as follows:

Fiscal year	Increase in cost per discharge [1]	Update factor	Exceptions reduction factor	Budget Neutrality factor	Federal rate (after outlier reduction)
1992	6.43	N/A	0.9813	0.9602	415.59
1993	7.43	6.07	.9756	.9162	417.29 [2]
1994	8.48	5.19	.9379	.9367	431.43
1995	8.44	5.28	.9000	.9597	446.55
1996	8.47	6.93	.9000	N/A	497.55
1997	8.51	7.95	.9000	N/A	537.11

[1] NOTE: Adjusted for estimated 2.0 percent annual increase in case-mix index.
[2] NOTE: Includes the DRG/GAF adjustment factor of 0.9980 and the change in the outlier adjustment from 0.9497 in FY 1992 to 0.9495 in FY 1993. Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Comment: A few commenters expressed concern about the sensitivity of estimating per case capital payment rates to the assumptions used in the capital projection model. These commenters claim that there are clear differences between the model and actual data for factors such as the amount of obligated capital, and number of hold-harmless hospitals, exceptions, and outlier payments.

Response: It is important to draw a distinction between the model, and the assumptions used by the model. The model must necessarily be sensitive to changes in assumptions. As information becomes available, we refine our assumptions, and the model responds appropriately. Since we are setting budget neutrality prospectively, we must make assumptions about future changes, and about factors which have not been completely determined, or which have not yet been reported to us.

As stated in the June 4, 1992 proposed rule and repeated in the above description of the model, we modified the FY 1992 capital acquisition model to incorporate actual data to the maximum extent possible. As more data become available, we will incorporate this additional data. Until audits and hospital-specific rate determinations and obligated capital have been completed, it is not possible to improve our estimates of obligated capital, exceptions and outlier payments and the number of hold-harmless hospitals.

We have confidence in our model. It is the only model that is constrained to historic and projected capital levels, and reacts in an appropriate manner to all the provisions and factors in the capital prospective payment system. We are monitoring emerging experience, and we will continue to modify our assumptions in conformance with the experience. We will also continue to incorporate actual data to the maximum extent possible.

Comment: Several commenters requested that HCFA increase efforts to assure that funds set aside for exceptions and outlier payments are paid to hospitals.

Response: As part of the rate-setting process, we estimate anticipated exceptions payments and reduce the Federal rate and hospital-specific rate by the estimated value of the exceptions payments. (In addition, the Federal rate is reduced by the estimated value of outlier payments.) There are, however, no funds "set aside" for these payments. As with the budget neutrality adjustment, the estimates are based on the best data available at the time the rates are established and actual payments may be more or less than the estimated amounts. Although capital outlier payments are lower than we estimated when the FY 1992 capital rates were established, we estimate total capital payments will exceed 90 percent of what would have been payable on a reasonable cost basis. Based on our current estimates, capital payments will equal 92.85 percent of reasonable costs. Taking the phase-in of the capital prospective payment system into account, this represents excessive capital payments of approximately $90 million. We do not make retroactive adjustments for any of our estimates. Instead, we are refining our FY 1993 estimates for outliers and exceptions payments and the budget neutrality adjustment factor on the basis of the more recent data. We will continue to refine our estimates for future rate-setting as more recent data become available.

Commenter: A commenter requested that we separately report the DRG recalibration and geographic adjustment factor budget neutrality factors.

Response: We determine a joint budget neutrality adjustment factor because of potential interactive effects between the DRG changes and the geographic adjustment factor. However, we have computed separate factors to determine the magnitude of each on the combined adjustment factor. We first determined that to achieve budget neutrality for the changes in the geographic adjustment factor using the FY 1992 DRG weights the budget neutrality adjustment factor be .9984. We then compared what aggregate Federal rate payments would be based on the FY 1992 DRG relative weights and the FY 1993 geographic adjustment factor to aggregate Federal rate payments based on the FY 1993 relative weights and geographic adjustment factor with the 0.9984 adjustment factor applied in both cases. 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 DRG weights, a further budget neutrality adjustment factor of 0.9996 in addition to the 0.9984 should be applied to the FY 1993 Federal rate. This yields a total adjustment of 0.9980.

Appendix C: Recommendation of Update Factors for Rates of Payment for Hospital Inpatient Operating Costs

I. Background

Several provisions of the Social Security Act (the Act) address the setting of update factors for services furnished in FY 1993 by hospitals subject to the prospective payment system and hospitals excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(VIII) of the Act, as enacted by Public Law 101–508, 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 updating the average standardized amounts, the hospital-specific rates and the target rate-of-increase limits for hospitals excluded from the prospective payment system as provided for in section 1886(b)(3)(B) of the Act, as set forth above.

Sections 1886(e)(2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1 of each year an update factor for the next fiscal year that takes into account changes in the market basket index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. As required by section 1886(e)(5) of the Act, we published the recommended FY 1993 update factors as appendix D of the proposed rule (57 FR 23835).

II. Secretary's Final Recommendations for Updating the Prospective Payment System for Operating Costs Standardized Amounts

We received several public comments concerning our proposed recommendation. After consideration of the recommendations presented by the commenters, we have decided that our final recommendation will be the same as our proposed recommendation. That is, we are recommending that the operating standardized amounts be increased by an amount equal to the market basket percentage 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. Based on the currently forecasted market basket increase of 4.1 percent, the recommended updates are 2.55 percent for hospitals in urban areas and 3.55 percent for hospitals in rural areas.

We are recommending that the hospital-specific rate applicable to sole community hospitals be updated by an amount equal to the market basket percentage increase minus 1.55 percentage points, or 2.55 percent. With the exception of the higher update for the rural standardized amount, we believe that the considerations used to develop our update recommendation for the standardized amounts are also applicable to the hospital-specific rate for sole community hospitals. Our recommendation for a higher update to the rural standardized amount is intended to reduce the differential between the standardized amounts for other urban and rural hospitals, which is not an applicable consideration for hospital-specific rates.

In recommending these increases, we have followed section 1886(e)(4) of the Act, which indicates that we should take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In addition, as required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of ProPAC.

We are recommending an update that is consistent with the Administration's budget proposal that all hospitals receive an update in their payments for FY 1993 based on the current market basket forecast with the adjustments set forth in Public Law 101–508. The latest forecast shows that the FY 1993 rate-of-increase in the hospital market basket will be 4.1 percent.

Our recommendation is supported by our analyses, which measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix. We are recommending that the standardized amounts applicable to urban hospitals and the hospital-specific rates applicable to sole community hospitals be updated in FY 1993 by an amount equal to the market basket percentage increase minus 1.55 percentage points. However, we believe a differential update for the standardized amount applicable to rural hospitals is appropriate in order to phase out the differential between the rural and other urban standardized amounts. Therefore, we are recommending that the rural standardized amount be updated by an additional 1.0 percentage point, for a total update of 3.55 percent (that is, market basket minus 0.55 percentage points).

Comment: Several commenters believe that the hospital market basket does not properly reflect increases in costs faced by hospitals.

Response: The process used to develop the hospital market basket was specifically designed to reflect price increases that are appropriate for efficiently managed hospitals. The methodology and rationale are described in detail in the September 4, 1990 final rule (55 FR 36044). Since we provided a thorough response to comments on the hospital market basket in the September 4, 1990 final rule and did not propose any changes in the June 4, 1992 proposed rule, we are not responding to specific comments on the hospital market basket in this final rule. We believe that the market basket continues to recognize appropriate input price increases for efficiently managed hospitals.

Comment: A commenter believes that we should adjust the hospital market basket rate of increase to account for the cost-increasing effects of new technologies.

Response: In the framework used to support our update recommendations, we adjust the market basket rate of increase to account for the costs of new technology. This factor is encompassed as part of the update framework, rather than the market basket itself. In the framework used to support our FY 1993 update recommendation, we include a +0.3 to +0.5 percent increase for science and technology.

Comment: A few commenters advocate an update factor equal to the market basket rate of increase, rather than those updates set by the statute.

Response: Section 1886(b)(3)(B)(i)(VIII) of the Act requires that the update factors be set at the market basket rate of increase minus 0.55 percentage points for rural

hospitals, and the market basket percentage rate of increase minus 1.55 percentage points for urban hospitals. We are required by the statute to implement these update factors.

Comment: ProPAC disagreed with our recommendation that the hospital-specific rate applicable to sole community hospitals be updated by an amount equal to the urban update, or the market basket percentage increase minus 1.55 percentage points. The Commission believed that the update applied to the hospital-specific rate should be the rural update factor, that is, the market basket percentage increase minus 0.55 percentage points. The Commission believed that our recommendation is contrary to Congress' intention to provide financial relief to these hospitals.

Response: We responded to a similar comment in the FY 1992 final rule (56 FR 43354). We continue to believe that the differential update for the rural standardized amounts is intended to phase out the lower rural payment rates. Sole community hospitals are assured payment at the greater of the Federal rate or the hospital-specific rate. Hospitals that are paid at the hospital-specific rate are already benefitting from payments higher than other rural hospitals receive. We do not believe that these high cost rural hospitals that are already receiving higher payments should also benefit from a payment change intended for rural hospitals paid at a lower Federal rate. Rather,we are recommending that the hospital-specific rate applicable to sole community hospitals be updated by the market basket percentage rate of increase minus 1.55 percentage points, or 2.55 percent.

Comment: ProPAC disagreed with the framework we used to develop our recommended updates for the standardized amounts. In particular, they objected to the use of a practice patterns adjustment that was based on a study done in the early years of the prospective payment system. ProPAC believed that our adjustment for science and technology was too low. Finally, they believed that we should consider within-DRG severity and should not adjust for the effects of DRG reclassification and recalibration in setting the CMI component of our update framework.

Response: Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of ProPAC, recommend for each fiscal year update factors that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Since FY 1986, we have used an analytical framework to support the update recommendation. In appendix D to the FY 1992 final rule (56 FR 43354), we noted that we were in the process of refining that analytical framework. Our intent is to develop an expanded conceptual framework and appropriate measures for each component, that would be used to support our update recommendations. In appendix C to the FY 1992 proposed rule (56 FR 25321), we invited public comment on the appropriate factors and measures that should be taken into consideration in determining an appropriate update.

Under the current framework used to calculate our recommended updates, we look at the hospital market basket rate of increase and make adjustments to take into account both policy adjustment factors and changes in case mix, as well as corrections to forecast errors in previous estimates of the market basket rate of increase. The policy adjustment factors consist of measures of change in hospital productivity, quality-enhancing scientific and technological advances, and changes in practice patterns. The productivity measure consists of a normative standard, based partly on economy-wide increases in productivity, that accounts for the effect on prices that productivity increases would have in a competitive industry. The science and technology factor adjusts for the diffusion of new technology that is also quality-enhancing. Finally, the practice pattern adjustment is designed to ensure that the government shares in any improvements in practice patterns that make the provision of care less costly, while maintaining quality of care.

The adjustment in the current framework consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change which we believe is due to increased severity of illness rather than coding improvements, and an adjustment for the effect of reclassification and recalibration changes, to reflect what the total case-mix index change would have been if a new GROUPER and relative weights had not been instituted. The adjustment for the reclassification effect may be either a positive or a negative adjustment and represents a correction to the observed case-mix change. It is determined by comparing the average case weight for the actual cases in a given year based on the DRG relative weights for that year with the average case weight for the same cases based on the DRG relative weights for the previous year. Since the actual cases for the fiscal year are used on both sides of the comparison, the difference represents the change in the case-mix index and, therefore, reflects aggregate payments attributable to the new GROUPER and relative weights.

Presented below is a modified analytical framework for the update recommendation. We are considering using the revised framework to develop our recommendation for updating the prospective payment system standardized amounts beginning in FY 1994. We are presenting it in order to solicit comments and suggestions for improvement. So that we may take any comments into account prior to development of the proposed update recommendation for FY 1994, any comments should be sent to the following address by December 31, 1992: Update Framework, Division of Hospital Payment Policy, 1–H–1 East Low Rise, 6325 Security Blvd., Baltimore, Md. 21207.

III. Modifications to the Update Framework

A. General

The modified framework we are presenting is similar to our current framework, except in the definition of the policy adjustment factors. We have continued to use our current framework with the FY 1993 update recommendation; however, we are considering using the modified framework beginning in FY 1994. Our current framework and the modified framework are both based on the following formula:

$$\frac{\text{Nominal cost}}{\text{Discharge}} = \frac{\text{Real Outputs}}{\text{Real caseweights}} \times \frac{\text{Real caseweights}}{\text{Discharges}} \times \frac{\text{Real noncapital inputs}}{\text{Real outputs}} \times \frac{\text{Nominal costs}}{\text{Real noncapital inputs}}$$

(A) (B) (C) (D) (E)

In the formula, (A) represents the average cost per discharge, (B) represents our measure of case-mix constant intensity, (C) represents the case-mix index, (D) represents the inverse of service productivity, and (E) represents the hospital market basket. The main differences between the current and the modified frameworks lie in the data used to develop the productivity standard, and in the definition of intensity. The current framework divides intensity into a practice patterns adjustment and an adjustment for science and technology, while the modified framework uses a direct measure of intensity.

Under the modified framework, we would have two policy adjustment factors: Productivity and intensity. The first would reflect a forward-looking adjustment for expected changes in services level productivity in hospitals. This measure would reflect the efficiency with which individual services (for example, laboratory tests, diagnostic procedures) are produced. The intensity component would reflect how these services are utilized to produce the final output—the discharge. This component would account for the intensity of services per discharge and would include changes in the use of quality-enhancing services including new technologies and expected modification of practice patterns to remove cost-ineffective services. It would also be used to account for changing resource requirements due to variations in within-DRG severity of illness. The intensity component would replace our previous separate components for science and technology and practice patterns, and would take into account within-DRG severity changes. Throughout the following discussion, we compare our modified framework to the existing ProPAC framework.

The following is a summary of the FY 1993 update ranges supported by our modified analyses compared to our existing framework and ProPAC's framework.

TABLE 1.—Comparison of FY 1993 UPDATE RECOMMENDATIONS

	Current HHS	Modified HHS	ProPAC
Market Basket	MB	MB	MB
Difference Between HCFA & ProPAC Market Baskets			+0.2
Subtotal	MB	MB	MB +0.2
Policy Adjustment Factors:			
Productivity	−1.0	−0.8 to −1.0	−1.0
Intensity		+1.0 to +1.1	
Science and Technology	+0.3 to +0.5		+1.0
Practice Patterns	−1.8 to 0		(1)
Real Within-DRG Change			(2)
OSHA Modification to 29 CFR Part 1910.1030	+0.14	(3)	(3)
Subtotal	−2.36 to −0.36	+0.0 to +0.30	+0.0
Case-Mix Adjustment Factors:			
Observed Case-Mix Change	−2.5	−2.5	−2.5
Real Across-DRG Change	+1.0 to +1.3	+1.0 to +1.3	+1.5
Real Within-DRG Change	(4)	(5)	+0.3
Effect of 1990			
Reclassification and Recalibration	−1.0	−1.0	
Subtotal	−2.5 to −2.2	−2.5 to −2.2	−0.7
Forecast Error Correction	−0.9	−0.9	−0.8
Total Recommended Update	MB −5.76 to MB −3.46	MB −3.40 to MB −2.80	MB −1.3

[1] Included in ProPAC's Productivity Measure.
[2] Included in ProPaC's Case Mix Adjustment.
[3] Included in HHS' Productivity Adjustment and ProPAC's Science and Technology Adjustment.
[4] Included in HHS' Practice Patterns and Science and Technology components.
[5] Included in HHS' Intensity Factor.

There are two basic reasons for having a modified framework that recognizes two levels of production in hospitals. First, the modified framework allows us to refine the concepts of productivity, efficiency, and cost-effectiveness as they apply to the hospital setting, because we envision employing and developing a wider range of relevant data series to use in formulating our annual recommendations. For example, we would be able to evaluate our productivity standard with respect to unit productivity and real output data from both the hospital industry and the general economy. Second, this framework recognizes that while hospitals are largely responsible for the efficiency with which individual services are produced, the cost-effective use of these services in providing care during the hospital stay is jointly determined by the hospital and its medical staff. Therefore, by distinguishing the two levels of production, we can in the future improve the consistency between the objectives embodied in the cost-effective practice component of the prospective payment system update recommendation and our Volume Performance Standard (VPS) recommendation for the physician fee schedule.

In employing this framework, we would recognize that the potential for changes in service productivity is related to the overall output of services. Economy-wide, unit productivity tends to increase most rapidly during periods of output growth, and grow more slowly or decrease during periods in which output declines. Thus, in formulating our recommendation for the productivity component of the update factor, we would consider expected growth in total hospital services including admissions, case mix, technology and cost-effective practice. Our expectations for output, which are partly determined by our policy target for the intensity component (which includes many of these factors), will therefore influence our service productivity recommendation. In the discussion below, we first describe how our recommendation for the intensity component would be determined

followed by the development of our productivity recommendation.

B. Intensity Component

We would base our intensity standard on the combined effect of three separate factors: changes in the use of quality-enhancing new technology, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For 1993, we would have recommended that this factor be 1.0 percent to 1.1 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level for quality-enhancing technology changes. Typically, a specific new technology increases costs in some uses and decreases costs in other uses. Concurrently, health status is improved in some situations 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 new technologies 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 recommended adjustment is for the cost-increasing effect of new technologies only, and for FY 1993 assumes the range of estimated costs for these technologies at 0.9 to 1.0 percent, with a best estimate of 1.0 percent. ProPAC includes the cost-decreasing effect on new technology in its productivity adjustment factor.

The quality-enhancing technology component is intended to recognize the use of services that increase cost, but whose value in terms of enhanced health status is commensurate with these costs. Such services may result from technological change, or in some cases, increased use of existing technologies. The latter recognizes that as cost and medical effectiveness studies become available, some increased use of existing, as well as new, services may be warranted.

The component for reduction of cost-ineffective practices recognizes that some improvements in practice patterns could be made so that the intensity of services provided is more consistent with the efficient use of limited resources. That is, improvements could be made so that the number of services provided during an inpatient stay, and their complexity, produce an improvement in health status that is consistent with the cost of care. This component of our update recommendation is intended to encourage both hospitals and physicians to consider more carefully the cost effectiveness of medical care.

In our current framework, the component for real within-DRG change is implicitly recognized in the new science and technology factor and in the practice pattern components. In our proposed framework, it would be recognized in the intensity component.

Since 1985, intensity of services per inpatient admission has increased, even after adjusting for the growth in real case mix each year. These increases, which are similar to pre-prospective payment system increases, followed intensity decreases in both 1984 and 1985. ProPAC, following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, has estimated that case-mix constant intensity per admission increased at an average of 1.5 percent annually from 1985–1990. We have developed Medicare-specific intensity measures for inpatient services based on 1985–1991 MEDPAR billing data. Consistent with ProPAC, case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Medical Consumer Price Index hospital component and changes in real case mix. Past studies of case-mix change by the RAND Corporation indicate that the change in real case mix ranges from 1.0 percent to one-half of total case-mix change. If we assume that real case-mix change is one-half of total case-mix change, we estimate case-mix constant intensity to have grown by an average of 2.0 percent each year during the 1985–1991 period, a cumulative increase of 12.8 percent. If we assume that real case mix has been growing at 1.0 percent annually, case-mix constant intensity has grown by an average of 2.3 percent annually, for a cumulative increase of 14.3 percent.

We believe that the estimated intensity increases have been due to a combination of changes in science and technology, within-DRG severity, and cost-ineffective practice. Currently, however, there are no conclusive studies that quantify either the net impact of new science and technology on operating costs or on within-DRG complexity changes. Thus, we cannot estimate precisely what portion of the overall intensity increase was due to a combination of quality-enhancing technology and within-DRG complexity, and what portion was due to cost-ineffective practice. We are instead assuming that one-half of the 2.0 to 2.3 percent annual increase was due to a combination of quality-enhancing services and within-DRG complexity. Therefore, based on these trends, our proposed recommendation would have included a 1.0 percent to 1.1 percent positive adjustment to the update to allow for a cost-effective increase in the intensity of services in FY 1993.

While we would continue in the future to examine historical trends in formulating the intensity component, our intent is that it will become a forward-looking factor that incorporates expanding knowledge from medical effectiveness studies. Our eventual objective is to identify a set of efficient or "best practice" hospitals to serve as a basis for this adjustment. In addition, in recognition of the joint roles of hospitals and their medical staff in furnishing inpatient care, we intend to examine methods for calibrating our hospital update recommendation with our annual volume performance standard (VPS) recommendation for the Medicare physician fee schedule. In evaluating methods for calibrating our two recommendations, one potential area of study will be to examine those services billed simultaneously by physicians under Part B and by hospitals under Part A.

C. Productivity Component

Service level productivity is defined as the ratio of total service output to full time equivalent employees (FTEs). It is also called service productivity since these services become inputs for the production of a hospital discharge. While we recognize that productivity is multifactor in nature (that is, a function of labor, non-labor material, and capital inputs), we propose to use a labor productivity measure in the modified framework since the current update framework applies to operating payment. To recognize that we are apportioning the short run output changes to the labor input, we propose to weight our productivity measure for operating costs by the appropriate share of labor input to total operating input to determine the expected effect on cost per case. In our proposed framework for updating capital payments (see Appendix D), we discuss unifying the

capital and operating frameworks by considering expanded productivity concepts with regard to the capital input.

ProPAC believes hospitals should be given an incentive to improve productivity. In its recommended update framework, 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). This year, ProPAC assumes a per case productivity gain of at least 2.0 percent and recommends a −1.0 percentage point adjustment in determining the update on the basis that any productivity gains should be shared equally by Medicare and hospitals. However, ProPAC's measurement is based on per-case productivity rather than service productivity, so ProPAC's productivity measurement includes the effect of changes in practice patterns and cost-decreasing new technology. As explained earlier, the productivity measurement in the proposed framework embraces only changes in service productivity. We would make an adjustment to reflect average expected gains in service productivity; a hospital would retain in full any service growth at 3.8 percent annually, implying a ratio of service productivity gains it achieves above this level.

Our proposed recommendation for the service productivity component is based on historical trends in productivity and total output for the hospital industry and the general economy, as well as projected levels of future hospital service output. ProPAC has also estimated cumulative service productivity growth to be 4.6 percent from 1985–1989, or 1.1 percent annually. At the same time, it estimates total service growth at 3.8 percent annually, implying a ratio of service productivity growth to output growth of approximately 0.3 percent. Our MEDPAR analysis implies total Medicare service output (charges per admission, adjusted for CPI change) increased 22.1 percent from 1985–1991, or 3.4 percent annually. It is not possible at this time to develop a productivity measure specific to Medicare patients. We also examined output (gross domestic product) and productivity (output per hour) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 percent to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with an 0.3 to 0.35 percent change in output per hour).

Under the modified framework, the recommended update would be based in part on expected productivity, that is, projected service output during the year multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket. This method would estimate an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. In doing so, the recommendation allows for unit productivity to be smaller than the historical averages in years in which output growth is relatively low, and higher in years in which output growth is larger than the historical trend. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected "real" case-mix growth and expected quality-enhancing intensity growth, net of expected decline in intensity due to reduction of cost ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply product of the expected change in intensity (1.0 to 1.1 percent), projected admissions change (2.3 percent for 1993) and projected "real" case-mix growth (1 percent for 1993), or 4.3 to 4.5 percent. The share of direct labor services in the hospital market basket (consisting of wages, salaries, and employee benefits) is 61.7 percent. Multiplying the expected change in total hospital service output by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage provides our productivity standard of 0.8 percent to 1.0 percent.

In the December 6, 1991 **Federal Register** (56 FR 64004), the Occupational Safety and Health Administration (OSHA) published a final rule (29 CFR 1910.1030) implementing regulations 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 will be additional costs of 0.14 percent of total revenues. Under the existing framework, we are providing for a positive adjustment of 0.14 percent to account for these additional costs. This is a one-time adjustment, since the 0.14 percent will be built into the rates for subsequent years. Under the modified framework, we would have included the adjustment in the productivity factor. ProPAC has not recommended any explicit adjustment for the effects of these regulations but has implicitly included the costs in its adjustment for new science and technology.

D. Case-Mix Adjustments

Our modified update framework continues to take into account changes in case mix, net of 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 increase at 1.0 percent to 1.3 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 that do not reflect greater resource requirements. This estimate is supported by past studies of case-mix change by the RAND Corporation. In addition, we estimate that DRG reclassification and recalibration in FY 1991 resulted in a 1.0 percent increase in the case-mix index. This estimate results from classifying cases using the FY 1991 and FY 1990 GROUPERS using actual FY 1991 cases received by HCFA as of December 31, 1991. Any resulting change in the case-mix index based on the FY 1991 GROUPER as compared to the FY 1990 GROUPER must be the result of reclassification and recalibration effects. 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 −2.2 percent (the sum of −2.5, +1.0 to +1.3, and −1.0). The −2.5 and 1.8 percent figures used in the ProPAC framework for their FY 1993 update recommendation represent ProPAC's projection for observed case-mix change and 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 June 30, 1992.

E. Forecast Error Correction

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 4.3 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 −0.9 percentage points. Our policy has been to make a forecast error correction if our estimate is off by 0.25 percentage points or more. We would continue to make corrections for forecast errors under the modified framework, and would therefore include a forecast error adjustment of −0.9 percentage points in setting PPS rates for FY 1993. ProPac's FY 1993 recommendation includes a forecast error adjustment of −0.8 percentage points, based on an earlier estimate of the FY 1991 market basket rate of increase.

F. Comparison of Increases in Expected Costs and Payments

In addition to comparing our modified update framework with the existing framework and ProPAC's recommended framework, we examined the expected increase in costs implied by the framework from FY 1985 through FY 1991. Applying the analysis of the modified framework, the costs for efficiently operated hospitals would have been expected to increase 41.2 percent during that time, assuming the "real" increase in the case-mix index (CMI) growth was one-half of the total CMI growth for each fiscal year:

CUMULATIVE PERCENTAGE CHANGE IN EXPECTED COST PER CASE INCREASES, ASSUMING ONE-HALF OF ACTUAL ANNUAL CMI GROWTH IS REAL

Fiscal year	Actual market basket	Productivity	Real CMI growth	Allowable intensity	Total
1986	3.9	−0.8	1.7	1.7	6.6
1987	3.7	−0.8	1.3	2.4	6.6
1988	4.7	−0.8	1.1	1.4	6.5
1989	5.4	−0.8	1.3	0.3	6.3
1990	4.5	−0.8	1.1	0.2	5.0
1991	4.3	−0.8	1.0	0.1	4.6
Cumulative Change (Compounded)					41.2

Note: Actual market basket figures include correction for any forecast errors. The productivity amount is based on average annual increases in real Medicare output of 3.4 percent from FY 1985 through FY 1991. Real CMI growth for FY 1988 is determined as half of the CMI growth remaining after allowing for the 1.22 percent growth determined to be caused by administrative factors (and for which the DRG weights were reduced in FY 1990). The FY 1990 and FY 1991 CMI growth is adjusted for the DRG weight change implemented in FY 1990. The components of change must be multiplied together to obtain the total percentage change.

If "real" CMI growth is assumed to be 1.0 percent annually, the cumulative percentage change in expected cost per case would be 40.3 percent.

We also determined the increase in prospective payments from FY 1985 through FY 1991:

ACTUAL PERCENTAGE INCREASE IN PPS PAYMENTS PER CASE, FY 1985–FY 1991

Fiscal year	Average published update	PPS CMI growth	Residual payment change	Actual increase
1986	0.5	3.4	−0.7	3.2
1987	1.2	2.5	1.5	5.3
1988	1.5	3.3	1.3	6.2
1989	3.3	2.7	−0.1	6.0
1990	5.8	1.0	−1.2	5.5
1991	3.4	2.7	−1.5	4.6
Cumulative Change (Compounded)				35.0

Note: Payment growth rates are calculated from Medicare cost report data. Residual payment growth is due to factors such as increased IME and DSH factors, and legislative changes (such as increases in the DSH adjustment formula). CMI growth rates are calculated by HCFA's Office of the Actuary.

Payments in FY 1985 were more than adequate for the efficient and cost-effective delivery of quality health care to beneficiaries, as shown by the prospective payment system margins exhibited by hospitals in that year. The average prospective payment system FY 1985 operating margin was 14.5 percent. In fact, when setting the update to the standardized amounts for FY 1986, we stated in our September 3, 1985 final rule (50 FR 35708) that a negative update was justified due to the overstatement of the base year costs used to determine the FY 1984 and FY 1985 standardized amounts, but that we believed that such a negative update would be disruptive and cause unintended consequences that could compromise the quality of care provided to Medicare beneficiaries. Instead, we anticipated that payments would increase more slowly than expected cost increases, in order to gradually adjust the standardized amounts to their appropriate levels. ProPAC agreed that the FY 1985 standardized amounts were set at too high a level, and also agreed that a precipitous adjustment would not be appropriate. The Commission, in its April 1, 1987 report to the Secretary, recommended that an average 5.4 percent reduction to the standardized amounts be made over a 3-year period to reflect the inappropriate levels of base year costs reflected in the original standardized amounts.

Although the expected increase in the cost of providing cost-effective and quality care was between 40.3 and 41.2 percent, we believe that the increase in payments of 35.0 percent was more than adequate to cover the costs of efficiently operated hospitals, given the high margins in FY 1985 and the overstated FY 1985 standardized amounts. We will continue to examine the relationship between payment increases and expected cost increases in order to monitor the adequacy of Medicare

payments for inpatient hospital operating costs.

IV. Secretary's Final Recommendations for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

We are updating the rate of increase limits in accordance with section 1886(b)(3)(B)(ii) of the Act, which establishes a uniform update factor for excluded hospitals and units at the market basket rate of increase. (The market basket for excluded hospitals is currently estimated at 4.2 percent.) However, as we proposed in the June 4, 1992 final rule, we are recommending an average update for excluded hospitals that would result in total payments comparable to those resulting from an update equal to the market basket rate of increase. More specifically, 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 1990 market basket rate of increase of 0.9 percentage points, plus the forecast error in the FY 1991 market basket rate of increase of 0.7 percentage points.

In addition, we recommend, and ProPAC agrees, 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 FY	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 recommend, and ProPAC agrees, that any additional update allowance be made in a budget neutral fashion. 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 a 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 2.6 percent update (4.2 percent market basket for excluded hospitals minus 1.6 percent) 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 have used the results of the analysis of the cumulative difference between the market basket rate-of-increases and the update factors to determine differential additional adjustments that will result in program outlays that approximate the outlays that would result if a 4.2 percent update were applied in FY 1993. Our recommended update factor is 2.6 percent for all excluded hospitals and units, plus an additional update for hospitals and units with a base year beginning during the period FY 1983 through FY 1987. The recommended updates are as follows:

Base year began in FY	General update	HCFA recommended additional adjustment	HCFA recommended FY 1993 update
1982	2.6		2.6
1983	2.6	1.8	4.4
1984	2.6	3.8	6.4
1985	2.6	6.0	8.6
1986	2.6	3.9	6.5
1987	2.6	1.8	4.4
1988 and later	2.6		2.6

Comment: A commenter stated the update for excluded units and hospitals should equal the entire excluded hospital market basket rate of increase.

Response: Section 1886(b)(3)(B)(ii) of the Act sets the FY 1993 target rate-of-increase limits for hospitals excluded from the prospective payment system at the market basket rate of increase for excluded facilities. Our recommendation is to provide an average update equal to the market basket rate of increase while providing differential updates to those facilities with base years that began in FY 1983 through FY 1987. The update that will be implemented, however, is that set in law.

Comment: Several commenters objected to our use of the FY 1990 and FY 1991 TEFRA market basket forecast error to finance the differential updates for excluded hospitals and units with a base year beginning between FY 1983 and FY 1987. The commenters believe that it is inappropriate to lower the update amounts for excluded facilities with base years that began in FY 1982 or after FY 1987 in order to finance the differential updates for other facilities. The commenters indicated that the differential updates should be financed with additional funds. Another commenter supported our recommendation.

Response: We believe that it is appropriate to remove market basket forecast errors from future updates. These errors in estimation of the increase in payments are permanently built into the excluded facilities' target amounts. As a result, the target amounts do not properly reflect the updated cost per discharge necessary for efficiently operated hospitals to maintain quality care for Medicare beneficiaries. We are in no way penalizing any excluded facility, regardless of its base year, but are ensuring that the appropriate market basket rates of increase are reflected in the target amounts.

Our recommendation for updates for all excluded facilities in this final rule is based on a 2.6 percent update for FY 1993 (consisting of an estimated excluded hospital market basket rate of increase of 4.2 percentage points, and forecast error adjustments of −0.9 percentage points for FY 1990 and −0.7 percentage points for FY 1991). We are recommending that the 1.6 percentage points, consisting of the FY 1990 and FY 1991 forecast errors, be used to fund the higher updates for those hospitals with base years beginning in Federal FYs 1983 through 1987, which were subject to the prospective payment system updates for those years. Additionally, some exceptions payments to these hospitals will no longer be necessary as a result of the higher updates, and we have taken our estimation of this effect into consideration in developing the differential updates.

We believe that the differential update should be budget neutral because it is not clear that an aggregate

increase in payments in excess of the market basket rate of increase 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 directed toward groups of hospitals whose costs are systematically above the rate-of-increase limit. We believe any increase in aggregate payments to excluded hospitals and units is premature until the reasons why some hospitals have been adversely affected by the rate-of-increase limits and others have received substantial incentive payments are more fully understood.

Comment: Two commenters oppose our recommendation that the costs of new technology should be offset by productivity gains. These commenters believe that the TEFRA system provides an automatic sharing of productivity gains between the facility and HCFA, through the capping of hospital gains, when the facility's costs are less than its target amount. These commenters believe that no additional productivity adjustment is warranted.

Response: As a systemwide standard, 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. The sharing of gains when the target amount exceeds cost is based on individual hospital behavior above and beyond the standard we believe all excluded facilities should meet.

Appendix D: Development of Update Framework for Prospective Payment System for Inpatient Hospital Capital-Related Costs

I. Introduction

For FY 1992 through FY 1995, § 412.308(c)(1) provides that the update for the capital prospective payment rates (Federal rate and hospital-specific rate) will be based on a 2-year moving average of actual increases in Medicare inpatient capital costs per discharge. Beginning in FY 1996, the regulations provide that HCFA will determine the update in the capital prospective payment rates based on an analytical framework that will take into account (1) changes in the price of capital (which we will incorporate into a capital input price index), and (2) appropriate adjustments to account for changes in capital requirements, such as the development of new technologies, diffusion of existing technologies, existing hospital capacity and utilization, and other factors. The objective of the update framework is to provide a rate of increase in aggregate capital prospective payments which, along with a rate of increase in DRG payments, ensures a joint flow of capital and operating services for efficient and effective care for Medicare patients.

Although the analytical framework will not be employed to determine the annual update factor until FY 1996, we are presenting a preliminary model, using available data and concepts, of an update framework for the capital prospective payment system. The preliminary update framework below includes a capital input price index which parallels the operating input price index. The capital input price index measures the changes in input prices for capital-related costs necessary to maintain the composition of capital in the base year. The composition of capital is the mix of capital inputs, that is, the mix of type, quantity, and age of capital, as well as a proportion of expenses for movable equipment and for buildings and fixed equipment. As such, the composition of capital reflects the underlying capital acquisition process. For consistency with the operating input price index, we have selected 1987 as the base year for this preliminary capital input price index. We would periodically update both the operating and the capital input price indexes to reflect the changing composition of inputs for capital and operating costs. We expect to have rebased the capital and operating input price indexes by the time we implement the final capital update framework for FY 1996. The preliminary capital input price index below illustrates the methodology we propose to employ.

The preliminary capital update framework, like the proposed operating update framework, incorporates several policy adjustments in addition to the capital input price index. We would adjust for case-mix index-related changes, for intensity, and for the efficiency and cost-effective use of capital (i.e., movable equipment, buildings and fixed equipment, etc.) in the hospital industry, as well as for error in the capital input price index forecast.

We have developed the following model of a capital prospective payment system update framework in conjunction with the proposed changes to the operating prospective payment system framework discussed in appendix C. In developing this model, we have attempted as much as possible to maintain consistency with the proposed operating framework in order to facilitate the eventual development of a single prospective payment system update framework. We have also been concerned to promote the goals that motivated the adoption of a prospective payment system for inpatient capital-related costs, especially the goals of promoting more effective and efficient utilization of capital resources in the hospital industry and establishing incentives for hospitals to make cost-effective decisions regarding acquisition of new capital resources.

It is important to emphasize that this presentation represents our current thinking, and that we encourage submission of comments and recommendations for improvements. We are especially interested in suggestions regarding the capital input price index, the adequacy of the proposed policy adjustment factors, and alternative methodologies for deriving the factors. We are also interested in information concerning empirical studies and sources of data that could be useful in developing the framework. Comments should be sent by December 31, 1992 to: Update Framework, Division of Hospital Payment Policy, 1-H-1 East Low Rise, 6325 Security Boulevard, Baltimore, Maryland 21207.

In conjunction with the prospective payment system rule-making processes for FY 1994 and FY 1995, our current plan is to provide successively more developed models based on our further study of the conceptual and empirical foundations of the framework and on our evaluation of the comments and recommendations submitted in response to this preliminary discussion. However, in view of ProPAC's recommendation that we implement a capital update framework beginning in FY 1994, we also invite public comment on this issue.

II. Measurement of Capital Input Price Increases

A. Introduction

Our capital update framework would utilize a capital input price index to parallel the existing operating input price index. Both indexes measure price aspects of changes in input resources. The operating expense input price index measures per unit price changes in labor and other non-capital materials and services; the capital input price index measures the price changes in capital-related expenses per unit of real capital still in use.

The capital input prices index would differ from the operating input price index in one respect. The operating input price index measures changes in costs related to flows of labor and non-capital goods and services over time.

The proposed capital input price index would measure changes in costs related to stocks of real capital assets rather than costs related to flows of capital services.

The stock of capital is the physical quantity of depreciable resources whose nominal and/or real value is measured annually (for example, at the end of a fiscal or calendar year). Depreciable capital includes movable equipment, buildings, and other manufactured, non-labor resources that have a useful life of two years or more.

A hospital uses capital services generated by capital stocks to produce outputs. The flow of capital services is measured over time. For example, flow of x-ray machine services is measured as the number of available x-ray machine hours over a given period of time.

It is the flow of capital services (for example, the number of available x-ray machine hours), not the stock of capital (for example, the nominal and/or real value of the x-ray machines), that is most relevant to hospital production. It would therefore be desirable to measure capital-related expenses related to flows of capital services. Measuring flows of capital services would also preserve a more complete parallel with the operating input price index. However, it is necessary to measure capital-related expenses related to stocks of real capital assets because no information on the flow of hospital capital services is currently available. In the absence of such information, we assume that the flow of capital services per unit of real capital stock has remained constant over time, and that, therefore, the ratio of changes in capital-related costs per unit of real capital stock is an appropriate measure of change in a capital input price index.

We selected 1987 as the base year for the capital input price index to parallel the operating input price index. The most recent rebasing of the operating input price index employed relative weights from the year 1987. Employing the same base year for the capital input price index will facilitate the eventual development of a joint update framework for capital and operating expenses. We will rebase the capital input price index periodically in conjunction with the rebasing of the operating input price index to account for the changing composition of capital stock.

B. Consistency with the Capital Acquisition Model

The capital input price index uses weights, asset life assumptions, and financing patterns derived from the capital acquisition model developed for the August 31, 1990 final rule (see 56 FR 43417–43422). Since the model successfully reproduced Medicare capital costs per discharge distributions among hospitals, and since the model was designed to be consistent with observed capital patterns, we believe that it is a good source of weighting factors for the capital input price index.

- Three categories of capital-related expenses for owner-operated capital are considered in the index, including depreciation, interest, and other expenses (capital-related taxes and insurance). Since leases and rentals are a substitute for owner-operated capital, and since cost increases for leases and rentals are assumed to grow at a rate similar to owner-operated capital, we implicitly included leases and rentals in rates of change for the depreciation and interest categories. We are currently studying cost patterns for leases and rentals. After further study, we may continue to treat leases and rentals like depreciation and interest, or we may treat them separately in another category if we are able to determine an appropriate price proxy for leases.
- Two categories of straight-line depreciation expense are recognized, including depreciation expense for buildings and fixed equipment and depreciation expenses for movable equipment.
- In determining depreciation amounts, we adopted a 25-year useful life for building and fixed equipment and a 7-year useful life for movable equipment.
- In determining interest amounts, we adopted an expected 20-year life for debt instruments associated with the purchase of buildings and fixed equipment and an expected 6-year life for debt instruments associated with the purchase of movable equipment.
- We incorporated an amortization adjustment to interest costs to account for effects of aging of the debt instrument.
- The relative expenditure weights for owner-operated capital expenses by type of capital-related expense in the 1987 base year were .655 for depreciation, .295 for interest, and .050 for other capital-related expenses (taxes and insurance). In 1987, the relative internal expenditure weights for depreciation amounts were 54.0 percent for building and fixed equipment depreciation and 46.0 percent for movable equipment depreciation. In 1987, the relative internal expenditure weights for interest amounts by type of debt instrument were 85.4 percent for debt instruments related to building and fixed equipment purchases and 14.6 percent for debt instruments related to movable equipment purchases. The full complement of relative expenditure weights for the capital input price index are, therefore, as follows:

RELATIVE EXPENDITURE WEIGHTS

Type of Expense	Relative weight
Depreciation:	
Building and fixed equipment	.354
Moveable equipment	.301
Interest:	
Building and fixed equipment	.252
Moveable equipment	.043
Other Capital-related Expenses	.050
	1.000

We will continue to study all relative expenditure weights for appropriateness.

Since the capital input price index is intended to measure price changes in capital-related costs per unit of real capital assets over time, we examined the determinants of price change in each of the major components of capital-related costs. Below we present a discussion of each of these components: depreciation, interest, and "other" capital-related costs.

C. Depreciation

Current depreciation costs represent the sum of the depreciation costs for all items of currently depreciable capital stock. The depreciation cost for each item is determined by dividing the nominal (actual) purchase price by the useful life of the item. We assume that the useful life of the stock for a particular category of assets does not change over time and that the same amount of depreciable real capital stock was purchased in each year starting with the current year back to the year representing the earliest year in the useful life of the stock type. Since the nominal amount of all past purchases of currently depreciable capital stock is the purchase price per unit of stock multiplied by the amount of real capital stock purchased, depreciation costs per unit of real capital stock change under our assumptions only because the average purchase price of currently depreciable assets change.

Some capital stock currently in use was fully depreciated before the current period and thus there are no current depreciation costs associated with such capital stock. Therefore, the depreciation portion of our capital input price index, which measures changes in capital costs per unit of capital stock still in use, requires some estimate of the changes in the proportion of total capital

still in use which represents fully depreciated capital stock. We assume that the proportion remains constant over time and, therefore, is not a factor in the capital input price index.

For purposes of developing the capital input price index, we selected the building cost index derived and maintained by the Engineering News-Record (ENR) as the best currently available source of measuring changes in costs of fixed assets. The ENR building index is published monthly by the Bureau of Economic Analysis in its Survey of Current Business (Current Business Statistics). This index tabulates surveyed cost changes in 20 cities for three major building categories and three classifications of skilled tradesmen predominantly utilized by the construction industry. The ENR index assigns aggregate weights to fixed quantities of structured steel, Portland cement, and lumber. In the labor component, it calculates an average wage paid to carpenters, bricklayers, and structural ironworkers. The actual weights are based on the relative importance of the various components in construction that were obtained from a survey of construction authorities. Because the ENR index deals only with the effects of trends in wage rates and material prices, it is considered an appropriate means of updating the fixed asset component of the hospital input price index. (A number of other indexes were reviewed and evaluated for use, including some hospital or health-specific measures. This board-based index met several criteria. We are continuing research in this area.) A 25-year moving average in this index provides rates of change in average purchase prices for currently depreciable building and fixed capital stock.

For purposes of developing the capital input price index, we selected the percentage change in the cost of machinery and equipment as measured by the Producer Price Index (SIC code #11) as the best currently available source for measuring changes in the purchase price of movable equipment. The index is published monthly by the U.S. Department of Labor, Bureau of Labor Statistics, in the Monthly Labor Review. We selected this broad based index of machinery and equipment as a price proxy for all hospital movable assets because it encompasses a wide range of heavy duty electrical and mechanical products. Included in the array of manufactured products are furnaces and ovens, power tools and accessories, pumps and compressors, scales and balances, elevators, and air-conditioning and refrigeration equipment. Many electrical product components are also evaluated within this variable. Of special note, this proxy incorporates x-ray equipment and other testing and measuring instruments, as well as commercial laundry equipment. A 7-year moving average in this index provides rates of change in average purchase prices for currently depreciable movable capital stock.

D. Interest

Current interest costs represent the sum of all interest costs related to past debt instruments that are still alive. Thus, current interest costs are the product of:

- Nominal amounts of all past purchases of capital stock within the expected life of the debt instruments. These nominal amounts are the product of the average purchase price per unit of capital stock multiplied by the number of units of real capital stock purchased;
- The proportion of the nominal purchase amounts that were financed by debt (and not by equity financing). Current evidence from Medicare Cost Reports indicates that this proportion has remained constant over time and, therefore, is not a factor in changing interest costs per unit of capital stock;
- The amortized interest patterns in the periodic debt payment as a function of the interest rate applicable on the loan, the life of the debt instrument, and the age of the debt instrument;
- The proportion of the debt which represents interest costs in the current period (a function of the interest rate applicable to the loan, the life of the debt instrument, and the current age of the debt instrument).

In the capital input price index, where our concern is interest costs per unit of real capital still in use, we assume that the amount of real capital stock implicit in any debt instrument as a proportion of real capital stock still in use remains constant over time and, therefore, is not a factor of change in the capital input price index.

The interest component of the capital input price index is therefore composed of the summed changes in the product of past purchase prices, past interest rates, and current amortized effects of past interest rates.

The external price proxy used to represent interest rates in the capital input price index is a weighted average of the percentage changes for two interest rate series:

- The average yield on domestic municipal bonds, Daily Bond Buyer (20 bonds) is given a 85 percent weight; and
- The average yield on Moody's AAA corporate bonds is given a 15 percent weight.

Data for municipal and corporate bonds is published by the U.S. Department of Commerce, Bureau of Economic Analysis (BEA), in the Survey of Current Business, Finance Section. BEA publishes the yield on the Thursday nearest the end of the month.

The internal weights applicable to each bond type were estimated from long term debt data reported in Medicare cost reports by type of hospital control. Percentage changes in the municipal bond rate approximate interest rate changes paid by the non-profit and government sectors of the industry and the percentage changes in the AAA bond rate approximate interest rate changes paid by the for-profit sector. A 20-year moving average of the product of this composite interest rate and the price proxy for building and fixed equipment, adjusted for amortization, provides a measure of change in interest costs per unit of building and fixed capital stock. A 6-year moving average of the product of this composite interest rate and the price proxy for movable equipment, adjusted for amortization, provides a measure of change in interest costs per unit of movable capital stock.

E. Other Capital-Related Costs

In addition to depreciation and interest, which account for the bulk of capital costs, there are several other relatively minor cost expenditures that are considered capital-related. Payments for fire and allied property insurance, and real estate taxes all fall within this category. A measurement of rent costs would implicitly recognize these related cost factors, and thus reflects changes in costs for the "other" capital-related costs. Since no commercial rental proxy exists, residential rental is a reasonable proxy that can, over time, reflect the trend in price movements of the residual capital-related costs. We used the residential rent component of the Consumer Price Index for All Urban Consumers as a price proxy for this component. This index is prepared by the U.S. Department of Labor, Bureau of Labor Statistics, and is published monthly in the Monthly Labor Review.

F. Review of Data Sources

We continue to explore data sources and applications in order to refine and to improve the weights and price proxies in our capital input price index. We use at least three basic criteria to evaluate price proxies to enter into our price

indexes: The price proxy data must be publicly available, it must be based in valid sampling designs, and it must have been collected for a sufficiently long period of time to ensure stability and credibility. These criteria exclude a number of proprietary and anecdotal data bases and other recently devised indexes that are frequently cited as alternatives to the price proxies which we selected.

Although we have selected the best price proxies currently available to us under these criteria, we are aware that other price proxy data bases may exist which are superior to those we have chosen. Therefore, we invite suggestions and recommendations for any changes which may be required.

G. An Application

We have combined the weights and price proxies discussed previously in Table 1 to produce annual rates of change in our proposed capital input price index. The price projections used in this exercise were prepared by Data Resources Inc., a forecasting service engaged by the Health Care Financing Administration.

TABLE 1.—CAPITAL INPUT PRICE INDEX: PERCENT CHANGE FOR TOTAL INDEX AND FOR INDEX COMPONENTS, FEDERAL FISCAL YEARS 1987 TO 1997

	Total	Depreciation		Interest		Other
		Fixed	Movable	Fixed	Movable	
1987 Weights	1.000	0.345	0.301	0.252	0.043	0.050
Fiscal Year:						
1987	4.5	5.8	3.8	5.3	−6.2	4.5
1988	4.2	5.6	2.8	5.5	−4.0	3.8
1989	3.8	5.4	2.3	4.3	−2.8	3.8
1990	3.7	5.2	2.3	3.9	−1.8	4.2
1991	3.5	5.0	2.3	3.2	−0.7	3.9
1992	3.1	4.9	2.1	2.5	−0.6	2.6
1993	3.0	4.7	2.1	2.5	0.6	2.0
1994	3.1	4.5	2.3	2.3	1.3	3.8
1995	3.0	4.4	2.5	1.9	1.5	3.4

NUMBER OF YEARS IN MOVING AVERAGES	
Depreciation	
Fixed	25
Movable	7
Interest	
Fixed	20
Movable	6
Other	Not Applicable

Interest Rate Adjusted for Purchase Price and for Amortization.

Source: Health Care Financing Administration.

III. Case-Mix Adjustment and Adjustment for Forecast Error

The case-mix index (CMI) is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the CMI corresponds to an equal percentage increase in hospital payments.

The case-mix index is the measure of the average DRG weight. The case-mix index can change for any of several reasons: because the average resource use of Medicare patients changes ("real" case-mix change), because changes in hospital coding of patient records result in higher weight DRG assignments ("coding effects"), and because the annual DRG reclassification and recalibration changes may not be budget neutral ("reclassification effect"). In the current framework, we adjust the update upward to reflect increases in real case mix, but remove the effects of coding. In addition, we remove the effect on total payments of changing the DRG classifications and relative weights, in order to retain budget neutrality for all changes other than patient severity and the update.

In the present update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all CMI-related changes other than patient severity (for example, we adjusted for the effects of the FY 1991 recalibration and reclassification as part of our FY 1993 update recommendation). The proposed operating framework retains these adjustments. The operating adjustment consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change that we determine is due to real case-mix change rather than coding modifications, and an adjustment for the effect of prior DRG reclassification and recalibration changes. We would adopt this CMI adjustment as well in the capital update framework.

The proposed operating update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the following year. In any given year there can be unanticipated price fluctuations that can result in differences between the actual increase in prices faced by hospitals and the forecast used in calculating the update factors. We therefore believe that the capital update framework should also include a forecast error adjustment factor. In setting a prospective payment rate under the proposed framework, we would make an adjustment for forecast error only if our estimate of the capital input price index rate of increase for any year is off by 0.25 percentage points or more. Thus, for example, in determining whether to make a forecast error adjustment in FY 1993, we would look at the forecast error for FY 1991.

IV. Policy Adjustment Factors

The capital input price index measures the changes in input prices for capital-related costs necessary to maintain the composition of capital in the base year. We would address through the policy adjustment factor appropriate changes in the amount and composition of capital stock.

The existing update framework for the prospective payment system for operating costs includes factors designed to adjust the input price index rate of increase for policy considerations. Appendix C describes the revised policy adjustment factors that we are proposing for the operating framework. Under the proposed operating framework, we would adjust for service productivity (the efficiency with which providers produce individual

services such as laboratory tests and diagnostic procedures) and intensity (the amount of services used to produce a discharge).

The proposed service productivity factor for the operating update framework would reflect a forward-looking adjustment for the changes that hospitals can be expected to make, on the basis of a normative standard, in service-level productivity during the year. A hospital would retain any productivity increases above the average.

The intensity factor for the operating update framework would reflect how hospital services are utilized to produce the final product—the discharge. This component would account for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services. We intend the quality-enhancing practice component to recognize the use of services that increase cost but whose value in terms of enhanced health status is at least commensurate with those costs. The component for real within-DRG change is intended to capture changes in resource requirements resulting from increases in case complexity within DRGs. The real within-DRG component allows hospitals to be compensated for this otherwise unmeasured portion of real case-mix change. The component for reduction in cost-ineffective practice recognizes that some improvements in practice patterns could be made so that the intensity of services provided is more consistent with the efficient use of limited resources. We intend this component to encourage both hospitals and physicians to consider more carefully the cost-effectiveness of medical care.

We believe that the proposed intensity adjustment factor can be adopted in the capital update framework. Under the proposed operating update framework, we would calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component) and changes in real case mix. The use of total charges in the calculation of the proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. We can therefore incorporate the proposed intensity adjustment from the operating update framework into the capital update framework. We know of no reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity. We would therefore assume, as in the proposed operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework would thus provide an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG complexity and the adoption of quality-enhancing technology.

Productivity is intrinsically a multi-factor concept. In our proposed operating update framework, we allocate a share of productivity to labor according to labor's share of total inputs, as calculated in the input price index for the prospective payment system for operating costs. We considered developing a multi-factor productivity measure for use both in the proposed operating update framework and in the capital update framework. However, we lack an adequate measure of the flow of capital services from capital inputs for use in developing such a measure. In the absence of an adequate multi-factor productivity measure based on the flow of capital services, we are unable to propose a single productivity adjustment adequate for use in both frameworks.

Other considerations suggest that the capital update framework should incorporate a productivity adjustment distinct from the measure employed on the operating side. Operating inputs are more variable and adjustable in the short run. The productivity target incorporated into the proposed operating framework thus operates on a short-run, year-to-year basis. We believe that there should also be targets for improved efficiency and effectiveness of capital, but capital efficiency and effectiveness targets must be on a longer-run basis. This is because the level of capital inputs is generally fixed in the short run, and therefore longer periods of time are needed to adjust these inputs to levels consistent with cost-effective output, that is, to achieve longer-run productivity improvements. We believe that the capital update framework should incorporate an adjustment for long-run efficiency and cost-effectiveness. Such an adjustment would require a long-run concept of the efficient and cost-effective level of capital resources.

In developing an adjustment for the long-run efficiency and cost-effectiveness of capital (movable equipment, buildings and fixed equipment, etc.), we believe that we should take into account that the existing resources of the hospital industry are not being used with sufficient efficiency and effectiveness. Prior to the adoption of the prospective payment system for capital-related costs, Medicare payment policy for capital-related costs, as well as the policies of other payers, did not provide sufficient incentives for efficient and cost-effective capital spending. As a result, capital costs per case, and therefore base year prospective capital rates, may be higher than would have been consistent with capital acquisition policy in more efficiency-oriented competitive markets. Volume and intensity of capital acquisition have far outpaced the increase in capital input prices during the years between the implementation of the prospective payment system for operating costs and the introduction of the capital system. Hospitals may have responded to the incentives of the cost-based reimbursement system for capital by expanding beyond what was necessary for efficient and cost-effective delivery of services.

As a preliminary examination of this issue, we analyzed the change in actual Medicare capital cost per case for the years 1986–1991 in relation to the change in the capital input price index (which accounts for change in the input prices for capital-related costs), and the other adjustment factors we propose to include in the framework, for which we currently have measures, that is, the increase in real case mix, and the increase in intensity due to quality-enhancing technological change and within-DRG complexity. We could not, of course, include any adjustment for efficiency since we have not identified an appropriate measure. We found rates of increase in spending per case that exceeded the rate of increase attributable to inflation in capital input prices, quality-enhancing intensity increases, and real case mix growth. (These numbers would be higher or lower if an efficiency adjustment were included). From a high of 11.4 percent in 1986, the residual increase over inflation, quality-enhancing intensity increases, and real case mix growth fell until 1988. In that year, the increase in the average cost per case was only 0.7 percent greater than the rate of increase in inflation, intensity, and real case mix growth. However, the residual increase in cost rose again beginning in 1989. It rose from 1.3 percent in 1989 to 4.3 percent in 1990 before declining again to 2.7 percent in 1991. Cumulatively, the residual of actual increases in average

cost per case over increases in cost attributable to inflation, intensity, and real case mix from 1986 to 1991 was 28.9 percent.

CUMULATIVE PERCENTAGE CHANGE IN COST PER CASE DUE TO INFLATION, REAL CMI, AND INTENSITY, 1986–1991

Year	Capital price index [1]	Real CMI [2]	Allowable intensity [3]	Resulting increase [4]	Actual % change cost/case [5]	Residual [6]
1986	5.4	1.7	1.7	9.0	21.4	11.4
1987	4.5	1.3	2.4	8.4	14.8	5.9
1988	4.2	1.1	1.4	6.8	7.6	0.7
1989	3.8	1.3	0.3	5.5	6.8	1.3
1990	3.7	1.1	0.2	5.1	9.6	4.3
1991	3.5	1.0	0.1	4.6	7.5	2.7
Cumulative (compounded)				46.3	88.7	28.9

[1] Figures for 1987 to 1991 are from Table 1, Part B; the figure for 1986 was supplied separately by HCFA OACT.
[2] Assuming that real CMI is one-half of observed CMI.
[3] One-half of observed intensity increase as determined by the methodology of the proposed joint operating/capital intensity measure.
[4] The increase attributable to inflation, real CMI, and allowable intensity, calculated as the product of the rates of increase of those factors (i.e., $1.054 \times 1.017 \times 1.017 = 1.09$ for 1986).
[5] Figures supplied by HCFA's Office of the Actuary.
[6] The actual increase in average cost per case divided by the appropriate increase in cost (i.e., $1.214/1.09 = 1.114$, a residual of 11.4% for 1986).

If real CMI growth is assumed to be 1.0 percent annually, rather than half of observed case mix, the cumulative residual of actual increases in average cost per case would be 30.0 percent. Therefore,we believe that the long-run adjustment for capital efficiency and cost-effectiveness should take into account the efficiency and effectiveness of the capital resources present in the base year for the prospective payment system for capital-related costs. We do not believe that Medicare capital payment rates should provide for maintenance of capital in excess of the level that would be produced in an efficiency-oriented competitive market. The capital productivity adjustment should be designed to give hospitals an incentive to reduce inefficiency and ineffectiveness in capital resources. At the same time, the estimate for long-run productivity must allow for enhancements in capital resources as existing capital resources deteriorate. At this time,we are beginning to evaluate alternative efficiency measures. We welcome comments and recommendations on the merits of such an adjustment and on methodologies and factors for determining the amount of the adjustment.

Finally, we are aware that certain geographic areas may, during the coming years, experience insufficient bed supply for their Medicare populations. We solicit comment on the unique capital problems of these geographic areas in assuring a sufficient bed supply in a budget neutral manner. We do not intend to make any facility-specific adjustments.

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